

Safer Bristol: 5 Jun 09

(These meeting notes have been prepared by Crisis Centre Ministries and circulated to those present. Any references to 'we' and 'us' refers to CCM, and not to the people round the table. To the best of our knowledge, this is an accurate and reasonably complete record of what was said.)

Present

Alan Goddard (CCM Drop-in Centre Manager), Paul Hazelden (CCM General Manager), Sue Bandcroft (Safer Bristol Senior Commissioning Manager), Claire Main (Safer Bristol Commissioning Projects Officer), Glenn Mower (BSDAS Senior Social Worker), Kristin Dominey (AWPT Head of Substance Misuse Services), Jane Baker (BSDAS Team Leader) and Barbara Coleman (NHS Bristol Associate Director Public Health).

Objectives

Implicit in the context of the meeting were two objectives:

- To 'distinguish between fact and opinion' in the circulated notes from the meeting with Stephen Williams.
- To establish, as far as possible, the relevant facts.

At the start of the meeting, three others were suggested:

- To gain a greater understanding of the issues, as seen by each party.
- To help CCM understand how people gain access to treatment in Bristol.
- To determine if there is any way to improve cooperation between Safer Bristol and the Voluntary Sector in Bristol.

Context

One part of the context for this meeting is the previous meeting with Stephen Williams MP, and the notes circulated from that meeting. Unfortunately, most of the people present had not seen these notes and did not have a copy, so any discussion of the detail in the notes was difficult.

The second part of the context, for CCM, is that in the Coffee Shop we frequently see people being 'recycled' – going into treatment in Bristol, and lapsing, over and over again.

The third part of the context are some outstanding questions from Alan:

- How many people have been sent out of Bristol in past year to funded residential rehabs?

- How many people have come in to Bristol to attend funded residential rehabs?
- Have we funded residential treatment for alcoholics in the past year? If so, how many people were funded, and how much did this cost?

This information is not easily available. Sue has tried to get hold of some answers to these questions, but did not succeed in time for this meeting. She promised to make it available shortly.

Identifying what is Happening

In discussing how CCM could set about finding out what is happening in this area, several meetings were mentioned:

- There is a quarterly NHS meeting about alcohol treatment.
- There is a monthly drug treatment task group which looks at the national strategy and Bristol's annual treatment plan.
- The Providers Forum
- The Harm Reduction Group

We were informed that minutes of all these meetings are posted on the Safer Bristol web site. *(Post-meeting note: we have made several searches on the web site and, so far, failed to find these minutes.)*

People from Safer Bristol are welcome to attend the meetings of the BCAN Homeless Forum (on the second Thursday of alternate months, venues posted on the BCAN web site – www.bcan.org.uk), as are people from other statutory or funded groups.

Access to Services

Alcohol treatment does not have the same level of funding as drug treatment. This is essentially a political decision: it is not due to a lack of treatment options, but due to a lack of will to pay for it. However, the alcohol funding has increased recently.

When people have both drug and alcohol needs, as is frequently the case, Safer Bristol intend to provide help for both needs. The two areas have been 'brought together' to facilitate this combined approach, but it is not immediately clear what this means.

Safer Bristol have made a conscious decision to 'maximise residential rehab within Bristol' as this enables better deals to be made with the treatment providers, and so more treatment can be offered within the budget. The policy was developed with the providers – the treatment services – with the two aims of maximising the resource we have in Bristol and of encouraging people to maintain the links they have with families. "We buy block beds in advance because it is cheaper that way, so we get more treatment for the money."

While CCM accepts that Safer Bristol have chosen this approach, we are not yet convinced that it is the best one, either for the individuals being treated, or from the perspective of simple economics.

It seems obvious to us that, if you ask the treatment providers in Bristol, they will favour an approach which maximises the amount of treatment they provide, and hence the amount of money they make.

It also seems obvious that, if a person has been living in addiction for some time, then their current relationships (whether with family or friends) have been encouraging and facilitating that addiction, so it is unlikely that these same relationships will suddenly encourage a drug-free life post-treatment.

And it also seems obvious that you can maximise the *quantity* of treatment provided by choosing the cheapest treatment available, but this is not the same as choosing the most cost-effective method of treatment: it is at least possible that a more expensive form of treatment may prove to be more cost-effective than a cheaper form.

It is our conviction that the most ethical form of treatment (that which is most likely to produce a successful outcome: where the treatment programme is completed, and where the individual remains drug-free after treatment) is actually in the long run the most economical approach.

Further Discussion

Sue listed the many sources from which Safer Bristol gets money to commission the services listed in the Bristol Drug Treatment Directory. Anyone in Bristol can access these services.

There is an 'open access' service, the Alcohol Misuse Service, run by ARA.

There is a structured day care programme: the people who use it may be on a script or drinking, but the goal is abstinence.

There is a 5 day a week harm reduction programme available via BDP, which provides help with areas like goal setting.

All the people in these programme should have a key worker, who would provide access to the specialist services through the Community Care Assessment Review process. The funding for this comes from the Community Care budget.

All the people in these programmes should have a care plan which identifies what they will do once the treatment is complete. However, Alan knows of two people currently in detox for whom there is no plan – or, at least, the plan is to put them back into a hostel where they are very likely to relapse. Sue thinks this should not be the case, and would like the details. Alan will ask for permission to give her the details.

When it is a question of life or death, Safer Bristol (actually, a panel consisting of Sue, Kristin Dominey and a senior social worker) will accept people in to Acer (the Acer Specialist Drug and Alcohol Inpatient Unit at Callington Road Hospital, where they provide inpatient stabilisation and detox) without a plan, but not otherwise. If

clients are referred to Acer they will have a key worker, so we need to find out from the key worker why they are planning to go back to the hostel and then pass this information on to Sue.

Safer Bristol plan to do 200 Community Care Assessments each year. From these 200 assessments came 152 placements last year.

Several places that Safer Bristol has used were identified. Sue has started the process of finding out details of the people who have been placed in funded residential treatment outside Bristol, and will pass on the results to CCM as soon as she has them.

Why Keep People In Bristol for Drug Treatment?

Several points were made to support the policy of keeping people in Bristol for drug treatment:

- If we place someone outside Bristol, we send a letter (to the local DAT and Social Services Department) saying that we have an ongoing responsibility for the individual. When people come to Bristol for treatment, we should receive notification, but this rarely happens.
- Addicts have a fantasy that they will do better outside Bristol – that they will go somewhere new and their life will get sorted out.
- We have to ask people: why not use the services which have already been commissioned?
- We do not prevent people from going outside Bristol if this is the right thing for them.
- Quite a lot of people who are sent out of Bristol will walk away from the treatment centre within 24 hours.
- Safer Bristol are implementing the national policy.

It was suggested that people from CCM should meet the people from Walsingham House, as Walsingham House are asking for Bristol people to come and fill their vacant places.

Access to Alcohol Treatment

Funding for treatment at Serenity House needs to go through the Community Care Assessment. This treatment is not being offered, but neither is it being prevented. At present, nobody is going to Serenity House because nobody is asking to go.

In this context, the comment was made that ‘Bristol is wall-to-wall with twelve step’.

The New Street Wet Centre is open on two days each week now.

There is now more access to alcohol treatment at the Salvation Army than there

used to be. They have 6 beds for the year for alcohol treatment as a pilot project.

The preferred option is to do community based alcohol detox, but this is not suitable for many people.

There are around 70 or 80 referrals from GPs each month for alcohol treatment.

People cannot do a detox at the Salvation Army any more because alcohol detox is now funded by Safer Bristol, and therefore Safer Bristol need to make sure the 'governance' is correct and safe. If Safer Bristol fund the programme and any problems occur, Safer Bristol will be 'up in front of the coroner'.

On 26 June the Robert Smith Unit will be moving to Colston Fort.

Community Care Assessments

Alan asked: how do we make sure that our clients have access to Community Care Assessments? The initial answer was that we need to make sure they have a way in to the treatment services through accessing the tier 2 services (it would probably be helpful to be clear what these are...).

The panel meets every two weeks to consider the Community Care Assessments. It would be helpful to know who is on this panel.

CCM can refer people for Community Care Assessments. We did not know this before. Alan will aim to get some completed in the near future.

How long will it take for someone to access treatment through this route? It varies according to the individual needs, but the target is 28 days to do the Community Care Assessment, and then provide treatment within 3 months. Sometimes the treatment can happen within 4 or 5 weeks.

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