Glossopdale drugs & alcohol health needs assessment

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Executive Summary

Health Needs

Glossopdale is characterised by its proximity to Manchester to the West and to rural Derbyshire to the East. The boundary issues, geographical location and relative lower level of need compared with the rest of Tameside and Glossop, has impacted on historical service provision within Glossop.

Compared with the rest of Derbyshire, Glossop has a relatively high level of substance misuse-related health need. For example, both alcohol related and attributable mortality have, between 2007 and 2011, been higher in Glossopdale than in Derbyshire as a whole, and for alcohol attributable deaths the trend has been increasing in Glossopdale whilst it decreased county wide. Alcohol specific and attributable hospital admissions for men have also been increasing in Glossopdale.

Alcohol-related community safety issues have improved in the area over recent years though the area still has a higher rate of alcohol-related violent crime than average for the police division.

Class A drug use is seen as relatively low by service providers and agencies working in the area, but interviews with service users suggest there may be a greater problem than agencies are aware of. While service providers report declining prevalence, service users perceive a local increase and report that class A drugs are more available in the area than before.

Cannabis use is reported to be high in the area and is perceived to be socially normalised. However, cannabis related offending rates are low.

Substance misuse issues are less visible in the area compared to neighbouring Tameside & Greater Manchester, and stigma may play a role in this alongside less visible and accessible service provision.

Service Provision

Specialist drug and alcohol services available to Glossopdale residents are currently provided by Tameside-based services. Shared care alcohol support is available at two local GP practices. One GP practice provides a drug misuse enhanced service and Pennine Care run a weekly clinic from the practice.

Both service users and providers identify difficulties in travelling out of the area as the most significant barrier to accessing services for Glossopdale residents. Lack of awareness of what services are available was another important barrier. Caring responsibilities and/or concern about potential impact on family cohesion can prevent some from accessing support.

Gaps in service provision were also identified, by both service users and providers. Most notable was the lack of follow-up care after a detox for people recovering from either alcohol or drugs.

There is currently no commissioned support to families and carers of people with substance misuse problems in the area.

Recommendations

Substance misuse service commissioners should:

- consider the delivery of alcohol & drugs services from an accessible base within Glossop, ideally a multi-agency environment
- support building local recovery capacity to ensure substance misuse clients are offered support to access services that promote reintegration including housing, education, employment, personal finance, healthcare and mutual aid
- consider provision of support to families and friends affected by substance misuse in the area so their needs can be assessed
- design workable mechanisms for SK13 residents to access residential rehab without unnecessary bureaucracy and delay
- ensure MARAC clients' substance misuse needs are addressed during MARAC meetings and keyworkers represented where appropriate
- Commission services in line with NICE commissioning guidance and quality standards (QS11 & QS23)

Local agencies should:

- develop increased awareness of available support, and ensure clear referral pathways and improved signposting
- build capacity to deliver holistic support for marginalised people to enhance community integration and sense of worth
- consider training frontline health and social care workers in Glossopdale in substance misuse awareness and brief intervention
- Engage with local schools and youth services to address the normalisation of cannabis use amongst young people in the area
- Explore how best to meet the treatment needs of clients with caring responsibilities

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Project Team

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1.0 Introduction

1.1 Background

Glossopdale is the administrative area covering Glossop, Hadfield, Gamesley and the surrounding villages. Local people do not recognise Glossopdale as a distinct community or area. It falls within the County of Derbyshire but has historically been associated with the Tameside area of Greater Manchester. Lack of co-terminosity between agencies, and boundary changes, has meant that responsibility for the provision of services to the area is complex.

When public health departments moved from PCTs into local authorities in April 2013, as part of the reforms set out in the Health & Social Care Act 2012, this heralded a change in the commissioning arrangements for drug and alcohol services for Glossopdale. These services were previously commissioned by Tameside & Glossop Primary Care Trust, which was disestablished along with all PCTs. The Tameside public health team within Tameside Metropolitan Borough Council (TMBC) continued to commission the services from April 2013 by arrangement with Derbyshire County Council. However, since the Derbyshire public health commissioning responsibilities transferred to Derbyshire County Council (DCC), which has a footprint that includes Glossopdale, a planned transfer of responsibility for drugs and alcohol services from TMBC to DCC was commenced. This needs assessment is designed to inform that transfer. The principal commissioners of health services for the Glossopdale area are Tameside & Glossop Clinical Commissioning Group.

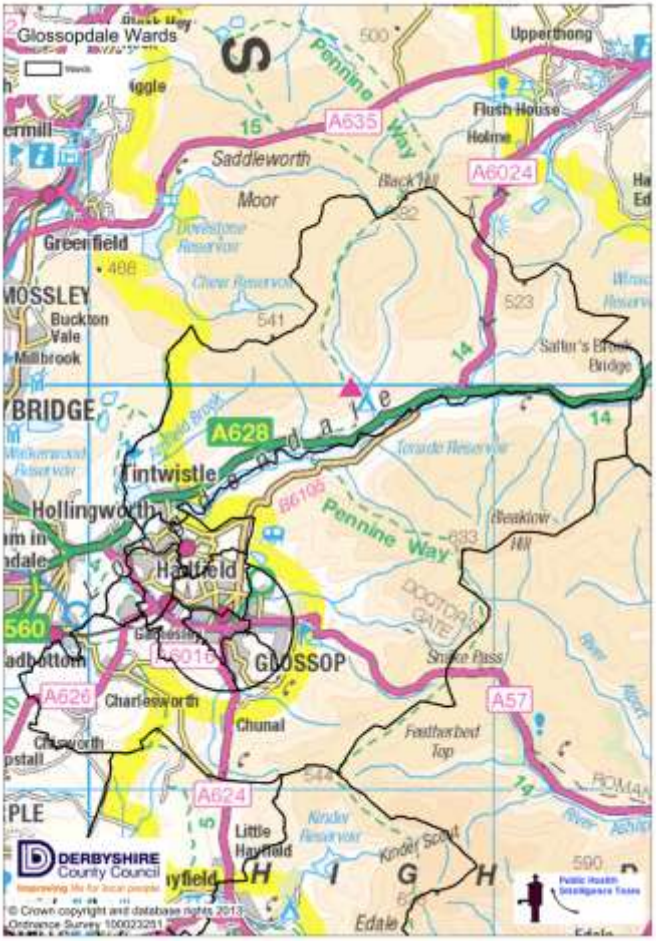
Health needs assessment (HNA) is "a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities."[1] The transfer of commissioning to DCC provides an opportunity to make an assessment of the need in the area for drug and alcohol services, review current provision, and design needs-led services that occupy, as far as possible, the overlapping section of the Venn diagram between need and supply.

[1] NICE. Health needs assessment: A practical guide 2005 [cited 2011 Nov 7];Available from: http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/health_needs_assessment_a_practical_guide.jsp

1.2 Scope of Needs Assessment

The target population for this HNA is adults who misuse drugs or alcohol in the Glossopdale area of Derbyshire (as shown in the map below). This is equivalent to the SK13 post code area.

The health needs assessment (HNA) also aimed to consider the needs of family members affected by substance/alcohol misuse in the area. However, this aspect of the HNA has been limited by a lack of response from some service providers. The HNA does not include in its scope the needs of young people affected by substance misuse.



The focus is on need for tier 2 and 3 drugs and alcohol services[2] as opposed to tier one preventive interventions.

1.3 Objectives

This HNA aims to inform the re-procurement of specialist drugs and alcohol services to meet the needs of the Glossopdale population.

The objectives will be to:

- Review existing sources of information / data relevant to alcohol or drug misusers in Glossopdale
- Assess current specialist drugs / alcohol service provision (tiers 2 & 3) for the Glossopdale population
- Describe current client profile
- Seek the views of the target population and of relevant practitioners and service providers
- Attempt to access the views of those with potential to benefit from services but who are not currently in service
- Identify any unmet drugs / alcohol service need, including those in need of services not currently accessing them, and also ways in which services could better meet the needs of current service users living in Glossopdale
- Make evidence-based recommendations for re-procurement of services to best meet local need (looking at service configuration, scale and location)
- Develop plans to evaluate the HNA to check that the recommendations are having the desired effect of meeting population needs

[2] See glossary for definitions

1.4 Methods used

The HNA used both quantitative and qualitative data to build up a picture of local need.

Existing local and national datasets were reviewed and interpreted.

Client profile data were sought from existing service providers in the area.

Key informants consulted included drug and/or alcohol service providers and representatives of organisations with close links to the community or to groups with high prevalence of substance misuse.

Key informants were consulted on the nature of current provision, their perceptions of local need, and barriers to accessing services. This was done face to face for the majority of service providers, or otherwise via telephone or email.

Service users were interviewed to explore local issues, and their experiences of accessing support. These were face-to-face audio-recorded semi-structured qualitative interviews. Written consent for participation in interviews was obtained. £10 shopping vouchers were given to participants to thank them for their time and contribution. Snow-balling was used to reach potential participants not currently in service, i.e. service users were asked to suggest peers who were not necessarily in service who might be willing to take part.

Service user interviews were analysed using thematic analysis. This was undertaken jointly with both co-researchers to reduce researcher bias.

2.0 Health Needs

The health harms associated with alcohol consumption in England are widespread, with around 9 million adults drinking at levels that pose some level of risk to their health, and with 1.6 million adults showing some signs of alcohol dependence.

In England 2.7 million adults used an illegal drug in the past year, there were 299,000 heroin and crack users in England and 1.2 million people were affected by drug addiction in their families – mostly in poor communities.

DEMOGRAPHICS

At the 2011 census, the Glossopdale area had a population of 33,090 people (16207 males, 16883 females). There was an adult (20+) population of 25,122.

The percentage of Glossopdale residents reporting 'very good health' was 48.7% (High Peak 47.5%, East Midlands 45.3%).

2011 Census data show that Glossopdale has a similar age structure to the High Peak area, with a slightly smaller proportion of people of retirement age.

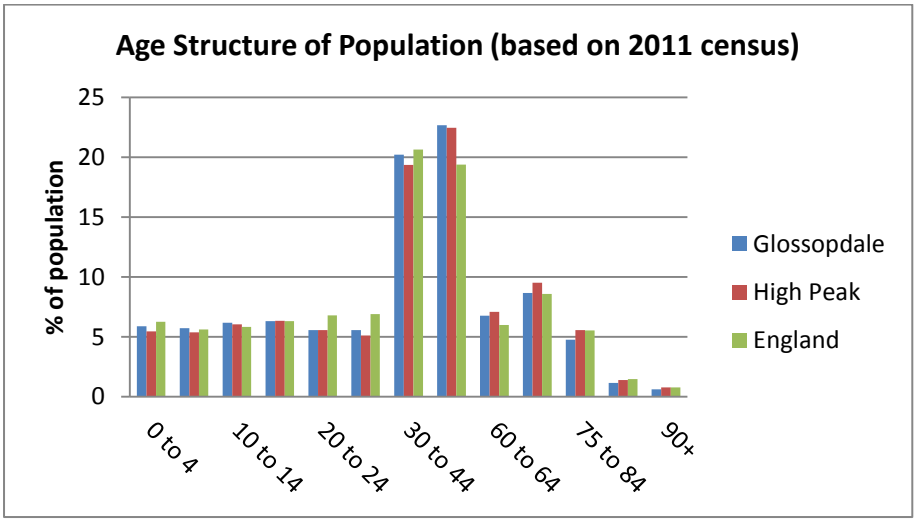


Figure 1 Age Structure of Glossopdale Population

Glossopdale, in common with the High Peak area as a whole, has low ethnic diversity, with 95.7% of people identifying as White British, compared to 95.6% in High Peak and 79.8% in England.

	Glossopdale		High Peak		England
	n	%	*n*	%	%
All categories: Ethnic group	*33090*		*90892*		
White British	*31677*	95.73	*87131*	95.86	79.8
White: Irish	*242*	0.73	*596*	0.66	1.0
White: European Mixed	*47*	0.14	*179*	0.20	0.6
White: Any other ethnic group	*53*	0.16	*158*	0.17	0.6
Mixed: White and Black Caribbean	*169*	0.51	*348*	0.38	0.8
Mixed: White and Black African	*59*	0.18	*113*	0.12	0.3
Mixed: White and Asian	*99*	0.30	*284*	0.31	0.6
Mixed: Any other ethnic group	*48*	0.15	*102*	0.11	0.3
Any Asian/Asian British	*261*	0.79	*247*	0.27	7.5
Any Black/Black British	*90*	0.27	*184*	0.20	3.4
Any 'other'	*39*	0.12	*99*	0.11	0.9

Figure 2 Ethnicity of Glossopdale Population

The level of deprivation varies a great deal between wards in Glossopdale, with Gamesley having a much higher average IMD score (51.89) than Dinting (4.11). Overall, Glossopdale is more deprived than average for the High Peak.

2010 Electoral Ward	**Average IMD 2010 score**
Gamesley	*51.89*
Whitfield	*32.64*
Hadfield North	*31.64*
Howard Town	*21.91*
Tintwistle	*18.24*
Padfield	*13.59*
Hadfield South	*12.94*
St John's	*12.26*
Old Glossop	*10.44*
Simmondley	*5.75*
Dinting	*4.11*
Glossopdale	19.58
High Peak	15.81
Derbyshire	18.47

Figure 3 Deprivation of Glossopdale Population

The percentage of 2011 census respondents stating they were unemployed was higher in Glossopdale (4.6%) than either High Peak (3.8%) or the East Midlands (4.2%).

Job Seekers Allowance claimant rates in February 2014 are higher in Glossopdale than the High Peak overall, with rates highest in the wards of Gamesley and Howard Town.

JSA claimant count with rates

ONS Crown Copyright Reserved [from Nomis on 8 April 2014]

date	February 2014
sex	Total
rate	Proportion of resident population aged 16-64

Area	**Total claimants**	
	number	rate
Dinting	*15*	1.3
Gamesley	*92*	6.0
Hadfield North	*33*	2.7
Hadfield South	*53*	1.7
Howard Town	*113*	3.8
Old Glossop	*48*	1.5
Padfield	*40*	2.0
Simmondley	*39*	1.2
St John's	*15*	1.2
Tintwistle	*25*	1.7
Whitfield	*44*	3.3
High Peak	*1,194*	2.1

Figure 4 JSA claimant rates in Glossopdale

NEIGHBOURHOOD CHARACTERISTICS

Glossopdale is made up of several communities, each with its own distinct identity and characteristics. The main three communities are Glossop, Hadfield and Gamesley.

Glossop

Glossop is a market town with a population of around 30,000 and has a stable population with little migration. It was historically a cotton mill town. Public transport links into Manchester city are good, but less good towards the rest of High Peak. In terms of the substance misuse agenda, the qualitative data from the needs assessment characterised the town as 'behind the curve' on alcohol/drugs trends.

Gamesley

Gamesley is a 1960s-built Manchester overspill estate. It is a close knit community where social capital[3] is high but not always positive, at times reinforcing potentially harmful shared values. The area has very high levels of economic deprivation. Poverty and its impact on individuals and communities underlie most health problems in this community. Gamesley is more Manchester-facing than Glossop, which is more provincial.

The needs assessment indicated that those with substance misuse problems tend to associate together, reinforcing damaging behaviour patterns.

According to Gamesley community workers, many people have multiple behaviours such as gaming, lottery scratchcards, cannabis and alcohol. People in Gamesley are marginalised because of their geographical isolation and deprivation. Those misusing drugs and alcohol in Gamesley were described as being *"on the margins of the margins"* (community worker).

[3] Social capital describes the pattern and intensity of networks among people and the shared values which arise from those networks

The café is seen by the community as neutral ground (at any one time dealers, police and users may be at the café sitting at different tables), and is run by community activists.

Hadfield

Hadfield is a small mill town just north of Glossop. There is a predominance of stone built terraced housing. Hadfield is the terminus for a train-line into Manchester Piccadilly and was the film location for 'The League of Gentlemen'. There are no late night pubs in Hadfield.

2.1 Health needs: Alcohol

2.1.1 Prevalence

Synthetic estimates of alcohol consumption for the High Peak area suggest consumption is not significantly different from the national average, whereas estimates for Tameside suggest higher than average binge drinking and corresponding high levels of alcohol-related mortality (LAPE:2014). Alcohol consumption data are not available at the Glossopdale level of geography.

Hospital data are presented below for alcohol morbidity and mortality. Note that part of the explanation for differences in hospital data can be down to varying coding practices between hospitals.

Alcohol related mortality (ie those causes regarded as being most directly due to alcohol consumption) in Glossopdale is statistically similar to Derbyshire or England as shown in figure 5 below. Directly standardised rates take into account the differences in age and sex structures of the populations being compared.

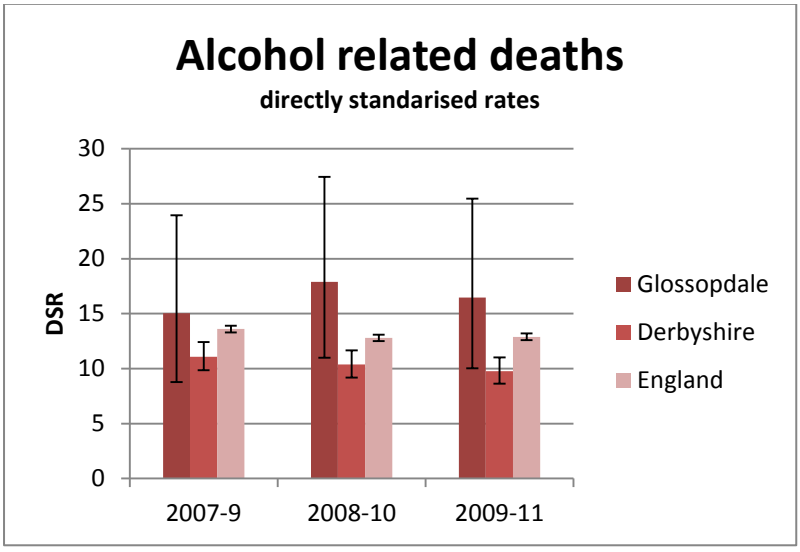


Figure 5 Alcohol-related mortality

Mortality from alcohol attributable deaths in Figure 6 (i.e. based on applying attributable fractions to causes of death) has been increasing in Glossopdale since 2007, in contrast to the Derbyshire trend of decreasing alcohol attributable mortality.

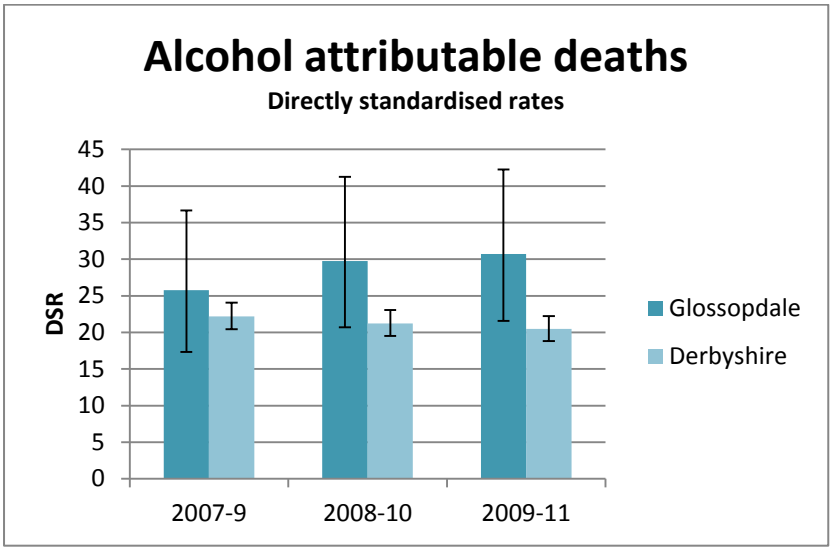


Figure 6 Alcohol-attributable mortality

Hospital admissions data in Figure 7 show that for men the rate of alcohol specific admissions has risen in Glossopdale since 2008/9. Although High Peak and National rates were both starting to decline in 2012/13, the Glossopdale rate continued to rise.

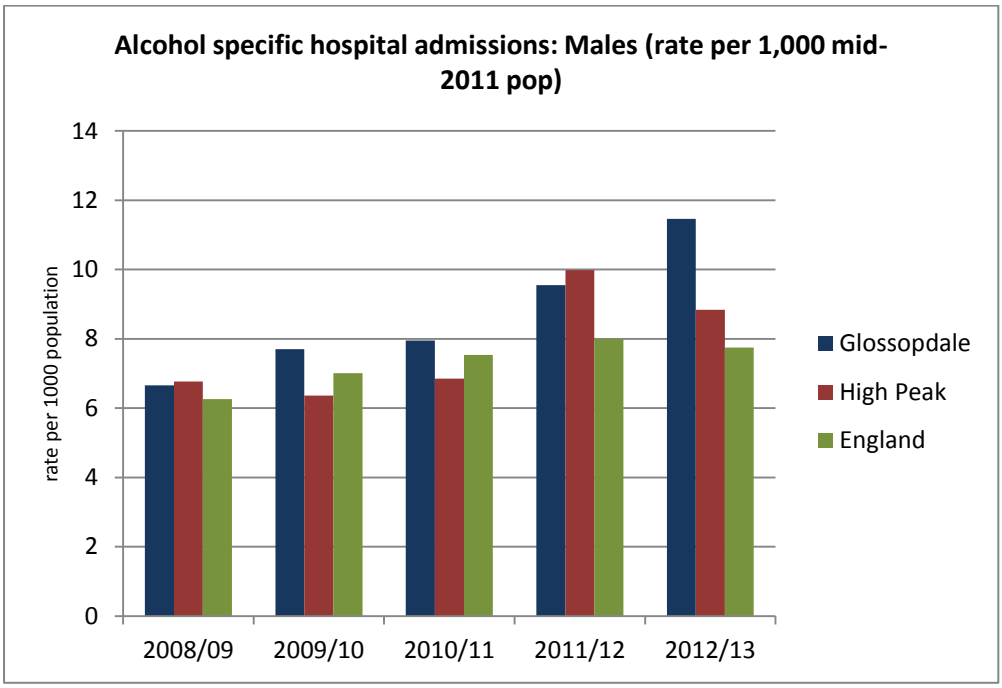


Figure 7 Alcohol specific admissions (Males)

In Figure 8, female alcohol specific admissions show a different pattern, starting off similar to High Peak but exceeding the High Peak rate from 2011/12. Both male and female rates were consistently higher than National rates with the exception of female admissions in 2010/11.

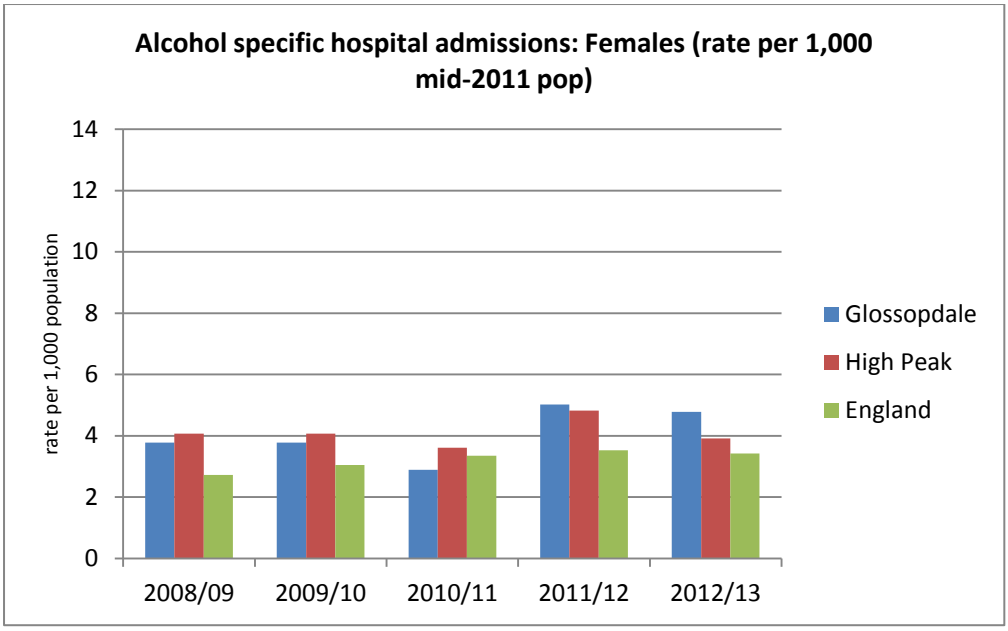


Figure 8 Alcohol specific admissions (Females)

Alcohol attributable admissions (Figure 9) have risen since 2008/9 for males in all areas shown, however the rate of increase has been higher in Glossopdale.

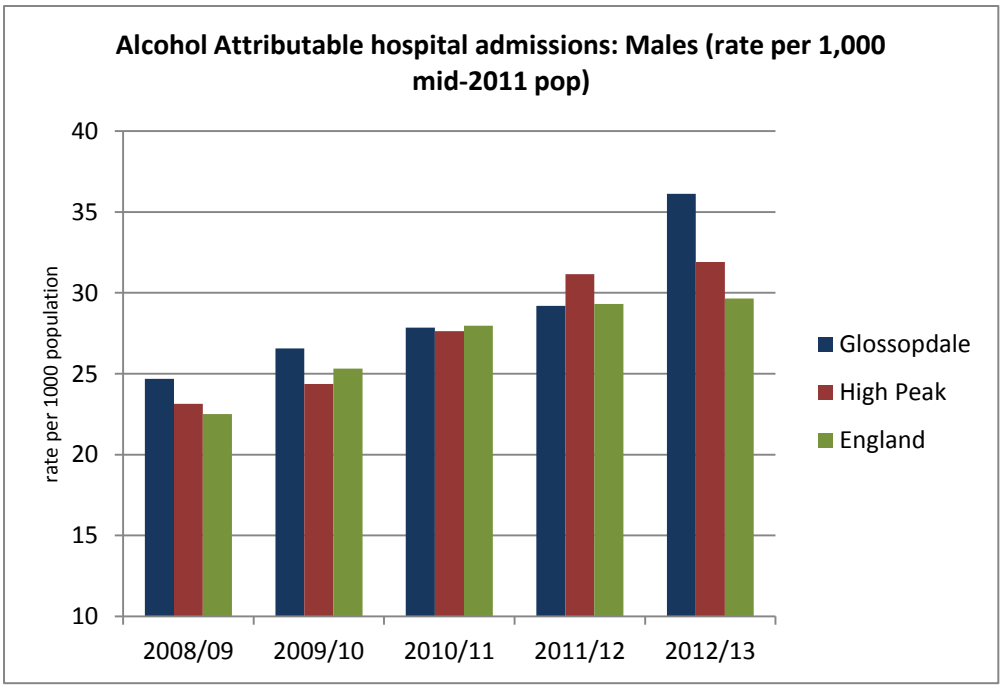


Figure 9 Alcohol -attributable admissions (Males)

Alcohol attributable admissions for females (Figure 10) have fluctuated around a lower level than for males with no clear trend.

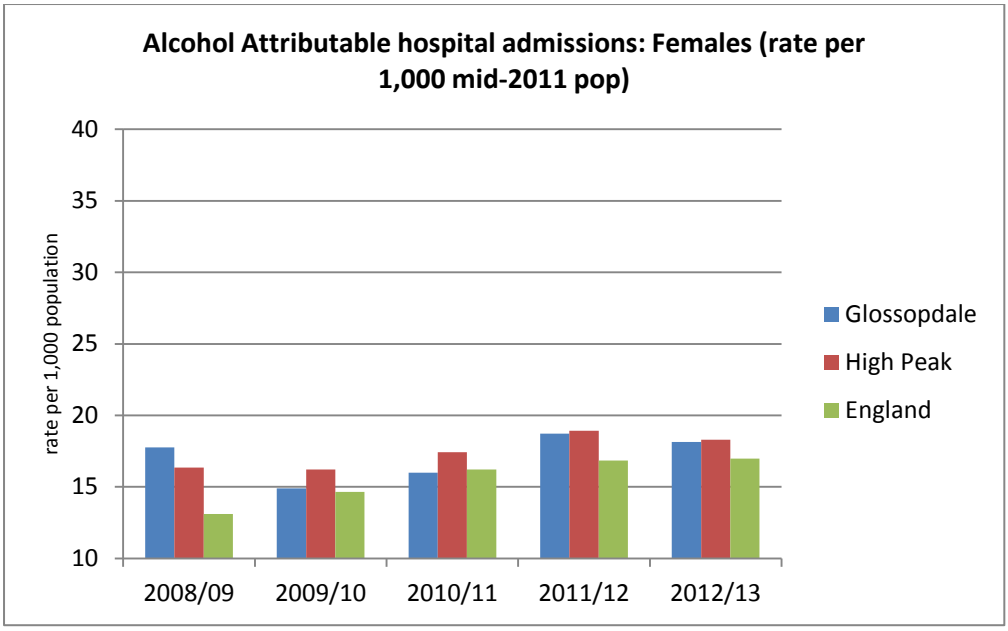


Figure 10 Alcohol-attributable admissions (females)

Glossopdale falls within Derbyshire Police's Division B area, which covers the High Peak and Derbyshire Dales. Alcohol-related offending rates for the year 2013 by type of offence are given in figure 11. The data within the table include crimes tagged as 'alcohol related crime' by the officer in the case. Rates of alcohol related crime are broadly similar, with alcohol related violence slightly higher in Glossopdale than in the Division as a whole.

	B division		***SK13***	
	count	rate per 10,000 population	*count*	*rate per 10,000 population*
VIOLENCE AGAINST THE PERSON	454	27.9	*107*	*31.6*
CRIMINAL DAMAGE	69	4.2	*13*	*3.8*
THEFT & HANDLING STOLEN GOODS	37	2.3	*11*	*3.2*
SEXUAL OFFENCES	11	0.7	*2*	*0.6*
DRUG OFFENCES	9	0.6	*0*	*0.0*
OTHER OFFENCES	9	0.6	*2*	*0.6*
BURGLARY	4	0.2	*1*	*0.3*
ROBBERY	1	0.1	*0*	*0.0*
FRAUD AND FORGERY	1	0.1	*0*	*0.0*
NON RECORDABLE	1	0.1	*0*	*0.0*

Figure 11 Alcohol-related offences 2013

It should be noted that these data do not reflect the true extent of offending, only those offences that were recorded.

The trend for alcohol-related crimes across the High Peak area has been decreasing, as shown in figure 12 below.

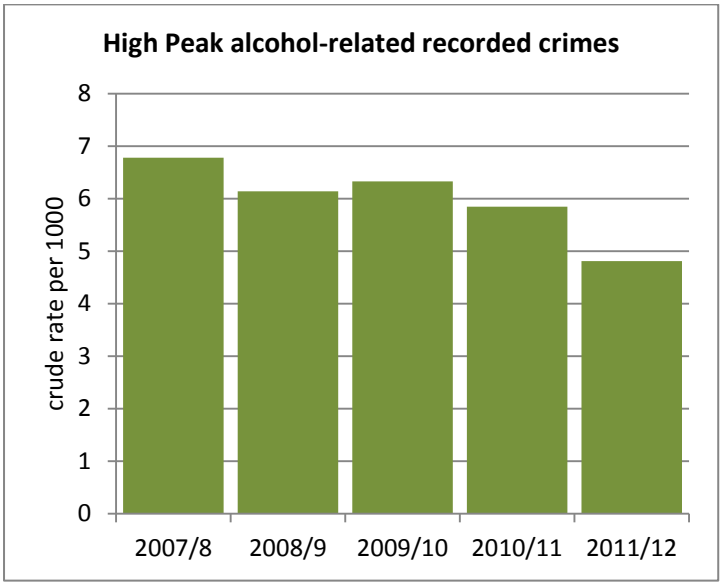


Figure 12 Trend in alcohol-related crime in High Peak (Source: LAPE)

2.1.2 Community Factors: Key Informants' Perspective

Consultation with local Police highlighted the below key findings:

- Alcohol use is much less problematic than previously in the Glossopdale area. There is a well-established pubwatch scheme in the area which has around 45 members.
- Pubs tend to adhere to the challenge 25 scheme, whereby customers who look under 25 are asked to provide ID to show they are legally old enough to buy alcohol.
- Police are not aware of any problems with off-licences in the area.
- Young people are less frequently picked up by police drunk than in the past. Young people tend to look after each other more, and socialise in local parks.
- Youth antisocial behaviour (ASB) is an issue but is not typically alcohol fuelled.
- Adults' drinking problems are mostly hidden from view until domestic violence (DV) emerges. Reported DV prevalence is stable and affects all groups within the community.
- According to the Vulnerable Person Policing team, most vulnerable adults they encounter who are clearly drinking at harmful levels believe they can control it.

ALCOHOL IN NEIGHBOURHOODS

Glossop

Glossop used to have a busy night-time economy with three clubs and people travelling there from surrounding area. Police report that there used to be pub fights every Friday & Saturday night. Now the night-time economy is much quieter with one remaining nightclub. It was reported that the economic downturn means that people can't afford to drink as much, and the norm now is to preload[4] and go out at 11pm. According to Police, street drinking is not an issue in this area.

A national discount chain pub opened in the town centre in May 2013, bringing more drinkers into Glossop. This pub sells beer at markedly lower prices than other pubs. It closes at 1am when many of the clientele move on to the local nightclub. This large pub does comply with police requirements, however staff do not attend police courses as the chain provides in-house training.

Cheap alcohol is also readily available at a large supermarket and a local discount off-licence.

Gamesley

Consultation with local community and police workers highlighted the below key findings:

- Hazardous drinking was reported to be widespread and getting drunk was reported to be socially acceptable up to a point.

- In general, addressing addiction is not a priority for people with chaotic and/or difficult lives.

  *"What they want to do is to sort out all the things in their lives. Because **they're** not sorted, they drink or they smoke too much"* (Community Worker)

- There is wariness towards anything official, and fear of consequence, which prevents some from accessing alcohol services.

[4] Preloading refers to the practice of buying cheap alcoholic drinks to drink at home before going out.

“There's a fear you could get your kids taken off you” (Community Worker).

Hadfield

According to local GPs in Hadfield, the prevalence of alcohol misuse is increasing locally. They see alcohol as a significant issue for their population.

According to Police, youth ASB in the area is often associated with cannabis and/or alcohol, though less alcohol-fuelled than it used to be.

There are no late night pubs in the town.

2.2 Health Needs: Drugs

2.2.1 Prevalence

Estimating prevalence of drug misuse for this level of geography is problematic due to lack of data.

According to the National Crime Survey, drug use has been declining in England & Wales amongst younger adults over the past few years as shown in figure 13 below.

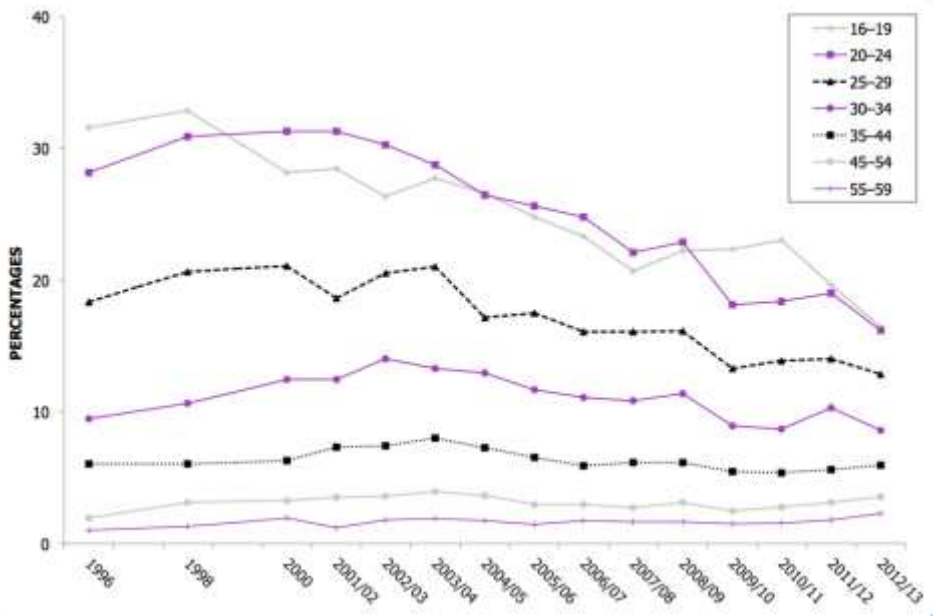


Figure 13 Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012 to 2013 Crime Survey for England and Wales

Glossopdale lies in the far north west of the East Midlands region and neighbours the North West. Figures 14 and 15 below show trends in drug use over time for both these regions, and for England (National Crime Survey).

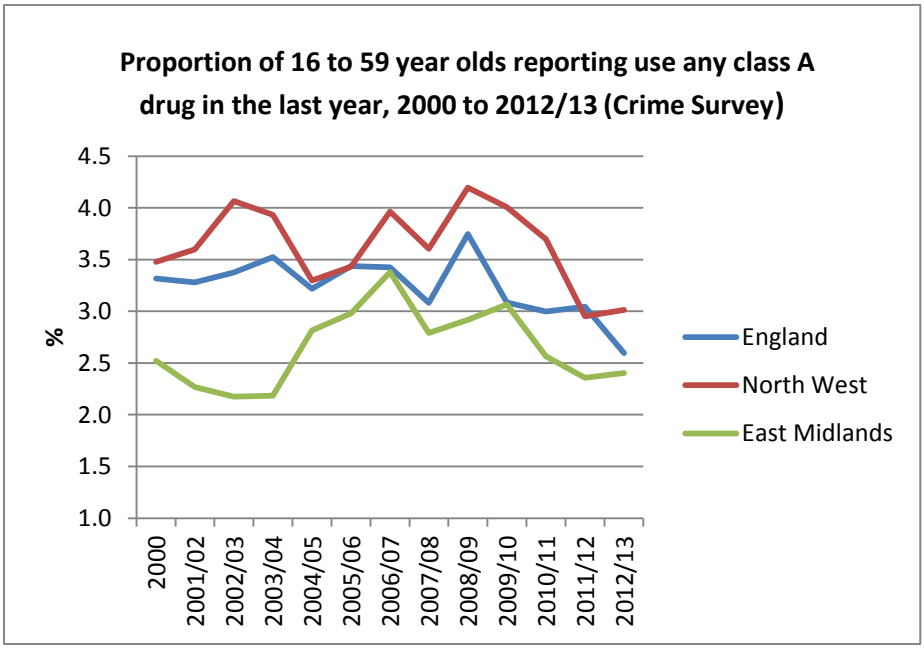


Figure 14 Trend in Class A drug use

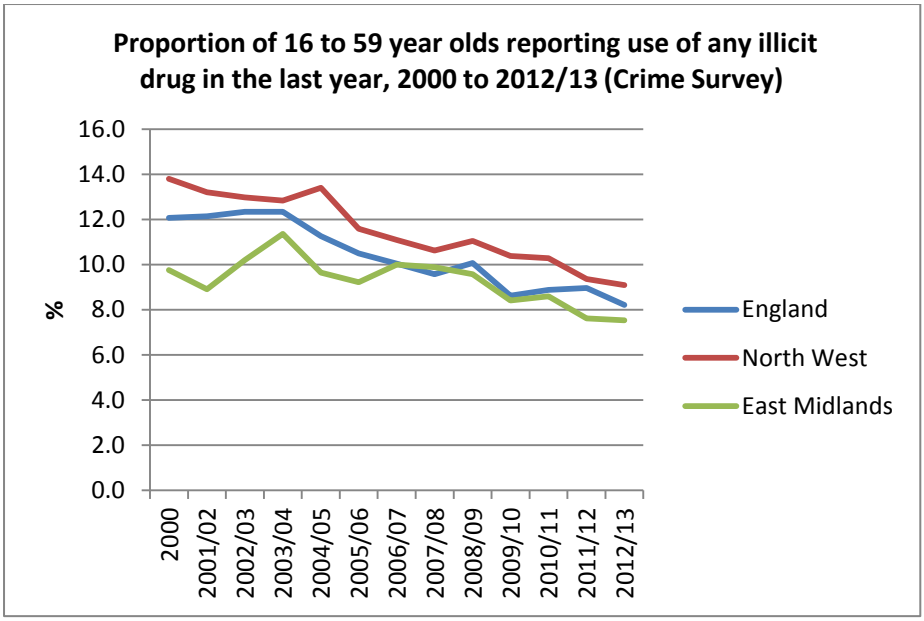


Figure 15 Trend in any illicit drug use

We can see that the East Midlands tends to have lower than average drug use, where the North West has higher than average use. Overall use has declined in all areas. The latest figures show a slight upturn in class A use for the North West.

Prescribing

Two practices in the SK13 area were prescribing for substance misuse between April & September 2013, Cottage Lane Surgery (which provides substance misuse enhanced services) and Manor House Surgery.

Buprenorphine and Methadone are used to treat opioid addiction. In terms of cost, the amount spent on drug misuse prescribing in Tameside was ten times higher than that spent in the Glossopdale area. However, it should be noted that the majority of prescribing for SK13 would be undertaken by the Pennine Care Substance Misuse Team, and hence coded as Tameside not Glossopdale.

	Opioid substitution prescribing	Total Items	Cost
Total SK13	**Generic items**	**48**	**£1,152.46**
	Branded items	**20**	**£1,067.29**
	TOTAL	**68**	**£2,219.75**
Total Tameside	***Generic items***	***956***	***£13,903.27***
	Branded items	***176***	***£6,306.52***
	TOTAL	***1132***	***£20,209.79***

Source: ePACT

Figure 16 Substance misuse related prescribing for SK13 and Tameside from April to September 2013

Pharmacy Services

A needle exchange service is offered by three pharmacies in the SK13 area. However, the majority of service use during the six month period from April to September 2013 took place at a single pharmacy in Glossop. Compared to other needle exchange services in the Tameside & Glossop area, service use in SK13 is very low.

A supervised consumption enhanced service is provided by three pharmacies in the SK13 area, although as with the needle exchange no provision was reported during April – September 2013 in one of the three. The use of this service in the SK13 area is very much lower than in participating Tameside pharmacies.

Drug/service		Total transactions (Apr-Sep '13)
Buprenorphine	**SK13 Total**	**41**
	Tameside Total	*3666*
Methadone	**SK13 Total**	**53**
	Tameside Total	*12382*
Needle exchange	**SK13 Total**	**28**
	Tameside Total	*6351*

Figure 17 Number of needle exchange and supervised consumption transactions at Tameside & Glossop Pharmacies between April & September 2013

Offending

Proxy measures for drug misuse prevalence include rates of drug-related reported offending. Police data for the year 2013 below show that recorded drug-related offending was lower in Glossopdale than in the Division as a whole. These data do not reflect the true extent of offending, only those offences that were recorded. Offences relating to cannabis were higher than for any other substance.

	B division		SK13	
SUBSTANCE	count	rate per 10,000 population	*count*	*rate per 10,000 population*
Cannabis	443	27.2	*32*	*9.4*
Cocaine	50	3.1	*6*	*1.8*
Amphetamine	27	1.7	*0*	*0.0*
Heroin	20	1.2	*0*	*0.0*
Mephedrone	19	1.2	*0*	*0.0*
Other Class A	11	0.7	*0*	*0.0*
MDMA	5	0.3	*0*	*0.0*
TOTAL	587		*38*	
OFFENCE				
Possession of Class B - cannabis	383	23.5	*20*	*5.9*
Production of Class B - cannabis	32	2.0	*6*	*1.8*
Possession of Class A - cocaine	23	1.4	*5*	*1.5*
Supplying Cocaine	22	1.3	*0*	*0.0*
Possession with intent to supply cannabis	17	1.0	*5*	*1.5*
TOTAL	587		*38*	

Figure 18 Recorded drug-related offending 2013

High Peak Women's Aid reported that amphetamines are the substance most used by the young women they support and there is an increasing trend. Around 20% of HPWA's clients have a serious drug or alcohol problem, with a far higher proportion displaying hazardous use.

2.2.2 Community Factors: Key Informant Perspective

The local drugs market

The following insight into local drugs use was gathered from local key informants including Police Sergeants, a Derbyshire Police drugs expert and community workers. They reported that:

- Glossop has a lower level of **heroin** use than you'd expect for somewhere so close to Manchester, and users are ageing.
- Police have never had a big heroin or crack seizure in the area.
- Nationally, there is a glut of heroin in the market at the moment meaning it is being cut less. Police are concerned that there is a risk dealers may try and remarket to young people getting into 'legal highs'.
- Glossop has always had an active night-time economy. People tend to socialise locally because the public transport back from Manchester is poor. MCAT is reportedly not used much in Glossop. Ecstasy is very rarely used these days.
- **Cannabis** use is very high and normalised. Police are inundated with intelligence about cannabis in Glossop, but have limited capacity to respond. People resent police interference in cannabis because of the extent of its normalisation.
- The trend for cannabis use is increasing and the age people start smoking it is lowering (many now starting aged 13/14). Once they start people tend to carry on smoking it through life. *"It sucks the ambition out of you. ASB crime has declined hugely, maybe because everyone's too stoned!"* (Community Worker)
- **Home-growing** is increasing. Most will be earning a wage from a dealer. The dealers are reported to disperse their risk across ten or so houses. Typically it is vulnerable unemployed people who become involved, such as single mums. Changes to benefits, such as increasing use of sanctions, is perceived to have a negative impact, for example by driving a cottage industry in cannabis home-growing. This makes cannabis very affordable and available.
- **Cocaine** has been of very low quality in the area. Cocaine has been detected in pub toilets in several venues in the area. It is being used by a much wider age group (teens to 60s) than before.
- The use of crack cocaine has reportedly increased in Gamesley over recent years, with younger ages using.
- **Benzodiazepines**. Use of diazepam and temazepam has a history of high prevalence in the area. There has also been a high level of benzodiazepine prescribing in Tameside & Glossop in the past (such that the PCT employed a Benzodiazepine reduction worker in 2006 to reduce prescribing).
- **Legal highs** do not appear to be a significant issue in the area yet.
- Local police describe **Gamesley** as a 'closed shop'. They get very little drugs intelligence for the estate. Low drug crime figures consequently reflect low reporting levels and mask the scale of the issue.
- Substance misuse is reported to be prevalent on the **Whitfield** estate according to local community safety and housing workers.
- Police report low level cocaine use in **Hadfield** pubs associated with professionals, often residing out of the area.

2.2.3 Community factors: Service user perspective

Fourteen service users were consulted as part of this needs assessment (ten men and four women). Their expressed views on community factors relating to drug misuse are summaries in the themes and illustrative quotes below.

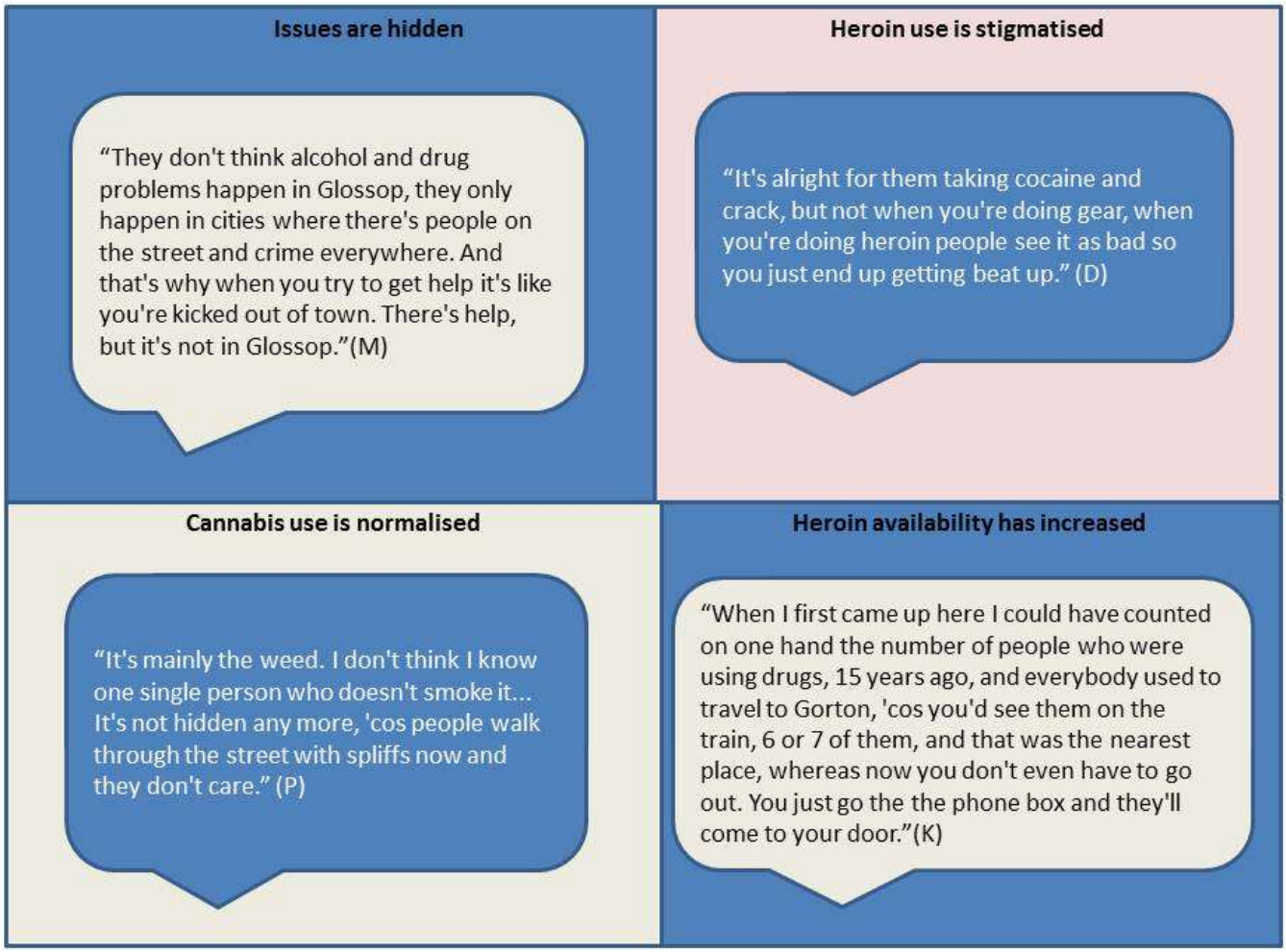


Figure 19 Community factors: Service user perspective

3.0 Current Service Provision

During 2013 it is estimated that there were around 100-120 Glossopdale residents in service for drug and/ or alcohol misuse at any one time (ie 0.4% of the adult population). Because patient identifiable data were not accessed it is impossible to determine the extent of double-counting. Further, the data obtained from the various sources were not always for the same time period (ie a June point prevalence from NDTMS, a November point prevalence from TMBC, a December point prevalence from Pennine Care, ADS, and Acorn). However, given these caveats, clients were distributed across services in the proportions shown below.

Service	n
Pennine alcohol	38
ADS alcohol	36
Acorn alcohol	<5
Pennine drugs	27
Phoenix futures drugs	<5
Acorn drugs	<5
Lifeline drugs	<5
Pennine drugs & alcohol	<5

Figure 20 Numbers of SK13 service users by service, 2013 estimate

3.1 Description of Services

Intervention	Comments
Tier 2 alcohol services *(Providers: ADS; Lambgates and Cottage Lane surgeries; HALS and RAID at Tameside General Hospital; Acorn; Lifeline)*	
Provision of information and advice Triage assessment Referral to structured alcohol treatment Brief psychosocial interventions Harm reduction Aftercare	**ADS** • Screening & assessment • Brief intervention • Structured treatment • Group-work • Psychosocial interventions • Complementary therapies • Family support **GP** alcohol 'enhanced service' including: • Screening of patients using self-assessed Audit-C • Active alcohol assessment of all patients with chronic diseases • Brief interventions via nurses and Health Care Assistants • GP lead for alcohol • Hosting ADS worker clinics • Referrals from other practices • Referrals to ADS/ Pennine Care and quarterly meetings to discuss complex cases • Tier 2 alcohol support • Support to individuals undergoing home detoxification **Other GP surgeries** offer initial information and advice then refer to Pennine Care if required for triage.

	HALS: • Assessment using the Audit-C of hospital patients aged over 18 attending Tameside General Hospital for either urgent or planned care. • Those scoring 16 or over are referred to the HALS. • Ambulatory clinic which provides brief intervention and specialist onward referrals. • Referral to a range of community or detox services. **RAID (Pennine Care)** • assess hospital patients who may require mental health or alcohol support to ensure they receive this support quickly • additional practical, emotional and social support • Signposting to other services **Acorn Treatment** • pre-treatment engagement programme • RAMP (not currently in SK13) • post-treatment support with employment, training and housing **Lifeline Tameside** • support people into treatment • signposting • advocacy and engagement work
Tier 3 alcohol services *(Providers: Pennine Care; Acorn)*	
Provision of community based specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison *(Pennine Care Substance Misuse Service at Lees St, Ashton-Under-Lyne)*. Structured day-care programmes *(Acorn)*	**Pennine Care Alcohol team** • Treatment in Ashton-Under-Lyne, or Charles St Glossop if required • Specialised care-planned treatment service • Community detoxification • Referral to in-patient detoxification centres • Referral to residential rehab programmes **Acorn Treatment** • recovery focused support • mutual aid • DEAP programme (runs from Dukinfield): an abstinence based substance misuse treatment based around behavioural and emotional change
Tier 2 drugs services *(Providers: Pennine Care; Cottage Lane Surgery;3 needle exchange pharmacies)*	
Provision of information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction (including needle exchange) and aftercare.	**Pennine Care Substance Misuse team** • single point of access for services and triage assessment **Cottage Lane Surgery** 'enhanced service' • Opioid substitute prescribing • Weekly drugs clinic staffed by Pennine Care • Regular benzo nurse clinic • Close liaison with partner organisations **Needle exchange** service offered by three pharmacies in the SK13 area. **Lifeline Tameside** • support people into treatment • signposting • advocacy and engagement work
Tier 3 drugs services	

(Providers: Pennine Care; General practice)	
Provision of community based specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison *(Pennine Care Substance Misuse Service at Lees St, Ashton-Under-Lyne)*. Benzodiazepine specialist worker *(Pennine Care)* Substitute prescribing *(mainly Cottage Lane surgery, but also Manor House)* Structured day-care programmes *(Acorn)*	The **Pennine Care Drugs team** • Substitute opioid prescribing • Community detoxification • Specialist individual therapeutic input • Based in Ashton-under-Lyne • Multi-disciplinary team including a Consultant Specialist in Substance Misuse • CLI (a peer support buddy system (Ashton-based)) **Cottage Lane Surgery** • provide care to complex and intermediate patients who wouldn't travel to Ashton-Under-Lyne • Opioid substitute prescribing **Acorn Treatment** • recovery focused support • mutual aid • DEAP programme (runs from Dukinfield): an abstinence based substance misuse treatment based around behavioural and emotional change
Family & Carer Support services	
Very limited current provision	**Acorn Treatment** • family programme run from Tameside **Substance Misusing Family Support Service (SUFFS)** • no longer commissioned for SK13 area **SPODA** provide support to the family and carers of people who misuse substances in Derbyshire. However the service is not currently commissioned for the SK13 area. **Al-anon**, affiliated to Alcoholics Anonymous, have weekly support meetings in Glossop for family and friends of alcoholics.
Recovery support	
Mutual Aid	ADS used to run a group from Charles St No SMART group in the area. AA groups in Glossop and Hadfield; reportedly new NA group being set up in Glossop

3.2 Service User Profiles

3.2.1 Service user profile: Alcohol

NDTMS data indicate that at the end of June 2013 there were nineteen SK13 residents accessing Pennine Care tier 3 alcohol services and one accessing Acorn for alcohol. The most common referral route into alcohol services was GP, followed by hospital. However, as the table in Figure 21 suggests, there may be some under-reporting to NDTMS as data obtained directly from the service in December indicate 38 active alcohol clients at that time.

According to the NDTMS data, of the 20 SK13 residents in alcohol treatment in June '13, 17 had been in treatment for up to 6 months and the remainder for 6-12 months.

	Service Provider	**Pennine Care (Dec. 2013 point prevalence)**		**ADS (2013)**		**Acorn (2010-2013)**	
		N	%	*N*	%	*N*	%
Sex	male	*23*	60.5	*21*	58.3	*10*	62
	female	*15*	39.5	*15*	41.7	*6*	38
Age	20-39			*9*	25	*11*	71
	40+			*27*	75		
Neighbourhood	Glossop	*23*	60.5	*10*	27.8		
	Gamesely/Charlesworth	*6*	15.8	*6*	22.2		
	Hadfield	*8*	21.1	*13*	36.1		
	Other	*1*	2.6	*7*	19.5		
Ethnicity	White British	*30*	78.9	*32*	88.9		
	Not stated or other	*8*	21.1	*4*	11.1		
Time in treatment	up to 1 year			*177*	91.7		
	1 to 2 years			*9*	4.7		
	3+ years			*7*	3.6		
Treatment type	Tier 2			*11*	30.6		
	Tier 3			*19*	52.8		
	Post Tx			*6*	16.6		
SK13 clients as % of total clientbase			8%		12%		4%

Figure 21 Alcohol service user profile for Pennine, ADS & Acorn (data obtained direct from services)

Trend data were obtained from ADS, showing the number of SK13 clients they have seen has risen over the last five years (figure 22). This reflects the increase in the number of clinics provided at Lambgates Surgery.

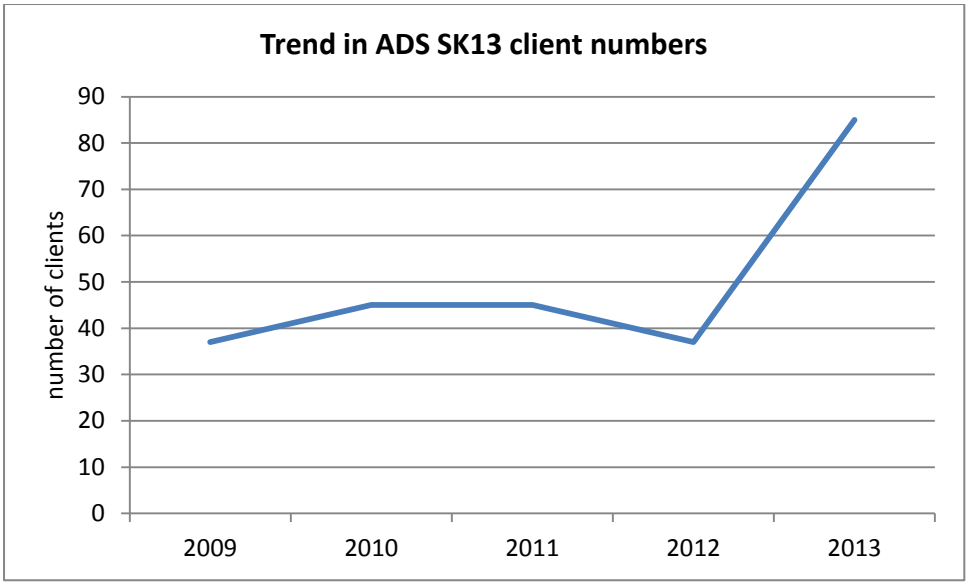


Figure 22 Trend in ADS activity level

Figure 23 shows the age profile of ADS SK13 clients and how this has changed over the last 5 years. The number of clients in their 30s has risen during this time, while the number of clients in their 70s has declined.

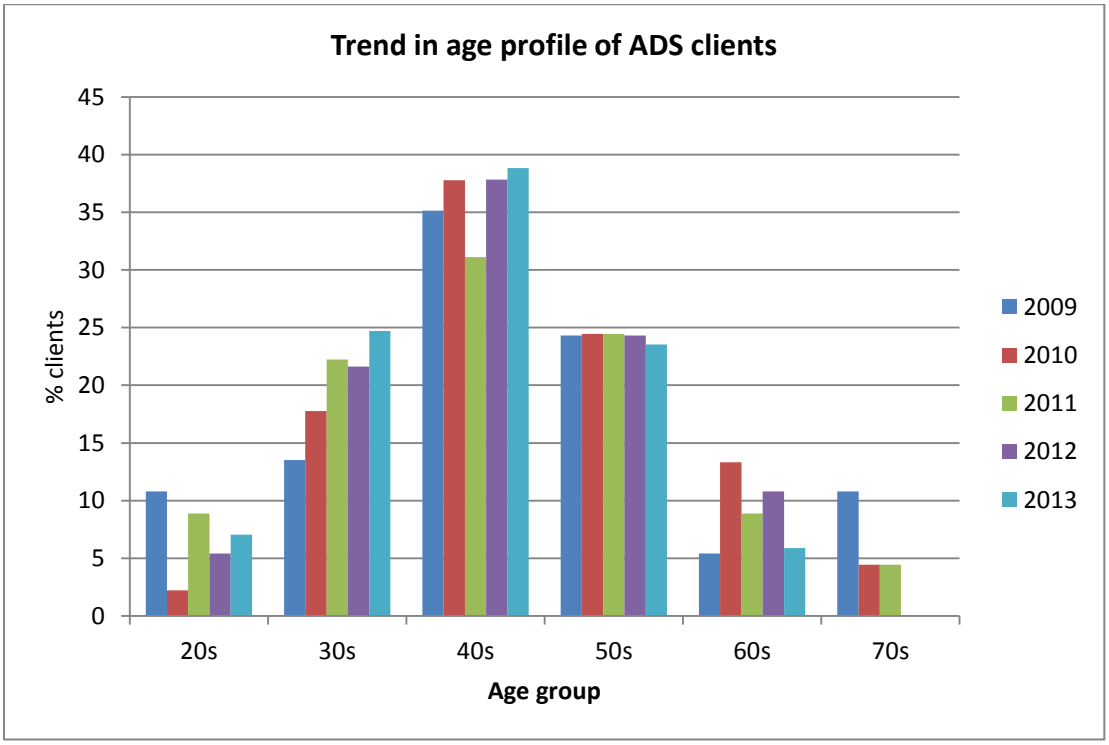


Figure 23 Trend in age profile of ADS clients

Tameside General Hospital's Alcohol Liaison Service (HALS) was set up in April 2013. By December 2013 they had a total of 873 patient attendances, 89 of which were from the SK13 area (ie 10%). Of the 89 attendances, 17 were repeat attendances (ie 20%).

Figure 24 shows that SK13 HALS patients had a greater number of clients aged in their forties than any other age group. The gender spilt for SK13 clients was two thirds male.

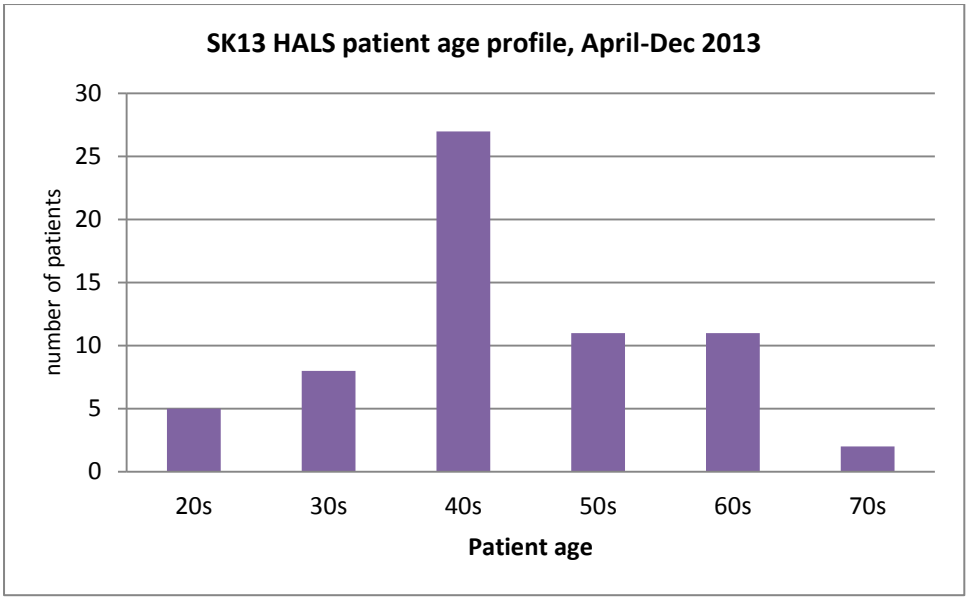


Figure 24 HALS client age profile

The SK13 HALS patients had a relatively high level of alcohol dependence, with 86% scoring 16 or above on the Audit tool.

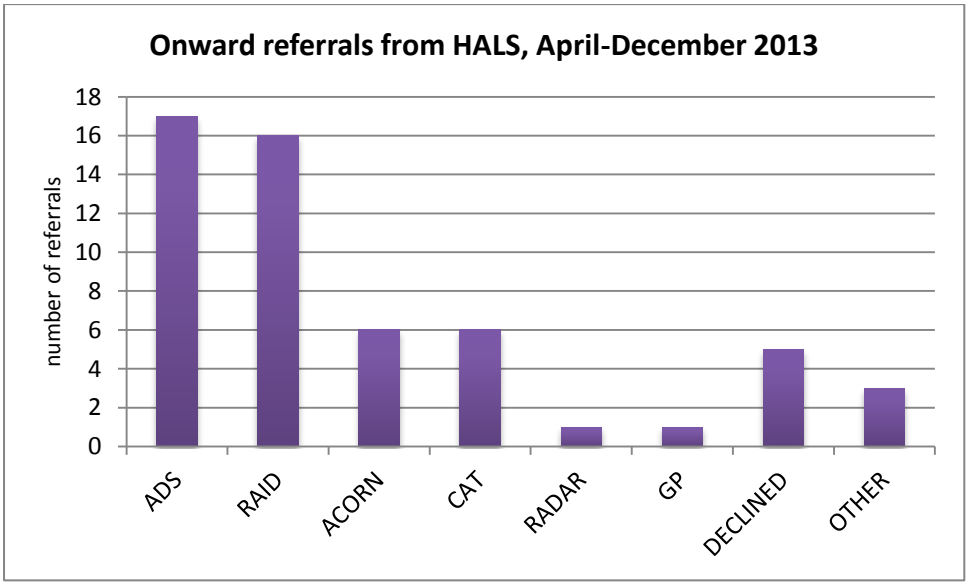


Figure 25 Onward referrals from HALS

AUDIT : definition of scores are:-

0-8 = Acceptable Drinking

9-15 = Hazardous Drinking

16-19 = Harmful Drinking

20+ = Possible Alcohol Dependence

NB: referral to Acorn commenced mid-August 2013.

3.2.2 Service user profile: Drugs

NDTMS data indicate that at the end of June 2013 there were 19 SK13 residents accessing drugs services: 10 using Pennine Care drugs services, 6 using Acorn, 2 using the Derbyshire SMS, and one using Branching Out (for young people). The most common referral route into drugs services was self (9 of the 19).

Of the 19 SK13 residents in drugs treatment at that time 7 had been in treatment for up to 6 months, 6 for 6-12months and 5 for over a year.

Heroin was the most common primary substance for those in treatment (44%), followed by cannabis (17%).

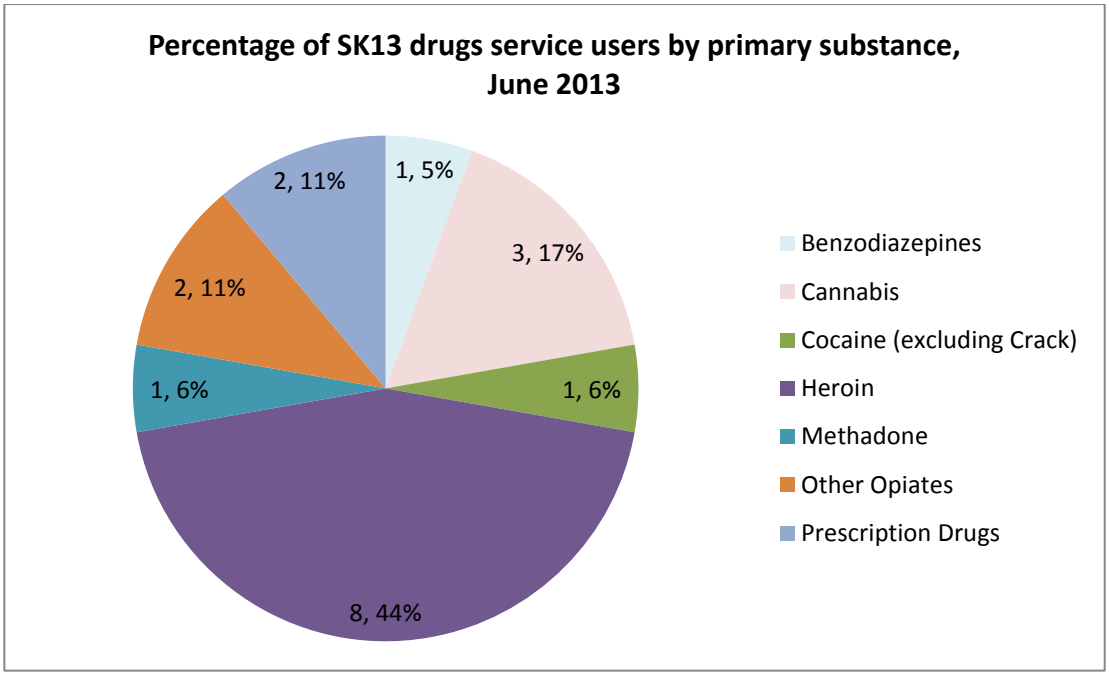


Figure 26 Primary substance of SK13 drugs clients

The proportion of SK13 Pennine Care drugs service users who are male is higher than it is for alcohol services at nearly three quarters, compared with around 60% of alcohol clients.

Two thirds of SK13 drugs in December 2013 lived in the Glossop area (note the data in figures 26 and 27 are from different points in time).

		n	%
Sex	male	*20*	74.1
	female	*7*	25.9
Neighbourhood	Glossop	*18*	66.7
	Other SK13	*9*	33.3

Figure 27 Pennine Care SK13 client profile, Dec 2013 point prevalence

The majority of current Pennine Care patients have had one or two episodes of treatment, as shown in figure 28.

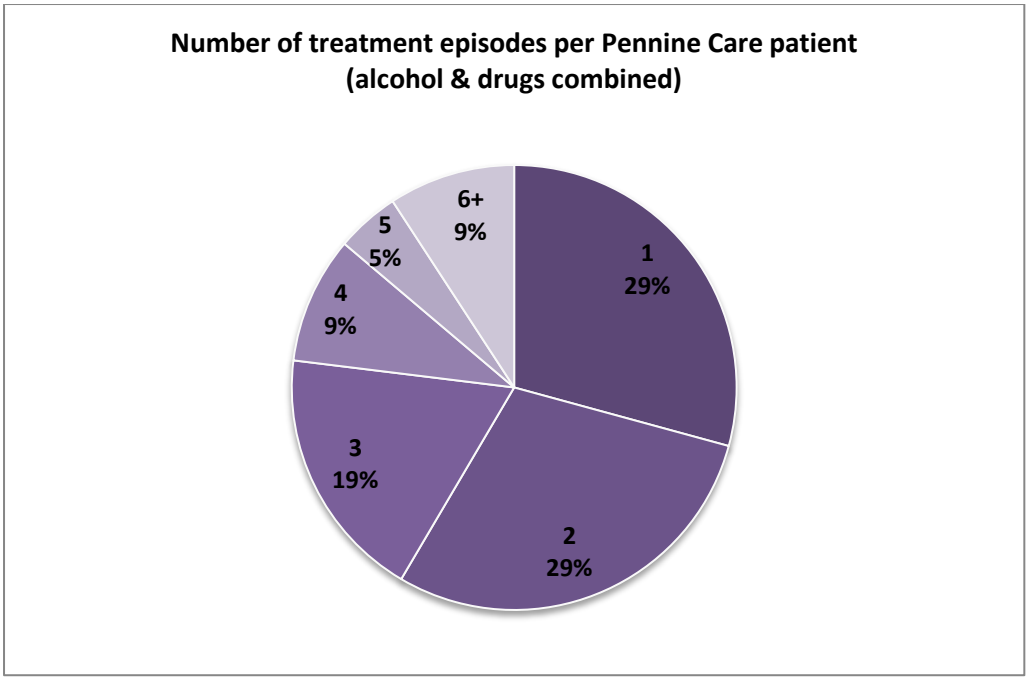


Figure 28 Pennine Care SK13 clients: number of treatment episodes per patient

At the time of this client profile, about 30% of current episodes had a duration of less than one year, but a quarter of clients had been in continuous treatment for 7 or more years.

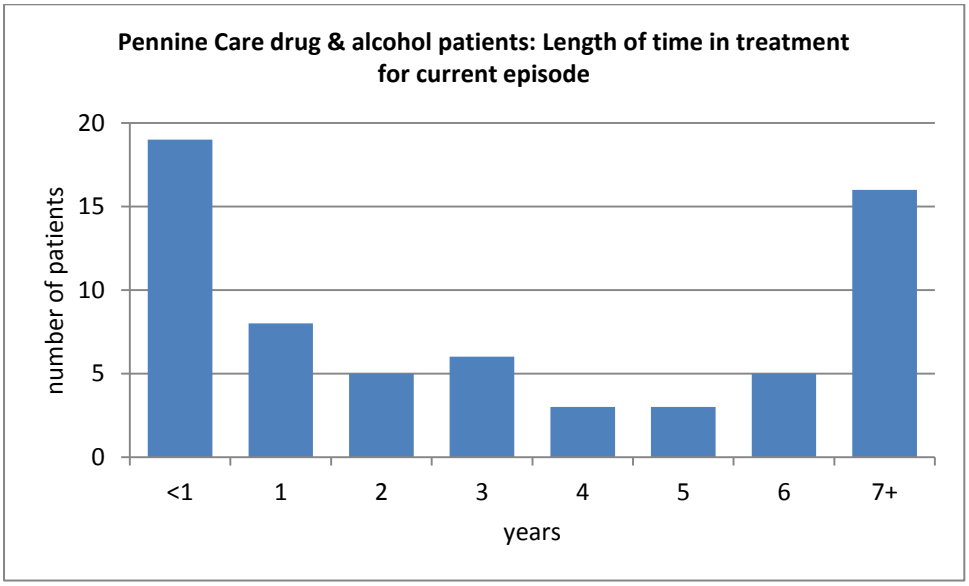


Figure 29 Pennine Care SK13 clients: Length of time in treatment

Phoenix Futures provide drugs treatment to SK13 offenders who are on a treatment order (Drug Rehabilitation Requirement: DRR). In December 2013 Phoenix Futures had a total of 5 SK13 clients, all male and all White British. Primary substances included heroin, cocaine and cannabis. These clients constitute a very small proportion of their total client base.

3.3 Patient experience of local services

3.3.1 Primary Care

The views of people registered at a wide range of local practices (Cottage Lane, Lambgates, Manor, Simmondley, Hadfield Medical Practice, Howard Street) were ascertained. Experiences in accessing support via primary care were mixed. Some practices are aware of local substance misuse services and refer patients; others appear to have limited awareness and are less likely to refer.

Helpful alcohol support

A Hadfield respondent reported that his surgery is very well geared up to provide alcohol support with widespread use of alcohol-screening, posters and AUDIT-C forms in reception.

One respondent reported her GP had been very supportive in preventing alcohol relapse. She had received a prompt and well-coordinated response. “It took years but I do trust him now. He doesn’t look down his nose at you”.

Problems accessing alcohol services

Another respondent said she had been advised to cut down her drinking by her GP but it took years, and a move to a practice providing alcohol enhanced services, before she was referred to alcohol services.

Some GPs support home detox, but several respondents said they felt unsupported afterwards and that the detox addresses the physical but not the psychological aspect of the problem, leading to quick relapse.

One respondent had a very upsetting experience when she asked a GP for alcohol support because “she phoned social services on me”. This respondent is now very cautious about seeking help.

Advice given by GPs is sometimes felt to be inappropriate, eg being told to read a self-help book.

An AA group member felt alcohol support in General Practice was more accessible than specialist services but not necessarily what he needed: *“When I was drinking I could manage to walk to my doctor's surgery. What I got there was not what I needed. But the thought of having to get on a bus and go to Ashton was a whole world away.” (E)*

AA members reported that some GP surgeries refuse to display AA leaflets and most seem to be reluctant to signpost patients to AA.

Problems accessing drugs services

One respondent was told when his GP retired he would have two weeks to find another practice because his practice would no longer prescribe Methadone, but was given no guidance as to where to go.

Another Hadfield respondent, who has mental health and drugs issues, was given a leaflet for the Pennine Substance Misuse Service which he “tossed away and thought, I can’t be bothered … it was just the thought of having to find the money to get down to Ashton”.

A respondent with drugs issues reported that he was never referred to substance misuse services by his GP. Instead he self-referred to The Pennine Substance Misuse Service which he knew about through word of mouth.

One respondent said he felt Glossop GPs are inclined to keep patients on a steady methadone dose compared with Manchester where they focus more on progressively reducing methadone dosage.

3.3.2 Specialist Services

Principal themes relating to service users' experiences of local drug and alcohol services are summarised in the diagram below.

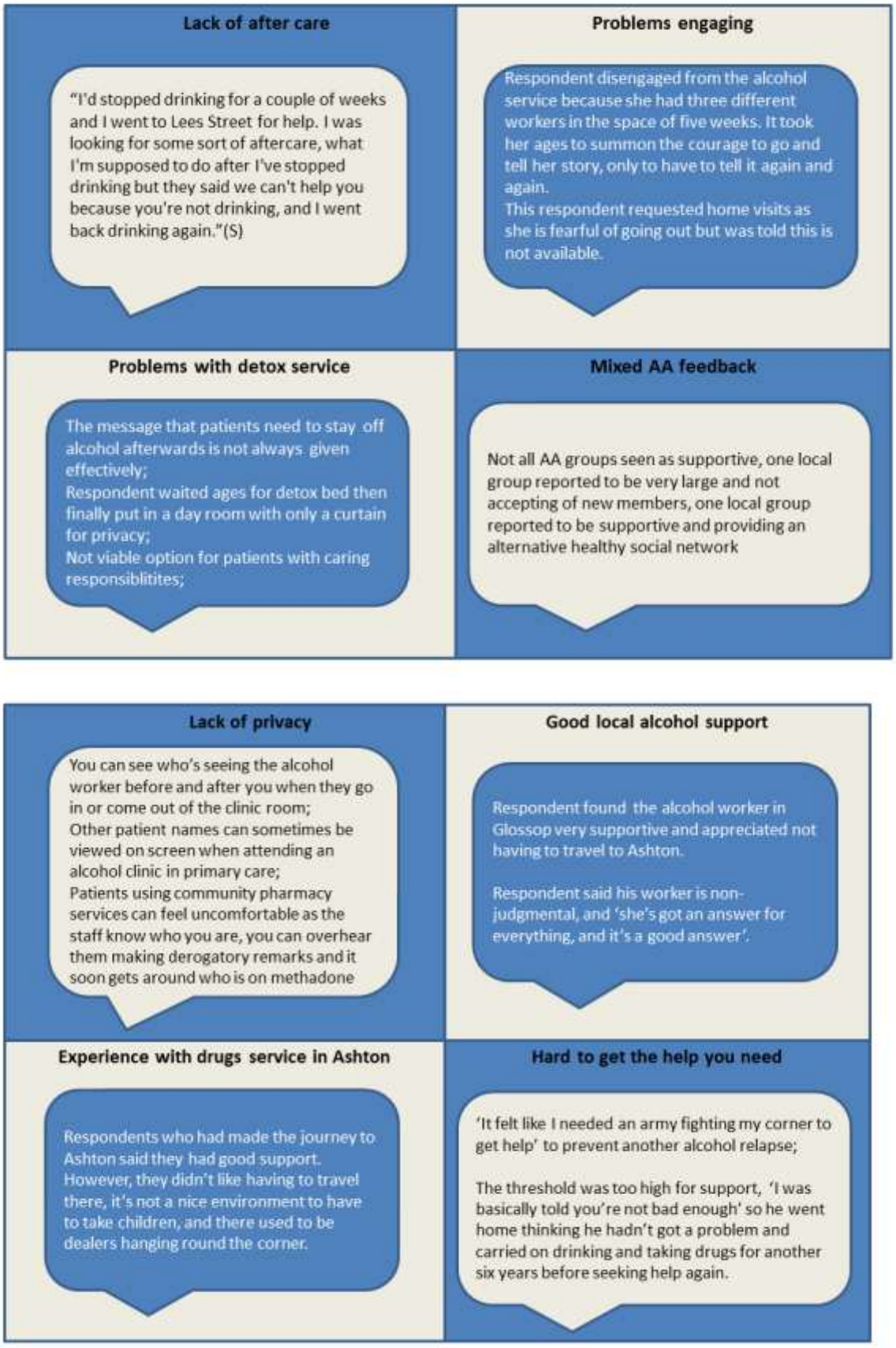


Figure 300 Service user experience of specialist services: key themes

3.4 Partner Agencies

3.4.1 High Peak Mental Health Project

This project provides individual support and various recreational and therapeutic group activities for people experiencing a wide range of mental health problems. On average about 100 people are using the service at any given time. The project has played a valuable role in providing a local base for services for which clients would otherwise have to travel into Tameside.

Many services are provided from Charles Street and from the client's point of view it is seamless and joined up. Having the physical base enables provision of holistic support.

They support a number of people who have a dual diagnosis of mental health / substance misuse issues (mainly alcohol, but also drugs for some individuals). Their main role in these cases is to help clients cope with the mental health element of their problems, although inevitably they also become involved in helping them deal with the distress which arises as a result of them being dependent on substances.

They liaise closely with ADS and Pennine Care, both of which have in the past run groups from the HPMHP premises on Charles Street, Glossop. Both these services welcome self-referrals and when one of their clients expresses a wish to access the support available, contact details are passed onto them and assistance provided where necessary by giving the support and information they need to self-refer. They also arrange appointments to see alcohol clients who cannot travel to Ashton at Charles St.

ADS used to run an alcohol support group (and also met with individual clients) for a period of several years a few years back. The group was well attended with very low DNA rates. It included focused sessions on relapse prevention, anger management etc. However the ADS worker's role changed and the group folded. Attempts by Pennine Care to re-establish the group have been unsuccessful.

Context: HPMHP may be undergoing major changes in future and there is much uncertainty. How HPMHP will sit with new social care and mental health service structures is currently being worked out, and this may prompt a change of emphasis for the project.

3.4.2 Police

The area is covered by three safer neighbourhood teams, Gamesley & St Johns, Glossop town centre, and Hadfield & Tintwistle. According to the safer neighbourhood team sergeants for the area, cannabis is by far the most prevalent substance they deal with. Alcohol present fewer neighbourhood safety issues than it has in the past, and class A offences are rare.

On the streets, police awareness of alcohol or drugs services for the area is low and neighbourhood officers would tend to advise someone to go and see their GP if concerned, or they would ring 'Call Derbyshire', DCC's single point of access.

The cannabis users the police have contact with generally don't want to engage with drugs services, but police do deal with severe paranoia that can develop.

Police do not currently get information from the NHS on alcohol-related admissions and they would value this sort of information to inform local preventive strategies (such as the Cardiff Model).

Police involvement in mental health related work has reportedly increased in the area over last few years. Neighbourhood sergeants report frequent suicide threats and 'near misses'. They expressed concern regarding the lack of resource in mental health services to adequately meet patient needs.

When someone leaves the custody suite (in Buxton) for alcohol/drug related crime they are routinely signposted to services, and staff will offer to pass on the person's details to alcohol or drug services.

If police visit a household where adult/s have alcohol or drug issues and children are present, this generates a referral to child protection. The police work closely with Multi-Agency Teams and youth services to support children in households where substance misuse is an issue.

The police have a Vulnerable Person's Unit (Buxton) for serious complex cases; the unit works in partnership with adult social care and mental health services. If a person has drug or alcohol issues and gives their consent then the PSH (persons susceptible to harm) officer refers to Pennine Care single point of access. But the opt-in mechanism whereby the client receives a letter to which they must respond is said to be a significant barrier to most of the people they deal with – "they're not going to write back, are they?" (PSH Officer).

According to the Vulnerable Person's Unit, the wait for treatment can be an issue because a situation can deteriorate or personal motivation can wane a great deal over a period of two to three weeks on a waiting list. Support is required ideally within days.

The PSH officer was unaware of Lifeline, although they could potentially provide appropriate support for his clients in order to engage with services.

3.4.3 High Peak Women's Aid

HPWA provide community-based services including outreach, floating support, counselling and children's aftercare. They also run a refuge for young women and children seeking safe accommodation and support.

Victims of domestic violence face additional barriers to accessing substance misuse support if they need it. They may have no settled address, be highly stressed or suffering anxiety or depression. Perpetrators sometimes force or encourage a woman to misuse alcohol or drugs, and may prevent a woman from attending appointments. Alcohol is often used by victims of domestic violence as a prop, making it difficult to accept it is a problem. If the perpetrator himself is in treatment then this can be a barrier to a woman seeking help.

If police are called to an alcohol-fuelled domestic violence incident it was reported that they can occasionally appear judgemental and underestimate the extent of the domestic violence, for example if the victim is presenting as aggressive.

If a woman wants substance misuse support the HPWA worker will typically refer to Pennine Care Substance Misuse Service for triage.

Occasionally Pennine Care have arranged to see women with alcohol problems at Charles St in Glossop if getting to Ashton is not feasible.

In general terms, it was felt drugs and alcohol services could usefully work more closely with Women's Aid as they tend to know the woman and can enable more effective support. For example sometimes there is an inappropriate

unilateral decision to withdraw a service, leading to relapse, when a stepped down approach would have been better.

Because boundaries for the NHS and Local Authority are not coterminous, coordinating support for victims of domestic violence in SK13 is challenging. The MARAC meets in Buxton. For women with substance misuse issues living in SK13 no representative from Tameside & Glossop substance misuse services attends their MARAC. This can result in women's substance misuse issues not being properly addressed or considered as part of the MARAC process.

3.4.4 Local Authority Housing

The main High Peak Borough Council social housing neighbourhoods in SK13 are Gamesley and Whitfield (with a total of around 2000 tenancies in the SK13 area). The levels of anti-social behaviour and street drinking in these areas have according to local housing officers declined over recent years. The main drug housing officers come across is cannabis which they say is ubiquitous (especially in Whitfield where there is a lot of single person accommodation). Home-growing of a small number of cannabis plants is apparently prevalent, especially in the Glossop flats. If it is a small amount the housing department write a warning letter, then if found a second time they will take action. Housing officers will inform police if they suspect dealing.

HPBC have not made any evictions for drugs in the last two years.

There is a specialist housing officer who works to support vulnerable tenants. She has built trusting and supportive relationships with tenants. However she points out that tenants are reluctant to admit they have a drink or drugs problem as they fear being in breach of their tenancy contract.

3.4.5 Probation

Glossop probation office closed in 2010. Since then, all SK13 offenders on probation are required to travel to Buxton. The Derbyshire drug treatment service is co-located with probation in Buxton. Offenders with drug or alcohol misuse issues may be given one of three types of order:

1. DRR (drug rehabilitation requirement). The Criminal Justice drugs worker will consider whether the offender is willing to engage and what level of misuse it is. The standard DRR is for 6 months, but they have recently introduced shorter 2 month DRRs for cannabis. The offender has to have twice weekly drugs tests plus a supervision order. A prescribing clinic is provided where needed. The DRR works on an intensity model with regular review. If the offender tests positive they may be subject to breach or recalled to prison. After the DRR is completed, continued treatment is voluntary. Some choose to stay on with the team in Buxton, and others are signposted to other providers.
2. ATR (alcohol treatment requirement). This requirement is designed for more dependent drinkers. It is provided by Addaction and consists of 12 sessions over a 6 month period. After the ATR is completed continued treatment is voluntary. Some choose to stay on with the worker in Buxton, and others are signposted to other providers.
3. ASAR (alcohol specified activity requirement). This 6 session brief intervention requirement is designed for non-dependent drinkers. It is provided by DAS (Derbyshire Alcohol & Advisory Service). There are 2 or 3 clinics from Buxton per week.

The main barrier to offenders accessing drug or alcohol support via these orders is that travel to Buxton is required. Magistrates take this into account in their decision-making. They consider the likelihood of the offender engaging in the DRR/ATR/ASAR before issuing it.

Drug/alcohol workers signpost to follow-on services after an order completes. But they only have onward input or information if the offender reoffends and goes round the cycle again.

The restructure of probation services in April 2014 means that most alcohol or drug related offenders will be dealt with by Community Rehabilitation Companies (CRCs).

Phoenix Futures provide drugs treatment in Buxton and New Mills for SK13 offenders who are on a treatment order. The main issue they have with this group of clients is the lack of a Glossop base, resulting in a high rate of non-attendance at appointments due to travel difficulties.

Phoenix Futures offer full wraparound treatment including psychosocial support, prescribing (via consultants if needed or via non-medical prescribers), signposting, MAPPA (dangerous offenders), MARAC (domestic violence).

Offenders are risk assessed in custody and prioritised in line with need. Those that agree to seeing a drugs worker are given priority for the service. Where a SK13 resident is arrested outside area, eg in Tameside, bail restrictions are imposed.

The criminal justice system is monitored on successful DRRs. It may be that if the proportion of successful DRRs for SK13 declined after the service was withdrawn from Glossop, then number of DRRs issued to SK13 residents declined in response, to avoid increasing proportions of DRRs being revoked or offenders being resentenced.

Phoenix Futures have a good working relationship with Pennine Care. For example, if a client is being treated by Pennine Care in Tameside and reoffends, instead of being referred back to Phoenix Futures, they will stay on in Tameside in the interests of continuity of care.

3.5 Family & Carers Support

Substance misuse affects not only individuals but also their families, friends and communities. For example, the children of parents or carers who are dependent on drugs or alcohol are more likely to develop behaviour problems, experience low educational attainment, and be vulnerable to developing substance misuse problems themselves (NTA).

In the past the Substance Misusing Family Support Service (SUFFS) used to operate from Ashton-Under-Lyne and was available to families from the SK13 area, but this was recommissioned and the new service only covers Tameside.

SPODA provide support to the family and carers of people who misuse drugs in Derbyshire. However the organisation is not currently commissioned to provide services in the Glossopdale area.

Al-anon, affiliated to Alcoholics Anonymous, have weekly support meetings in Glossop for family and friends of alcoholics.

4.0 Gap between need and access

4.1 Key Informant perspective

Travel

Distance to agencies was identified by all service providers as the main barrier to accessing drugs or alcohol services for residents living in Glossopdale.

Having to get the bus to Ashton is reported to be a major barrier.

> *"It's like the back of beyond. They just don't go. I can think of 5 – 10 people who really might access drugs services if they were in Glossop, but won't go to Ashton" (community worker).*

Public transport links into Tameside and Manchester from SK13 are much better than those into Derbyshire.

Poor service integration

Services are not always joined up to support highly vulnerable adults such as the homeless. Individual services will reportedly go so far to try and help, but are unable to meet the needs of very complex cases.

Late Presentation

By the time people with drug misuse problems go to see their GP it is reported that they often have several health problems resulting from their substance misuse. This can indicate difficulties in accessing services.

Gaps in local provision

- Health centre provision out of hours (OOH) is limited in Glossop, with no 24hr service in the town. The nearest OOH is in Ashton, and patients need an appointment.
- SUFFs has changed and is no longer available for SK13, SPODA likewise does not cover the SK13 area. So there is a major gap in service for family and carer support.
- There is no residential detox facility in the area. Securing residential support placements can involve a long delay and referral via Adult Care in Derbyshire with provision in Tameside.

4.2 Service User perspective

Travel

By far the most important barrier to accessing services, cited by *all* respondents, is having to travel out of the area. Whether travelling from Glossop, Gamesley or Hadfield, the bus to get to the Pennine Care Substance Misuse Service in Ashton takes between 45mins and an hour.

> *'It can be a nightmare getting out of Glossop if you're not feeling well'(GQ2)*

> *"It was, yeah go to Ashton, well to me then the thought of going to Ashton in three months' time, you might as well have said to me in a year's time you're gonna go to France and then you'll get better; It was too far in distance, and too far time-wise". (E)*

> *"It's like you cross a border you know, if you go outside of Glossop into other areas there's loads of stuff [services], but if you come into Glossop it's like a ghost town, there's no services or anything. But with my personal circumstances I can't access those groups." (M)*

For some it is hard to get the bus fare together. A Stagecoach Dayrider bus ticket costs £4. One service user said he knows people who have stolen in order to get the bus fare. Service users report that staff at the Substance Misuse Service tend to say if you can find money for heroin, you can find £4 for the bus.

Many are fearful of travelling to somewhere unfamiliar. Some are fearful of leaving the house.

> *""I had to learn to use buses and I was terrified. I had to stand around people at bus stops and I had so many fears it was untrue." (J)*

Glossop and Hadfield both have train stations, but the line only goes into Manchester. To travel east or south into Derbyshire using public transport, bus is the only option.

Caring responsibilities can be a barrier for some. Especially if you are having to take children with you to access services in Ashton.

Inadequate public transport in the evenings prevents people attending NA meetings as they cannot get home afterwards.

Lack of recovery services

Service users highlighted a lack of recognition amongst service providers that many need access to some on-going support to avoid relapse and continue the recovery process.

Lack of tier 2 service

Two service users talked about the threshold for accessing services being too high - although their experience was some years ago, so the situation may now have changed.

> *"It got the point that I was physically ill before I got any help; I was near to death's door and I was crying out for help, then I actually got the help... the damage had already been done." (M)*

> *"til I went to hospital I didn't have any support" (GQ1)*

Waiting time

Many reported waiting a long time for home detox (6 months), and for ADS (3 months). However, these experiences were from some years ago, so may not reflect the current waiting times.

Lack of awareness of what is available locally

Several service users reported that some workers lacked awareness of available support for substance misuse. For example, not telling patients who are travelling to Ashton that there is a clinic in Gamesley they could access, and only finding out through friends.

> *"I first started drinking heavily at 18 and now I'm 36, and I don't know of much support, and if I had known I wouldn't have drunk for as long as I did, I think I'd have sought help a lot sooner had it been available and had I been aware of it, and it wasn't for lack of trying or lack of looking." (M)*

Some patients we spoke to who were registered at practices that don't have an alcohol enhanced service felt they were less likely to be referred for alcohol support: *'My GP didn't seem interested' (GQ2).*

Social environment

Alcohol service users talked about how alcohol is ubiquitous and it can be difficult to avoid social situations where others are drinking. Recovery involves establishing a new healthy social network and disassociating oneself from previous 'drinking buddies'.

Service users in recovery for opiate addiction reported that it is impossible to avoid encountering other substance misusers on the street.

Stigma

Several of the service users we spoke to talked about the way stigma associated with substance misuse prevents people seeking help, or delays help seeking in the area.

> *'Mention drugs and people turn their backs' (D).*

One service user talked about the shame that prevented them from accessing support:

> *'It takes years to admit you've got a problem'(E).*

Some expressed a fear of people finding out you have a problem, and concern about having drug addiction on their medical records. One felt this could impinge on custody over children or other decisions.

Caring responsibilities

Detox, either residential or home, is not felt by some to be appropriate for a parent with children at home.

> *'I don't want my kids finding out' (G).*

Another reported that there was no financial support for his family if he were to go into rehab, meaning that rehab was not a viable option for him.

Poor help-seeking behaviour

Some service users felt not being able to express needs well, perhaps because of their substance misuse, prevented them accessing the support they needed. For one service user this lead to frustration and thinking 'what's the point', followed by relapse.

5.0 Suggestions for service improvement

During the course of the interviews with both key informants and service users, many suggestions were made for how the support for people with substance misuse problems in Glossopdale could be improved.

5.1 Service user views

Service type / characteristics

- Provide holistic treatment that deals with the physical, the social and the psychological
- Having lots of services under one roof is convenient and less stigmatising
- Offer a choice of services and involve the patient in shaping their care, then if things don't work out they don't feel like it's the end of the line, there is something else they could try.
- Ensure adequate follow-up support available after detox to prevent relapse, including psychosocial support, perhaps referral to AA or groupwork
- More recovery support. Including budgeting, cooking, life-skills; and mental health support to develop better coping strategies, and deal with the flood of previously suppressed emotions that can occur once a person is clean/dry; and diversionary activities, volunteering, educational opportunities.
- Include peer-run services in the mix. Addicts in recovery are a relatively untapped resource.
- Some specifically requested home visits be available for those fearful of going out.
- Provide support for families and carers of clients, including better information about where to get help, understanding addiction, and what to do for the best

Access to Services

- Prompt access to support, as people soon lose motivation to change
- Service provision *in Glossop* – Somewhere the client can feel safe & their privacy is protected. George St clinic would be an appropriate setting. *"It's a lot easier if it's where you live. You feel more comfortable with it." (D)*
- If travel is unavoidable, provide support in getting there. Eg a buddy the first time, a free wayfarer bus ticket.

Improved process

- Give people the choice to change worker if they are not connecting with them
- Ensure patients' privacy is protected when accessing services (eg not using a room clearly visible from the waiting area; not letting patients see others' details onscreen).
- Ensure pharmacy staff treat methadone substitution patients with respect and protect their privacy

- Review methadone prescribing regularly with aim to reduce, and build trust and independence

Engaging people in service

- For those wary of using services, help them engage
- Initial contact with a service should avoid form-filling. Build rapport and trust first. If you start with 'how much are you drinking', the answer will be a lie.
- For mums it may take someone getting to know them and working supportively with them, explaining they are in a better position with social care if they are getting treatment than not.
- For people with dual diagnosis, provide joined up services, perhaps with a health trainer or keyworker model

Better signposting

- Work with police to provide drugs & alcohol advice to offenders
- Even if a person isn't ready to get help, workers should still signpost. Then they might be more likely to access support when they are ready, and more aware of what's available.

Awareness-raising

- Better promotion of services available; to primary care, amongst referring agencies, and to the general public
- Employers need to understand substance misuse and how to deal appropriately with it in the workplace

5.2 Key Informant Views

Local provision

There is a need for premises from which substance misuse services, including group work, can be delivered in Glossop, ideally in a multi-agency environment.

Holistic, joined-up support from prevention to recovery

People on the edge of society need to be brought in by making them feel more worthwhile in their own communities.

Establish a support group in Gamesley where people can get involved doing something practical and meaningful, not necessarily focusing on substance misuse. This would be a distraction from cravings and would build self-worth and tackle social isolation.

Ensure support services are joined up so vulnerable people do not 'slip through the cracks'.

Provide something further upstream than primary care to either prevent substance misuse or help people recognise it is a problem earlier.

Drugs treatment services will need to develop new/better treatment pathways for emerging harmful substances.

Partner agencies such as Citizens' Advice Bureau, Food Banks etc to have referral pathways in place for substance misuse.

Increase awareness amongst young people of dangers, especially not knowing what is in substances; Promote new community safety website: www.doyouknowwhatsinit.org.uk

Better aftercare

After detox / rehab, support people to develop an alternative way of living, protecting them from the temptation of pushy dealers or friends continuing to misuse.

Better data

Share hospital data with Community Safety teams so enable preventive measures to be implemented in a targeted way.

Improve recording of harm from legal highs. Hospital admissions associated with legal highs are not currently coded as such because it is legal.

6.0 Policy context

National

In March 2012 the government published its Alcohol Strategy. It aimed to reduce binge-drinking and alcohol-related crime as well a supporting effective health measures such as brief interventions, alcohol treatment and hospital Alcohol Liaison Nurses.

The government's Drugs Strategy was published in 2010 with a clear focus on recovery from addiction. The strategy also focuses on restricting supply, reducing demand, and tackling emergent psychoactive substances.

Local

Derbyshire's Council Plan for 2014 – 2017 states that the council will "develop a co-ordinated approach to the challenges posed by excessive alcohol consumption with our partners to reduce the damage that it can cause. We also want to focus our effort on preventing drug and alcohol misuse and supporting people to recover from addiction so that they can pick up their lives again".

Derbyshire has an Alcohol Harm Minimisation Plan which focuses on developing skills of frontline workers to deliver brief intervention, an Alcohol Diversion Scheme, sharing intelligence between health and criminal justice, and encouraging workplace substance misuse policy.

The Derbyshire Substance Misuse Strategic Commissioning Group recently reviewed the strategic priorities for tackling substance misuse across Derbyshire. This is shown below.

Derbyshire Substance Misuse Strategic Commissioning Group
Strategic Priorities 2014-16

AIM: TO REDUCE ILLICIT AND OTHER HARMFUL DRUG & ALCOHOL USE, AND INCREASE THE NUMBERS RECOVERING FROM DEPENDENCE		
Strategic objective 1	**Strategic objective 2**	**Strategic objective 3**
To ensure effective prevention and early intervention in order to minimise harm to individuals, families and communities	To protect from harm those affected by substance misuse	To maximise opportunities for recovery from substance misuse
Delivery and monitoring of strategic objectives		
Increasing understanding of the risks and consequences of substance misuse	Commissioning effective, integrated substance misuse services	Development of pathways from substance misuse services into recovery
Building resilience and skills to support healthy choices	Identifying and protecting those most at risk from substance misuse of others	Build capacity and sustainability of recovery capital across Derbyshire
Identifying groups and individuals at risk and delivering early intervention	Tackling substance related violence, crime and anti-social behaviour	Support the longer-term rehabilitation of those recovering from substance misuse

7.0 Recommendations

- Alcohol & drugs services to be delivered from **a Glossop base** to remove the major barrier currently posed by required travel out of the area. If travel is unavoidable, provide support in getting to appointments.

- Alcohol & drugs services to be delivered ideally **in a multi-agency environment** which is not only more convenient for clients accessing more than one service but also fosters better collaborative working, and enhanced levels of privacy for clients
- **Better support for recovery**. Substance misuse clients to be offered support to access services that promote reintegration including housing, education, employment, personal finance, healthcare and mutual aid
- Commission **support to families and friends** affected by substance misuse in the area so their needs can be assessed; this support is currently offered by SPODA in other parts of the county
- Local agencies to have better awareness of available support, clear referral pathways and improved **signposting**
- Frontline health and social care workers in Glossopdale to be adequately **trained** in substance misuse awareness and brief intervention
- **Holistic** support for marginalised people to enhance community integration and sense of worth
- Engage with local schools and youth services to address the normalisation of cannabis use amongst young people in the area
- Work with Tameside HALS to ensure SK13 hospital patients are signposted to appropriate support
- Design workable mechanisms for SK13 residents to access residential rehab without unnecessary bureaucracy and delay
- Ensure MARAC clients' substance misuse needs are addressed during MARAC meetings and keyworkers represented where appropriate
- Services to be commissioned and delivered in line with NICE commissioning guidance and quality standards (QS11 & QS23)
- Explore how best to meet the treatment needs of clients with caring responsibilities

Appendices

Who we consulted: Service users

Gender	
Female	4
Male	10
Service used	
Pennine Care	7
ADS	6
AA	5
Neighbourhood of residence	
Glossop	6
Hadfield	2
Gamesley	3
Tintwistle	1
Unknown	2
Primary substance	
Alcohol	9
Drugs	3
both	2
Interview type	
One-to-one face-to-face	7
One-to-two face-to-face	1
Focus group	1
Source of interviewee	
Pennine Care	4
High Peak Mental Health Project	1
Geoffrey Allen Centre, Gamesely	2
ADS	1
AA	5
Snowballed	1
Acorn	0

Who we consulted: Key Informants

Professional stakeholders who contributed towards this needs assessment are listed below.

NAME	ROLE
Alan Alker	Pennine Care NHS Foundation Trust (alcohol)
Alan Dow	GP, Cottage Lane Surgery, Gamesley, North Derbyshire CCG
Amy King	Derbyshire Healthwatch, community development officer
Anne Gribben	PCSO, Gamesley Neighbourhood Safety Team
Barry Gilman	Pennine Care NHS Foundation Trust (drugs)
Cheryl Pike	Service Manager, Adult Care
Clare Liptrott	Pharmacy & shared care coordinator (T&G CCG)
Dot Inger	SPODA
Dr Matthew Kinsey	GP, Howard St Med Centre
Dr Palmer (GP) and Kathryn Leys (PM)	Lambgates Surgery
Ed Smith (manager), & Kevin Morris (frontline)	Acorn Treatment & Recovery
Elaine Penning	Community Development worker, Gamesley
Ellie Wilcox	Borough and County councillor
Emily Todd	Lifeline
Frank Wood	HPBC, Housing, neighbourhood coordinator for Gamesley
Gill Morgan	practice nurse, Cottage Lane surgery, Gamesely
Hannah Dyer	HPBC, Housing, neighbourhood coordinator for Glossop & Hadfield
Jane Cook	housing support officer for high peak
Billy Hooley	ADS (addiction dependency solutions)
Kath Bailey	practice manager, Cottage Lane surgery, Gamesely
Kerrie Pryde	Bridges Project, New Charter Housing Trust in partnership with Turning Point
Kerry Lyons & Joyce Southern	Alcohol Liaison Service, Tameside General Hospital
Linda Dunn	Health Trainer (Pennine Care)
Linsey Bell	Tameside MBC
Neil Myers	PSH officer
Nick & Donna	Gamesley Community Café
Nicki Richmond	public health analyst
Pam Whittle	Glossop Women's Aid
Pat Javeneau	DCC community development, Gamesley food bank
Phil Toker	DIP (Drug Interventions Programme) workers at Buxton
Roland Javanaud	High Peak Mental Health Project
Sacha Wyke	Public Health England, Knowledge & Information Team
Sarah Langley	Probation services
Sean Meehan	NDTMS (national drug treatment monitoring service)
Sgt Trevor Steed and Sgt Phil Booth	Safer Neighbourhood teams (police)
Simon Morton	Locality Commissioning Manager, T&G CCG
Siobhan Lucas	Police data analyst
Steve Holme	Police drugs expert

Glossary

ADS	Addiction Dependency Solutions
ASB	anti-social behaviour
AUDIT	(Alcohol Use Disorders Identification Test) tool used to screen and identify people who are at risk of developing alcohol problems
CAT	Community Alcohol Team, Pennine Care
DCC	Derbyshire County Council
HALS	Hospital Alcohol Liaison Service
HPBC	High Peak Borough Council
HPMHP	High Peak Mental Health Project
HPWA	High Peak Women's Aid
IBA	Identification and Brief Advice
IMD	Index of Multiple Deprivation
JSA	Job Seekers' Allowance
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System (Public Health England)
PSH	Person Susceptible to Harm
RADAR	Inpatient Detoxification Unit at Prestwich
RAID	Rapid Interface and Discharge Service
tier 1 services	Refers to the Department of Health's Models of Care (2002) four tier framework. Tier 1 includes provision of drug-related information and advice, screening and referral to specialised drug/alcohol treatment.
tier 2 services	Refers to the Department of Health's Models of Care (2002) four tier framework. Tier 2 includes provision of substance-misuse information and advice, triage assessment, referral to structured treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.
tier 3 services	Refers to the Department of Health's Models of Care (2002) four tier framework. Tier 3 includes provision of community-based specialised assessment and co-ordinated careplanned treatment and drug/alcohol specialist liaison.
tier 4 services	Refers to the Department of Health's Models of Care (2002) four tier framework. Tier 4 includes provision of residential specialised drug/alcohol treatment, which is care planned and care coordinated to ensure continuity of care and aftercare.