What do we know?

Summary

Drug treatment data and estimates for Problem Drug Use (PDU) prevalence have reached a point now whereby information is robust and minimum data sets are sophisticated enough to pick up on trends, gaps and needs. There does exits a certain time lag between reports being submitted and then released in their validated form however this does not pose major issues. No data is currently received about drug related hospital admissions.

Alcohol treatment data is reliable, however the minimum data set is small therefore insight into population trends is limited. Data relating to alcohol related hospital admissions is available and can be used to look at demographic trends in each district.

Facts and figures

The most recent PDU Prevalence Estimate for Lincolnshire gives a mid point estimate of 2676 people, this is only available at partnership level and is updated yearly by national Drug Treatment Monitoring System (NDTMS) regional teams (normally at Quarter 2). The lower bound 95% confidence interval (CI) is 2243; whilst the upper bound 95% CI is 3143.

The latest dependant drinker estimate for Lincolnshire gives an estimate of 17,160. Again this is only available at partnership level and is reviewed yearly by Department of Health (DOH) and North West Public Health Observatory (NWPHO).

Alcohol related hospital admissions information is released on a quarterly basis on the Local Alcohol Profiles for England (LAPE) website, compiled by Department of Health (DH) and North West Public Health Observatory (NWPHO). These estimates give a rate of alcohol related admissions per 100,000 head of population, up to Quarter 2 of 2010/11 the Lincolnshire average was 821 (a 12% increase from the previous year) this can be split down by Local Authority District (LAD) areas, here we see wide variance across the county with Lincoln sitting above regional and national averages at 1,137 (an increase of 21% on last year). For the same period the regional and national averages were 902 and 942 respectively.

The number of substance misuse clients receiving services in the community is released in validated form each quarter by the NDTMS. This is available for drug treatment at district level and for alcohol treatment at county level. It can split down, substance of choice, waiting times for treatment, demographics and treatment exit method (i.e. planned or unplanned). At Quarter 3 of 10/11 1654 PDU's were engaged in effective drug treatment with a further 187 non PDU adults in services. This is indicative of a penetration rate of 62% into the PDU estimate for the county (above wider averages). The number of adults engaged in alcohol treatment at Quarter 3 of 10/11 is 721; this is a penetration rate of 4.2% based on the dependant drinker estimate (slightly below the national average of 6%).
Trends

Drugs - In terms of drug misuse; local forecasting shows that penetration into the PDU population is good. for the next 2 - 5 years it is anticipated that this will continue to improve albeit it at a slower rate than has been seen in previous years given that the 'pool' of treatment naïve clients is becoming smaller and harder to access. It is anticipated that going forwards more non PDU clients will access services (for example people with dependencies on substances such as amphetamine).

Locally, work is underway to remodel treatment services - for drug clients one goal of this will be to increase throughput, this will mean that year on year the numbers of new treatment journeys will grow however the overall numbers of people in treatment will drop slightly because people are moving out of treatment and back into society in a structured way.

Longer term projections are difficult given the unpredictable nature of supply routes for illicit drugs into the county, however treatment providers have historically shown good levels of engagement with service users. Another factor which should be born in mind is the cohort of non-PDU clients, for which no estimates exist.

Alcohol - Penetration into the dependant drinker population is low in the partnership, the expectation for the partnership is that this will increase over the coming years (in both the short and medium term). A target of 15% penetration rate has been set in the short term and performance against this will allow us to establish a baseline for activity and throughput going forwards, although the expectation is that the size of the alcohol treatment population will grow significantly from its current levels.

Preventative work which is underway across the partnership in terms of substance misuse will also have an impact on the long term forecasts for drugs and alcohol.

Targets

For the drug treatment service targets exist in the form of Vital Signs - PDU's engaged in effective treatment. 2010/11 is the final year of these targets, which for Lincolnshire were increases of 6%, 3% and 3% from the baseline set in 2007/08. The national expectation in terms of waiting times for first drug treatment intervention is that 90% of people should be seen within 3 weeks of their initial referral.

Also for drugs a national target exists in to form of Treatment Outcome Profile (TOP) completion. These are questionnaires filled out by service users and their key workers at the start, review and exit point of their treatment journey. The questions cover a range of topics from level of use, offending rates, housing situation and employment to quality of life and general wellbeing. If providers complete a minimum of 80% of their TOP forms then we are able to access partnership 'drilled down' reports each quarter. These then allow us to see what areas show the most and the least improvement during a stay in treatment.

Locally for the drugs service several other targets now exist; for harm reduction, the level of applicable clients receiving vaccines for Hepatitis B and testing for Hepatitis C (90%) and the level of people exiting treatment in a planned way (45%). For alcohol services no national targets have been set, locally targets are in the process of being reviewed. Service Level Agreements indicate a performance expectation of a minimum of 50% planned exits from services.
Performance up to and including quarter 3 of 2010/11:

- Vital Signs - PDU's engaged in effective treatment. At Q3 of 10/11 we are 18.4% above our target.
- Waiting times (drugs) - 93% 3 weeks and under.
- TOP compliance - Start = 81% Review = 84% Exit = 56%
- Harm reduction - HBV = 78% HCT = 82%
- Planned exit rate (drugs) - 42%
- Planned exit rate (alcohol) - 48.9%
What is this telling us?

Summary

Whilst commissioning activity does need to focus on improving services for drug and alcohol mis-users in Lincolnshire, strong foundations are in place in terms of effective engagement and penetration rates into heroin and crack dependant groups and therefore an intelligence led approach to treatment planning is possible.

Alcohol treatment services have seen improvements over recent years however not to the same extent as drug services. All information points to the main area of need being an increased penetration rate into the dependant drinker population, from this we will learn more about our treatment naïve cohorts and be able to tackle the barriers to treatment and health inequalities that they experience.

Local views

The process of assessing met and unmet need is ongoing throughout the year. This takes many forms and is consolidated annually at expert panel events which comprise provider representatives, stakeholders and service users. The results of this day are published within the Drug Treatment Needs Assessment document.

The partnership's Service User Involvement Officer acts as a conduit for information about commissioning decisions to be fed out to services users and for concerns or issues faced by service users to be brought back to stakeholders.

National and local strategies

The national drug strategy can be found at:


Current activity and services

The partnership is currently undergoing a remodel of drug and alcohol treatment services. This remodel is being done in conjunction with key stakeholders and service user representatives. For more details on the background to this and the proposed direction of travel please see the 2011/12 Community and Prison Drug Treatment Needs Assessment and Treatment Plan and the 2011/12 Alcohol Needs Assessment and Treatment Plan.
**Key inequalities**

Substance misuse in populations follows some complex patterns and all parts of our communities are affected in some form or another. However, a disproportionate burden falls on communities with material deprivation. Causation of this pattern is well debated in published literature and some relates to the predisposition of certain populations to related illness e.g. enduring mental illnesses; some is generational where children who live in households and environments where substance misuse is prevalent are more likely to go on to misuse.

People with substance misuse problems are therefore more likely to live in and be from more deprived communities and a likely to concentrate (especially for illicit substance users) in conurbations where substances and the means to pay for them are more readily available.

This creates additional inequality for the non misusing populations in these areas as misusers are more likely to cause nuisance, commit crime and consume resources that might otherwise have been available for other purposes.

Serious illicit drug use is more associated with younger people whilst serious dependent alcohol misuse occurs more often in the 25 to 45 age range. Men are more likely to be affected although the changing habits of women around substances has closed that gap significantly.

**Key gaps in knowledge and services**

Drugs - Historically commissioned pathways have meant that services are set up to deal with opiate mis-users primarily. Therefore the treatment population has been made up mainly of opiate mis-users, perhaps not representing the actual needs of the drug dependant population of the county. Furthermore the 'medical model' service provided means that people are coming into treatment and staying put for extended periods (over 400 people have been in services over four years). The current remodel will resolve this issue.

Alcohol - Whilst planned exit rates for alcohol treatment have declined recently, the main area of concern for this element of service is the penetration rate. A target dependant drinker population of over 17,000 people indicates that the potential ‘case-mix’ will be extensive and therefore barriers to access may be equally varied. Tackling this issue needs to be at the forefront of the Partnership’s work plan over coming years.

**Risks of not doing something**

Drug treatment services in Lincolnshire are estimated to save £6.24 to the public purse for every 1 pound that is spent on providing them. A large part of this cost benefit is brought about by crime reduction, in 2010/11 it is estimated that over 31,000 crimes have potentially been prevented because of drug treatment having been in place in the county. Whilst penetration rates are good in terms of drug mis-users there is still the potential to save a further £21 million in the county in there coming years (up to 2014/15).

The risks therefore lie in not remodelling services to ensure that for drugs and alcohol the penetration rates are as good as they can be and that treatment delivers sustainable outcomes.
What is coming on the horizon?

In line with the National drug Strategy (see national and local strategies section above) and best practice seen nationally, services are being remodelled along outcome focussed lines, aiming to get people into treatment at the right level and reintegrated back into society. Lincolnshire has been chosen as one of eight areas in England to test a new way of helping people with drug and alcohol problems. The scheme focusing on ‘Payment by Results’ (PbR) will mean that organisations providing treatment services in Lincolnshire will be paid based on the outcomes they achieve for people referred to them for help. This agenda will bring about significant changes over the coming years in terms of commissioning practices and service outcomes.

What should we be doing next?

For the next 12 months the main area of focus for commissioners and providers is likely to be the remodel of services and any PbR implementation. However most of the work brought about by this will be lead by Public Health commissioners and treatment services themselves.

From a wider perspective, all of the evidence indicates that our primary area of focus should be penetration into the dependant drinker population. Commissioners and providers can create a system which is able to treat such dependency but identification, signposting and access needs to be driven from agencies across the partnership.