Sheffield

Alcohol Needs Assessment 2015/16

Summary

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Alcohol Needs Assessment Data Summary Update 2015/16

1. Introduction & Background

This needs assessment summary update is written to assist in the commissioning and strategic direction of alcohol treatment services in Sheffield for the 2016-17 year. The document was produced at the end of 2015-16 and draws on latest available statistics produced by Public Health England (PHE) and also data collated locally. The document is a summary refresh of the detailed Needs Assessment completed in the 2014-15 year. The draft document has been consulted on with local treatment providers, stakeholders and professionals, in order to gain an updated perspective of the needs in Sheffield for alcohol treatment services. The summary will provide an update on the current position, emerging trends and future changes anticipated, to be used in line with commissioning priorities over the year.

In Sheffield there is an established night-time economy promoting a safe and enjoyable city centre culture. This is a product of partnership working between South Yorkshire Police, Sheffield City Council licensing and trading standards, health services, and Sheffield DACT. Sheffield's Purple Flag status (2011 and re-assessed and awarded in 2014) is an example of such positive work. However, the effects of binge drinking are still apparent: fixed penalty notice waivers continue to be issued in response to low level alcohol related offences; and audits completed in A&E still find a significant proportion of their caseload at weekends are for alcohol related injuries.

This report will show that over the last few years in Sheffield overall there have been fewer people accessing alcohol treatment, however, the most recent 12 months (Jan – Dec 2015) have shown a small increase in comparison to the 2014/15 financial year. It is estimated that 19% of the adult population drink at an increasing risk level and a further 7% of the adult population drink at higher risk levels. Not all individuals that drink at these levels will want to access treatment, the Rush model[1] anticipates that 10% of the dependent drinking population should access treatment per year. Provision of services therefore needs to be adequate to meet current and future need, taking into account local access rates, along with the vision to encourage people to access treatment and to have suitable capacity and quality of care available.

From 2014-15 onwards PHE implemented a new method of reporting performance data on drug and alcohol clients. There are different groups of comparators for opiate, non-opiate, and alcohol populations. Previously there were three substance groups used in reporting: opiate, non-opiate, and alcohol. From April 2014 substance misuse reporting consists of either seven or four groups. Which of the two mutually exclusive groupings is used depends on the type of report, the group of seven used mainly for activity reporting and the group of four used in higher level reports that are more outcome-focused. The two different groupings are shown below:

Seven mutually exclusive groups	Four mutually exclusive groups
1. Opiate only 2. Opiate and alcohol 3. Opiate and non-opiate 4. Opiate, alcohol and non-opiate 5. Non-opiate only 6. Alcohol only 7. Alcohol and non-opiate	1. Opiate 2. Alcohol only 3. Non-opiate only 4. Alcohol and non-opiate

The four mutually exclusive groups

- any mention of opiates in any episode means that the client is included in the opiate group (irrespective of other cited substances)
- clients who present with alcohol and no other substance fall into the alcohol-only group

[1] Rush, B 'A systems approach to estimating the required capacity of alcohol treatment services', *British Journal of Addiction* (1990) 85, 49-59

- clients who present with non-opiate substances (and not alcohol) are in the non-opiate-only group
- a fourth group will report clients who have a non-opiate substance and alcohol (but not opiates) recorded in any drug in any episode of their treatment journey.

The seven mutually exclusive groups (expanding on the four groups, providing more detail on opiate clients)

- Any mention of opiates in any episode means a client falls into one of the four opiate groups. If they:
  - Do not present with any other substance, they are opiate-only
  - Present with no other drug but cite alcohol in any episode, they are in the opiate and alcohol group
  - Present with another drug and no alcohol, they are in the opiate and non-opiate group
  - Present with another drug and alcohol alongside an opiate, they are in the opiate, alcohol and non-opiate group
- The alcohol only, non-opiate-only, and alcohol and non-opiate groups will be categorised in exactly the same way as in the four groupings above.

Although this Needs Assessment is focused on alcohol, the groupings listed above highlight that alcohol use is also prevalent as part of poly-substance use and alcohol treatment can be required alongside interventions for drug misuse. The use of multiple substances can also lead to more complex situations for individuals that make successful interventions harder to deliver and successful outcomes harder to achieve. Although there are many people who use solely alcohol, it cannot be viewed entirely as an issue on its own and as such this document interlinks with the Needs Assessment for Drugs[2]. Where nationally reported data is used in this report it is in reference to the alcohol-only cohort given that the alcohol and non-opiate cohort are included in the nationally reported drugs Public Health Outcomes Framework (PHOF) targets. Also, the alcohol-only cohort is around 850 people at the end of 2015, the alcohol and non-opiate cohort is around 125. The alcohol and non-opiate cohort comprises of clients that are in alcohol treatment at the alcohol service but also clients receiving treatment from the non-opiates service. Including the alcohol and non-opiate cohort would therefore not be a true reflection of alcohol treatment.

2. National Picture

The Government's National Alcohol Strategy 2012 aims to tackle the binge-drinking culture in the UK, prevent and reduce harms caused by alcohol and the offending rates that can result from drinking to excess. It acknowledges that the vast majority of people who drink alcohol, drink sensibly (an estimated 73.3% drink within the current Department of Health safer limits or abstain) but there is a cohort (estimated 20% increasing risk, 6.8% higher risk[3]) who drink at levels higher than DH recommendations. It is also estimated that 20.1% of drinkers engage in binge drinking[4]. Drinking at such levels can have negative repercussions on an individual's health, social functioning and offending. Alcohol consumption can also have wider societal impacts on anti-social behaviour, health system costs and capacity, criminal justice system costs and capacity, children and adult social care and other public sector services.[5]

In line with the strategy The UK Chief Medical Officers' (CMO) have reviewed and proposed new guidelines for alcohol consumption. The proposed guidelines are currently in consultations but the recommendations can be summarised as follows:[6]

- Not to drink regularly more than 14 units per week and to spread the weekly units evenly over 3 or more days. Having one or two heavy drinking sessions increases the risk of death from long term illnesses and from accidents and injuries.

[2] http://sheffielddact.org.uk/drugs-alcohol/resources/needs-assessments/
[3] LAPE 2012, synthetic estimates mid-2009. No further national updates to these estimates have been produced.
[4] Defined as drinking at least twice the recommended daily limit in a single drinking session.
[5] https://www.gov.uk/government/publications/alcohol-strategy
[6] https://www.gov.uk/government/consultations/health-risks-from-alcohol-new-guidelines

- Limit the total amount you drink on any one occasion, drink more slowly, with food, and alternating with water. Avoid risky places and activities when drinking.
- If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risk to your baby to a minimum.

The government has also recently published new guidance on harmful drinking and dependence[7]. The guidelines state that the effects of harmful drinking on individuals, their families and communities are wide-ranging and require a response at both a national and local level. It is estimated that the cost of alcohol to society is £21 Billion. It estimates that 10.8 million adults in England drink at levels that pose some risk to their health and 1.6 million adults may have some level of alcohol dependence. The guidance acknowledges that not all of these will need specialist or high intensity treatment, a proportion will benefit from a brief interventions.

Alcohol has been identified as a causal factor in more than 60 medical conditions; it increases the risk of cancer, and is the third leading risk factor for death and disability after smoking and obesity.

The guidance highlights that alcohol misuse is also associated with:

- Mental health problems; 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year and there was a history of alcohol misuse in 45% of suicides between 2002 and 2011.
- Unemployment; alcohol misuse is more likely to start or escalate after an individual becomes unemployed. The associated risk of mental health problems means that people with alcohol dependence can have issues finding work again.
- Hospital admissions; Nationally in 2013/14 admissions to hospital where the main reason was alcohol related increased by 1.3%, with the highest number of alcohol related admissions due to cancer.
- Liver disease; Alcohol accounts for over a third of all cases of liver disease, and most liver disease is preventable. Alcoholic liver disease was responsible for 70% of alcohol specific deaths (2011-2013)
- Children affected by parental alcohol use are more likely to have physical, psychological and behavioural problems. Parental misuse is also correlated with family conflict and domestic abuse. In cases of young offending where the young person misuses alcohol 78% were found to have a history of parental alcohol abuse or domestic abuse within the family. This links in with the triple risk factors, sometimes referred to as the trilogy of risk, where parental substance misuse, domestic violence and mental health issues are present in a household and combine to put a child at a high level of risk or harm[8]. It is well documented that children most at risk of suffering significant harm are those living in families exposed to multiple problems and the long term harm to children increases with exposure to multiple adverse experiences[9].
- Health inequalities; the impact of harmful drinking and alcohol dependence is much greater for people from the most deprived socio-economic groups, although this is likely to be due to a number of additional factors that affect these groups such as poor nutrition. There is also growing awareness about the considerable overlap of populations that experience severe and multiple disadvantages such as; homelessness, poor mental health, offending behaviours and alcohol and drug misuse. Tackling alcohol related harm is therefore an important route to reducing health inequalities overall.

Alcohol treatment can therefore contribute to improvements in:

- Reducing hospital admissions

[7] Health Matters: harmful drinking and alcohol dependence. January 2016 https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

[8] Nottingham Healthcare NHS Trust Trilogy of Risk Factors March 2011

[9] Children's Needs – Parenting Capacity, Cleaver, H. et al. 2011

- Reducing child poverty
- Employment for those with long term conditions
- Levels of social isolation
- Reduction in falls and injuries in those over 65
- Reduction in self-harm
- Treatment completion for tuberculosis
- Reducing premature mortality from liver disease
- Reducing cardiovascular disease cancer

The guidance states that brief interventions can be all that is needed to help some alcohol misusers to consider the reasons for changing their behaviour, however, for others further exploration of causal factors and goal setting with the individual may be required. For those receiving alcohol treatment, nationally 61% reported being free of alcohol dependence when they left treatment. Local Authorities (LAs) and Health and Wellbeing Boards are at the heart of the partnership needed to tackle alcohol issues and treatment for harmful and dependent drinkers is an essential element of alcohol policies that an authority needs to plan for and deliver.

Individuals receiving treatment should receive interventions in line with NICE guidance and have care plans involving goal setting that are regularly reviewed. Additional support for other needs including homelessness, education and training, and treatment resistant drinkers help to increase the rate of recovery and improve sustainable outcomes. These should be delivered alongside appropriate psychosocial and pharmacological interventions.

3. The Sheffield Picture

Sheffield City Council has an alcohol strategy to inform the strategic direction of alcohol related work in the city and action plan work streams. The 2010-14 strategy has been evaluated.

The 2010 – 2014 alcohol strategy for Sheffield achieved the following:

- Expansion of the **Best Bar None** (BBN) scheme, and Sheffield becoming the first city in Yorkshire to achieve **'Purple Flag'** (night time economy excellence) status, which was then renewed at the end of 2014;
- Continued enforcement on **underage sales**, as well as specialist projects addressing retailers selling non duty paid, and more seriously, **illicit alcohol** which is dangerous when consumed by humans due to the presence of industrial alcohol;
- **Fixed Penalty Notice Waiver** (FPNW) and **Alcohol Conditional Bail** (ACB) schemes were implemented and continue to achieve good completion rates;
- DACT invested significantly in polycarbonate 'glasses' for use in the night time economy, which reduced harm from 'glassing' incidents in licensed premises across Sheffield;
- A number of locality based projects were implemented to address alcohol misuse and anti-social behaviour;
- **The recovery agenda** in Sheffield was promoted and developed, with the re-focus of commissioned treatment services towards recovery, and a marked increase in the promotion of and provision of mutual aid within commissioned treatment services;
- **Domestic abuse** service staff have been trained in the use of an alcohol screening tool;
- A number of **alcohol related social marketing** campaigns were carried out, the largest being during Euro 2012, highlighting the connections between large football events and excess alcohol consumption, as well as the links to domestic violence incidents.
- High levels of industrial alcohol badged as 'normal alcohol' for sale in Sheffield was reduced to nil following a **targeted education and enforcement regime**, with one business owner losing their license due to the sale of industrial alcohol;

- Delivered a **city wide education campaign to raise awareness of illicit alcohol** and how to identify it; the campaign was taken up by other cities and shortlisted for a Ministry of Justice award in 2015.

In 2015 a new strategy was written and consulted on which will be ratified formally at Cabinet in 2016 and will be implemented during the period from 2016-2020.

The Sheffield Alcohol Strategy 2016-2020

The new strategy[10] will build on the achievements of the 2010-14 strategy, and expand the focus into five distinct themes:

1. *Alcohol and Health*: The aim of the strategy is to educate individuals about the impact of alcohol on their health, promote early intervention of alcohol related health issues, reduce the prevalence of alcohol related ill health, reduce hospital admissions for alcohol related conditions, and ensure those in need can access timely and effective interventions.

2. *Alcohol Treatment and Recovery*: A new contract for one single 'end to end' treatment service will be commissioned. This strategy aims to oversee the on-going commissioning of high quality and accessible treatment interventions further embedding of a recovery culture in Sheffield. Commissioned alcohol treatment services offer a range of interventions to individuals assessed as suitable to receive them including: identification and brief advice, extended brief interventions, psychosocial interventions, and specialist prescribing for alcohol misuse in the community. Each individual's treatment requirements are assessed through the SEAP process.

3. *Licensing, Trading Standards and the night time economy*: The 2016 – 2020 strategy aims to build on the achievements during the previous strategy that had a significant focus on Sheffield's night time economy, and how the city could offer a vibrant selection of entertainment whilst ensuring alcohol related harm was minimised. The strategy aims to implement a joint working protocol with Licensing and work closer with them and trading standards to implement a voluntary scheme among licensed premises to reduce alcohol related harm.

4. *Alcohol and crime:* There is a direct link between amounts of alcohol used and offending, and, an Offending Crime and Justice survey found that adults who binge drink were significantly more likely to have offended in the past 12 months than other groups – a smaller scale study supporting this showed that individuals 'pre-loading' before they went out, were 2.5 times more likely to be involved in violence. The aims of this section of the strategy are to prevent where possible, reduce, and address alcohol related crime with appropriate interventions.

5. *Community responses and vulnerable groups:* There are numerous vulnerabilities which make certain groups or individuals more likely to drink, misuse alcohol, or be disproportionately adversely affected by alcohol misuse. It is impossible to capture every one of them in a strategy, and one of the overarching principles of this strategy is that it should be responsive to emerging issues, and flexible enough to change its focus should priorities change during the four year strategy period. As such, and reflected in other themes; the initial action for this theme is for alcohol awareness and routes to support interventions being rolled out to organisations working with vulnerable groups and individuals, so that they may effectively support the agenda.

[10] Sheffield Alcohol Strategy 2016 – 2020, Helen Phillips-Jackson, Sheffield DACT, October 2015

Nationally produced data for Sheffield suggests that drinking habits in the city are similar to the national estimates, with an estimated 73.2% of those that drink alcohol, drinking within national NHS guidelines. However an estimated 26.7% of people aged 16+ in Sheffield that drink alcohol (19.5% increasing risk and 7.2% higher risk) drink at levels greater than the DH recommendations, similar to the national proportions.[11] It is also estimated that 26.9% of the 16+ population engage in binge[12] drinking. Using these estimates that were published in 2012 but have not since been updated, and applying them to the 2014 mid-year population estimate for people in Sheffield aged 16+[13], we can suggest that of the 461,150 Sheffield residents:

- 79,871 abstain from drinking alcohol
- 279,172 drink at a lower risk level
- 74,502 drink at an increasing risk level
- 27,605 drink at a high risk level
- 124,049 engage in binge drinking

The Alcohol Needs Assessment Research Project[14] (ANARP) found that 5% of 16 – 64 year olds in the Yorkshire & Humber region are dependent on alcohol, there will be dependent drinkers over the age of 64 but the ANARP focused on the 16 – 64 year olds due to the datasets available to carry out the research. We can use this along with the Rush Model[15] that suggests 10% of the dependent drinking population will require treatment in a given year, to produce an estimate of anticipated demand using the most recent population estimates. This suggests that the anticipated demand in Sheffield would be 1850 individuals per annum (between the ages of 16 and 64). In 2015, 961[16] individuals received structured treatment in Sheffield which equates to 5.2% (1 in 19) of the estimated dependent drinkers. If we looked at the whole population 16+ this would provide an anticipated demand of 2,243, meaning that 4.3% of the estimated dependent drinkers accessed treatment, therefore the actual percentage is likely to be between 4.3% and 5.2% in comparison to the Rush model anticipated demand of 10%. Treatment numbers are discussed in more detail in the next section.

During 2016Ithe contract for commissioned community alcohol treatment Sheffield is due to be re-tendered by Sheffield City Council and the intended start date for the new contract is 1 October 2016. This will run alongside the early period of the implementation of the 2016-2020 strategy.

4. Alcohol Related Harms

It is well documented in national strategies and research publications that excessive alcohol use (regular and long term drinking above the daily and weekly Department of Health guidelines) can result in individuals experiencing alcohol related health conditions. Such conditions are considered 'preventable' and in some cases can result in death.

Public Health England in their annual Local Alcohol Profiles for England (LAPE) (published in 1 March 2016) monitor the extent of alcohol related and specific illnesses and mortality by Local Authority and compare each to the England average[17]. The profiles were re-designed in 2015 to further breakdown hospital admissions in to cause groups and also alcohol treatment comparisons.

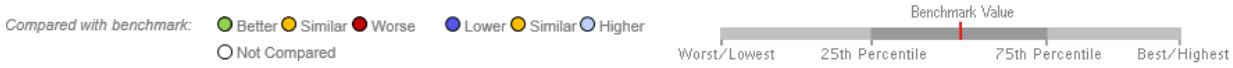
[11] LAPE 2012, synthetic estimates mid-2009. No further updates to these estimates have been produced.
[12] Defined as drinking at least twice the daily recommended amount of alcohol in a single drinking session.
[13] Population Estimates for local authorities in the UK, mid 2014, Office for National Statistics, June 2015, http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
[14] http://www.alcohollearningcentre.org.uk/Topics/Browse/Data/?parent=4644&child=4647
[15] Rush, B 'A systems approach to estimating the required capacity of alcohol treatment services', *British Journal of Addiction* (1990) 85, 49-59
[16] Figure includes those receiving treatment that also used non-opiate drugs
[17] LAPE http://fingertips.phe.org.uk/profile/local-alcohol-profiles

It is imperative for commissioners of community and secondary care alcohol treatment to understand the current extent of alcohol related and specific illnesses and mortality, since LAPE data can be used to:-

- better understand the use of health services by those with alcohol related problems,
- Support short term and long term commissioning for capacity planning purposes, ensuring enough capacity is available to meet the need of those at risk.
- Benchmark monitoring the outcome of health related pilot projects and initiatives commissioned with the aims of reducing or curbing the increase nationally in alcohol related hospital admissions and mortality.
- Compare similar cities to Sheffield to understand where best practice may be happening elsewhere in the country and investigate further.

The tables below show the latest reported data from LAPE for Sheffield along with a national and Yorkshire and the Humber (Y&H) comparison.

Mortality indicators



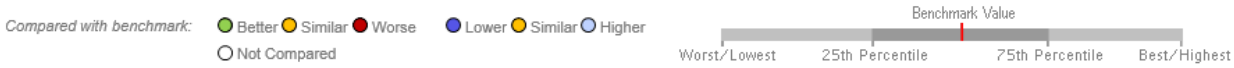
Indicator	Period	Sheffield		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
1.01 - Months of life lost due to alcohol (Male)	2012 - 14	-	13.6	12.9	12.0	26.5		6.5
1.01 - Months of life lost due to alcohol (Female)	2012 - 14	-	5.7	6.0	5.6	10.5		3.2
2.01 - Alcohol-specific mortality (Persons)	2012 - 14	233	15.8	12.8	11.6	26.6		5.0
2.01 - Alcohol-specific mortality (Male)	2012 - 14	164	22.7	17.6	16.1	36.8		5.8
2.01 - Alcohol-specific mortality (Female)	2012 - 14	69	9.1	8.1	7.4	18.1		2.1
3.01 - Mortality from chronic liver disease (Persons)	2012 - 14	171	11.9	11.7	11.5	27.4		6.2
3.01 - Mortality from chronic liver disease (Male)	2012 - 14	111	15.9	15.6	15.2	35.9		8.6
3.01 - Mortality from chronic liver disease (Female)	2012 - 14	60	8.1	8.0	8.0	-	*Insufficient number of values for a spine chart*	-
4.01 - Alcohol-related mortality (Persons)	2014	224	46.5	46.4	45.5	85.4		29.1
4.01 - Alcohol-related mortality (Male)	2014	153	68.4	66.8	65.4	127.0		40.6
4.01 - Alcohol-related mortality (Female)	2014	71	27.1	29.0	28.8	50.1		18.5

The table above for alcohol mortality shows that where a comparison is made the rate of mortality in Sheffield is similar to the England average on all indicators with the exception of Alcohol-specific mortality. Mortality from alcohol-specific conditions means that the cause of death is whole attributable to alcohol, for example, alcohol-related liver cirrhosis. Looking at all three indicators for alcohol-specific mortality (persons / male / female) we can see that it is mortality amongst males that contributes the most to the 'person's' indicator. Male alcohol related mortality has increased year on year since the 2008 – 2010 period. However, whilst the rate for females is statistically similar to the national average, it should be noted that it is close to the 25th percentile, the point at which only 25% of all rates for England fall. The Sheffield rates are also higher than the Y&H average. The rate for persons is the 4th highest out of the 7 core cities (Cardiff and Glasgow are not included) with Bristol, Manchester and Liverpool having a higher rate of alcohol-specific mortality.

This data suggests that significant benefit to the Sheffield population could come from education and information in regard to the long-term effects of drinking and the specific conditions it can cause, particularly targeted to males, as well as identification and early intervention amongst all groups. This supports two of the main themes of the Alcohol Strategy. Prioritising these actions will prevent the development in the longer term of alcohol related and alcohol specific conditions, and as such, reduce alcohol specific mortality. Work with those individuals who are already suffering alcohol related and specific health conditions is essential in order to maximise positive outcomes, but the long term future of

reducing significantly alcohol related ill health may lie in education, screening and early intervention when behaviours are less entrenched.

Hospital Admissions



Indicator	Period	Sheffield		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
5.01 - Alcohol-specific hospital admission - under 18s	2011/12 - 13/14	60	17.0	38.1	40.1	100.0		13.7
6.01 - Alcohol-specific hospital admission (Persons)	2013/14	1,920	371	392	374	1,074		131
6.01 - Alcohol-specific hospital admission (Male)	2013/14	1,265	501	535	515	1,494		170
6.01 - Alcohol-specific hospital admission (Female)	2013/14	655	244	255	241	658		95
7.01 - Alcohol-related hospital admission (Broad) (Persons)	2013/14	5,962	1,208	1,324	1,253	2,070		731
7.01 - Alcohol-related hospital admission (Broad) (Male)	2013/14	3,807	1,641	1,815	1,715	2,820		1,011
7.01 - Alcohol-related hospital admission (Broad) (Female)	2013/14	2,155	833	904	859	1,386		498
8.01 - Alcohol-related hospital admission (Narrow) (Persons)	2013/14	2,409	464	468	444	808		264
8.01 - Alcohol-related hospital admission (Narrow) (Male)	2013/14	1,540	619	629	594	1,049		338
8.01 - Alcohol-related hospital admission (Narrow) (Female)	2013/14	869	324	322	310	583		201
9.01 - Admission episodes for alcohol-related conditions (Broad) (Persons)	2013/14	10,171	2,083	2,276	2,111	3,493		1,115
9.01 - Admission episodes for alcohol-related conditions (Broad) (Male)	2013/14	6,346	2,766	3,124	2,917	4,848		1,582
9.01 - Admission episodes for alcohol-related conditions (Broad) (Female)	2013/14	3,825	1,498	1,562	1,426	2,392		727
10.01 - Admission episodes for alcohol-related conditions (Narrow) (Persons)	2013/14	3,651	718	697	645	1,231		366
10.01 - Admission episodes for alcohol-related conditions (Narrow) (Male)	2013/14	2,165	880	886	835	1,538		474
10.01 - Admission episodes for alcohol-related conditions (Narrow) (Female)	2013/14	1,486	571	528	475	940		274

Sheffield currently performs better than the England average in four of the indicators above; Alcohol-specific hospital admissions – under 18s; Alcohol related hospital admissions (broad)[18] for both persons and males; Admission episodes for alcohol-related conditions (broad) for males.

Sheffield currently performs worse than the England average in five of the indicators above; Alcohol-related hospital admissions (narrow)[19] all persons; admission episodes for alcohol-related conditions (broad) for females; admission episodes for alcohol-related conditions (narrow) for persons, males and females. Indicator 10.01 is also one of the indicators on the Public Health Outcomes Framework.

Admissions count individuals admitted to hospital for alcohol-attributable conditions, episodes counts each episode of admission that is for alcohol-attributable conditions.

Four of the five measures that Sheffield is worse on are the newer supplementary 'narrow' measures. These measures are more responsive to local action. They contain a larger proportion of acute conditions where excessive alcohol use may have played a part. It is easier to achieve a noticeable impact in respect

[18] Persons admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable diagnosis.
[19] Persons admitted to hospital where the primary diagnosis is an alcohol attributable code or the where the primary diagnosis does not have an alcohol attributable fraction but one of the secondary codes is an external cause code with an alcohol attributable fraction.

of acute conditions in a short period of time than it is to achieve a similar impact in chronic conditions which may take several years. Local action might include things such as managing access to alcohol through licensing, increased and improved treatment and effective identification and brief advice.[20] Performance against these measures therefore further supports the need for the new Sheffield Alcohol Strategy along with the focus of its aims.

Alcohol Related Crime: There is a direct link between amounts of alcohol used and offending, and, an Offending Crime and Justice survey found that adults who binge drink were significantly more likely to have offended in the past 12 months than other groups – a smaller scale study supporting this showed that individuals 'pre-loading' before they went out, were 2.5 times more likely to be involved in violence.

In Sheffield the highest levels of alcohol related crime[21] occur in Central Sheffield (646 incidents in 2013/14), Burngreave (129 incidents), Firth Park (124 incidents), Walkley (107 incidents) and Southey (105 incidents). By far the majority of alcohol related crime takes place in Central Sheffield – this is the area with the highest concentration of licensed premises, retailers selling alcohol, and offers the main leisure opportunities involving alcohol. Targeted work has been done to address alcohol related anti-social behaviour and associated crimes in community settings:

1. Public Space Protection Orders (PSPO)(previously Designated Public Place Orders (DPPO)

A PSPO restricts the consumption of alcohol in a public place if it has, or is likely to have a detrimental effect on the quality of life of those in the locality. It is enforced by SYP, however, is agreed with SCC's Licensing Committee before being implemented. A PSPO allows SYP to issue those failing to comply with an Order with a Fixed Penalty Notice or to prosecute. Intelligence from officers enforcing this scheme is that it has been a useful tool in reducing alcohol related incidents in areas that they work; particularly during the hours the night time economy is operational.

2. Substance Misuse Steering Groups

These multi-agency groups are held in Sheffield wards where substance misuse has been identified as a priority. The DACT chair the groups which provide a coordinated partnership response. Issues covered include street drinking, underage drinking, anti-social behaviour and illegal alcohol.

5. Alcohol Treatment

In Sheffield there are a number of support and treatment options available for individuals concerned about their consumption levels of alcohol. Different options are available to support the needs of the individual, the level of consumption and the impact it has on the person's health and life.

Screening

The NICE guidance PH24 '*Alcohol-use disorders: preventing harmful drinking'* recommendation 9 is that universal alcohol screening is ideal but if not possible then should be undertaken with those at most risk by the following sectors: - *'Health and social care, criminal justice and community and voluntary sector professionals in both NHS and non-NHS settings who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink[22]'*.

In Sheffield there is an alcohol screening tool based on the Alcohol Use Disorders Identification Test (AUDIT) developed by Sheffield Health and Social Care NHS Foundation Trust (SHSC). The tool is available for use by both health and social care partners including; GP Practices, Midwives, and domestic abuse support services. Some partners such as midwives use the tool for all clients. Others, such as GP

[20] https://publichealthmatters.blog.gov.uk/2014/01/15/understanding-alcohol-related-hospital-admissions/
[21] 2013/14 full year data – alcohol needs assessment. Due to Capacity SYP have been unable to provide more recent data
[22] http://www.nice.org.uk/guidance/PH24/chapter/1-Recommendations

Practices, use the tool to screen new patients or where an individual presents to the GP with concerns about their level of drinking.

In addition, GPs carry out NHS Health Checks which are offered to 40 to 75 years olds (sometimes referred to as a health 'MOT') every five years and from 2013/14 alcohol screening (AUDIT) was added to the criteria, therefore a significant number of people who may not necessarily have been screened for alcohol misuse are now being screened.

The data table below shows the utilisation of the screening tool:

Use of the Screening Tool	2012/13	2013/14	2014/15	2015/16 (first 3 quarters)
Number of surgeries/agencies involved who screened in the year	26	31	20	31
Number of people screened	226	541	231	669
Number of referrals made by practice to SEAP	60	119	48	107

There are currently 44 agencies (including 31 GPs) with licences to use the alcohol screening tool. During the first 3 quarters of 2015/16, 31 agencies have utilised the screening tool. This has led to 669 individual's being screened, 406 (60.7% of those screened) met the threshold for referral to SEAP, and 107 of them being referred to alcohol treatment. Therefore 26% of people screened so far this year, who met the threshold for referral, have been referred to treatment. There has been a significant amount of work undertaken to increase screening during the recent financial year which has been achieved, and the strategy period aims to increase this further. Whilst 16% would appear to be a low proportion of individuals referred into treatment using the tool, it should also be noted that individuals have to give their consent for a referral to be made, therefore there will be a proportion who met the criteria for treatment and refused a referral. However, everyone screened receives their own personalised information on their current drinking levels and recommended actions for harm reduction, and it is likely that for some individuals this will motivate behaviour change without a formal referral taking place, due to the effectiveness of brief interventions and advice. Alcohol screening completed during a GP appointment, also provides an opportunity for the GP to discuss a person's level of drinking. Therefore, for people who do not want or need a referral to specialist alcohol services, the use of the tool can act as a catalyst to allow a GP to provide some brief advice on the potential harm that can be caused by drinking alcohol above the recommended limits. This is also part of the NICE Guidance PH24 recommendation 10 to provide brief advice to adults who have been identified via screening as drinking a hazardous or harmful amount of alcohol. The tool also makes conversations about alcohol easier to have with patients or clients, as it has a set of questions which are standard to the tool rather than dependent on the individual approach of the professional.

The data also shows us that in comparison to previous years, more people have been screened in 2015/16 and it is very likely, based on the first 3 quarters info, that this will also lead to more referrals to alcohol services than there have been in previous years.

The table below shows the agencies that have made most use of the alcohol screening tool in 2015/16:

	Rank				
	1st	2nd	3rd	4th	5th
Most people screened in 2015/16 YTD	MAST (301)	Social Care (150)	Health Visiting (43)	Sheffield Medical Centre (20)	Pharmacists (17)
Most referrals made to SEAP	Social Care (21)	MAST (18)	Norwood MC (13)	White House Surgery (9)	Firth Park Surgery (7)

The Multi-Agency Support Team (MAST) have screened the most people using the tool, equating to 45% of all the people screened YTD, and have made the second highest number of referrals. A further 22% of the total screens have been made by social care and have also made the highest number of referrals following a screening.

Alcohol Treatment Activity

Commissioned Places 2015/16	**Summary of activity in 2015**	**Treatment interventions**	**% capacity (if applicable) achieved in the year**
	833	**unique individuals recorded in treatment with NATMS (period Jan 2015 to Dec 2015)**	
	2569	SEAP referrals	
2400	1666	triaged by SEAP	69%
756	616	pharmacological interventions	81%
533	509*	Psychosocial Interventions (includes carry over clients from 2014/15)	95%
200	111*	Alcohol Treatment Requirements (ATR)	56%
700	662	Extended brief interventions (EBI)	95%
42	85*	Inpatient detoxifications	202%
42	21*	new places agreed for residential rehabilitation	50%
	190	Fixed penalty notice wavers	

Notes:		
1	EBI is not recorded as in treatment with NATMS	
2	A number of people will receive more than one intervention	
3	The NATMS figure will remove any duplicate activity (e.g. where a client received both Pharmacological and PSI interventions	
4	The figures provided for Pharmacological and PSI include all activity, therefore if a person has returned to treatment (8% return within 6 months according to the latest available figure), they will count multiple times	
*	This is an estimated figure based on 3 quarters available data	

The table above summarises total treatment activity in Sheffield for 2015 as reported by the provider of the alcohol service; Sheffield Health and Social Care NHS Foundation Trust (SHSC). Unfortunately, due to a change in provider and a gap in reported data, it has not been possible to show data for the full 2015 calendar year for all of the reported areas above. Therefore, some data shown is for the first 3 quarters of 2015/16 extrapolated to give an end of year forecast. The data is also shown against the commissioned places for that service.

Where possible, for the remaining tables in this section of the report, data is shown for financial years with the calendar year 2015 being shown for the most recent 12 months. Where the change of provider has impacted on the reported numbers a forecast for 2015/16 based on the available data for April – December is shown.

Single Entry Access Point (SEAP): All referrals in to the treatment system are in the first instance referred to SEAP. The SEAP team undertake a triage assessment and a brief intervention with each individual and identifies the best treatment for them. In 2015 there were 1,666 SEAP triage assessments carried out, fewer than the number of assessments completed in the four previous financial years. This equates to 69% of the commissioned assessment places. This was a reduction in the number of assessments for the third consecutive year as is shown in the table below. This sends the message that more needs to be done to ensure awareness of alcohol and screening for alcohol misuse needs to be taken on by universal services who know where to refer people who would benefit from further interventions. Based on national profiling, there is more than enough need among the Sheffield population for alcohol services, but at present not enough demand is being created. The intention of the 2016-2020 strategy is to stimulate demand on the treatment system through educating the public on the impact of alcohol use and misuse, raising awareness of attributable health conditions, further outreach of the electronic screening tool, and developing further responsive services that can offer flexible delivery of interventions to meet the needs of any individual with alcohol misuse disorders.

	Activity	% of target achieved	Under used capacity
2011/12	1771	74%	629
2012/13	1729	72%	671
2013/14	2025	84%	375
2014/15	1805	75%	595
2015 calendar year	1666	69%	734
Data source: Sheffield Health and Social Care NHS Foundation Trust Performance Frameworks for 2011/12 through 2015/16			

Given that use of the alcohol treatment system is estimated to have been between 4.3% and 5.2% of the dependent drinker population in 2015 (against a suggested 10%) there is scope to increase the number of referrals to SEAP through promotion of the service and the screening tool. The table below shows the number of referrals to SEAP by the source of the referral. Caution should be taken however, as although treatment places utilised are below the commissioned capacity (with the exception of inpatient detox), they are close to the commissioned level.

Referrer	2013/14	2014/15	First 3 quarters 2015/16	Projection 2015/16	Referral source as %age of all referrals (projection 2015/16)	Projected %age change in referrals between 2013/14 and 2015/16
Self	891	914	655	873	34%	-2%
GP	634	493	322	429	17%	-32%
Other	262	237	182	243	10%	-7%
Non SHSC hospital	377	542	290	387	15%	3%
Fixed penalty notice waiver	256	169	137	183	7%	-29%
Probation	175	144	72	96	4%	-45%
SHSC Mental Health	226	139	84	112	4%	-50%
SASS	185	125	77	103	4%	-45%
Hospital Liasion Nurse	53	0	1	1	0%	-97%
Custody suite	127	31	2	3	0%	-98%
Social Services	100	70	43	57	2%	-43%
Addaction	46	40	36	48	2%	4%
Drink Wise Age Well*	0	0	6	8	0%	n/a
YTD TOTAL	**3332**	**2904**	**1907**	**2543**	**100%**	**-24%**
Data source: sheffield Health and Social Care NHS Foundation Trust Performance Frameworks for 2013/14, 2014/15 and 2015/16						
*added in 2015/16						

It is forecasted that most referral sources will refer fewer people to SEAP in 2015/16 than they did in 2014/15. The highest referrers to SEAP are GPs and self-referrals. The largest proportional decreases in the number of referrals to SEAP in 2015/16 have been from the custody suite, Probation, and Non SHSC hospitals. In 2016/17 the service should maintain the distribution of up to date promotional literature and liaise with partners to ensure that where identified, all appropriate individuals are referred to SEAP for an assessment.

Referrals to Treatment: After the triage assessment an individual is referred for support and / or treatment. The treatment a person is referred to will either be a Brief Intervention (BI), an Extended Brief Intervention (EBI), structured Psychosocial Intervention (PSI), or a Pharmacological intervention. Most clients receiving a pharmacological intervention will receive PSI alongside it.

Year	Pharmacological	Total requiring psychosocial interventions (PSI or EBI)	PSI	EBI	% psychosocial interventions	% pharmacological
2011/12	821	1189	372	817	59%	41%
2012/13	1141	1394	306	1088	55%	45%
2013/14	1222	1144	464	680	48%	52%
2014/15	963	1230	308	922	56%	44%
2015 calendar year	786	1387	385	1002	64%	36%
Data source: Sheffield Health and Social Care NHS Foundation Trust Performance Frameworks for 2011/12 through 2015/16						

The data above gives an indication of the treatment needs of those referred. The table shows that there has been a reduction in the number of people referred for a pharmacological intervention since the 2013/14 year. However, the total number of referrals to psychosocial interventions has increased. The data also tells us that although the number of referrals to SEAP has reduced, the number referred for a psychosocial intervention has increased on the previous year.

Pharmacological Interventions: MoCAM[23] states that '*Pharmacological therapies are most effective when used as enhancements to psychosocial therapies as part of an integrated programme of care. The Review of the effectiveness of treatment for alcohol problems1 identifies three classes of pharmacotherapy that are effective in the treatment of alcohol misusers:*

- *medications for treating patients with withdrawal symptoms during medically assisted alcohol withdrawal*
- *medications to promote abstinence or prevent relapse, including sensitising agents*
- *nutritional supplements, including vitamin supplements, as a harm reduction measure for heavy drinkers and high-dose parenteral thiamin for the prevention and treatment of individuals with Wernicke's encephalopathy.*

The availability of appropriate medications will be an essential element in any comprehensive local treatment system. Prescribed medications are not a stand-alone treatment option.

The number of new pharmacological interventions delivered over the last 3 years is shown in the table below.

Year	Number in prescribed treatment target	Prescribed clients	%
2013/14	756	657	87%
2014/15	756	628	83%
Calendar year 2015	756	616	81%
Data source: Sheffield Health and Social Care NHS Foundation Trust Performance Frameworks for 2013/14 through 2015/16			

Following a referral from SEAP in 2015 616 individuals commenced a pharmacological intervention with SHSC, 81% of the contract level, and 78.4% of the referrals from SEAP commenced the intervention. This represents a 2nd year decrease in the number of prescribed clients. However, in the same period the number of people referred for PSI and EBI has increased.

Pharmacological Interventions	Number exiting treatment	Number of successful exits	% successful
2013/14	1008	613	61%
2014/15	862	439	51%
2015/16 first three quarters	704	341	48%
Data source: Sheffield Health and Social Care NHS Foundation Trust Performance Frameworks for 2013/14 through 2015/16			

Data shows that the percentage of exits from a pharmacological intervention that are successful has been decreasing. This needs to be addressed to ensure that clients are receiving support appropriate to their needs and to ensure that completion rates do not continue to reduce. Work is currently ongoing to determine that there is accurate recording of clients leaving the treatment system. Plans are also being put in place to ensure that following the data review, there is a continued focus on increasing the successful completion rate, to address any reduction that is not due to data recording.

[23] *Models of care for alcohol misusers* (MoCAM)
http://www.alcohollearningcentre.org.uk/_library/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf

Psychosocial Interventions: MoCAM[24] states that *'A range of more intensive, structured psychosocial treatment interventions will be required for people with moderate and severe alcohol dependence, for those with recurrent alcohol problems, for those with complex needs and for those who may be particularly vulnerable'*.

Year	Number in PSI treatment target	PSI Clients	%
2013/14	533	473	89%
2015/16 forecast	533	509	95%
Data source: Turning Point Performance Framework for 2013/14 and Sheffield Health and Social Care NHS Foundation Trust Performance Frameworks for 2015/16			

This table shows that the forecast for 2015/16 is that the number of PSI clients will increase in comparison to the 2013/14 year. Complete data in 2014/15 is not available due to the change in provider. The numbers reported here include clients that were receiving PSI at the start of the year (89). YTD there have been 315 new clients to PSI (out of 331 referrals) which would forecast to 420 new by the year end. It also means that YTD 95% of the referrals from SEAP to PSI have commenced their intervention.

Year	Number exiting treatment	Number of successful exits	% successful
2013/14	292	186	64%
2014/15	414	220	53%
2015/16 first three quarters	289	181	63%
Data source for 2013/14: Turning Point Performance Framework *Data Source for 2014/15: Sheffield Health and Social Care NHS Foundation Trust Performance Frameworks* *Dats source for 2015/16: NDTMS data for alcohol-only clients*			

Successful completions for those receiving PSI have increased to 63% in 2015/16 (YTD as at the end of Q3) as a proportion of all exits. The percentage successful from a psychosocial intervention has remained above 50% in all of the previous 3 years.

Alcohol Treatment Requirements: Part of the PSI cohort is made up of individuals that are on an Alcohol Treatment Requirement (ATR). ATRs are a court ordered treatment disposal. They have two parts - the court order for an ATR (usually for 6 months duration) and during this time alcohol treatment is provided. The ATR target is for 200 clients to commence and for 104 to successfully complete per annum.

The forecast for 2015/16 is that there will be around 111 commencements and 86 successful completions. Although this is below target the completion rate (77.5%) is high for those who do commence an ATR. The number of ATRs is also dependent upon them being ordered by the court, the provider has no control over the number of ATRs the court orders.

Extended Brief Interventions: As well as the structured PSI the service also offers brief interventions and extended brief interventions. The number of extended brief interventions is shown in the table below:

[24] Models of care for alcohol misusers (MoCAM)
http://www.alcohollearningcentre.org.uk/_library/BACKUP/DH_docs/ALC_Resource_MOCAM.pdf

EBI	2012/13	2013/14	2014/15	2015
Number of people receiving EBI	563	694	841	662
Total EBI Sessions held	2453	3179	4169	4337
Avg. number sessions per person	4.4	4.6	5.0	6.6

The number of people receiving EBI has decreased in the most recent 12 months in comparison to the 2014/15 financial year, following increases between 2012/13 and 2014/15, we can see that the average number of sessions delivered per person has increased year on year. This tells us that those referred for the lower level intervention of EBI are requiring more support which might suggest that some clients are becoming more complex and / or that some of them may benefit from the structured PSI offer. Data collected between July and December 2015 has told us that 17.5% of referrals to EBI have required more than 6 sessions. Looking at the referrals to EBI and comparing them to the number of people that received EBI, 66% of referrals received the intervention. This represents the highest dropout from referral to treatment of any of the groups.

Inpatient Detoxification – MoCAM states this Tier four treatment intervention is *'Dedicated specialised inpatient alcohol units are ideal for inpatient alcohol assessment, medically assisted alcohol withdrawal (detoxification) and stabilisation. Inpatient provision in the context of general psychiatric wards may only be ideal for some patients with co-morbid severe mental illness, but many such patients might benefit from a dedicated addiction specialist inpatient unit'.*

Over the last three years[25] 42 inpatient detoxification places have been commissioned annually in Sheffield, however in each year the number who have received such treatment has been significantly over target (64 people April – December 2015), this is because of the careful assessment and efficiency of the process. 78% of all those receiving inpatient detoxification were successful (alcohol free) on exit.

Residential rehabilitation – purchased on a case by case basis, there is a thorough needs assessment and subsequent approval process (care management panel) where all new starts and treatment continuation packages (both of 12 weeks treatment duration) are approved. The care management panel (which includes social workers, the DACT Commissioning Manager and SHSC (social workers have completed the assessment process with the client) reviews each case and determines the outcome, including which residential provider to use. The choice of provider is determined by a number of decisions which include location (within 100 miles radius of Sheffield) and previous client outcomes.

A total of 16 new treatment packages[26] (100% of those presented) and 17 continuation packages were agreed between April and December 2015. Of the 24 completions in the year, 14 (58%) were successful.

NATMS Treatment Data: Public Health England provides regular analysis on data submitted to the National Alcohol Treatment Monitoring System (NATMS). This informs providers and commissioners on the performance of services and the treatment clients receive. NICE guidance *'Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults – commissioning guide'* states that commissioning should have a particular focus on outcomes from treatment (e.g. increasing access and provide recovery based treatment). This links to the Government's alcohol strategy which aims to *'increase the effective-(ness)* of *treatment for dependent drinkers'.* A further measure of the success of treatment is reported by PHE. Following a successful completion from treatment data is monitored to see if the client re-presents to treatment with 6 months of the successful exit. Data reported by PHE for Sheffield and England for 2015 is shown in the tables below.

[25] Data provided by SHSC, as part of their quarterly performance monitoring framework to DACT
[26] Data provided by SHSC, as part of their quarterly performance monitoring framework to DACT

Successful completions (12 months to December 2015)	Sheffield	National
Numbers in treatment - rolling 12 months	833	83297
Total completions - rolling 12 months	241	32709
Successful completions as a proportion of number in treatment - rolling 12 months	29%	39%

The nationally reported data for alcohol-only clients shows that 29% of the Sheffield treatment population in the last 12 months have completed treatment successfully in comparison to 39% nationally. The majority of people not recorded as successfully completing remain in treatment. Performance against this measure showed a decline from the start of the 2014/15 year but more recently has begun to show increases. It is worth noting that the numbers reported here are exits from the treatment system. The data shown previously was for exits from an intervention which may or may not have been an exit from the treatment system.

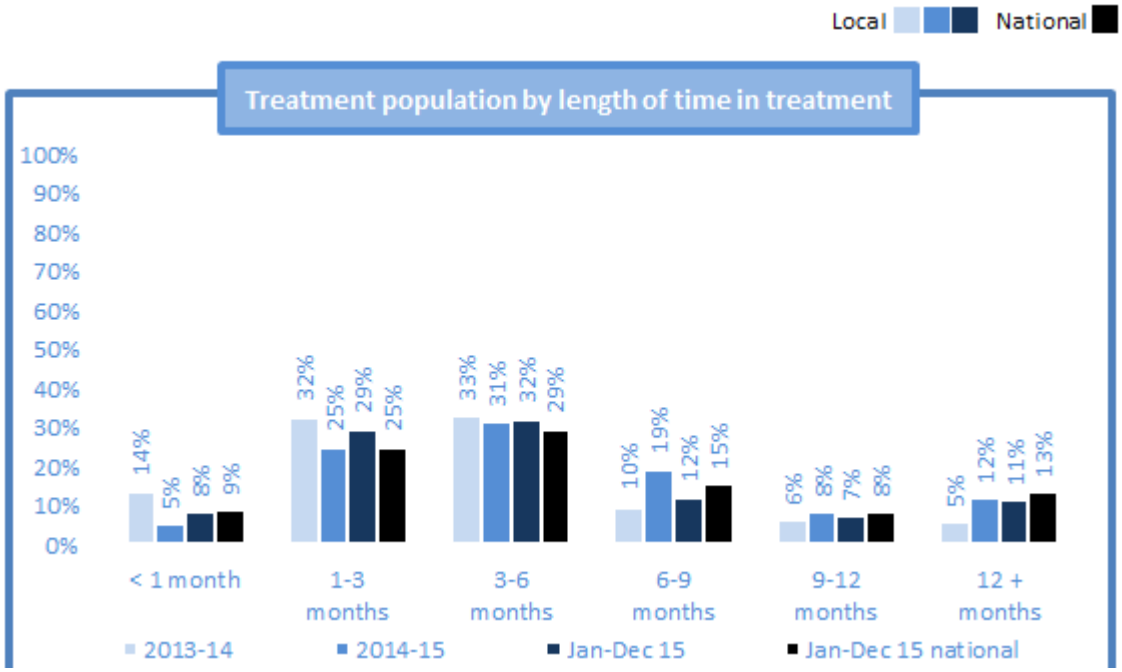
Successful completions (12 months to December 2015)	Sheffield	National
Number of clients successfully completing treatment in the first 6 months	123	18555
Number who re-presented for treatment within 6 months of completion	17	1881
Re-presentations as a proportion of successful completions	14%	10%

The table above shows the re-presentation rate for clients who completed treatment in the first 6 months of 2015. A re-presentation to treatment is one that occurred within 6 months of the date of the successful completion hence why the data only looks at completions in the first 6 months; to allow for the 6 month re-presentation window. In Sheffield there were 17 re-presentations out of 123 completions that occurred between January and June 2015, equating to 14%, which is an increase on the previous two years. This compares to a re-presentation rate of 10% nationally. The limitation of this data is that it does not tell us the proportion that have re-lapsed post treatment but have not yet re-presented to the treatment provider.

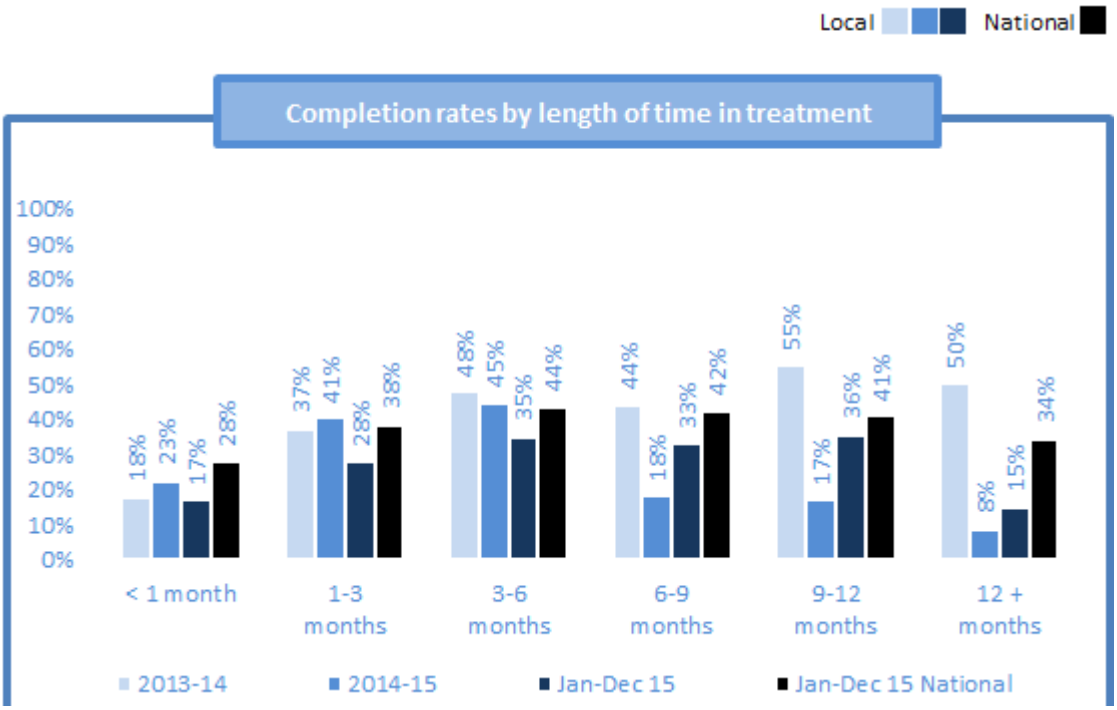
It is important that the commissioners and providers work together to ensure that the successful completion rate improves but without an increase in re-presentation rates.

NATMS also release data on successful completions by length of time in treatment and previous treatment journeys. The two charts below show the treatment population by the length of time in treatment, and the successful completion rate for people in treatment for this length of time[27].

[27] Data and evidence in the following section is taken from the Recovery Diagnostic Toolkit 2015.



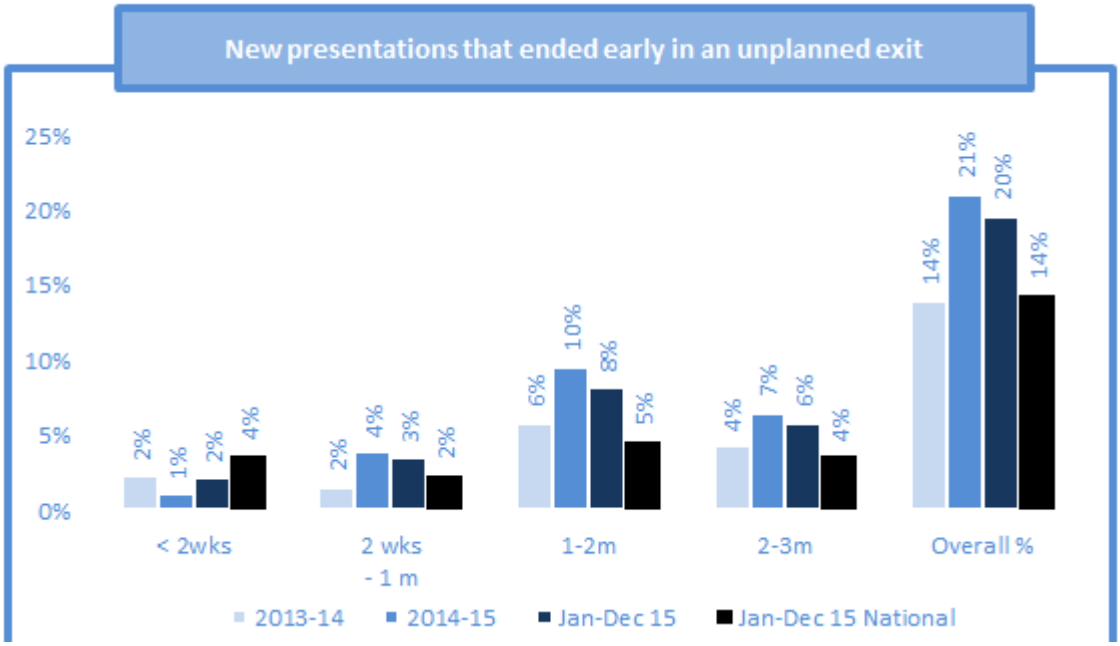
In the main, length of time in treatment in 2015 has been similar to the national data, peaking for both groups between 1 and 6 months in treatment. Sheffield had a slightly higher proportion than nationally in treatment for this time, and slightly lower proportions in treatment longer than this period. Evidence suggests that fewer people remain in treatment longer than 12 months, and those that do are less likely to successfully exit. There may be reasons for remaining in treatment longer, such as having low levels of recovery capital, or ill-health may mean that staying in treatment is best for the client. The provider's performance managers alongside clinicians should ensure however, that they continually review clients in treatment for long periods of time to identify those who may be ready to escalate their efforts.



This chart shows the percentage of people that successfully completed by the length of time they were in treatment. In Sheffield there are lower completion rates than seen nationally for all groups. In the last 12 months the completion rate has dropped significantly for those who were in treatment between 1 and 6

months. Sheffield also has a significantly lower rate of completions for people in treatment 12 months+ than is seen nationally, even though the proportion in treatment for this length of time is similar to the proportion nationally. This reinforces the need to review clients who, with support, may be in a position to increase their efforts to successfully complete treatment.

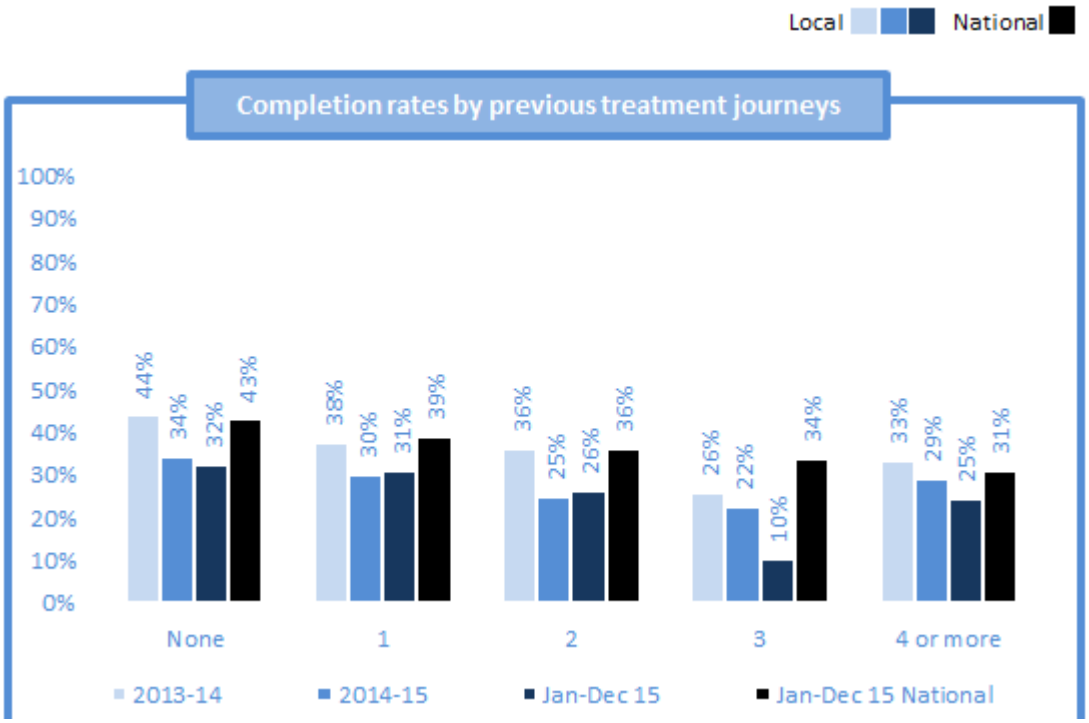
Individuals who have numerous previous treatment journeys, especially those with unplanned exits, are less likely to complete treatment successfully.



Generally early unplanned exits for new treatment journeys have reduced in the most recent 12 months, as can be seen in the chart above. However, overall 20% of new presentations end in an unplanned exit, higher than the 14% seen nationally. These clients will limit the benefit they have received from treatment and also increase the risk of relapse. This may also lead to them re-presenting and becoming a client with multiple treatment journeys.

45% of the Sheffield treatment population in 2015 had not had a previous treatment journey, however, this proportion has decreased year on year, and is a pattern that is seen nationally.

The chart below shows that the likelihood of completion decrease with each treatment journey, and that completion rates for people with no previous treatment journey is also decreasing. In Sheffield there is an increase in the proportion of people completing treatment who have had 4+ previous journeys, this bucks the trend seen nationally.



The recovery diagnostic toolkit suggests that those with multiple unsuccessful treatment journeys may suggest that previous packages of care did not work for the client.

In Sheffield there is a need to understand more about those in treatment longer periods of time and the proportion that do not exit successfully. Reviewing these clients may lead to improved outcomes and better packages of care to support the individual achieve and sustain recovery.

Mutual Aid: Mutual aid is peer led open access support for individuals who either do not wish to have formal treatment at the given time, who wish to have that additional support when in treatment or who are post treatment to aid their recovery. Usually held in groups these can be based in any location and generally have a theme (art group, music group) or a set of values and vision (Alcoholic anonymous' aim is *'to stay sober and help other alcoholics to achieve sobriety'*[28]). Mutual aid services are <u>not</u> commissioned; therefore DACT is not responsible for the governance of these services.

In the last couple of years support for mutual aid has increased, with active support given by both the Advisory Council on the Misuse of Drugs (ACMD) recovery committee and Public Health England.

In Sheffield the DACT Mutual Aid response has been to raise the profile and encourage an increase in the number of mutual aid groups available. This has been mainly driven by the introduction of SMART recovery and some groups have been introduced in commissioned treatment services.

Sheffield Alcohol Support Services (SASS) are the provider of SMART and the Alcohol Recovery Community (ARC) in Sheffield, commissioned services and SASS work in partnership to address alcohol misuse.

DACT's role is not to commission mutual aid but to:-

- Discuss with alcohol treatment providers in their DACT review the mutual aid response by clients and their own mutual aid provision.

[28] Quotes taken from http://www.alcoholics-anonymous.org.uk/

- Co-ordinate mutual aid provision via the SURRG, which now has mutual aid leads attend regularly from SMART recovery, AA and Jesus Army. Part of this is to co-ordinate the Sheffield response to National recovery month which happens each September. In 2013 the response was only a week of action; which included installing AA support books in Sheffield libraries. In 2014 there will be a full month of MA profile raising and additional activities available for individuals to try.
- To promote the time table of MA groups and activities available via the DACT website. DACT does not endorse any of these groups and it is for individuals to choose to attend and determine if it is the most appropriate group for them.

Over recent years the offer of mutual aid groups has expanded greatly from there being a couple of sessions per week in limited locations to their now being sessions available every day of the week in a large number of locations.

6. Diversity and Vulnerabilities

Gender & Age: In Sheffield, the most recent data shows that 66.5% of the people receiving treatment for alcohol are male and 33.5% female. This compares to 61% males and 39% females nationally.

The age group with the highest proportion of individuals in treatment locally is 45 – 49 years, with 18.5% of people in treatment falling in to this group. It is also the age group with the highest proportion of people in treatment across the country, however nationally; it is 17.1% of the treatment population.

Data reported by the Health and Social Care Information Centre (HSCIC)[29] states that adults aged 45 – 64 were most likely to report drinking alcohol in the last week than other age groups, with men in that age group drinking more than women, 71% and 59% respectively. Those aged 16 – 24 were most likely to report drinking heavily (more than 12 units for men and 9 units for women) at least once in the last week (27%), 26% of men and 28% of women.

Ethnicity & Nationality

88% of the Sheffield treatment population are white British in comparison to 81% of the overall Sheffield population. This also compares to 84% of the whole of the alcohol treatment population in England.

1.8% of the treatment population are other White, in comparison to 2.3% in Sheffield, and 3.6% nationally. All other ethnicities each make up less than 1% of the Sheffield treatment population. This is similar to what is seen nationally.

Religion

Data on a person's religion is only collected locally. Out of the alcohol clients who were asked the question in 2015, 59% stated that they were Christian, 1.4% Muslim, and 38% stated they were of no religion.

Sexual Orientation

A person's sexuality is also only collected locally. Out of the people that were asked the question; 78% said they were Heterosexual, 1% were gay males, and 21% did not want to answer the question. Numbers for bisexual and lesbians were not reported due to the low number of people stating that this was their sexual orientation.

Disability

Data on disability has not been reported locally by the provider. The data is to be collected nationally via NATMS from 1st April 2016.

Neighbourhood areas

Higher risk prevalence:

[29] Statistics on Alcohol, England 2014, Health and Social Care Information Centre, Published May 2014.

Local PHE analyst teams have created local profiles for each of the 100 neighbourhoods using the higher risk prevalence data and binge drinking prevalence data[30].

The data shows that the top five neighbourhoods with the greatest prevalence for higher risk drinkers in Sheffield were Endcliffe (15.2%), Crookesmoor (15.1%), City Centre (14.9), Highfield (14.6%) and Broomhill (14.5%).

Binge drinking prevalence

The six neighbourhoods in Sheffield with the highest prevalence of binge drinking were: - City Centre (41.1%), Crookesmoor (39.1%), Highfield (39.6%), Endcliffe (39.4%), Broomhill (37.5%) and Netherthorpe (37.5%).

The seven wards[31] with higher than average levels of childhood poverty are Central, Arbourthorne, Burngreave, Darnall, Firth Park, Manor Castle and Southey Green.

Burngreave is ranked in the top twenty wards with the highest prevalence rate for higher drinkers but does not fall in the top ten.

Burngreave and Darnall are in the top 11-20 neighbourhoods with the highest prevalence for binge drinking.

	Alcohol: High Risk Drinkers (Age 16+), 2011				Alcohol: Binge Drinkers (Age 16+), 2011				Alcohol: Admissions for Alcohol-Specific Conditions (All Ages), 2011				Alcohol: Admissions for Alcohol-Attributable Conditions (All Ages), 2011			
	Numbe	% of adults (age 16+	LL 95% C	UL 95% C	Numbe	% of adults (age 16+	LL 95% C	UL 95% C	Numbe	DASR per 100,000	LL 95% C	UL 95% C	Numbe	DASR per 100,000	LL 95% C	UL 95% C
Arbourthorne	545	12.9	4.7	32.2	1500	30.2	25.8	34.9	155	830.3	703.9	972.8	444	2244.0	2036.4	2466.7
Burngreave	452	13.1	4.8	32.6	1303	32.2	27.6	37.3	91	627.4	501.5	774.7	319	2166.0	1922.6	2424.8
Darnall	726	13.0	4.8	32.4	2104	32.1	27.5	37.2	122	572.8	472.4	687.8	442	1900.9	1719.2	2095.9
Firth Park	160	13.0	4.8	32.4	457	31.5	27.0	36.5	12	210.0	108.0	367.5	83	1531.9	1213.9	1905.4
Manor	825	12.9	4.7	32.3	2322	30.9	26.5	35.8	240	852.0	746.6	967.9	724	2498.7	2317.0	2690.7
Southey Green	496	12.8	4.7	32.1	1361	30.0	25.7	34.7	157	912.8	774.8	1068.2	418	2347.5	2124.8	2587.0

Arbourthorne, Manor and Southey Green are in the top 11-20 neighbourhoods with the highest rate of alcohol admissions to hospital for specific conditions.

Manor is in the top ten of neighbourhoods with the highest rate of alcohol attributable admissions to hospital whilst
Arbourthorne, Burngreave and Southey Green are in the top 11-20 neighbourhoods.

Only Firth Park is not ranked in the top 20 for any of the four factors.

Treatment area information is provided at high postcode level and therefore is not directly comparable to the neighbourhood's data. The data in the table below is for clients in treatment during 2015.

[30] Each profile gives a snapshot overview of key Health and Well Being indicators in a chosen Neighbourhood, with comparisons to Sheffield. This profile may be used for non-commercial purposes provided the source is acknowledged: Source: Sheffield Neighbourhood Health & Well-Being Profiles 2012, Public Health Intelligence Team, SCC. v1.1: 15th May 2013 https://www.sheffield.gov.uk/caresupport/health/health-wellbeing-board/health-and-wellbeing-across-sheffield/sheffield-health-and-wellbeing-indicator-tools.html

[31] The wards with higher than average child poverty levels are: Arbourthorne, Burngreave, Central, Darnall, Firth Park, Manor Castle, Southey, Walkley., The most up to date specific levels can be found at http://www.hmrc.gov.uk/stats/personal-tax-credits/child_poverty.htm

First part of postcode	Activity	%	First part of postcode	Activity	%
S5	140	14.10%	S9	41	4.10%
S2	107	10.80%	S3	32	3.20%
S6	94	9.50%	S14	28	2.80%
S8	94	9.50%	S36	27	2.70%
S13	92	9.30%	S4	24	2.40%
S20	57	5.70%	S7	21	2.10%
S12	55	5.50%	Out of Sheffield	18	1.80%
S35	49	4.90%	S17	14	1.40%
S10	46	4.60%	S1	10	1.00%
S11	42	4.20%	Not provided	3	0.30%
			Total	994	

The data shows that those who reside in an S5 postcode (Longley, Shiregreen, Southey Green, Sheffield Lane Top, Firth Park) contributed to the highest number of people in treatment, followed by S2 (Manor, Manor Park, Arbourthorne, Wybourne, Norfolk park, High field, Lowfield) and S6 (Hillsborough, Malin Bridge, Birley Carr, Wisewood, Wadsley, Wadsley Bridge, Loxley).

Consideration should be given to specific areas in Sheffield, as there are some links between those areas of higher than average childhood poverty and those accessing treatment with some of these areas also in the top 20 for prevalence and hospital admissions. However the areas with the highest prevalence of drinking; are more affluent and have a lower number accessing treatment.

Domestic and Sexual Abuse

The National Coalition Against Domestic Violence in the US[32] provides a useful summary to drug and alcohol use and its relationship with domestic violence. *'While substance abuse does not cause domestic violence, there is a statistical correlation between the two issues (1). Studies of domestic violence frequently indicate high rates of alcohol and other drug use by perpetrators during abuse (2). Not only do batterers tend to abuse drugs and alcohol, but domestic violence also increases the probability that victims will use alcohol and drugs to cope with abuse (3). The issues of domestic violence and substance abuse can interact with and exacerbate each other and should be treated simultaneously (4)[33].'*

Local data reported in Sheffield for 2015 shows that substance misuse services referred 26 individuals to domestic and sexual abuse services, and that domestic and sexual abuse services referred 3 people to the alcohol service. This is not reflective of other data collected; however, a service user at any service would have to consent to a referral to other services for the referral to be made. For example, in 2015 there were 921 cases discussed at MARAC and 33% of the cases were recorded as having alcohol as a significant contributing factor. Also, out of 1420 people accessing domestic abuse services, 13% stated they misused alcohol.

South Yorkshire Police record an intoxication flag (under the influence of drugs / alcohol) for both domestic abuse crimes and incidents. The flag is recorded against all suspected / accused persons and for some complainants. The most recent data made available by South Yorkshire Police (SYP) is for the 2013/14

[32] www.ncadv.org/images/Substance_Abuse.pdf
[33] The National Coalition Against Domestic Violence (NCADV) cites the following references 1 Fazzone, Patricia Anne, et al. "Substance Abuse Treatment and Domestic Violence: Treatment Improvement Protocol." U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information. 2, 3 "Making the Link: Domestic Violence & Alcohol and Other Drugs." U.S. Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information. 4 Fazzone, Patricia Anne, et al.

year. At the time of requesting 2014/15 data the service was unable to provide the data due to capacity issues.

In 2012/13 36.7% of all suspected / accused persons were recorded as under the influence of drink/drugs and this reduced to 32.4% in 2013/14. Out of the complainants who did have an intoxication status recorded, 27.2% were recorded as intoxicated in 2012/13. This percentage also reduced in 2013/14 when 24.7% were recorded as intoxicated.

Alcohol and drugs as an aggravating factor are recorded for all domestic abuse crimes but not for incidents. There was an 11.1% increase in the number of domestic related crimes in 2013/14 when compared to 2012/13. However, domestic related crimes that were alcohol aggravated reduced by 4.7% between the two years, with 759 recorded for 2012/13 and 723 in 2013/14.

It should be noted that for both crimes and incidents the intoxication status is not determined by testing but subjective judgement, most often made by the complainant.

A new process is being implemented by SYP when attending domestic related crimes and incidents. Where it is identified that the perpetrator and / or the victim are intoxicated SYP will seek consent from the individual for their details to be passed to the appropriate substance misuse service. The service will then contact the individual to offer them an initial assessment.

Pregnancy

The UK health departments recommend that women should avoid drinking alcohol before and during pregnancy. The Opinion and Lifestyle Survey 2013[34] found that 72% of pregnant females reported themselves as not drinking alcohol at all, with 9% reporting that they had drunk some alcohol in the last 7 days. The Department of Health says that pregnant women who do choose to drink alcohol should not exceed one or two units of alcohol once or twice a week.

The Infant Feeding Survey (2013)[35] found that in England during 2010 women were less likely to drink during pregnancy (41%) than five years previously in 2005 (55%). Of those who drank before their pregnancy (80% of the total), 48% gave up drinking altogether, 47% drank less and 2% remained drinking as before with the main reason (86%) for their change in drinking habits was the harm it may cause to the baby.

In 2010, two in five mothers (40%) drank alcohol during pregnancy, which is a lower proportion than in 2005 (54%). Mothers aged 35 or over (52%); mothers from managerial and professional occupations (51%) and mothers from a White ethnic background (46%) were more likely to drink during pregnancy.

The Infant Feeding Survey has now ceased and therefore more recent data is not available.

Older Drinkers

It is estimated that 1.4 million individuals in the UK aged over 65 exceed alcohol unit recommendations, and that 3% of men and 0.6% of women between the ages of 65-74 are dependent drinkers. 39% of the Sheffield treatment population are males aged 45-64 which does support the indication that there is a significant issue of alcohol misuse among older cohorts. In quarter 1 of 2015/16, 9.1% of individuals in alcohol treatment were aged over 60 years. Sheffield has been selected as a demonstration area for the Big Lottery funded 'Drink Wise Age Well' project, which aims to reduce alcohol related harm in the over 50s

[34] http://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/compendium/opinionsandlifestylesurvey/2015-03-19/adultdrinkinghabitsingreatbritain2013#drinking-in-pregnancy

[35] The Infant Breastfeeding Survey 2010, http://www.hscic.gov.uk/catalogue/PUB08694

by awareness raising and campaigning, resilience building activities and age appropriate alcohol interventions and support.

Adjunctive Drug misuse

Between April and December 2015 there have been a total of 997 people in treatment who cited the use of alcohol as a problematic substance, 71% of them cited only the use of alcohol as a problematic substance. However, 10.8% stated that they also used non-opiates, 3.4% stated that they used opiates, and 14.5% stated that they used alcohol, opiates and non-opiates.

For those who did report the use of other substances the most common drug used is Cannabis. 45% of people who used other substances cited the use of Cannabis. 26.8% cited the use of opiates, and an additional 35.5% cited the use of opiates and crack.

7. Night time Economy

The National Alcohol Strategy explains the challenge faced nationally that drills down to local areas, with Sheffield no different to any other major city. How to create a safe drinking environment, build a robust and entertaining night time economy that draws people and businesses into the city thus boosting the local economy whilst addressing the minority that misuse alcohol in the same environment.

Initiatives such as Purple Flag, Best Bar None and the update to the Licensing Act (2003) applied locally work to create a safe drinking environment including the safe sale of alcohol, partnership work in the city-centre between major agencies – the police, safer neighbourhood officers, the city council, trading standards, safeguarding, DACT and health services work together to manage and reduce the levels of alcohol related crime, health issues and harm caused by the effects of alcohol misuse.

The aim of the local alcohol strategy 2016-2020 is to build on the focus of the 2010-2014 strategy to offer a vibrant selection of entertainment whilst ensuring alcohol related harm was minimised. Significant achievements have been made in this area.

Work on alcohol and the night time economy (NTE) in Sheffield must be pragmatic: people use alcohol as part of their leisure time and social life, to discourage this completely would be unrealistic. Rather, there must be a balance between supporting Sheffield to achieve the strong economy identified as a goal in the Corporate Plan, and minimising harms from alcohol use in the night time economy, to ensure the health and well-being of its citizens. Below are some examples of what has already been achieved in this area in Sheffield:

Purple Flag - In 2011, Sheffield was the first city in Yorkshire to be awarded 'Purple Flag' status. This is a national accreditation status given to 'town centres that meet or surpass the standards of excellence in managing the evening and night-time economy'.[36] Sheffield was re-accredited in 2014.

Best Bar None: a Home Office supported accreditation scheme for responsible practice by licensed premises, and its assessment is based on the principles of licensing practice. Currently in its 7th year, 39 premises are accredited. The scheme is open to licensed premises within the city centre ring road, Ecclesall Road and Sharrowvale Road. The scheme has raised awareness about good licensing practice among licensed premises in the city, improved links between the LA and licensed premises and given a visible 'brand' to a safe night time economy. In 2013 an 'app' was created which identified all BBN accredited premises in a free downloadable form. Promotion of the app was made difficult by lack of resources.

[36] https://www.atcm.org/programmes/purple_flag/WelcometoPurpleFlag

8. Children & Young People

Alcohol misuse does not just affect those of legal drinking age; there are two perspectives in which alcohol can affect young people negatively:-

1. It is well known that young people ages 17 and under drink alcohol and that some drink beyond above the Department of Health healthy drinking guidelines for adults.
2. Young people can be affected in a number of ways by an adult's alcohol misuse problem.

The Silent Voices report by the Children's commissioner writes that children living with alcohol misusing parents are slower to be identified than those living with a drug misusing parent. However we do know the following:-

- around 23% of all child protection conferences had alcohol misuse as a compounding factor in 2015
- 6% of all pregnant mothers referred to and discussed at the Substance misuse Multi Agency Pregnancy Liaison and Assessment Group (MAPLAG) in 2015 were known to be alcohol misuse parents[37]
- 41% of those in community based alcohol treatment were parents and living with a child[38].

We also know that the latest LAPE data tells us that Sheffield has the 8th lowest rate (out of 148) of alcohol related hospital admissions for those under the age of 18. This is also the lowest rate out of all of the core cities.

Sheffield's Safeguarding Children Board Manager chairs a quarterly meeting on 'Hidden Harm'. This specifically addresses the issue of safeguarding children and young people who live in households with parental/family member substance misuse.

Much of the work of Sheffield's services, including substance misuse services, in relation to hidden harm and supporting children and young people whose parents misuse drugs and alcohol is contained in the *Sheffield Hidden Harm Strategy 2013-2016*.[39]

9. Future Commissioning

The Alcohol Service contract is due to be tendered in 2016/17. The procurement process to commission a new treatment system is in progress and is an action in the new alcohol strategy (due 2015).

The procurement consultation process has been wide and included experts, providers, service users and the general public. The current proposal is to commission a one provider model, where all clients can start and end their treatment journey with the same provider. This is considered the most effective and cost efficient method to address known needs.

The new contract will not remove any treatment commissioned previously but will enhance what was commissioned in the past, and includes new services.

Headlines from the new alcohol specification:-

1. **Single Entry and Assessment Point (SEAP) and Identification and Brief Advice (IBA)**
   SEAP will provide the assessment stage of treatment. Validated screening tools will be used and all will receive personalised harm reduction advice as well as appropriate onward referral into treatment.
2. **Pharmacological Interventions**

[37] Sheffield Safeguarding Children report, DACT Provider Monitoring framework Q4 2013/14.
[38] JSNA Alcohol and drugs JSNA Support pack; key data to support planning for effective drugs prevention, treatment and recovery: Sheffield. Public Health England (2013). Data quality issues mean that robust more recent data is not available.
[39] www.safeguardingsheffieldchildren.org.uk/welcome/sheffield-safeguarding-children-board/safeguarding-children-substance-misuse-service/hidden-harm.html

Including community detoxification, prescribing interventions to reduce harm (for example nutritional prescribing, and prescribing to prevent relapse (Naltrexone, Disulfiram, Acamprosate).

3. **Formal Psychosocial Interventions**
   Formal PSI will be offered as either 3-6 weeks of extended brief interventions (EBI) or 6-12 weeks of Psychosocial interventions, based on clinical need.
4. **Nurse Support Services**
   A and E/Hospital Liaison Nurse and GP/Primary Care Liaison Nurse for alcohol will be provided and will identify people in primary care or hospital settings who have alcohol misuse problems alongside other health problems. The nurse support will include screening, harm reduction advice and onward referral into structured treatment where appropriate.
5. **Criminal Justice / Enforcement Routes to Alcohol Treatment**
   The service will provide appropriate interventions to those mandated to attend treatment appointments as part of criminal justice or other enforcement measures. This will be provided using screening and treatment capacity already in place for Parts 1, 2 and 3.

The contract will be awarded by Sheffield City Council using their procurement processes.

10. Gaps and Priorities

Utilise this data update to the Alcohol Needs Assessment alongside the 2014-15 full Needs Assessment to assist in achieving the goals of the 2016 – 2020 Alcohol Strategy for Sheffield.

Put out for tender the new alcohol service contract. On awarding the contract, monitor the mobilisation and performance of the provider during the first year of the contract.

Work with providers to ensure data consistency and accurate reporting to the national database, including the successful implementation of NATMS Core Dataset-M.

Provide information and education in regard to the long-term effects of drinking and the specific conditions it can cause, particularly targeted to males, as well as identification and early intervention amongst all groups.

Maintain the distribution of up to date promotional literature and liaise with partners to ensure that where identified, all appropriate individuals are referred to SEAP for an assessment.

Continue to increase the number of licences / users of the alcohol screening tool and encourage its use amongst partners and existing users and assist the drug treatment provider to implement a screening tool for drug misuse.

Increase numbers in to treatment.

Increase number of successful completions.

Monitor the proportions of individuals receiving a pharmacological intervention and PSI.

Understand more about those in treatment longer periods of time and the proportion that do not exit successfully. Reviewing these clients may lead to improved outcomes and better packages of care to support the individual achieve and sustain recovery.

Monitor and encourage uptake of the Post Treatment Recovery Support offer.

Maintain links with employment agencies and efforts to assist service users in to employment as part of building recovery capital.