East Sussex Health Overview and Scrutiny Committee

FULL REPORT

East Sussex Health Overview and Scrutiny Committee Project Board

Alcohol, Tobacco and Substance Misuse Review Report

September 2004

ALCOHOL, TOBACCO AND SUBSTANCE MISUSE REVIEW

Report of the Project Board

FULL REPORT

Contents

INTRODUCTION

1. Project Board

1.1 The Project Board for this review was established by the Health Overview and Scrutiny Committee (HOSC) in December 2003 with the following membership: Cllr Ann Leigh (Chairman), East Sussex CC; Cllr Beryl Healy, East Sussex CC; Cllr Phil Scott, East Sussex CC; Cllr John Webber, Lewes DC; Rosemary Iddenden, Alzheimer's Society.

1.2 The Project Board was supported by Vic Kempner, Project Manager (Consultant); Roger Howarth, Scrutiny & Best Value Co-ordinator; Mary Clarke, Democratic Services Manager, Hastings BC and Sam White, Scrutiny Support Officer, East Sussex CC.

2. Review remit

2.1 The Project Board's remit was to examine the effectiveness of strategies and policies in place to combat alcohol, tobacco, drugs and substance misuse, and place particular emphasis on children and young people.

2.2 The review has been conducted within a wide framework in order to do justice to the brief. It has considered the contribution made by the promotion of healthy lifestyles i.e. not using or not misusing alcohol, tobacco, drugs and substances; the part played by strategies for encouraging existing users to stop; and the place of harm reduction programmes for users.

2.3 Children and young people have been taken to cover those from secondary school age through to the under 25s, although it has not always been possible to adhere fully to this definition.

2.4 The subject matter for this review has been challenging when viewed in the strict health role of the HOSC. Tackling alcohol, tobacco and substance misuse is very much a multi-agency activity involving a range of statutory (public) organisations as well as the voluntary sector. In addition, for alcohol and tobacco products, the private sector through the manufacturing, retail and entertainment sectors have a significant part to play.

2.5 In all of this, whilst the NHS plays a major part, it is not always straightforward to separate out the health aspects. Joined up and co-ordinated working is the key to success with partner organisations coming together so that the whole is greater than the sum of the parts.

2.6 The Project Board has noted that nationally there have been inconsistent and even contradictory messages. For example, within a few days of the national Alcohol Harm Reduction Strategy being published, statements were being made about extended and more liberal licensing hours in the context of new legislation.

2.7 Although the report has been structured so that alcohol, tobacco and substance misuse are examined separately, organisations and individuals delivering services and providing support are more concerned with the client or patients as an individual. In practical terms, many see the whole area as one of substance misuse irrespective of whether the substance is alcohol, drugs or tobacco, this is particularly the case with services for younger people.

2.8 In this report the word client has been used generically to refer to both patients (as used in the health context) and clients (as used in other contexts). Where statistical sources of health data refer to patients, the terminology of the source has been followed.

3. Approach to the review

3.1 Information gathering has formed a very significant part of the review, involving a combination of desk-based research and direct information collection through discussions with various organisations, presentations to Board members, and a survey. The Project Board wishes to acknowledge the help from the many statutory and voluntary organisations for their willingness to contribute to the review; without their input it would have been impossible to prepare this report.

OVERVIEW

4. Alcohol, tobacco and substance misuse

4.1 There are a number of well-established links between lifestyle and mortality and morbidity. Some of the keys ones are shown in the following table [1].

Health problem	**Main determinants**
Circulatory disease	Smoking, alcohol abuse
Cancer	Smoking, alcohol abuse
Asthma and other respiratory problems	Smoking
Accidents and injuries	Inappropriate use of alcohol and drugs
Neuropsychiatric disorders	Alcohol abuse, drug abuse
Infections (including blood borne viruses such as hepatitis C)	Drug abuse
Low birth weight	Smoking, alcohol abuse, drug abuse

4.2 The table below puts this in a local context by looking at the mortality of the under 75s from lung cancer and coronary heart disease for the three years between 1999 and 2001 [2].

PCT	**Lung cancer**		**Coronary heart disease**	
	Number of deaths	**Rate** (see note)	**Number of deaths**	**Rate** (see note)
Bexhill & Rother	76	19.0	172	43.6
Eastbourne Downs	144	23.8	335	54.4
Hastings & St Leonards	94	35.5	167	63.2
Sussex Downs & Weald	104	20.2	224	42.6

Note: The directly standardised rate is per 100,000 population and allows comparisons to be made with other areas by controlling for differences in age structures.

4.3 Risk factors are known to apply unequally across social class, this is shown for smoking and alcohol in the table below [3]. The differences are particularly great amongst male smokers and slightly less marked in female smokers.

Risk factor	**Social class based on occupation** (see note)					
	I	**II**	**III (n)**	**III (m)**	**IV**	**V**
Current smoking %						
Males	15	22	28	34	38	42
Females	14	21	29	28	36	37
Alcohol consumption per week %						
more than 21 units - Males	28	35	32	30	31	29
more than 14 units -Females	20	22	20	15	13	12

Note: I = professional; II = managerial and technical; III (n) = skilled non-manual; III (m) = skilled manual; IV = partly skilled; V = unskilled.

[1] *Securing Good Health for the Whole Population: Population Health Trends* Derek Wanless (2003) HM Treasury
[2] *Report of the Director of Public Health 2003/04* (2004) Sussex Downs & Weald PCT
[3] *Securing Good Health for the Whole Population: Population Health Trends* Derek Wanless (2003) HM Treasury

4.4 Some misusers have multiple problems, for example, using drugs as well as alcohol whose extent of misuse creates a range of social problems.

4.5 The different levels of investment which alcohol, smoking and substance misuse attract are not necessarily related to the extent of their adverse health impact. The following table attempts to show this lack of correlation.

	Health effect	**Investment**
Alcohol	Misuse in the UK leads to [4]: • 150,000 hospital admissions per year, • alcohol related liver disease leads to over 30,000 hospital admissions per year, • between 15 and 22,000 deaths per year [5].	The amount spent on prevention of alcohol misuse is not available. NHS spending on specialist alcohol treatment services is estimated at £23.6 million [6] [7]
Smoking	• 120,000 deaths per in the UK (cancer, chronic obstructive lung disease, coronary heart disease) [8]	£30 million for smoking cessation services in England in 2001/02 [9]
Substance misuse	• 250,000 problematic drug users in England & Wales [10] • Number of drug users dying was between 1076 and 2997 in 1998 (England & Wales) [11]	£1,344 million planned direct expenditure in England & Wales for tackling drugs in 2004/05 [12]

5. Collaborative and partnership working

5.1 The provision of activities and services in support of alcohol, tobacco and substance misusers is not confined to the NHS. In the broader social context, the NHS is one of a considerable number of important contributors from the public and voluntary sectors. The main public sector organisations are the 6 local authorities, 12 health bodies, 85 GP practices and 4 other organisations.

5.2 The public sector organisations work together through a number of partnerships, principally the local strategic partnerships and those covering crime and disorder. A full list of organisations, groups and partnerships is given in Appendix 1.

5.3 In the voluntary sector, 19 organisations were identified as having a relevance to this review; however, it is possible that not every relevant voluntary organisation in the County has been covered. An information gathering postal

---

[4] *Choosing health factsheet* (2004) Department of Health

[5] Deaths from the direct effects of alcohol were 5789 (England & Wales 2000 – Office for National Statistics) plus an estimate of deaths from indirect effects of alcohol ranging from 9,500 to 16,000 (*Alcohol misuse: how much does it cost* Cabinet Office 2003)

[6] *Alcohol misuse: how much does it cost* (2003) Cabinet Office

[7] As part of general healthcare expenditure, considerable sums are spent on treating the consequences of alcohol, for example, cirrhosis of the liver.

[8] Health Development Agency

[9] *NHS smoking cessation services* (1999) Circular HSC 1999/087 Department of Health

[10] *Choosing health factsheet* (2004) Department of Health

[11] *Reducing drug related deaths* (2000) Advisory Council on the Misuse of Drugs

[12] *National drugs strategy* (updated 2002) Home Office

survey was conducted by sending a questionnaire to each of the 19 voluntary organisations. The 79% response rate has resulted in some useful material for this review. An analysis of this appears in Appendix 2.

5.4 The voluntary organisations surveyed target all age groups and provide a broad geographical coverage of East Sussex. Most organisations accept clients who refer themselves, and those accepting referrals from agencies identified GPs and other members of the primary care team, social services, voluntary organisations, and the probation service as the main sources. In commenting on the main things that limited the effectiveness of their services, most identified limited resources and the certainty of funding as the main factor.

5.5 A final part of the equation in relation to the supply of alcohol and tobacco products is the private sector through manufacturing, marketing and retail businesses.

ALCOHOL

6. National perspective

6.1 Some high level facts [13]:

- 5.9 million people in England drink above the Government's recommended daily guidelines on some occasions.
- 38% of men and 25% of women drink on 3 or more days in the week.
- 24% of children aged 11 – 15 years drink alcohol, and they drink an average of 10.5 units per week.
- Alcohol misuse is associated with 150,000 hospital admissions each year.
- Alcohol-related liver disease is responsible for over 30,000 hospital admissions each year.
- Around one-third of all accident and emergency department attendances are alcohol-related.
- Between 15,000 and 22,000 deaths each year are associated with alcohol misuse.

National strategy

6.2 The aim of the national strategy [14] is to prevent any further increase in alcohol-related harms. It recognises that the vast majority of people enjoy alcohol without causing harm to themselves or to others and that they can also gain some health and social benefits from moderate use. However, it is clear that for some people alcohol misuse is a real problem leading to health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace, and problems for those who misuse alcohol and their families (including domestic violence).

6.3 Two patterns of drinking are identified as particularly likely to raise the risk of harm, that associated with binge drinking and chronic drinking.

6.4 Binge-drinkers are those who drink to get drunk and are likely to be aged under 25. They are more likely to be men, although women's drinking has been rising fast over the last ten years. Binge drinkers are at increased risk of accidents and alcohol poisoning. Men in particular are more likely both to be a victim of violence and to commit violent offences. There can also be a greater risk of sexual assault. The impacts on society are visible in, for example, high levels of attendance at A&E related to alcohol.

6.5 Chronic drinkers are more likely to be aged over 30 and around two-thirds are men. They are at increased risk of a variety of health harms such as cirrhosis of the liver (which has nearly doubled in the last 10 years), cancer, haemorrhagic stroke, premature death and suicide. They are also more likely to commit the offences of domestic violence and drink-driving.

---

[13] *Choosing health factsheet* (2004) Department of Health
[14] *Alcohol harm reduction strategy for England* (2004) Cabinet Office

6.6 The strategy is intended to provide a strong base for where Government should intervene and lead, whilst recognising that responsibility for alcohol misuse cannot rest with Government alone. The approach relies on creating a partnership at both national and local levels between government, the drinks industry, health and police services, and individuals and communities to tackle alcohol misuse.

6.7 It includes a series of measures aimed at achieving a long term change in attitudes to irresponsible drinking and behaviour, including:

- making the "sensible drinking" message easier to understand and apply;
- targeting messages at those most at risk;
- providing better information for consumers, both on products and at the point of sale;
- providing alcohol education in schools that can change attitudes and behaviour;
- providing more support and advice for employers; and
- reviewing the code of practice for TV advertising to ensure that it does not target young drinkers or glamorise irresponsible behaviour.

6.8 The strategy proposes a number of measures to improve early identification and treatment of alcohol problems including:

- improved training of staff to increase awareness of likely signs of alcohol misuse;
- piloting schemes to find out whether earlier identification and treatment of those with alcohol problems can improve health and lead to longer-term savings; and
- better help for the most vulnerable – such as homeless people, drug addicts, the mentally ill, and young people – who often have multiple problems and need clear pathways for treatment from a variety of sources.

6.9 It also proposes a series of measures to address the problems of town and city centres that are blighted by alcohol misuse, and for closer working with the alcohol industry (manufacturers, retailers, pubs and clubs).

6.10 In spite of the importance placed by Government on tackling the worst excesses of alcohol misuse, and the fact that alcohol consumption is increasing, no additional resources have accompanied the strategy.

<u>Guidelines on alcohol consumption</u>

6.11 The Department of Health guidelines (1995) advise that men should not drink more than 3 - 4 units of alcohol per day, and women should drink no more than 2 - 3 units of alcohol per day. These daily benchmarks apply whether drinking every day, once or twice a week, or occasionally. The DoH gives the following examples with their unit equivalents:

1 unit	• 10ml of pure alcohol • A pub measure of spirits
1.5 units	• An alcopop
2 units	• A pint of bitter • A pint of ordinary strength lager or cider • A 175ml glass of red or white wine
3 units	• A pint of strong lager

The Licensing Act 2003

6.12 Under new legislation, responsibility for granting licenses is expected to become a local authority responsibility from January 2005 [15]. The Act removes statutory limitations to hours or days on which alcohol may be sold or supplied and gives this responsibility to each local authority.

6.13 Local authorities will be expected to produce a licensing policy against which decisions on granting licenses will be assessed and have regard to the four objectives of:

- prevention of crime and disorder,
- public safety,
- prevention of public nuisance, and
- protection of children from harm.

Accident & Emergency

6.14 It is estimated that nationally, 40% of attendances in hospital A&E departments are drink related rising to 70% between midnight and 5 am [16].

7. East Sussex perspective

7.1 A local survey of young peoples' drinking habits [17] showed:

Units drunk over the past 7 days	**Nothing %**	**1 – 3 units %**	**4 – 14 units %**	**More than 14 units %**
Girls				
1993	46	28	22	4
1999	50	23	23	4
Boys				
1993	42	20	29	9
1999	46	18	26	10

[15] The effective is dependent upon Parliamentary approval to formal guidance.
[16] *Opportunity cost – externalities and alcohol use* (2003) Mind Your Business (www.bized.ac.uk)
[17] *Health Related Behaviour Survey in East Sussex , Brighton & Hove* (Spring 1999) PSE Advisory Team. The survey was undertaken amongst over 3000 pupils in year 10 from 24 LEA schools.

7.2 The PCT Public Health Reports for 2004 include the results from a Health Counts Survey undertaken in 2003. Some of the key features are shown in the table below.

PCT	Bexhill & Rother	Eastbourne Downs	Hastings & St Leonards	Sussex Downs & Weald
Frequency of consumption	%	%	%	%
Every day	15	13	12	17
3 to 6 days a week	21	21	19	23
Less than once a week	29	30	35	27
Never drink	11	13	14	11
Consumption				
Average weekly intake	8.5 units		10.7 units	13.8 units (10.3 in 1992)
Men	11.3 units	11.8 units	16.0 units	
Women	6.3 units	6.7 units	6.2 units	
Exceeding 21 units per week		10%	16% (10% 1992)	20% (11% 1992)
Exceeded 10 units in a day -				
in the past week		7%		10%
in the past month		5%		8%
in the past 6 months		7%		9%
Tried to cut down drinking	12%	10%	12%	13%

7.3 From the same survey, in Eastbourne, 18% of men admitted to drinking more than 21 units a week (10% in 1992); and 11% of women said they were drinking more than 14 units a week (7% in 1992). (21 units a week for men and 14 units a week for women were the pre-1995 recommended limits.)

8. Targets

8.1 Alcohol misuse is not currently an area with any associated national or local overt targets for the NHS; however, there are targets for local authorities to reduce alcohol related crime, drink driving, and domestic violence.

9. Strategies

9.1 Bexhill & Rother and Hastings & St Leonards PCTs had a jointly developed strategy but are in the process of completing and approving their own strategies. Eastbourne Downs and Sussex Downs & Weald do not have specific PCT alcohol strategies, the latter signs up to the Action for Change programme.

10. Commissioning services

10.1 The PCTs commission services from the voluntary sector (Action for Change). The services include advice, counselling, specialist nursing and social care assessments, and motivational training.

10.2 Under the new GP contract (general medical services), PCTs are able to introduce an enhanced service for patients who are alcohol misusers. The enhanced service, which is defined in the contract, is over and above the essential service which all GPs are expected to provide. Locally, PCTs are examining the feasibility of introducing and funding enhanced services; Hastings & St Leonards PCT is letting a contract for enhanced services to patients who misuse alcohol.

10.3 Under the Healthy Schools Scheme, a local partnership of two LEAs and the PCTs, the Personal Social and Health Education Team (PSHE) [18] has responsibility for the drug education programme. Drugs are taken to include, substances, alcohol and tobacco. The goal is for children and young people to develop the knowledge, skills and attitudes to appreciate the benefits of a healthy lifestyle, promote responsibility towards the use of drugs and relate these to their own actions, both now and in their future lives.

10.4 The PSHE Team is principally active in primary and secondary schools in the state sector, although more so in secondary schools. The service also includes sixth form and tertiary colleges but not independent schools although guidance material is sent to them. The PCT's collaborate with PSHE staff in their contacts with schools, Bexhill & Rother PCT's Alcohol Strategy Worker works with the PSHE Team in implementing alcohol awareness for 14-16 year olds.

11. Effectiveness

11.1 The challenge for all services is to change society's perception of excessive drinking. This has been achieved successfully through legislation on drinking and driving and the associated publicity campaigns, but it is clear that there is a need for continual reinforcing of the message.

12. Findings

12.1 There is a range of community wide strategies to be deployed in reducing the effects of alcohol misuse. Under the new licensing regulations, local authorities are to be encouraged to use their powers to implement responsible licensing policy.

12.2 The retail trade generally, and clubs and pubs in particular, need to recognise a duty of care to its staff who may be in danger from those who drink in excess, and to their customers who may harm themselves and others. As part of this, there is a need to balance the commercial and social responsibilities of the availability of inexpensive alcohol through, for example, extended hours of low priced drink sales and "happy hours".

12.3 Initiatives such as proof of age schemes, pub and bar watch, and taxi marshal schemes are to be encouraged.

[18] The PSHE Team is a joint arrangement for East Sussex and Brighton & Hove.

TOBACCO

13. National perspective

13.1 Some high level facts [19]:

- Over 1 in 4 adults in England smoke – only slightly lower than the rate at the beginning of the 1990s.
- Seven out of ten smokers say they want to stop and 4 in 5 wish they had never started.
- Smoking causes a third of all cancer deaths and 1 out of every 7 deaths from heart disease.
- Nearly 1 in every 5 pregnant women smoke.
- Smoking among people in non-manual groups has fallen more quickly than people in manual groups, around 1/3 of whom still smoke.
- Half of people's workplaces are completely smoke free.

13.2 The White Paper *Smoking Kills* [20] set out some graphic effects from smoking:

- Smoking is the single greatest cause of preventable illness and premature death in the UK with more than 13 people dying every hour from a smoking related cause.
- 82 per cent of smokers take up the habit as teenagers. Smoking is addictive, and many of the children and young people who smoke will go on to smoke all their lives.
- Those who smoke regularly and die of a smoking-related disease lose on average 16 years from their life expectancy compared to non-smokers.
- Smoking causes 3 out of 10 cancer deaths (lung, mouth, larynx, oesophagus, bladder, kidney, stomach and pancreas), 8 out of 10 deaths from chronic obstructive lung disease (including bronchitis), and 1 out of every 7 deaths from heart disease. Smoking is also linked to many other serious conditions including asthma and osteoporosis (brittle bone disease).

13.3 Smoking in pregnancy is associated with a range of adverse outcomes including low birthweight, prematurity and increased risk of infant mortality [21].

13.4 Smoking as a risk factor applies unequally across social class with marked differences amongst male smokers as shown in the table below [22].

Current percentage of population smoking	**Social class**					
	I	**II**	**III (n)**	**III (m)**	**IV**	**V**
Males	15	22	28	34	38	42
Females	14	21	29	28	36	37

[19] *Choosing health factsheet* (2004) Department of Health
[20] *Smoking Kills* (1998) Cm 4177 The Stationery Office.
[21] *Securing Good Health for the Whole Population: Population Health Trends* Derek Wanless (December 2003) HM Treasury.
[22] *Securing Good Health for the Whole Population: Population Health Trends* Derek Wanless (December 2003) HM Treasury.

13.5 Views on smoking in public places were tested in a national survey [23] with the following results:

Percentage agreeing smoking should be restricted	All people %	Current smokers * %
At work	86	72
In restaurants	87	71
In pubs	50	25
In other public places	85	82

* 27% of the adult population in England currently smoke.

13.6 In the forward to *Forty Fatal Years*, Professor Sir George Alberti says: "The humble cigarette is responsible for a dozen times more deaths in the UK in the past 40 years than British casualties from World War II – over 5 million. This is not a cold statistic, but a human tragedy. Five million people – people who deserved better; their lives ended prematurely by complicated patterns of disease, aided and abetted by the addictive power of nicotine, social attitudes and pressures, tobacco company marketing, and finally, years of Government inaction or half-hearted initiatives that failed to protect them from the consequences of smoking." [24]

13.7 Recent evidence [25] shows that ceasing to smoke can increase life expectancy of smokers. Cessation at ages 30, 40, 50 and 60 can add about 10, 9, 6 and 3 years respectively.

Smoking and sexual health

13.8 A BMA report [26] shows that smoking harms sexual and reproductive health in both men and women, with damaging effects throughout reproductive life – from puberty, through young adulthood and into middle age. Smoking can compromise the capacity to have a family, and parental smoking can have long-term and serious consequences for child health. Exposure to secondhand smoke is a risk during pregnancy, and harms infants and children. It demonstrates that giving up smoking reduces or eliminates many of the risks to reproductive life and health.

13.9 Smoking accounts for one half of the difference in life expectancy between social classes I and V, and the burden of smoking on reproductive life falls most heavily on the least privileged. Smoking rates increase with every marker of social disadvantage, as does smoking-related ill-health. Exposure to secondhand smoke is also highest among the most vulnerable: those in manual and service groups are most likely to be exposed to second-hand

[23] *Smoking related behaviour and attitudes 2001* Office for National Statistics
[24] *Forty Fatal Years – a review of the 40 years since the publication of the 1962 report of the Royal College of Physicians on smoking and health* (2002) ASH and Royal College of Physicians.
[25] *Mortality in relation to smoking: 50 years' observations on male British doctors* (22 June 2004) Richard Doll, Richard Peto, Jillian Boreham, Isabelle Sutherland; British Medical Journal.
[26] Smoking and reproductive life: the impact of smoking on sexual, reproductive and child health (2004) British Medical Association

smoke at home and at work. Babies and children born into these groups are most likely to suffer the longer-term health effects of parental smoking.

13.10 The report says that smoke-free public places cut smoking rates across most population groups, including young adults. When fewer young adults smoke, children's exposure to second-hand smoke in the home decreases. Smoke-free public places also reinforce the message that second-hand smoke is harmful and provide encouragement for parents to restrict smoking in their homes, and smoke-public places and smoke-free homes reduce the risk of young people taking up smoking. This could be particularly important in breaking the cycle of tobacco dependence in communities where smoking is still the norm, rather than the exception.

Passive smoking

13.11 Professor Carol Black, President of the Royal College of Physicians has said of passive smoking, "Environment tobacco smoke in pubs, bars, restaurants and other public places is seriously damaging to the health of employees as well as the general public. Making these place smoke free not only protects vulnerable staff and the public, it will also help over 300,000 people in Britain to stop smoking completely." [27]

13.12 Recent evidence [28] shows that earlier studies into the effect of passive smoking on risk from coronary heart disease have probably underestimated the impact.

14. East Sussex perspective

14.1 A local survey of young peoples' smoking habits [29] showed:

Number smoked in the past 7 days	**None** **%**	**1 – 10** **%**	**11 – 25** **%**	**More than 25** **%**
Girls				
1993	77	9	5	9
1999	70	11	8	11
Boys				
1993	79	7	3	11
1999	79	6	4	11

14.2 The PCT Public Health Reports for 2004 include the results from a Health Counts Survey undertaken in 2003. Some of the key features are shown in the table below.

[27] *One hospitality worker dies every week from passive smoking* (17 May 2004) Royal College of Physicians news release.
[28] *Passive smoking and risk of coronary heart disease and stroke: prospective study with cotinine measurement* (30 June 2004) Peter Whincup et al; British Medical Journal
[29] *Health Related Behaviour Survey in East Sussex , Brighton & Hove* (Spring 1999) PSE Advisory Team. The survey was undertaken amongst over 3000 pupils in year 10 from 24 LEA schools.

PCT	Bexhill & Rother	Eastbourne Downs	Hastings & St Leonards	Sussex Downs & Weald
Smoking status	%	%	%	%
Current smokers	18	21	31	20
(1992)		(23)	(27)	(26)
of whom: smoke daily		17	24	15
smoke occasionally		4	7	5
Ex-smokers		37	33	37
(1992)		(36)	(35)	(34)
Average number of cigarettes smoked per day		14	14	
Main reason for smoking	%	%	%	%
Habit		23	30	28
Addiction		21	18	22
Pleasure / enjoyment		18	18	25
Stress / nerves		11	13	10
Relaxation		7	11	8
Because friends smoke		1	3	2
Give up smoking	%	%	%	%
Would like to	57	52	56	63
(1992)		(74)	(76)	(72)
Unsure if would like to	18	17	25	20
Seriously tried to give up in the past 12 months	%	%	%	%
		29	32 men	33
(1992)		(42)	39 women	(46)
Smokers aware of local smoking cessation services	%	%	%	%
	48	43	51	45
Had tried services	19	14	18	14

14.3 It is of concern that the decline in proportion of smokers wanting to give up has fallen so markedly since 1992.

14.4 From the same survey, for respondents aged 18 to 24 in two PCTs:

	Eastbourne Downs		Hastings & St Leonards
	Male %	Female %	All %
Smoking now	32	33	42
Ex smoker	12	17	30
Never smoked	56	50	28

14.5 Compared to similar surveys in 1992 in East Sussex, younger age groups are smoking more heavily now than they were 10 years ago. The reduction in smoking levels is most marked in the older population. This is similar to national trends.

15. Targets

15.1 The current targets for the NHS are [30]:

Cancer - Reduce the rate of smoking, contributing to the national target of:

- reducing the rate in manual groups from 32% in 1998 to 26% by 2010;
- 800,000 smokers from all groups successfully quitting at the 4 week stage by 2006

Coronary heart disease - In primary care, patients with CHD to continue to receive appropriate advice on smoking.

Reducing health inequalities - Deliver a one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy, focussing especially on smokers from disadvantaged groups

15.2 Recommendations from the Health Development Agency to help PCTs meet the above targets [31] are:

- PCTs take on and continue to develop the specialist smoking cessation services that serve their populations.
- PCTs fund a single service – co-ordinated at least at the level of a large PCT, or combining resources from several PCTs – preferably continuing existing services.
- The service is funded on a permanent basis to avoid losing key personnel due to job insecurity.
- Services offer both group treatment and individual, face-to-face counselling where possible (but group treatment may not be practical in sparsely populated areas or where transport is limited) and ensure that all treatments offered are evidence based.
- Services are co-ordinated by a full-time equivalent (FTE) to act as point of contact with other services and agencies, to commission and organise training, to oversee monitoring, and to ensure the service adapts to changing needs.
- Services employ a minimum core staff of three FTEs per averaged sized PCT, in addition to the co-ordinator, to provide treatment to smokers and/or support a larger cadre of community smoking cessation specialists and primary care teams.
- Substantial efforts are made to increase referral/recommendation rates via GPs and other members of the primary care team, who are a major source of clients for specialist smoking cessation services.
- Nicotine replacement therapies and bupropion continue to be an integral part of the treatment package offered by services.

[30] Improvement, expansion and reform: the next 3 years: Priorities and planning framework 2003 – 2006 (2002) Department of Health

[31] Meeting Department of Health smoking cessation targets – recommendations for primary care trusts (2003) Health Development Agency

- Each service has a strategy to reach all smokers, but with a focus on low-income and pregnant smokers, and to develop links with local community groups to ensure the needs of minority ethnic populations are catered for.
- Each service has links with acute hospital trusts and mental health trusts to ensure its patients receive treatment for smoking cessation (eg prior to undergoing elective surgery, and while in hospital).
- Services continue rigorous monitoring, using nationally agreed indices, to contribute to the maintenance and development of standards, and develop routine mechanisms for reporting to local stakeholders and policy-makers.
- Services maintain and develop the smoking cessation skills of all staff through a programme of training and continued professional development.
- Services maintain and develop links with other local and national tobacco control initiatives, which should promote treatment services at all appropriate opportunities.

15.3 In parallel with the above, the Health Development Agency issued specific recommendations for service providers.

16. Strategies

16.1 Bexhill & Rother, Hastings & St Leonards and Sussex Downs & Weald PCTs have strategies which were issued in 2003. Eastbourne Downs PCT has a service action plan but will be developing a strategy.

16.2 Bexhill & Rother and Hastings & St Leonards PCTs strategies share a common basis. The approach of their joint smoking cessation action plan is for:

- Expansion of specialist smoking cessation services providing both group treatment and individual counselling and the training of health professionals and other health promoters to give brief smoking cessation advice and referral;
- Development of an in-patient service within the hospital setting;
- Targeting pregnant women, young people, people in manual social groups, black and minority ethnic communities;
- Support and encouragement for the intermediary trainers.

16.3 Eastbourne Downs PCT aims to refer 3000 people to smoking cessation service this year and will be increasing the referral and service capacity to do this. Bexhill and Rother is targeting over 5,500 smokers by the end of March 2006 in order to meet its target quit rate and Hastings and St Leonards over 6,800 smokers over the same period. Sussex Downs & Weald PCT aims to support over 700 people in quitting smoking in 2004/05 and plans to achieve a 3 year target of 2153 by March 2006.

17. Commissioning services

17.1 Whilst the PCTs commission smoking cessation services, they also provide some services directly through clinics and teams which they staff. Other services are provided through practice based primary care teams.

17.2 Hastings and St Leonards PCT plans to introduce a locally enhanced service via the new GP contract (GMS) which should lead to a higher level of service.

18. Effectiveness

18.1 Some numerical data on local smoking cessation services for the period April 2002 to March 2003 is given in the following table [32].

	Number setting a quit date	**Successfully quit at 4 weeks follow-up (self-reporting)** (see note)	
		Number	**Success rate (%)**
England			53
Bexhill & Rother PCT	361	235	65
Eastbourne Downs PCT	406	211	52
Hastings & St Leonards PCT	474	285	60
Sussex Downs & Weald PCT	164	127 (*)	77

Note: Smoking cessation services were expected to follow up clients to find out their smoking status at 4 weeks after the quit date, based on self-reporting by clients. A successful quitter was defined as someone who had not smoked at all since two weeks after the quit date (to allow for initial lapses).
* A revised figure of 168 has been advised by the PCT.

18.2 As shown in the table above, three PCTs have quit rates significantly above the 53% national level.

18.3 Of those who book to attend a clinic only about half actually turn up; the high did not attend (DNA) rate is a national problem. This means that to achieve targets, about double the number of people have to be referred to smoking cessation services compared with the number who will actually attend and give up smoking. This represents a significant challenge.

18.4 Waiting times for smoking cessation clinics do not seem to be an issue in East Sussex. For example, Eastbourne Downs PCT aims to respond to referrals within 2 weeks and arrange for them to be seen within 4 to 6 weeks, whilst Sussex Downs & Weald PCT's practice is to book patients to start the next available course.

18.5 Bexhill & Rother and Hastings & St Leonards PCTs conducted follow up surveys of successful 4 week quitters at one year. This showed that 40% of those who had quit smoking had remained non-smokers after a year, and 8% had restarted (the status of 52% was not known).

18.6 Smoking cessation services have been successful in achieving their objectives; however, the PCT's surveys in 2003 show how the proportion of

[32] *Statistical Bulletin 2003/25* (November 2003) Department of Health

smokers wanting to give up is significantly lower than in 1992. This suggests that in future years smoking cessation services will be trying to recruit from a population of smokers who are less inclined to stop and will present major challenges to PCTs.

19. Findings

19.1 During the course of this review, the ban on smoking in public places in Eire was introduced. The Irish Office of Tobacco Control [33] reported that two surveys were conducted a month apart - one at the end of March prior to the introduction of the new law and the other at the end of April. The research indicates that the number of non-smokers visiting pubs/bars has increased slightly since the introduction of the new law, while the number of smokers visiting has remained the same.

19.2 The public sector is a very major employer in East Sussex and is urged to make its premises smoke free zones where they are not already thus classified. For local authorities, this should include premises operated under contract, for example, municipal theatres.

19.3 As part of their duty of care to staff who work in their buildings and to the public who use them, the private sector, where it has not already done so, is encouraged to create smoke free zones.

19.4 Smoking cessation service providers offer to operate work-based sessions and this direction is to be encouraged (subject to resources permitting an expansion of the service). Bexhill & Rother and Hastings & St Leonards PCTs have appointed a workplace smoking cessation adviser.

19.5 In the same manner that cardiac resuscitation tuition has been provided by appropriately trained and supervised members of the public, Bexhill & Rother and Hastings & St Leonards PCTs are creating a bank of trained individuals to provide smoking cessation advice.

[33] Press release May 31st 2004

SUBSTANCE MISUSE

20. Introduction

20.1 The Audit Commission [34] describes drug misuse as illegal and illicit drug taking which leads a person to experience social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence.

20.2 As the Audit Commission notes [35], because drug taking is an illicit activity, reliable data on prevalence are hard to obtain. Results of self-reported surveys may be questionable and are likely to under-represent drug misusers who are more difficult to contact including those with chaotic lifestyles, homeless people and people resident in institutions.

21. National perspective

21.1 Some high level facts [36]:

- Around 4 million people use at least one illicit drug each year and around 1 million people use at least one of the most dangerous drugs such as ecstasy, heroin and cocaine.
- Many of these individuals will take drugs once, but for around 250,000 problematic drug users in England and Wales, drugs cause considerable harm to themselves and others.
- Drug misuse gives rise to between £10 billion and £18 billion a year in social and economic costs, 99% of which are accounted for by problematic drug users.
- There are strong links between problematic drug use and crime. Around three-quarters of crack and heroin users claim to be committing crime to feed their habit.
- The most effective way of reducing the harm drugs cause is to persuade all potential users not to use drugs.
- Drug treatment works by saving lives, improving health and making communities safer. In a study of more than 1000 drug users in the UK, around 40 per cent of those who completed a comprehensive programme were drug free after five years.
- Volatile substance abuse, the deliberate inhalation of volatile substances such as lighter fuel, glue or aerosols, is responsible for more deaths in young people aged 10-16 years in England and Wales than illegal drugs.

21.2 Funding to tackle substance misuse is allocated through seven Government Departments – Home Office; Department of Health; Lord Chancellor's Department; Customs and Excise; Department for Work and Pensions;

---

[34] *Changing habits: the commissioning and management of community drug treatment services for adults* (2002) Audit Commission

[35] *Changing habits: the commissioning and management of community drug treatment services for adults* (2002) Audit Commission

[36] *Choosing health factsheet* (2004) Department of Health

Department for Education and Skills; and Department for Transport, Local Government and the Regions.

21.3 Drug misuse and treatment has become part of the star ratings for PCTs based on the numbers in contact with drug treatment providers. The co-ordination of actions associated with this is vested in the National Treatment Agency [37].

22. East Sussex perspective

22.1 The estimated number of Class A drug users in East Sussex is 8357 (extrapolated from the British Crime Survey) [38]. Estimates by PCT are shown in the following table.

PCT area of residence	Estimate of number of people using Class A drugs (eg heroin & cocaine) in the last year	
	Aged 15 to 59	Aged 15 to 19
Bexhill & Rother	1443	409
Eastbourne Downs	2667	698
Hastings & St Leonards	1472	418
Sussex Downs & Weald	2775	819

Source: Bexhill & Rother PCT Public Health Report 2003-04

22.2 A local survey of young people asked if they had ever taken an illegal drug [39] and elicited the following:

	Percentage saying "yes"
Girls	
1993	17
1999	25
Boys	
1993	24
1999	26

22.3 An audit of substance misuse related deaths in East Sussex identified 21 deaths in 2000 and 14 in 2001; the distribution by PCT is shown in the following table.

PCT area of residence	Number of drug related deaths	
	2000	2001
Bexhill & Rother	1	2
Eastbourne Downs	9	8
Hastings & St Leonards	8	2

[37] The NTA is a special health authority, created in 2001 to improve the availability, capacity and effectiveness of treatment for drug misuse in England. Their overall purpose is to double the number of people in effective, well-managed treatment by 2008 and increase the proportion of people who successfully complete or, if appropriate, continue treatment.

[38] The National Treatment Agency estimates there are 2300 problem drug users in East Sussex.

[39] *Health Related Behaviour Survey in East Sussex , Brighton & Hove* (Spring 1999) PSE Advisory Team. The survey was undertaken amongst over 3000 pupils in year 10 from 24 LEA schools.

Sussex Downs & Weald	3	2

Source: Hastings & St Leonards PCT Public Health Report 2003-04

23. Targets

23.1 The current national targets for the NHS are [40]:

- To contribute to delivery of the National Drugs Strategy by reducing the harmful effects of substance misuse. This will be achieved through expansion and improvement of drug treatment services, and by contributing to the Strategy target to reduce the use of Class A drugs, and frequent use of any illicit drug by young people. This will include agreement through the local DAAT of arrangements for commissioning integrated drug treatment and prevention programmes jointly with other partners.

- Increase the participation of problem drug users in drug treatment programmes by 55% by 2004 and by 100% by 2008 (against 1998 baseline), and increase year on year the proportion of users successfully sustaining or completing treatment programmes.

- Reduce drug-related deaths by 20% by 2004 (against 1999 baseline).

24. Strategies

24.1 The East Sussex Drug and Alcohol Action Team (DAAT) is responsible for implementing the national strategy, ensuring co-ordination between key agencies and assessing whether local spending plans and initiatives are aligned to key Government targets. The team includes senior representatives from the local authorities, health, and the police. The DAAT covers the geographical area of East Sussex to ensure effective co-ordination with all services including housing, social services and education.

24.2 The main elements of the national strategy [41] are:

- reducing the harm that drugs cause to society – communities, individuals and their families:
    - preventing young people from using drugs,
    - reducing the prevalence of drugs on the streets,
    - reducing drug related crime including expanding treatment provision in prisons,
    - reducing the demand for drugs by reducing the number of problematic drug users.
- preventing today's young people from becoming tomorrow's problematic drug users:
    - clamping down on dealers,
    - expanding prevention programmes,

[40] Improvement, expansion and reform: the next 3 years: Priorities and planning framework 2003 – 2006 (2002) Department of Health

[41] *National drug strategy* (updated 2002) Home Office

- improving services for parents and carers,
- expanding provision of substance misuse treatment within the youth justice system.

- reducing drug related deaths through harm minimisation including increasing treatment capacity, reducing waiting times for treatment and greater involvement of GPs.

24.3 The four PCTs have agreed in principle to implement the nationally enhanced service for drugs misuse under the new GP (GMS) contract. Funding will be through a combination of pooled budgets managed through the DAAT and local PCT sources. The aim is to focus treatment and care on the primary care team where that is appropriate. This will also help ensure that those using the specialist services are in need of that level of support. The target is to have 30% of practices involved in the enhanced service.

24.4 Local strategic partnerships, with the exception of Rother, have made commitments in their community strategies / plans to tackle substance misuse.

LSP	**Statements**
East Sussex (June 2003)	➢ Over the next 3 years: • increase participation of drug users in treatment programmes. • bring about improvements in levels of substance misuse. ➢ Tackle the problems of the most deprived communities by: • increasing the participation of drug users in treatment programmes by 55% by 2004 and by 100% by 2008. • increasing year on year the proportion of drug users successfully sustaining or completing treatment programmes.
Eastbourne (May 2003)	➢ To target drug dealers and provide support for substance misusers.
Hastings & St Leonards (July 2003)	➢ Substance misuse – reduce drug related deaths by: • 10% by 2005 • 15% by 2008 • 20% by 2013
Lewes (April 2003)	➢ To reduce the misuse of drugs and alcohol
Rother (March 2004)	No specific reference
Wealden (December 2002)	➢ A reduction in drug and alcohol misuse

24.5 The DAAT has set the following targets (percentages) for successful completion of treatment:

Treatment modalities	2002/03 %	2003/04 %	2004/05 %	2005/06 %
In-patient treatment	0	0	33.3	33.3
Residential rehabilitation	28.6	32.1	32.1	35.7
Specialist prescribing	5.8	6.7	7.0	7.3
GP prescribing	10.0	10.0	12.5	15.0
Structured day programmes	25.0	27.0	29.0	30.0
Structured counselling	25.0	27.0	29.0	30.0
Totals	14.3	15.3	16.3	17.4

Source: DAAT

25. Commissioning services

25.1 To meet the needs of substance misusers a range of services has evolved with the aims of:

- reducing the harm which individuals cause to themselves, and others, including family and society;
- stabilising and reducing the consumption of illicit drugs; and
- rehabilitating misusers.

25.2 These services include:

- counselling and providing information and advice;
- substitute prescribing;
- detoxification;
- structured day care programmes;
- relapse prevention programmes;
- guidance on harm reduction;
- GPs working in shared care schemes;
- specialist treatment services focussing on more challenging clients.

25.3 Nationally agreed models [42] identify eight modalities of service:

- open access services,
- advice and information services,
- needle exchange facilities,
- care planned counselling,

[42] *Models of care for the treatment of adult drug misusers* (2002) Department of Health. [Adults are defined as people aged 18 and over.]

- structured day programmes,
- community prescribing,
- in-patient drug misuse treatment, and
- residential rehabilitation.

25.4 PCTs commission treatment services through the DAAT's Joint Commissioning Group (adult services) and the Aim 1 (young people) Group. Services are provided by GPs, voluntary organisations, East Sussex County Healthcare NHS Trust, and the Under 19s Substance Misuse Service.

25.5 In Hastings and St Leonards, the PCT plans to introduce a locally enhanced service in the new GP contract to support those GPs providing shared care for drug misusers. This local enhanced service is an earlier adoption of the national enhanced services (paragraph 24.3).

25.6 PCTs are required to have 30% of general practices engaged in shared care for substance misuse treatment. One PCT has already exceeded the target, two are approaching the target, and one is considerably below as shown in the following table.

PCT area	Number of GP practices	Practices engaged in shared care	
		Number	Percentage
Bexhill & Rother	13	5	38
Eastbourne Downs	22	3	14
Hastings & St Leonards	28	8	29
Sussex Downs & Weald	22	6	27

Source: Hastings & St Leonards PCT Public Health Report 2003-04

25.7 In the 12 months from April 2003 to March 2004, 683 people started treatment in East Sussex. Details of the distribution between PCT and adults and young people is shown in the following table.

PCT area	Adults	Young people	Total
Bexhill & Rother	41	9	50
Eastbourne Downs	298	42	340
Hastings & St Leonards	168	37	205
Sussex Downs & Weald	68	20	88

Source: DAAT

25.8 Lewes Prison runs a detoxification service with the aim of getting prisoners off drugs before they are released. Over half of the inmates are local to Sussex.

25.9 The East Sussex Under 19's Substance Misuse Service aims to provide a drug and alcohol specialist service to young people under the age of 19 years and their families/carers, who are normally resident in East Sussex, or registered with a GP in East Sussex. It is a joint service developed by the NHS and County Council.

25.10 Multi-disciplinary teams deliver specialist substance misuse services from a variety of young peoples centres. The service provided includes an

assessment and casework function as well as direct access to a range of other specialist interventions. The service provides treatment for young people who need specialist help with a serious drug problem by bringing together expertise from social work, Child and Adolescent Mental Health Services and substance misuse services.

25.11 The structure of the team is based upon the four tier model of service delivery set out below [43].

Structure	Tier 1	Tier 2	Tier 3	Tier 4
Aim	Maintenance of health, educational attainment and identification of risks.	Reduction of risks and vulnerabilities; reintegration and maintenance of young people in mainstream services.	To address the complex and often multiple needs of the young person, aiming to reintegrate him/her back to their family, school etc	To provide specialist interventions and setting for a particular period of time and for a specific function
Tasks	Screening and referral, universal drug/alcohol education and information	Targeted prevention, holistic assessment, practical and crisis support, appropriate therapies	Comprehensive assessment, pharmacotherapy provision, uncomplicated detox, needle syringe provision, specialist mental health interventions	Crises management, containment and care, child protection and places of safety, complicated detox
Providers	Schools, Police, Health Promotion.	Young People's Services with a specialist remit.	Specialist multi disciplinary team.	Local Authority Secure Units, Adolescent in-patient units, specialist foster placements.
Target Group	All young people.	Vulnerable groups and more problematic users.	Dependent or problematic users often combined with multiple underlying problems.	Young people with complicated substance problems and/or care and protection issues.

26. Effectiveness

26.1 In the 2004/05 treatment plan which the DAAT has submitted to the National Treatment Agency, it lists the progress made in East Sussex as:

- Substantial increase in the numbers of people entering treatment;
- Reduction in waiting times for treatment before models of care implementation;
- Reorganisation of treatment system to comply with models of care;
- Development of strong links with the Criminal Justice System;

[43] *The Substance of Young Needs* Health Advisory Service Thematic Review

- Establishment of the East Sussex Under 19 Substance Misuse Service.

26.2 Details of the 96 patients completing treatment in the 12 months between April 2003 and March 2004 are shown in the following table.

PCT area	Adults	Young people	Total
Bexhill & Rother	4	5	9
Eastbourne Downs	40	4	44
Hastings & St Leonards	14	10	24
Sussex Downs & Weald	14	5	19

Source: DAAT

26.3 The East Sussex Under 19's Substance Misuse Service in 2003/04 (first full year of service so may not be typical) had 304 referrals. 130 young people were assessed as requiring Tier 3 or above services and 174 Tier 2 services. There are currently 62 young people receiving Tier 3 / 4 services within the County.

26.4 Reasons for referral reason were: cannabis 67, alcohol 63, cannabis and alcohol 69, poly drug use 49, heroin 11, heroin and crack 13, crack 10, solvents 10, children of substance misusing parents 8.

26.5 The main source of referral was from the Youth Offending Team 166 (all young going though youth justice are screened by the Under 19s Service), with Connexions 27, parents 18, the Leaving Care Team 14, Social Services 13, hospitals 6, foyer/hostel 7 and self referrals 6.

Area of referral	Number
Hastings & St Leonards	84
Bexhill & Rother	33
High Weald	31
Lewes & Ouse Valley	34
Eastbourne & South Downs	122

26.6 Waiting times for substance misuse services in East Sussex have, for 5 of the 6 principal service modalities, now met the national targets. The following table shows the average waiting times for the 6 modalities compared with the national targets. (Source: DAAT)

Modality	Target March 2004	30 June 2003	30 Sept 2003	31 Dec 2003	31 Mar 2004
Inpatient treatment	2 weeks	n/a	3 weeks	n/a	n/a
Residential rehabilitation	3 weeks	4 weeks	3.2 weeks	5 weeks	4.0 weeks
Specialist prescribing	3 weeks	2.4 weeks	1.7 weeks	3.5 weeks	1.3 weeks
GP prescribing	2 weeks	1.6 weeks	0.3 weeks	1.3 weeks	1.0 week
Day care	3 weeks	1.9 weeks	1.7 weeks	0.6 weeks	0.7 weeks

Structured counselling	2 weeks	1 week	1 week	3.6 weeks	1.8 weeks

26.7 The National Treatment Agency (NTA) performance manages DAAT treatment plans and achievement of national targets. According to the NTA, East Sussex DAAT's service delivery is seen as improving. The NTA considers partnership arrangements are satisfactory, which they adduce through attendance and involvement of key partners [44].

26.8 The Audit Commission [45] has suggested a number of ideas to help commissioners begin to gauge how well community drug services and street agencies are performing; these are reproduced in Appendix 3.

27. Findings

27.1 Substantial proportions of children are placed on the child protection register due to the actions of parents who are substance misusers. Access to treatment services for these adults may be affected by a shortage of services to support their children, for example, the availability of child care to enable the parent to leave their child while they are receiving treatment.

Contact officers:

Vic Kempner
Project Manager

Tel: (01424) 851676
E-mail: vic@kempner.fsbusiness.co.uk

Roger Howarth
Scrutiny & Best Value Co-ordinator

Tel: (01273) 481327
E-mail: roger.howarth@eastsussex.gov.uk

[44] Personal communication (13-5-'04) with the National Treatment Agency's Deputy Regional Manager South East.
[45] *Changing habits: the commissioning and management of community drug treatment services for adults* (2002) Audit Commission

APPENDIX 1

Organisations, groups and partnerships

Statutory	Local authorities (note 1)	❑ East Sussex County Council ❑ Eastbourne Borough Council ❑ Hastings Borough Council ❑ Lewes District Council ❑ Rother District Council ❑ Wealden District Council
		❑ Town and Parish Councils
	Health	❑ Bexhill and Rother Primary Care Trust ❑ Eastbourne Downs Primary Care Trust ❑ Hastings and St Leonards Primary Care Trust ❑ Sussex Downs and Weald Primary Care Trust ❑ East Sussex County Healthcare NHS Trust ❑ East Sussex Hospitals NHS Trust ❑ Surrey and Sussex Strategic Health Authority ❑ Sussex Ambulance Service ❑ General Medical Practitioners (GPs) (note 2) ❑ South Downs Health NHS Trust (note 3) ❑ Brighton & Sussex University Hospitals NHS Trust (note 4) ❑ East Kent Hospitals NHS Trust (note 5) ❑ Maidstone & Tunbridge Wells NHS Trust (note 6)
	Other	❑ Sussex Police and Sussex Police Authority ❑ Probation Service ❑ Prison Service ❑ Connexions
Voluntary		❑ Action-for-Change ❑ Addaction ❑ Aftercare Services Co-ordination ❑ Al-Anon ❑ Alcoholics Anonymous ❑ Communities Against Drugs ❑ Community Alcohol Team Projects Ltd ❑ Drugs and Alcohol Information Service ❑ Face to Face ❑ Infopoint ❑ Nationwide Teetotallers Register ❑ Open Door ❑ Patched ❑ Phoenix House ❑ Seaside Centre ❑ Sidley Community Association ❑ Stumped ❑ SuccessUK ❑ Turnaround Project (CRI)

Partnerships	Strategic	❑ East Sussex Strategic Partnership ❑ Eastbourne Strategic Partnership ❑ Lewes Strategic Partnership ❑ Rother Strategic Partnership ❑ Wealden Local Strategic Partnership ❑ Hastings Local Strategic Partnership
	Health Improvement	❑ Bexhill & Rother Health Improvement Partnership ❑ Healthy Eastbourne Board ❑ Healthy Hastings Board ❑ Healthy Wealden Partnership ❑ Lewes District Partnership Group
	Crime & Disorder	❑ Eastbourne Crime Reduction Partnership ❑ Safer Hastings Partnership (formerly Hastings CDRP) ❑ Lewes & District Crime & Disorder Reduction Partnership ❑ Rother Crime & Disorder Reduction Partnership ❑ Wealden Crime & Disorder Reduction Partnership
	Other	❑ Children & Young People's Strategic Partnership Board

Notes

1. A range of specialist services are provided within the local authority sector including: Youth Development Service; Under 19's Substance Misuse Service; Youth Offending Team; Community Partnerships (Community Safety Team, Drug and Alcohol Action Team); PSHE and Healthy Schools Advisory Team (jointly with Brighton & Hove City Council), and Trading Standards.
2. Bexhill & Rother 13, Eastbourne Downs 22, Hastings & St Leonards 28, Sussex Downs & Weald 22.
3. Provides mental health services to the eastern parts of Lewes District.
4. Provides acute hospital services to the western parts of Lewes District (Royal Sussex County Hospital, Brighton and Princess Royal Hospital, Haywards Heath).
5. Provides acute hospital services to the eastern parts of Rother District (William Harvey Hospital, Ashford).
6. Provides acute hospital services to the northern parts of Wealden District (Kent and Sussex and Pembury Hospitals, Tunbridge Wells).

APPENDIX 2

Survey of voluntary organisations

A short questionnaire was sent to 19 voluntary organisations in East Sussex. Responses were received from 16. Of these, one was from an organisation that was closing down due to lack of funding. Therefore with 15 usable questionnaires, the survey resulted in an effective response rate of 79%. Although a number of different sources were checked in order to find out which organisations should be surveyed, it is possible that not every relevant voluntary organisations in the County was covered.

An analysis of the 15 completed survey forms is set out below. In a number of questions the totals exceed 15 because some organisations' answers span several categories.

Area of involvement	Alcohol	Smoking cessation	Drug misuse	Substance misuse
Number of organisations	10	2	8	10

	Target age groups			
Number of organisations	**11 to 16**	**17 to 21**	**22 to 25**	**26 and over**
All (15)	5	13	14	13
Alcohol (10)	5	8	9	9
Drug and substance misuse (11)	2	9	10	9

	Towns / geographical areas served												
Number of organisations	Bexhill	Crowborough	Eastbourne	Hastings & St Leonards	Hailsham	Lewes	Newhaven	Peacehaven / Telscombe Cliffs	Seaford	Uckfield	Rural Rother	Wealden	Rural Lewes
All (15)	10	6	10	10	8	7	7	7	7	6	6	4	6
Alcohol (10)	7	5	7	6	6	5	5	5	5	4	4	3	4
Drug & substance misuse (11)	6	2	6	6	5	3	3	3	3	2	3	1	3

Three of the organisations working in the alcohol area and one of those concerned with substance misuse are part of country-wide networks / charities.

Number of organisations	**Clients self-refer**	**Clients referred by someone else**
All (15)	14	12
Alcohol (10)	10	7
Drug & substance misuse (11)	10	9

Number of organisations	Referring agencies						
	General practitioner	Other member of primary care team	Hospital	Social services	School / college	Voluntary agency	Other
All (15)	8	8	7	8	5	10	4
Alcohol (10)	6	6	5	5	3	7	2
Drug & substance misuse (11)	6	5	6	6	3	8	2

The questionnaire invited organisations to say how successful they were in meeting their aims by scoring themselves on a range from 1 to 10 where 10 was the highest. Of the 15 responses, 4 did not feel able to make a judgement, and for the 11 who did the average of their scores was 8.0.

One of the aims of the survey was to get an idea of the volume of service provided by the voluntary sector. Not all organisations collect their information in the same manner and some do not maintain records of calls received. Consequently, information was not available from all organisations, but it is estimated that the voluntary sector has contact with some 4,000 clients in a year through their information services, help lines, advice and guidance services, counselling and therapy services, and support groups.

The survey invited respondents to list the purpose or objective of their organisation, a range of these is set out below:

- To offer a teetotal lifestyle that is socially acceptable by linking enquirers up to others in their region.
- To help others recover from alcoholism.
- To offer understanding and support for families and friends of problem drinkers.
- Information, support and counselling to young people aged 13 to 25.
- To give substance misusers the opportunity to rebuild their lives in a way that ends their dependence on drugs and alcohol.
- Provide solution focused counselling to those with substance misuse problems.
- Helping individuals and communities to manage the effects of drugs and alcohol misuse.
- To offer support and services for the families, friends and carers of substance misusers or anyone in the local community experiencing the effects of someone else's drug problem.
- Professional advice targeting communities and families helping eliminate drug misuse.

The survey also invited respondents to list examples of their organisation's successes, a range of these is set out below:

- Peer education and training.
- Clients completing programme.
- Community development.
- Empowering clients.
- Clients remaining substance free and living happier lives.
- Helping clients cope more effectively with their own situation.

- Have achieved credibility with a variety of statutory and voluntary organisations.
- Meeting National Treatment Agency guidelines on waiting times.
- Supported housing.
- Improving peoples' social relationships, for example, with their families.
- Creation of substance misuse leaflets designed by our members for young people.
- Providing with skills to enable clients to get a job.
- Counselling outcomes.
- Needle exchange scheme running.
- Referrals to specialist services for homeless young people.
- Communities against drugs after school club.

The survey also invited respondents to list things that would improve the effectiveness of their services, a range of these is set out below:

- More time spent on publicising help available.
- More local support projects to refer callers to.
- Clients always coming to appointments.
- More staff / more paid workers.
- Charity status to access further funding.
- Financial support to offer a more flexible service.
- A more consistent flow of funds.
- Availability and accessibility of specialist services
- Working closer with other organisations.
- Less bureaucracy in legislation and less paperwork.
- More satellite clinics
- Health warnings about alcohol.
- Ability to pay staff more and offer permanent contracts.
- Open for longer hours.
- Bigger premises.

APPENDIX 3

Audit Commission guidance

The Audit Commission has suggested the following indicators for use by commissioners:

Waiting times
- Average waiting time for assessment.
- Average waiting time for a service (for example, methadone treatment slot, residential placement).
- The number of people waiting to begin treatment at the end of the reporting period.

Referrals
- The number of new referrals seen by each service, by source, age, gender, ethnicity and main problem drugs.
- Percentage of new referrals completing assessment process.
- Percentage of new referrals admitted to service and interventions provided.
- Percentage of new referrals referred to other agencies.

Care management
- Percentage of clients with a care plan.
- Percentage of missed appointments and key worker sessions.
- Percentage of clients re-contacted after missed appointments and key worker sessions.
- Percentage of clients jointly managed with other agencies.
- Percentage of clients completing treatment and leaving the service.
- Percentage of clients leaving treatment early/dropping out.
- Percentage of clients asked to leave the service.

GP registration and shared care
- Percentage of clients registered with a GP.
- Percentage of GPs and GP practices participating in shared care arrangements.

Hepatitis B vaccinations
- Percentage of clients offered Hepatitis B vaccinations.
- Percentage of Hepatitis B vaccinations completed.

Other suggestions are that indicators of needs and service patterns identified through service review should to trigger discussions between agencies on key topics:

- Is the right range of services and interventions being provided to meet the needs and tackle the risk situations?
- How do unit costs, take-up and retention compare between different agencies? Can lessons be learned about more efficient methods of delivery?
- Do funding and contracting mechanisms encourage high quality services? For instance, is it a key objective to secure rapid access to high quality residential provision? If so, the development of some block or volume contracts may yield cost savings and reduce the uncertainties many providers face, thereby allowing them to develop more high quality services.
- Are the right numbers and type of staff employed in each agency? For example, do their skills match the problems being tackled?
- Are services being provided in a timely and acceptable manner?

- Are there specific barriers to access, and how could these be tackled? For example, is there scope to improve signposting and develop new links with mainstream services?
- What role should specialist services play in supporting other agencies in a more skilled and responsive approach?