

Specialist Alcohol Treatment in the North East

Introduction

This paper describes the level of specialist alcohol treatment provision in the North East of England. Its purpose is to support Primary Care Trusts (the commissioners of services) and others in understanding patterns of care and to signal the availability of this information for future use. The data come from the National Drug Treatment Monitoring System (NDTMS) and is for the first two quarters of 2008/09 and updates an earlier report.¹

Since 1st April 2008 all providers of adult structured alcohol treatment have been obliged to submit data to NDTMS on patients receiving structured treatment for their alcohol misuse. The data collection supports the Government's *National Alcohol Harm Reduction Strategy*.² It also provides information for the National Treatment Agency for Substance Misuse and for commissioners on the provision of specialist alcohol treatment services at a local level.

The requirement for adult alcohol data collection has resulted from the recommendations of the National Strategy and the subsequent, *Alcohol Needs Assessment Research Project (ANARP)*³: an audit of the need for and provision of alcohol treatment needs. It also reflects the rising priority of dealing with harm caused by alcohol.

There are now official, publically available alcohol treatment statistics available on the website <http://www.ndtms.net/>

published at a National, Strategic Health Authority (SHA), Primary Care Trust (PCT) and treatment agency level. The first six months of these statistics, as published on 6th January 2009, have been used in this report to update the findings of *ANARP*.³ We illustrate the current provision within the North East at a PCT level and compare with the provision within other regions in England.

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Summary

- At 30th September 2008 there were 148 agencies across 12 PCTs providing structured treatment to 5,671 people in the North East.
- This appears to represent a seven-fold increase over 5 years in the number of people treated.
- However, only about 5% of harmful drinkers are in treatment.
- There is substantial variation across the region with 3% of harmful drinkers in treatment in Durham and 10% in treatment in Middlesbrough.

Background

In 2004, the *Alcohol Harm Reduction Strategy*,² published by the Prime Minister's Strategy Unit, highlighted the increase in harm resulting from alcohol misuse. One of the recommendations was that the Department of Health should conduct an audit of the demand for, and provision of, alcohol treatment in England. This was conducted during 2004 and published in 2005 as the *Alcohol Needs Assessment Research Project (ANARP)*.³ This study estimated the number of people in treatment by contacting known specialist alcohol treatment providers. It estimated demand using prevalence of dependent drinkers based on a re-analysis of data from the *2000 Psychiatric Morbidity Survey*⁴ and the 2001 General Household Survey.⁵ It showed that the North East was, apparently, trailing considerably behind other regions in terms of provision of specialist services for alcohol misusers. *ANARP* found only 818 individuals in treatment that is, only 1% of the alcohol dependent population were accessing alcohol treatment services.

During 2004, an electronically-based NDTMS was introduced across the North East to collect data on adult drug treatment and young people's drug and alcohol treatment. Most providers of specialist addiction services cover both drugs and alcohol. Also in 2004, the North East NDTMS team was established within the North East Public Health Observatory (NEPHO) by the National Treatment Agency for Substance Misuse (NTA) to monitor, maintain and support the collection of NDTMS data for the region. The North East NDTMS team recommended that providers of adult alcohol services also submit their data for local and regional analysis. Thus, the North East has been capturing alcohol treatment data for young people and voluntarily, for adult service users within NDTMS for approximately 5 years.

The data are reported routinely to Drug (and Alcohol) Action Teams (DATs), although adult alcohol services are the responsibility of PCTs. This report is written for a wide audience so that it can inform and support further planning, commissioning and improvement of alcohol treatment services for patients. It updates the findings of *ANARP*³ by illustrating the current provision and potential need for services within the North East.

The National Drug Treatment Monitoring System (NDTMS)

NDTMS is a development of the Regional Drug Misuse Databases, which had been in place since the late 1980s. It captures data on all clients receiving 'structured' drug (and now alcohol) treatment where the provision of treatment is in line with that prescribed in *Models of Care for Treatment of Adult Drug Misusers*⁶ or in *Models of Care for Alcohol Misuse (MoCAM)*⁷ and is delivered by specialist treatment services. The data collected does not include unstructured substance misuse treatments (such as Screening and Brief Intervention, Alcoholics Anonymous or Outreach) or treatment in other parts of the NHS for secondary complications arising from the substance misuse, e.g. liver or heart disease. Agencies which provide these treatments include NHS Trusts, some specialised GPs, voluntary agencies, and Local Authorities.

In May 1995, a White Paper: *Tackling Drugs Together*⁸ was introduced to outline plans to deal with drug misuse for the period 1995-1998. It recognised the need for the Home Office, Department of Education and Department of Health to work together to deal with the resulting issues of crime, public health and the effects of drugs and alcohol on young people. An important action was the establishment of Drug Action Teams (DATs) across England whose main remit was to implement the strategy at a local level and ensure the co-operation of such partners as police, youth services, GPs, social services, public health and treatment agencies. This White Paper was followed in 1998 by the publication of the Government's National Strategy for Drugs, *Tackling Drugs to Build a Better Britain*,⁹ which developed further the role of the DAT in ensuring partnership working, assessing spending plans and monitoring outcomes and value for money at a local level. In many areas, DATs included alcohol within their remit; in other areas responsibility remained within the National Health Service.

NDTMS has become a key data source for commissioners and providers of care for drug misuse with information on patient numbers, demographic characteristics, treatments offered, duration and effectiveness. All publicly funded specialist treatment services must provide information to NDTMS on their activities each month. This includes client information (such as age, sex and ethnicity), treatment journey (such as referral, care plan and treatment start and end dates), type of treatment and discharge reasons. There are also data on the service users' substance misuse (such as drugs used and routes of administration) and questions about alcohol consumption. Further data items cover a patient's social and general well-being such as accommodation needs, pregnancy, children at risk from living with misusing patients and parental status. Since 1st October 2007 the dataset has been expanded to include a *Treatment Outcomes Profile (TOP)*.¹⁰ These data fields illustrate the progress a patient is making in relation to illicit drug and alcohol use, injecting behaviour, criminality and health and social functioning. A more detailed definition of the NDTMS dataset can be found on the NTA website.¹¹

In the North East, data are now collected from about 150 agencies across 12 Drug (and Alcohol) Action Team (DAT) areas by the regional NDTMS team based at NEPHO. All DATs, PCTs and Local Authorities are geographically co-terminus in the North East region. We have reported by PCT in this report as they have responsibility for commissioning alcohol services. These data are collated nationally by the NTA who are also the commissioners for NDTMS.

In the North East, most agencies combine drug and alcohol services and so have been providing NDTMS data for some time. Nevertheless, a few specialist alcohol-only services were unfamiliar with the processes required for data submission on 1st April 2008. This is the first 6 months of 'official' alcohol data submission and caution should be exercised in interpretation at this stage. Variations may still be as much to do with new data collection processes at individual agencies as to differences in service delivery. It should be recognised that there are a number of newly commissioned programmes (e.g. in County Durham whose new county-wide service was only launched on 1st October 2008) and the re-commissioning of alcohol services currently being undertaken by PCTs and DATs in different stages of development. Some of these services are not yet operational and therefore do not appear within the NDTMS figures. In addition, primary and community care alcohol services may also vary, changing the need for specialist service provision. There may also be seasonal variation. Despite this potential for bias, we consider the data provide some useful indications of current patterns of provision.

Box 1: Categories of Alcohol Misuse

ANARP estimated the prevalence of alcohol use disorders based on a re-analysis of data from the *2000 Psychiatric Morbidity Survey*⁴ and the General Household Survey 2001⁵ and used three categories of alcohol misuse and their treatment needs. These categories were in turn based on the WHO ICD-10 categorisation of alcohol use disorders.¹² These categories are a pragmatic attempt to describe different types of misuse 'based on convenient cut-points along the continua of alcohol consumption, problems and dependence; they are not strictly defined, or even permanent labels but rough indications of current drinking patterns that individuals may move into and out of over time.'¹³ These categories were Hazardous, Harmful and Dependent drinking.

- **Hazardous drinking** refers to those who drink in excess of recommended limits (21 units a week for men or 14 units a week for women)¹⁴ and which leaves the individual 'at risk' of harmful consequences.
- **Harmful drinking** refers to 'A pattern of use which is already causing damage to health. The damage may be physical or mental.'¹² Such individuals will have alcohol-related problems, but not necessarily be seeking treatment. Harmful drinking is defined as consumption of more than 50 units of alcohol per week for males, and more than 35 units of alcohol per week for females.
- **Dependent drinking** refers to individuals who have a pattern of drinking which has led to significant impairment or distress; typically presenting to specialist services for treatment or help with social problems resulting from their misuse. This is the group which is most likely to be accessing general hospital services for alcohol-related conditions. *ANARP* also divided this category of drinkers into Moderately and Severely dependent; the former likely to have recognised the seriousness of their problem but not yet 'relief drinking' – drinking to avoid withdrawal symptoms, the latter having serious and long-standing issues, probably having experienced withdrawal symptoms and now drinking to avoid delirium tremens and seizures. There is no quantitative definition for dependency in units as there is for Hazardous or Harmful drinkers.

Numbers in Treatment

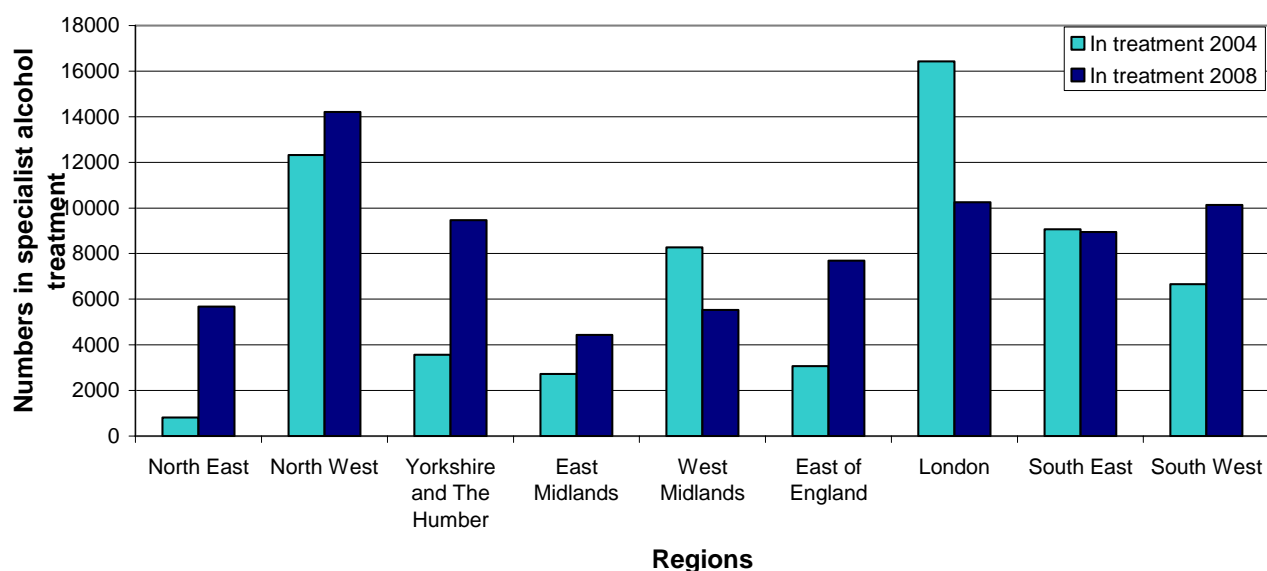
At 30th September 2008, there were 148 providers of treatment for adults or young people in the North East, actively reporting to NDTMS for either drug or alcohol structured treatment provision, of which 122 were providing structured alcohol treatment to patients. There were 5,671 North East residents receiving such treatment which represents a seven-fold increase in numbers since the *ANARP* report of 2003/04.

The numbers in treatment figures are a count of all individuals, by PCT of residence, active for any length of time in structured alcohol treatment during the first six months (April-September) of 2008/09. Apart from agency level reports, individuals are counted at a PCT level once per year regardless of any multiple presentation, multiple intervention or multiple-agency working. The matching of client records across the system is based on attributors (initials, date of birth, gender and PCT of residence) and it is understood that whilst this method sacrifices some degree of precision, it also provides an element of anonymity to patients who give explicit consent for their information to be included within NDTMS.

The numbers in treatment figures are subject to change during the course of the year as a result of the discharge date being back-dated to the last face-to-face appointment and the submission of previously omitted records, etc. There will be a 'frozen' dataset published after April 2009, which will provide the finalised figures for the year 2008/09.

Figure 1 below shows the numbers in structured alcohol treatment as estimated by *ANARP* during 2003/04 compared with the numbers published on <http://www.ndtms.net/> on 6th January 2009, for April to September 2008. While these two sources are not directly comparable (as different data collection techniques and different prevalence periods were used), Figure 1 does illustrate some regional changes which warrant further investigation.

Figure 1: Estimated Numbers in structured alcohol treatment 2004 and 2008 by Region



Rates of People in Treatment

In Table 1, crude treatment rates by PCT have been calculated using an estimate of the adult population from mid-2007 estimates and the NDTMS numbers in treatment

Table 1: Structured Alcohol Treatment in the North East

PCT Area	Population aged 15-64 (Mid 2007 Office of National Statistics population estimates)	Number in Treatment Year To 30/09/08	Rate per 1000 population	Increase in Number in Treatment between 31/3/08 and 30/9/08*	Estimated Discharges* until 30/9/08	Harmful drinkers (synthetic estimate)**	% Harmful drinkers in treatment
Northumberland	202118	441	2.18	162	241	11541	3.8
Newcastle	187865	747	3.98	188	377	14266	5.2
North Tyneside	129428	456	3.52	141	241	8339	5.5
Gateshead	125196	507	4.05	163	347	8613	5.9
South Tyneside	98898	499	5.05	143	380	6871	7.3
Sunderland	187763	575	3.06	170	353	13024	4.4
County Durham	335928	614	1.83	187	338	22882	2.7
Darlington	64980	260	4.00	97	124	4072	6.4
Stockton	127174	433	3.40	131	163	8304	5.2
Middlesbrough	91863	691	7.52	189	363	6860	10.1
Hartlepool	59484	130	2.19	80	32	4356	3.0
Redcar & Cleveland	90033	318	3.53	99	177	6322	5.0
North East	1,700,730	5,671	3.33	1,746	3,141	115,452	4.9
England	33,933,494	75,025	2.21	20,478	35,049	2,010,856	3.7

*Figures may exclude numbers <5 within their calculation

**The figures for Harmful Drinkers taken from Local Alcohol Profiles (See Box 2)

Treatment Related to Need

Defining the population needing structured alcohol treatment is very difficult. Box 1 above describes the categories of misuse but there is no direct link to treatment need.

ANARP made an assessment of the gap between need and service provision by estimating the alcohol **dependent** population, collating the number of people in treatment by survey, and calculated a 'Prevalence to Service Utilisation Ratio' (PSUR).

The North East PSUR rate of 102 compared with the England average PSUR of 18 and the best regional PSUR (North West) of 12. We estimated a PSUR for the North East, of 21 in our earlier paper¹ (a five fold improvement). However, we have found the use of PSUR can be confusing to partners particularly as low is 'good', high is 'bad'. We think a simple 'percentage in treatment' is more intuitive and will be using this measure for this report and in future.

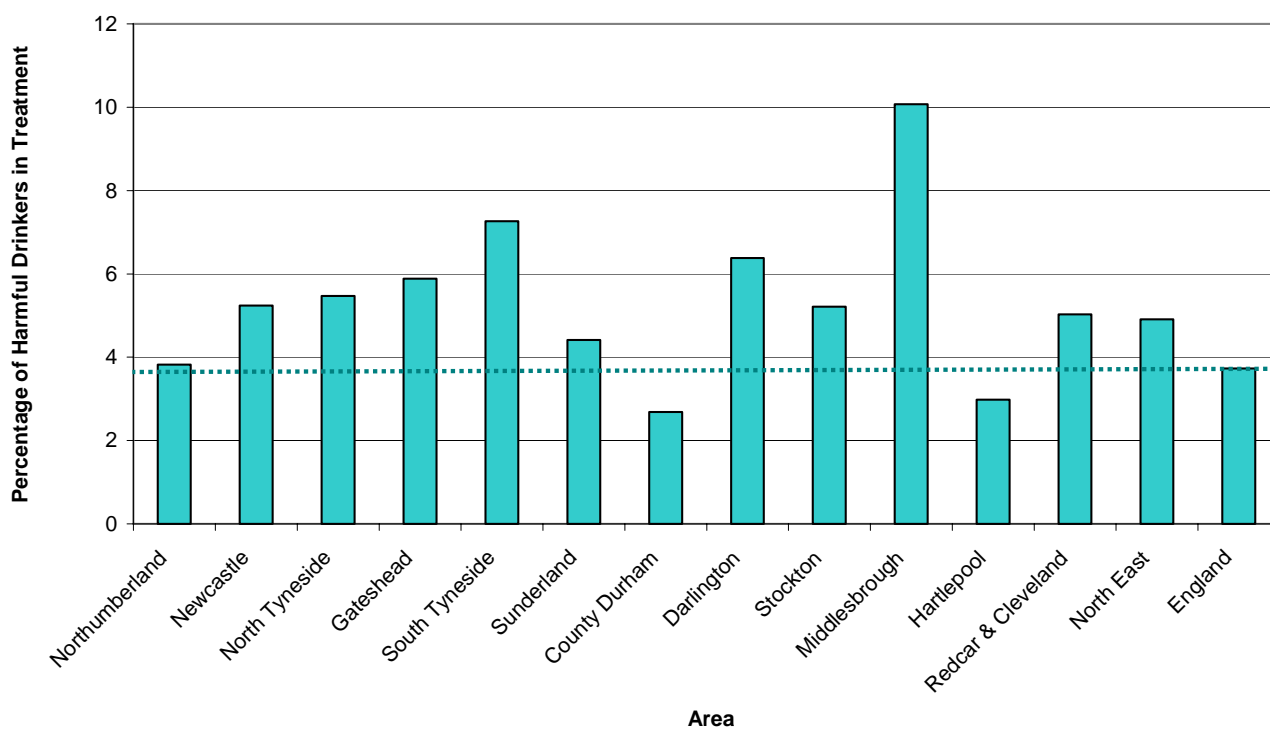
Furthermore there is a problem with using the dependent population as a measure of need. The data is old (2000), rarely updated and not available below regional level. We have therefore used the prevalence of **harmful drinking** as defined and made available within the Local Alcohol Profiles for England (Box 2 below) in Table 1 as the denominator against which treatment numbers have been measured. This has the advantage of a definition based on units so updating through surveys will be possible.

Table 1 shows (mid 2007) population figures; most areas in the North East are providing treatment for a higher proportion of these than the national average. Only County Durham and Hartlepool are below the national average.

Figure 2 shows that while most North East PCTs are providing a higher than average level of treatment compared to the England average there is considerable regional variation.

The analysis of the first quarter NDTMS treatment data¹ suggested that North East treatment agencies have made enormous improvement in delivering treatment and reporting treatment data to NDTMS in a short period of time. The North East was no longer an outlier in England in the provision of alcohol treatment and that it was probably near the national average at that time. It should be noted that whilst the North East has been collecting alcohol data (voluntarily) for some years, not all regions will have had a similarly 'stable' dataset and this apparent four-fold increase may be a reflection of more systematic data collection than elsewhere in England. Comparing the PSURs from the first quarter data with that calculated for the first two quarters of data shows an improvement in terms of 'bridging the gap' between dependent drinkers and treatment numbers, across all PCT areas in the North East.

Figure 2: Percentage of Harmful Drinkers in Treatment by North East PCT Area



As a region, the North East has the second best performance in the country for treatment provision when compared to the levels of Harmful drinkers in the population. Figure 3 below illustrates this.

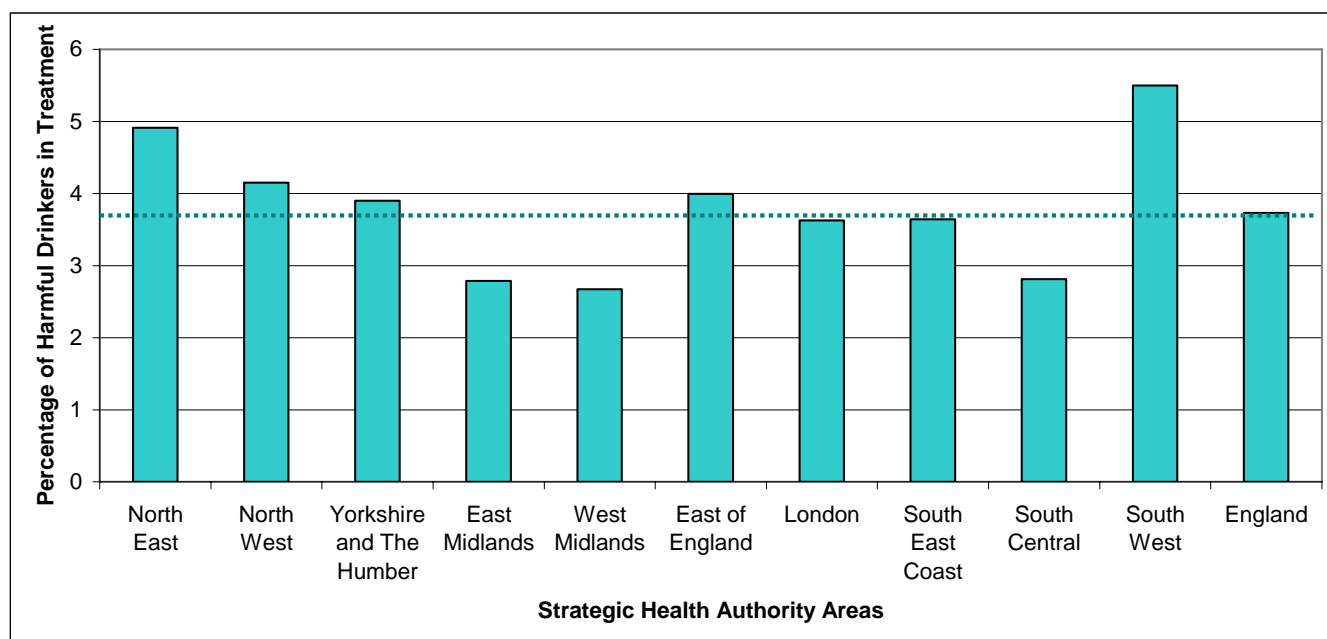
Box 2: Local Alcohol Profiles for England

<http://www.nwph.net/alcohol/lape/>

The Local Alcohol Profiles for England have been published in since 2006 by Liverpool John Moores University's Centre for Public Health and the North West Public Health Observatory. They provide a variety of measures relating originally to health, crime, mortality and binge drinking to show the impact that alcohol was having on 354 Local Authorities across England. Subsequently, these profiles have been refreshed and expanded to include such indicators as Hazardous and Harmful drinking and they will continue to be produced on an annual basis.

We have used the mid-2005 synthetic estimate of the percentage of the population aged 16 years and over who report engaging in harmful drinking as a denominator taken from these profiles.

Figure 3: Percentage of Harmful Drinkers in Treatment by Strategic Health Authority Area



Conclusions

There are obvious limitations to this analysis, as it is based on a new dataset and is only partial year data. There are a number of changes in the commissioning and re-commissioning of alcohol services which do not yet show up in the dataset. However, by focusing on numbers in treatment we still feel important messages can be obtained from the data.

The provision of structured alcohol treatment within the North East has improved since the *ANARP* findings in 2004. The North East is no longer an outlier in England in provision of alcohol treatment and is probably now above the national average. However, with a potential population of about 115,450 Harmful Drinkers with a potential need for treatment, and only 5,671 (4.9%) accessing treatment there is still a need to develop services further and engage with many more individuals.

Monthly statistics, further definitions and in future, more detailed analysis of the alcohol dataset are available from the NTA at <http://www.ndtms.net/>. NEPHO will make available comparative analysis for the region at quarterly intervals which will be accessible via <http://www.nepho.org.uk>. The NTA will shortly be publishing further information about alcohol treatment provision, including details on waiting times, demographics of patients, and treatments provided. The waiting time information in particular, will give a better idea about which areas are meeting demand, and extend our understanding of the needs of those who have not been in contact with services.

This report has been timed to coincide with the launch of the new North East regional alcohol office and also the first anniversary of the Better Health, Fairer Health regional strategy for health and well-being. Hopefully this paper will remind stakeholders that great effort has gone into data collection by treatment agencies and these data can now be used to improve health, reduce health inequalities and patient care.

Recommendations

- PCT commissioners should use these data for future planning and commissioning of alcohol services.
- The new regional office for alcohol should discuss with the SHA, Government Office North East and the NTA who will be using these data to oversee treatment commissioning and performance.
- Data are needed on Tier 1 and 2 treatments such as Screening and Brief Interventions delivered in primary care in order to get a full picture of alcohol treatment.
- All agencies involved in alcohol treatment should consider what further analyses could be useful from this dataset to improve care.

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ISBN
13 978-1-903945-94-0