Kent Joint Strategic Needs Assessment (Kent JSNA)

Kent 'Alcohol' JSNA Chapter Summary Update '2014-15'

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Kent Alcohol JSNA Chapter Update 2014

Introduction

Worldwide 3.3 million deaths every year result from harmful use of alcohol (World Health Organization, 2015); globally, this represents 5.9 % of all deaths. Alcohol also causes more than 200 disease and injury conditions accounting for 5.1% of disability-adjusted life years (DALYs) worldwide. The latest links to be identified are with infectious diseases such as tuberculosis and HIV/AIDs. It causes death and disability quite early in life and is the main cause of all preventable deaths (25%) and illness in working age adults aged between 20 and 39 years. It also causes a range of behavioural disorders.

Alcohol is now the third cause of preventable ill health in Europe (and England) after smoking and hypertension. Deaths from cirrhosis of the liver, an important indicator of population levels of alcohol-related harm, increased in England and Wales five-fold between 1950 and 2002, in contrast to reductions in most other European countries.

The latest data from the Office of National Statistics (ONS), Opinions and Lifestyle Survey (2012), report a consumption decline for men from 72% to 64% and women from 57% to 52% between 2005 and 2012. By 2013 alcohol was nearly 61% more affordable than it was in 1980. In the period 2009-12, spending on alcohol per household increased by 1.3% whilst consumption outside the household fell by 10%.

Approximately nine million adults drink at levels exposing them to some health risk and 2.2 million are drinking at higher risk levels. There are estimated to be 1.6 million people who have some degree of dependence; 250,000 moderately or severely dependent who would benefit from treatment (HSCIC, 2014).

The wider societal annual costs of alcohol-related harm include family breakdown, loss of productivity, homelessness, criminal and anti-social behaviour and injury amongst others. In England, alcohol-related harm is estimated to cost £21 billion. The NHS costs alone are estimated at £3.5 billion with the four largest disease conditions associated being heart and liver disease, stroke, and cancer. Accident and Emergency attendances (about 70% related to alcohol at weekends) and hospital admissions have more than doubled over the last 15 years to approximately a million episodes (Public Health England, 2014).

Health inequalities are clearly evident as a result of alcohol-related harm; Department of Health (DH) analysis of ONS data indicates that alcohol-related death rates are about 45% higher in areas of high deprivation and liver disease represents one of the few diseases where the inequalities gap is increasing.

The aim of this needs assessment update is to describe the pattern of alcohol misuse in Kent and review current service provision in relation to need and make commissioning recommendations for improvement and service development. For ease, adults and children / young people's services will be described separately.

More information including Ward level alcohol profiles and the Kent Public Health Annual Report (2015) are available at: http://www.kpho.org.uk.

Key Issues and Gaps

Alcohol Identifications and Brief Advice (IBA) and referral to treatment services is not routinely undertaken by all health or allied professionals as part of the assessment, diagnosis and referral processes they may undertake.

This is an important omission especially relevant for cancer, gastro-intestinal and cardio-vascular disease (CVD) groups most notably hypertension and stroke. The links and subsequent impact upon urgent and non-elective (emergency) commissioning in these respects should also be made.

There are also missed opportunities for allied care, partner organisations and commissioned providers to undertake systematic and opportunistic IBA and referral at point of public contact. There is scope in extending alcohol IBA and referral to treatment services with criminal justice agencies, pharmacies and families and social care professionals and other partner agencies including community and voluntary groups.

High levels of drinking, often street drinking; amongst residents from Eastern European states is an issue, with barriers to accessing services reported. In the Kent County Council (KCC) area, the second most dominant Ethnic Origins Group (excluding English, Celtic and Irish) is Eastern European; 1.49% of people aged 18+ are in this origins group (Western European is the most dominant group). Barriers to accessing services are also reported amongst the homeless.

There needs to be improved identification of dual diagnosis (those with a mental health condition and substance misuse problems). There is the need to review and support the implementation of the agreed protocol to better meet the needs of such clients and improve the knowledge and skill set of those working within mental health and substance misuse services. Timely and appropriate referrals are crucial and a clear care pathway should be in place. This should improve the quality of care, increase successful treatment outcomes and be evidenced in part by an increase of the number of joint care plans between substance misuse and mental health service providers.

Alcohol misuse remains a problem across the county and particular attention should be given to the increase in young female excessive drinkers as this group may become a major health need concern in the future. Men and women have different service needs and so the needs of women may need to be addressed by different treatment approaches. The emergence of the older population as those drinking frequently and consistently at harmful levels should be addressed.

Different areas have different needs and trends and these should be taken into account within a commissioning strategy and dealt with in association with local partnerships. For example, Canterbury has a considerable student population.

Who is at Risk and Why?

The context of alcohol misuse as a Public Health issue is complex with relationships to a range of issues:

- crime and public safety
- psychological issues and mental health
- links to other dependencies e.g. drug problems
- relationship and family problems
- lifestyle and physical health
- children safeguarding / adult vulnerability.

Age

The most recent Opinions and Lifestyle Household Survey reports that of those aged over 65 years, (18%) reported drinking on the five days prior to the survey – more than any other group. The next largest group at 14% were those aged 45-64 years. Those aged 16-24 years have the largest numbers of those drinking to excess (27%) but overall binge drinking trends in younger people have declined by a third from 29% to 18% since 2005. Smokers (25%) were twice as likely as non-smokers (11%) to have drunk very heavily at least once during the week (ONS, 2014).

Income

The negative health effect and outcomes between wealthier and poorer communities are extreme. Those in the poorest areas are two to three times more likely to die from conditions related to alcohol and three to five times more likely to die if the alcohol directly causes their disease. They are also two to five times more likely to be admitted to hospital.

Health

In 2012-13 a total of 23,288 alcohol admissions were recorded in Kent. This is a 29% increase since 2008-09 (Local Alcohol Profiles for England [LAPE]). These figures reflect not only admission for alcohol specific conditions e.g. alcoholic mental or behavioural problems and alcoholic liver disease but also the significant contribution of alcohol misuse to increased cardiovascular, gastroenterological and cancer admissions: also admissions due to accidents on the road, in the workplace and in the home (including falls).

Table 1 Increased health risks of drinking at increased levels

Condition	Men	Women
Hypertension *(high blood pressure)*	Four fold	Double
Stroke	Double	Four fold
Heart disease	1.7 times	1.3 times
Pancreatitis	Triple	Double
Liver disease	13 times	13 times

Source: Anderson (2007)

Research summary
Research and statistics tells us:

1. 53% of all violent crime (*n=704,000)* related to alcohol, and males were more likely to be involved (62%). Perpetrators were most likely to be strangers (64%), acquaintances (52%) and domestic incident (36%). Peak incident times are weekends between midnight and 6:00 am (ONS, 2015).

2. Serious Case Reviews (SCRs) repeatedly show that parental substance misuse, mental health issues and domestic abuse are the three most common features – the "toxic trio" with links to child protection plans and care and adoption processes (Brandon et al, 2013).

3. Men consume more alcohol than women. However, drinking varies greatly across age and socio-economic groups, resulting in a complex picture of alcohol consumption and alcohol-related harm across gender (DH, 2008).

4. National alcohol segmentation analysis of Hospital Episode Statistics data (Morleo *et al.* 2009) shows that those at highest risk of being admitted to hospital with a primary or secondary diagnosis that was linked to alcohol, are men aged over 35 who work in an unskilled or manual field or are unemployed.

5. People from most minority ethnic groups have higher rates of abstention and lower rates of consumption than the majority white ethnic group. However, drinking varies greatly both between and within minority ethnic groups and across gender and socio-economic groups, resulting in a very complex national picture of alcohol consumption and alcohol-related harm across ethnicity (Thom *et al.* 2010).

6. For women living in the most deprived areas, alcohol-related death rates are three times higher than for those living in the least deprived areas. For men living in the most deprived areas, this is even worse: alcohol-related death rates are over five times higher than for those living in the least deprived areas (DH, 2009).

7. Offenders in the criminal justice system are more likely than the general population to be drinking at increasing and higher risk levels. (The Social Exclusion Unit, [2002] notes that 63% of men in the prison population report drinking at hazardous levels, compared with 38% of men in the general population.)

8. Results from a number of small studies in the UK suggest that there are higher levels of alcohol misuse among lesbian, gay and bisexual people (Ellinas *et al.* 2008).

9. People with mental health problems are at increased risk of alcohol misuse. Depression, anxiety, schizophrenia and suicide are all associated with alcohol dependence (Ellinas et al.2008).

10. Alcohol related health problems are uncommon in people with learning disabilities (Ellinas et al. 2008).

The Level of Need in the Population

Table 2 displays the synthetic estimates and show 23% of the population is estimated to be drinking at either increasing or higher risk levels (LAPE 2013). This is higher than the England average of 22.3% and equates to approximately 272,258 people. Canterbury is estimated to have the highest numbers of higher risk and binge drinkers.

Table 2: Estimated use of Alcohol by the Kent population per district, 2012/13; > 16 years; population base 1.18m

District	Lower risk drinkers		Increasing risk drinkers		Higher risk drinkers		Binge drinkers	
	%	Estimated count	%	Estimated count	%	Estimated count	%	Estimated count
Ashford	72.78	70513	20.40	19761	6.83	6617	16.8	16278
Canterbury	71.88	93307	20.56	26685	**7.57**	**9822**	**18.3**	**23756**
Dartford	73.23	58471	20.05	16007	6.72	5363	17.7	14132
Dover	73.56	68551	19.85	18500	6.59	6137	17.0	15842
Gravesham	73.75	61288	19.72	16393	6.53	5427	14.9	12383
Maidstone	72.36	93320	20.86	26897	6.79	8753	17.8	22957
Sevenoaks	72.69	69090	20.85	19813	6.46	6141	17.1	16253
Shepway	73.98	67254	19.44	17676	6.58	5983	16.6	15092
Swale	73.70	82450	19.66	21995	6.63	7421	16.5	18458
Thanet	73.97	82499	19.09	21297	6.94	7741	15.2	16954
Tonbridge and Malling	72.82	71765	20.69	20387	6.50	6405	16.9	16656
Tunbridge Wells	71.78	67140	21.25	19876	6.97	6516	17.7	16555

Source: NWPHO, LAPE 2013

Dual diagnosis

Research by the National Mental Health Development Unit and the NHS Confederation (2009), estimates that half of substance misuse service users have mental health needs. When an individual has both a substance misuse issue and a mental health condition, this is known as a 'dual diagnosis'. Alcohol is the most commonly used substance among dual diagnosis clients in Kent (KDAAT 2011). As cited by Crawford et al (2003), UK data generally show that:

- increased rates of substance misuse are found in individuals with mental health problems affecting around a third to a half of people with severe mental health problems
- alcohol misuse is the most common form of substance misuse
- where drug misuse occurs it often co-exists with alcohol misuse
- homelessness is frequently associated with substance misuse problems
- Community Mental Health Teams (CMHTs) typically report that eight-15% of their clients have dual diagnosis problems
- prisons have a high prevalence of drug dependency and dual diagnosis.

The Dual Diagnosis Good Practice Guidance from the Department of Health (DH, 2002) has this to say in relation to dual diagnosis:

"Substance misuse is usual rather than exceptional amongst people with severe mental health problems and the relationship between the two is complex. Individuals with these dual problems deserve high quality, patient focused and integrated care. **This should be delivered within mental health services.**

This policy is referred to as "mainstreaming". Patients should not be shunted between different sets of services or put at risk of dropping out of care completely. "Mainstreaming" will not reduce the role of drug and alcohol services which will continue to treat the majority of people with substance misuse problems and to advise on substance misuse issues. Unless people with a dual diagnosis are dealt with effectively by mental health and substance misuse services these services as a whole will fail to work effectively."

Current Services in Relation to Need

The latest LAPE profiles (2011-13) have been released and allow for national and regional comparison across multiple indicators.

Table 3 Kent LAPE performances compared to England benchmark 2011-13

Indicator	Kent compared to England
Mortality	Better or similar
Hospital admissions	Better
Hospital admissions – group cause	Better or similar
Other – benefit claimants due to alcohol	Better

Source: http://fingertips.phe.org.uk/profile/local-alcohol-profiles

Locations

Adult substance misuse services are provided across Kent in all districts and Clinical Commissioning Groups, both in the community and in custodial settings (prison and police custody). Services are delivered through fixed site hubs and satellite sites across Kent eg GP surgeries, Healthy Living Centres, Gateway Centres and mobile recovery vehicles.

Services provided

- Early Intervention work includes:
    - IBA and extended IBA in provider service settings and community venues
- Structured treatment work includes:
    - Arrest Referral schemes

- Alcohol Treatment and Drug Rehabilitation requirement
- Alcohol and Cannabis Diversion scheme
- Structured Psycho-social and harm minimisation interventions
- Pharmacological Interventions
- Community and Ambulatory Detoxification
- Access to inpatient stabilisation and detoxification, and residential rehabilitation.
- Access to mutual aid and recovery communities including Alcoholics Anonymous and Smart
- Recovery groups

Projects
Several projects have been in progress since the last needs assessment update and have to be evaluated:

- AE / hospital in-reach
- IBA trainers
- GP and pharmacy IBA (Thanet and South Kent Coast)
- Prison in-reach
- Dual Diagnosis Champion training programme
- Alcohol Integrated Care Pathway

Service access

- Structured treatment was accessed by 1,648 alcohol users in the latest 12 month period. In the same period 1,169 individuals completed treatment successfully.

- Public Health England have introduced a new Public Health Outcome Framework measure (PHOF 2.16), recording the number of people entering prison with substance dependence issues who were not previously known to community treatment. In Kent 55% of individuals were unknown to community treatment services compared with 47% nationally (NDTMS, 2015).

- The service providers of adult treatment are Turning Point in East Kent, and Crime Reduction Initiatives in West Kent. Both contracts come to an end this financial year and will need to be re-tendered.

Children and young people's services
Early Intervention services for young people are provided on a one-to-one basis in youth hubs, integrated settings and in a group work basis in schools, youth offending services and children's homes by KCA. Both Early Intervention services and specialist treatments are offered.

Early Intervention work with children includes:

- One-to-one brief interventions
- Group work including RisKit, targeted at those who are likely to engage in risk-taking and problematic behaviour

Specialist treatment work includes:

- One-to-one psycho-social interventions
- Intensive one-to-one support
- Specialist prescribing
- Work with parents / carers

Service outcomes

- 8,177 young people accessed early intervention services in the previous 12 months
- 339 young people accessed specialist substance misuse treatment over latest 12 months. Treatment was successfully completed by 90% compared with 80% nationally. In Kent, as nationally, 93% of young people did not return to services within six months of completing treatment.

A more in depth analysis of Kent's performance and treatment outcomes using data from Public Health England's Recovery Diagnostic Tool is at Appendix A.

Projected Service Use and Outcomes in Three-Five Years and Five-10 Years

Short term (three to five years)
An increasing emphasis on alcohol IBA and referral to treatment services is likely to continue to increase demand for extended brief intervention and structured treatment services. Improved patient pathways from acute, primary care and community settings will magnify this effect.

The recent introduction of Nalmefene as a treatment option in Primary Care may also see an increase in demand for IBA and psychological / supporting therapies (National Institute for Health and Care Excellence, 2014) and a reduction in hospital admissions for condition specific and related alcohol harms.

As data capture improves and allows for triangulation of data sources, a more targeted approach to service delivery is likely i.e. targeting services at 'hot spots' geographically or trends i.e. young women. In addition, the growing workforce of partner agencies offering IBA as part of core activity within contract should mitigate the demand on specialist treatment services in this respect.

Medium term (five-10 years)
According to national and local trends the rate of alcohol related hospital admissions in Kent is expected to continue to rise across all age ranges with the exception of those aged under 25 years. Those aged 16-24 years are the only group who have shown a decreased trend in hospital admissions. The number of young adults reporting being teetotal has increased by over 40% to 27% in 2013 equalling the numbers of those aged 65 years for the first time (ONS 2015).

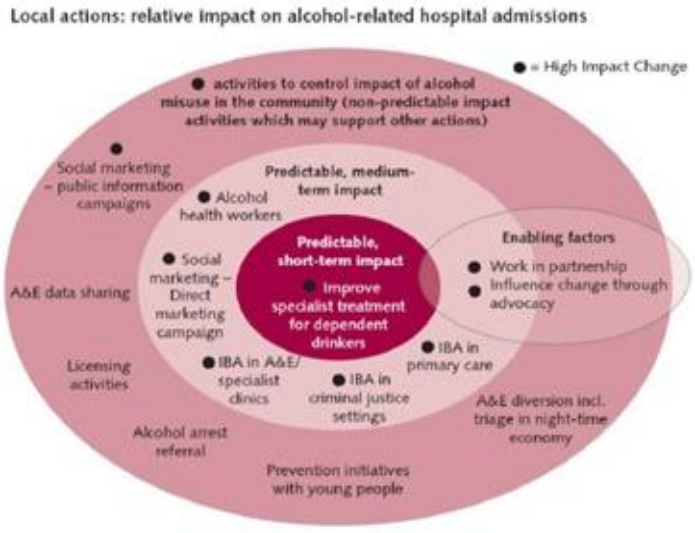
The interventions that have been put in place over the last 12 months should see reductions in alcohol misuse (as evidenced by the liver disease SDR and alcohol-

specific admissions). Some effect of this is already in evidence via project activity egg increased and early referral for treatment services. These projects will be fully evaluated for transferability. If effective and implemented, these should ultimately have an impact on service use and alcohol related hospital admissions.

Evidence of What Works

Evidence based high impact changes are recommended by the Department of Health to reduce hospital admissions for alcohol-related harm.

Figure 1 Local action relative to impact to alcohol –related hospital admissions



Source: Signs for Improvement (2009)

Early intervention with systematic brief intervention has some evidence that it is effective. A Cochrane Collaboration review (Kaner et al., 2007) showed substantial evidence for IBA effectiveness and a study by Moyer et al (2002) showed that for every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels.

A more recent study by Kaner et al. (2013) showed that brief advice and brief lifestyle counselling did not provide a statistically significant benefit in reducing hazardous or harmful drinking compared with a patient information leaflet given by a health professional.

Screening followed by simple feedback and written information may be the most appropriate strategy to reduce increasing and harmful drinking levels. This view has subsequently been supported by the NICE Technology Appraisal (TA325) which acknowledges that IBA in Primary Care Settings constitutes adequate and effective psychosocial behavioural support in this context.

The most appropriate intervention recommended for dependent drinkers is structured psychosocial intervention with inpatient or community detoxification as required.

Increasing risk and higher risk drinkers are likely to benefit from brief advice given by generic workers in almost any setting. Wraparound care, including help with, for example, family support, housing and employment are recommended by the most recent national Drug Strategy (Home Office, 2010).

Compared to prisons and custody suites, probation services were found to be the most suitable for screening, and participants were positive about receiving interventions for their alcohol use in probation settings (Coulton et al 2009).

Information, Policies and Strategies

Local

Kent Public Health Observatory (2014) Local Alcohol Profiles. Available: http://www.kpho.org.uk/health-intelligence/lifestyle/alcohol/alcohol-and-liver-disease-profiles [Online] Last accessed: June 2015

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National / International

World Health Organisation (2015) *Global status report on alcohol and health 2014. Available at: http://www.who.int/substance_abuse/publications/global_alcohol_report/en/ [Online] Last accessed June 1015*

Home Office (2012) *The Government's National Alcohol Strategy*. Available: https://www.gov.uk/government/publications/alcohol-strategy [Online] Last accessed June 2015

Alcohol Strategy consultation report: PHE response https://www.gov.uk/government/news/alcohol-strategy-consultation-report-phe-response Public Health England Updated 17 July 2013

Mortality Rates and Liver Disease http://longerlives.phe.org.uk/health-intervention/liver

Tackling drugs and alcohol : local government's new public health role Published 22/01/2013

NICE Guidelines (The National Institute for Health and Care Excellence)

TA325 (2014) *Technology Appraisal Guidance (nalmefene) [Online]* Available: https://www.nice.org.uk/guidance/ta325/chapter/1-guidance Last accessed: June 2015

PH24 Alcohol use disorders - preventing harmful drinking: guidance Published 27/05/2010

Alcohol-use disorders (pathway) Published 09/05/2011

CG115 Alcohol dependence and harmful alcohol use: full guideline Published 23/02/2011

Alcohol use disorders : harmful drinking and alcohol dependence : Evidence Update January 2013 Published 23/01/2013

QS11 Alcohol dependence and harmful alcohol use quality standard: NICE support for commissioners and others Published 23/08/2011

Alcohol dependence quality standard slide set Published 31/08/2011

CG115 Alcohol dependence and harmful alcohol use: costing report Published 23/02/2011

CMG38 Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults Published 30/08/2011

Clinical Knowledge Summaries Alcohol - problem drinking - NICE CKS Published 20/09/2010

Royal College of Physicians of London Assessment and management of alcohol dependence and withdrawal in the acute hospital Published 23/01/2013

Systematic Reviews
Cochrane Database of Systematic Reviews
Universal family-based prevention programs for alcohol misuse in young people Published 07/09/2011

Universal school-based prevention programs for alcohol misuse in young people Published 11/05/2011

Universal multi-component prevention programs for alcohol misuse in young people Published 07/09/2011

Database of Abstracts of Reviews of Effects Alcohol and drug prevention in nightlife settings: a review of experimental studies Published 12/02/2013

The effectiveness of brief interventions in the clinical setting in reducing alcohol misuse and binge drinking in adolescents: a critical review of the literature Published 25/05/2011

British Association for Sexual Health and HIV;Royal College of Physicians of London Alcohol and sex: a cocktail for poor sexual health: a report of the Alcohol and Sexual Health Working Party Published 01/12/2011

Public health and alcohol licensing in England : LGA and Alcohol Research UK briefing
Published 22/01/2013

Identifying promising approaches and initiatives to reducing alcohol related harm. A report to Alcohol Research UK and the Joseph Rowntree Foundation Published 01/01/2011

National Institute of Alcohol Abuse and Alcoholism (USA) Preventing alcohol abuse and alcoholism: an update. Published 01/02/2012

User Views

The Kent Partnership Alcohol Strategy was circulated for consultation by Kent Drug and Alcohol Action Team, to contact networks of Children, Families and Education (Kent Adult Social Services), Kent Police, Community Safety in second tier councils, providers of alcohol treatment services and user groups.

Feedback from the consultation was collated by the Kent Drug and Alcohol Action Team and discussed at length by the partnership. The strategy was updated and amended to reflect the views of those consulted. Local implementation plans in eastern and coastal, and west Kent for provision of Identification and Brief Advice reflect the overarching Kent Partnership Strategy.

Commissioning plans and service specifications for structured treatment reflect the overarching strategy and were also given out for consultation by Kent Drug and Alcohol Action Team, cascaded in a similar way and included focus group meetings of GPs and other stakeholders.

Principal feedback included support for a combined drug and alcohol treatment service and a desire to ensure that services continue to be accessible at a local level. Respondents also requited a single point of contact for both referrers and individuals to access services: and improved links between GPs and the services (pathways and communication).

Unmet Needs and Service Gaps

All organisations

Alcohol Identification and Brief Advice (IBA) and referral to treatment services is not routinely undertaken by all health or allied professionals as part of the assessment, diagnosis and referral processes they may undertake.

This is an important omission especially relevant for cancer, gastro-intestinal and cardio-vascular disease (CVD) groups most notably hypertension and stroke. The links and subsequent impact upon urgent and non-elective (emergency) commissioning in these respects should also be made.

There are also missed opportunities for allied care, partner organisations and commissioned providers to undertake systematic and opportunistic IBA and referral at point of public contact. There is scope in extending alcohol IBA and referral to treatment services with criminal justice agencies, pharmacies and families and social care professionals and other partner agencies including community and voluntary groups.

Primary, secondary and community care
There is a need to introduce systematic processes to provide patient education, early identification and proactive case-finding of at risk individuals and referral to treatment services in health and partner organisations especially within areas of deprivation. This is especially true of primary care and hospital settings as referrals are notably fewer than could be expected. Although the latter is improving via hospital, general practice and pharmacy projects, this is not yet systematically or comprehensively embedded in practice.

Criminal justice
This requirement is similar within the Probation and Criminal Justice system. The number of individuals entering prison unknown to treatment services should be cause for action. Youth community services need to improve engagement rates with Criminal Justice services; no young people were followed-up by a community service within three weeks of their release.

Vulnerable groups and areas of particular identified service need should be prioritised eg dual diagnosis, older populations, districts areas and wards / groups with identified high volume of alcohol related harms or hospital admissions, associated health conditions, women.

Recommendations for Commissioning

Public Health:

1. Should commission to industrialise routine delivery of Identification and Brief Advice (IBA) across all health, community and social care settings and commissioned contracts as appropriate; particularly for services addressing risky behaviour or high risk / vulnerable groups eg sexual health, smoking cessation, school and health visiting and falls service amongst others.

2. Through co-commissioning and local partnerships, continue to promote and embed training to facilitate opportunistic IBA and treatment service referrals.

3. Contract specifications should require accurate data recording and capture, effective and timely data extraction processes and reporting functions to enable performance monitoring and evaluation.

4. Should review, implement and monitor the joint working policy, procedure and care pathway for clients with mental health and substance misuse problems. This will require pathway development into alcohol / mental health dual diagnosis services.

5. Work with partners to roll out the alcohol integrated care pathway across Kent to facilitate IBA and treatment service referrals.

6. Review the model of service provision to meet the existing and predicted level of need in the population. Commissioned services should be flexible and responsive in meeting the emergent levels / areas of need.

7. Raise awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of drinking at increasing and higher risk levels and binge drinking. Give consideration to wider distribution of culturally, appropriate and accessible resources for communities.

NHS acute, primary, community care, NHS England and mental health commissioners

1. All contracting teams need to ensure that service providers are capable of timely and accurate data recording, data capture, extraction and report production by building specifications on this into contracts and service level agreements. This is important to monitor progress and evaluation of initiatives and ensure that relevant data are available for performance management, evaluation and to inform further JSNA refresh.

2. Systematically embed the requirement within contracts to identify a greater number of people across the county and ensure they are offered appropriate support from outside healthcare settings. This could include any public facing service eg families and social care staff, housing professionals, health trainers and pharmacists.

3. Develop links and promote awareness to Improving Access to Psychological Therapies (IAPT) programme and self-management initiatives eg Mutual Aid organisations.

4. A pathway and model of care should be available to particularly meet the needs of young people and adults for those:

    a. with a dual diagnosis
    b. on release from secure estate
    c. those using health services including mental health and AE services
    d. children and young people.

Recommendations for Needs Assessments

- levels of need and service response for dual diagnosis
- levels of need and service response in the Criminal Justice System.

Key Contacts

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Appendix A

Public Health England's Recovery Diagnostic Tool

Alcohol clients – key points

1.1. The number of clients in treatment for alcohol only use in Kent declined from 1,694 in 2011-12 to 1,440 in 2013-14. More recently a significant increase has been noted with the latest figures showing 1,648 clients in treatment (October 2014).

1.2. The number of clients in Kent successfully completing treatment for alcohol use (as a percentage of all in treatment) decreased by 10% from 2011-12 to 2013-14, falling below the national average (Table 2).

1.3. Latest available data suggests that the performance of this indicator is increasing with 40% of alcohol only clients successfully completing treatment in October 2014, now higher than the national average of 39%.

Table 4: Number of alcohol only clients who completed treatment successfully as a percentage of all in treatment (rolling 12 months)

ALCOHOL ONLY	2011-12	2012-13	2013-14	Oct 2014	Direction of Travel
Kent	47%	49%	37%	40%	↑
National	35%	38%	39%	39%	↔

Source: Public Health Kent, KDAAT, 2015

1.4. At the start of treatment clients are asked how many units of alcohol on average they consume each month. The consumption levels of clients in Kent closely reflect alcohol clients nationally.

1.5. Nationally, 12% of alcohol clients are in treatment for more than 12 months, in Kent this is only 4%. In Kent, those clients are in treatment for three - six months form the largest group (38%).

1.6. Completion rates by length of time in treatment in Kent closely mirror those nationally. This is with the exception of clients in treatment for 9 - 12 months, who are significantly less likely to complete treatment successfully in Kent than nationally. At a provider level, the RDT shows that this is a reflection on the low completion rate (12%) for this cohort in Turning Point.