Nottinghamshire Health & Wellbeing Board

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Executive Summary

Introduction

Definitions and overall approach

- 'Substance misuse' is defined here as 'intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs'[1]. 'Psychoactive substance' means a substance that changes brain function and results in alterations in perception, mood, consciousness, cognition or behaviour.
- For the first time in Nottinghamshire this topic combines both alcohol and drugs and young people and adults, adopting a life course approach.
- Drugs and alcohol are combined because the use of different substances share similar root causes and can have similar overall effects on the lives of individuals, families and on communities. Also, poly-substance use is very common[2].

This JSNA topic provides an overview of local need and current services regarding substance misuse and identifies unmet needs and gaps. It focusses on substance misuse in the community. It excludes substance misuse amongst prisoners, patients with long term health conditions as a result of substance misuse and family members and carers of substance misusers.

Health and social context:

Substance misuse is associated with a wide range of health and social issues and has enormous health and social care financial costs (Public Health England, 2014a). Dependency in particular is commonly associated with poor outcomes in relation to physical health, mental health, education, training, employment and housing and with anti-social and criminal activity that adversely affects individuals, families and communities.

Alcohol alone contributes to more than 60 diseases and health conditions and represents 10% of the burden of disease and death in the UK, placing it in the top three lifestyle risk factors after smoking and obesity (Alcohol Concern, 2015a).

The conditions most strongly related to health inequalities, such as cancer and cardiovascular disease, are associated with alcohol and drug use (Marmot, 2010). Resilience is an important personal factor and deprivation is an important social factor in the likelihood of substance misuse issues occurring. Effectively addressing a community's substance misuse issues means addressing the wider determinants of health and considering substance misuse in the context of the causes of broader health and risk-taking behaviour.

National context:

National evidence suggests that substance misuse in the UK has reduced significantly in the UK over the last decade. However, substance misuse remains a significant national challenge as:

- It is estimated that 2 million people are addicted to substances.

- There are approximately 1 million alcohol-related hospital admissions in England per year and this has been increasing consistently (Public Health England, 2014b) with significant increases regarding alcohol-related cardiovascular disease conditions.
- Between 2012 and 2014, there was a reported 42% increase in drug related deaths (from 1613 to 2120)[3] and a 6.9% increase in alcohol-related deaths (from 21,485 to 22,967)[4].
- Binge-drinking remains a concern as well as the emergence of new substances (e.g. New Psychoactive Substances).

For a summary of the evidence, see Appendix A

Addressing substance misuse remains a key national priority. The National Drug Strategy (2017) builds on the previous national drug strategy's ambition to promote sustained recovery from drug misuse and acknowledging the importance of a whole life approach with a focus on education and prevention. The National Alcohol Strategy (2012) focussed on reducing the number of people drinking excessively and making 'less risky' drinking the norm.

Since 1st April 2013 the Government has delivered major health structural reform. Health & Wellbeing Boards are in place and overall accountability is being developed through local institutions and elected individuals as well as centrally-driven performance targets. Local Authority-based Public Health is now responsible for commissioning drug and alcohol prevention, treatment and recovery support. This shift provides a platform for a more integrated approach to improving public health outcomes and addressing the root causes and wider determinants of substance misuse and the harm and impact they have.

It is expected that effective local systems will be those that demonstrate strong partnership working and a 'whole systems' approach to raising their prevention and recovery-orientated ambitions.

Local context:

Addressing substance misuse is a priority within the Nottinghamshire Health and Wellbeing Strategy and the Nottinghamshire Substance Misuse Framework for Action 2017-22 brings together a strategic partnership approach to tackling the harms caused by all substances. The overall vision of this strategy is to:

'Prevent and reduce substance misuse and related problems through partnership working and using the best available evidence of what works so that we can improve the quality of life for people who live, work and visit Nottinghamshire'.

Ensuring the delivery of the key priorities in the Framework is the responsibility of the Substance Misuse Strategy Group which is a sub group of both the Safer Nottinghamshire Board and The Health and Wellbeing Board. The Substance Misuse Strategy Group is a partnership group which includes Nottinghamshire County Council Public Health, the Office of the Police and Crime Commissioner, the local Community Safety Partnerships and Nottinghamshire Police. Activity under the Framework for Action is managed via three themed work streams: Reducing Demand, Restricting Supply and Reducing Harm.

Nottinghamshire's community substance misuse services were tendered in 2013/14 and are due to be re-tendered by April 2020. Change Grow Live (CGL) deliver all adult and young peoples services across Nottinghamshire.

The young peoples' service is focused on reducing harm, preventing substance use from escalating, and preventing young people from becoming substance–dependent adults, working as part of a wider network of universal (e.g. schools, colleges and youth clubs) and targeted (e.g. youth offending teams and non-mainstream education) services. The adult services represent a shift from maintenance-orientated treatment to recovery and reintegration-oriented behaviour change services. This involves transition from the clinic to the community as the locus of intervention and a commitment to partnership working to improve access to wider support for substance misusers such as sport and leisure, housing, welfare and debt advice, employment and education and opportunities to engage in mutual aid groups and other peer support activities.

Nationally, substance misuse appears to be declining but there are still significant areas of concern. An integrated substance misuse (drugs and alcohol) approach across the life course should be taken if the root causes and wider determinants of substance misuse are to be tackled.

Locally, substance misuse is a priority within the Nottinghamshire Health and Wellbeing Strategy. The Nottinghamshire Substance Misuse Strategy Group is responsible for delivering the Nottinghamshire Substance Misuse Framework for Action 2017-22.

Whilst good progress has been made in improving local substance misuse services in terms of both efficiency and outcomes, there still continues to be a substantial degree of need among the population, particularly in relation to alcohol misuse. Where substance misuse intersects with other social and health issues there are also further public health concerns to be addressed.

Historically, there has been a strong focus on drug (in particular, opiate and/or crack) treatment services. A new focus is needed on meeting broader substance misuse needs as well as action 'upstream' on education, prevention and early intervention – considering substance misuse in the context of broader risk-taking behaviour and inter-generational issues.

Unmet needs and service gaps

The prevalence of substance misuse in Nottinghamshire is difficult to establish, although synthetic modelling indicates that there is still substantial unmet need out there in terms of individuals who would benefit from a substance misuse intervention.

There needs to be a stronger focus and a more consistent approach to education and prevention across Nottinghamshire, with substance misuse being considered in the context of broader risk taking behaviour. Resilience programmes (including substance misuse) in schools and youth-centred venues are not currently quality assured.

More needs to be done by local partners across Nottinghamshire to reduce the supply of substances in communities, such as influencing the Licensing process and lobbying MPs on decisions that will positively influence the substance misuse agenda, support healthy behaviours and reduce health inequalities – e.g. minimum unit pricing. Lobbying is a powerful tool and is central to raising the profile of health issues and protecting and

promoting health and wellbeing. Elective representatives such as MPs and councillors not only have the power to make decisions, they can be strong advocates in their own right and help influence others regarding national and local policy. Lobbying needs to be a co-ordinated effort using up-to-date evidence.
Clarity is required on the Nottinghamshire pathway for certain cohorts of substance misusers – i.e. those with co-existing mental health and substance misuse issues and those with dependence on over the counter or prescription medications.

Via the Safer Nottinghamshire Board governance structure, a longer term solution to meeting the complex needs of the most vulnerable individuals in local communities is required (e.g. NPS users – 126 individuals were supported by substance misuse services in 17/18).

Knowledge gaps

Reliable Nottinghamshire substance misuse prevalence data is difficult to establish. Little is known of substance misusers who come into contact with other services, such as hospital Emergency Departments, primary care, maternity services, mental health services, pharmacy services, fire and rescue services, criminal justice services, social security services, social care services, ambulatory services, homeless and housing services and community and voluntary sector services. Substance misuse data is not consistently or reliably collected due to historical reasons or recent infrastructure changes. An analysis of the sources of referrals to treatment may indicate that substance misusing individuals are not being identified and referred on as levels of self–referral are high.

There is no current systematic process for sharing existing data between partner agencies to provide an overview and basis for action to tackle substance misuse strategically.

Recommendations for consideration by the local system partners

These recommendations should be considered by local partners in the context of having a stronger focus and more consistent approach to education and prevention across Nottinghamshire, with substance misuse being considered in the context of broader risk taking behaviour.

<u>Reducing Demand:</u>

1. Resilience programmes should be commissioned for delivery in targeted schools across the county where risk taking behaviour and problems are identified. Schools should be supported to identify substance misuse issues and should be advised as to quality evidence-based interventions that can be delivered.
2. Stakeholders and services should continue to engage in national campaigns and initiatives aimed at addressing substance misuse and promoting healthier lifestyles, such as Dry January, Sober in October and Stoptober.
3. A ‘Making Every Contact Count’ (MECC) approach should be systematically adopted within the delivery of all services, supported by the necessary staff training and IT infrastructure to record activity and outcomes.
4. Identification and Brief Advice (IBA) should be systematically offered by frontline workers to individuals who are drinking at increasing risk or high risk levels, supported by the necessary staff training and IT infrastructure to record activity and outcomes.

Reducing Supply:

5. Local partners should collectively take any opportunities to lobby at a national level on issues that will positively influence the substance misuse agenda. These efforts should be co-ordinated and make use of the best available up-to-date evidence.
6. Licensing Authorities (District Councils) should consider data presented in their local alcohol profile to inform future policy and decision making.
7. Closer partnership working with Trading Standards is required. This will align and join up activity between Nottinghamshire partners across the three strategic themes of Restricting Supply, Reducing Demand and Reducing Harm.

Providing Services:

8. Via the Safer Nottinghamshire Board governance structure, a long-term solution to meeting the complex needs of the most vulnerable individuals in local communities needs to be agreed. The main support needs of this cohort are mental health, housing and substance misuse (New Psychoactive Substances).
9. Commissioners and providers of mental health and substance misuse services should continue to implement the new Mental Health/Substance Misuse Pathway, including a process for reviewing the effectiveness of the pathway.
10. Reasons should be explored as to why Nottinghamshire and some of its districts are doing significantly worse than England and comparator areas for certain types of alcohol-related hospital admissions and partnership plans should be developed to address this.
11. Services that come into contact with the at-risk and most vulnerable populations should routinely and systematically include substance misuse in the Risk Assessments they complete and referrals should be made as appropriate.
12. Reasons should be explored for the high levels of adult self-referrals to local services and whether there are any barriers to other agencies identifying substance misuse issues or making referrals.
13. Those who have been in substance misuse treatment for 4 years or more should continue to receive targeted support to move them through the system and exit successfully. For those who are unlikely to leave treatment, improvements made whilst in treatment should be monitored.
14. Nottinghamshire should explore ways in which local frontline services can be more trauma smart, in line with the latest Director of Public Health Report. Any pilots should be formally evaluated and inform future commissioning.

Data:

15. Data gaps identified across other services such as hospital Emergency Departments, primary care, maternity services and criminal justice services (including prisons, probation and community rehabilitation companies), should be addressed as these prevent a complete picture and strategic overview.
16. Along with improved data collection, data and information sharing amongst these agencies should be improved and co-ordinated via the Nottinghamshire Substance Misuse Strategy Group to improve strategic overview and also district-level action.

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Full JSNA report

What do we know?

1. Who is at risk and why?

1.1 Risk and protective factors – across the life course:

There is no such thing as a 'typical' substance user as people experiment with or use substances at different points in their life for many different reasons. Everyone has the potential to misuse substances.

Risk factors increase an individual's chances for substance misuse while protective factors can increase the resilience of an individual when faced with a risk factor, thereby reducing the risk of substance misuse. A wide range of factors have been identified, some of which interact with each other, and the evidence suggests that the more risks an individual is exposed to the more likely substance misuse problems will develop. Equally, it is often observed that the more protective factors an individual demonstrates, the less susceptible they are to risky behaviours.

Research has shown that risk and protective factors - at the personal, family and social level - can affect individuals at different developmental stages of their lives particularly during formative major life transitions, as summarised in Appendix B. In the early years of life, these factors are inextricably linked with healthy child development.

1.2 Risk and protective factors – adverse life events:

Alongside the main formative life course transitions, substance misuse can also be triggered at any point throughout life by adverse events such as traumatic events, relationship breakdowns, conflicts, interpersonal losses, legal problems or financial concerns. Research suggests that an individual's ability to effectively cope (and therefore avoid problems such as substance misuse) will depend on the individual's level of 'capital', which will largely reflect the degree to which protective factors are or have been present in that individual's life. Capital can be described as the breadth and depth of internal and external resources that an individual has to draw upon in the following domains (Table 1):

Table 1: Capital domains

Personal capital	the skills, experiences and capabilities a person has, including the core enablers of self-esteem, self-efficacy, self-coping and a positive personal identity
Social capital	an individual's social network and connections with others and the resources and opportunities that arise from them
Collective capital	the broader context within which individuals live and the aspects of community life that impact on an individual's chances to effectively cope with adverse events[5]

1.3 Certain populations most at risk of substance misuse:

These are presented below in order of the strength of the evidence. For further information on these risks groups, see Appendix C. Services should be outreaching to these groups.

Young people and troubled family history: There is a growing body of evidence demonstrating that experiences during childhood can affect health throughout the life course (Adverse Childhood Experiences (ACEs))[6]. Children who experience stressful and poor quality childhoods are more likely to adopt health-harming behaviours such as substance misuse in later life and the more ACEs a child is exposed to, the more likely they are to develop problems[7].

Individuals living in deprived areas: Deprivation and social exclusion are likely to have an impact on the initiation and maintenance of substance misuse. People living in more deprived areas are more likely to have entrenched and complex needs and to be frequent substance users, as well as potentially lack access to resources and opportunities to help improve their personal and social capital[8 9].

Individuals with mental health issues: Co-existing mental health and substance use problems may affect 30-70% of those presenting to health and social care settings. However, although there are clear associations between mental health and substance misuse, causality is not always clear[10 11 12 13].

Offenders: Offenders and ex-offenders generally experience greater health inequalities, social exclusion and risk of substance misuse. Prisoners report higher levels of substance misuse: 44% report drug misuse and 31% report alcohol misuse, compared to 8.6% and 22% respectively in the general population.

***Individuals in substance misuse recovery*:** While successful completion of treatment is an important outcome for individuals who have accessed substance misuse services, relapse is often a threat. Individuals in recovery post-treatment are at risk of relapse and other associated risks such as substance-related death[14].

***Domestic violence*:** As well as links to the perpetration of domestic violence, substance misuse can be a response to domestic violence and can increase vulnerability to violence, for example where substances are used as a coping mechanism for people in violent relationships[15].

Men: are more likely than women to use substances and to die from using substances[16]. Approximately 62% of increasing and higher risk drinkers and 76% of frequent drug users are male (Drinkaware, 2015b) (Home Office, 2014).

Older people: Over 75% of increasing and higher risk drinkers are over 35, with the highest rates in the 45-64 age group.

Ethnicity: Adults from a mixed background are more likely to have participated in illicit substance taking in the last year compared to other ethnic groups.

Sexual orientation: Lesbian, Gay, Bisexual and Transgender (LGBT) individuals have significantly higher rates of substance misuse than their heterosexual counterparts, with the highest rates amongst males.

1.4 The impact of substance misuse on health and wellbeing

The harms arising from substance misuse are wide-ranging and vary depending on the substance used and the pattern and context of use, but it is well established that substance misuse represents a major public health burden. Substance misuse is linked to the development of a number of acute and chronic conditions, ranging from cancer to road traffic accidents. Substance misuse is known to have an impact on:

- *Physical and mental health*: The use of substances at an early age can have a significant impact on cognitive development and increases the likelihood of sustained use, and therefore greater health harms, in later life. Substance misuse is a contributing factor to many health conditions and long-term substance use can lead to conditions of the vascular system (strokes and heart disease) and liver damage and a range of mental health problems.

- *Sexual health:* Substance misuse can lead to risky behaviours such as early sexual activity, unprotected sex and teenage pregnancy.

- *Mortality rates:* High rates of alcohol-specific mortality and mortality from chronic liver disease indicate a significant population who have been drinking heavily and persistently over the last 10-30 years, with deaths being the highest among men aged 60-64 and women aged 55-59.

- *Relationships and families:* Substance misuse is commonly associated with domestic violence, amongst both victims and perpetrators. Substance misuse can reduce the capacity to parent effectively and the children of substance-misusing parents/carers are more at risk of behavioural problems, low educational attainment and substance misuse problems themselves. Family members and close friends of substance misusers can also be affected, experiencing stress and health problems as a result of being close to and concerned about the person with the substance misuse problem.

- *Crime and anti-social behaviour*: There is a relationship between alcohol and drug use and crime rates and anti-social behaviour, with alcohol in particular being a driver of violent crime and anti-social behaviour. It is widely reported that half of all serious acquisitive crime is drug-related and around three quarters of heroin and crack users commit crime to fund their habit. Higher levels of alcohol-related recorded crimes and violent crimes are likely to be significantly linked to binge drinking and the night-time economy. Alcohol is also a common feature in sexual assaults.

For more key facts, see Appendix D.

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Anyone could be at risk of developing a substance misuse problem during their lives. There are recognised risk and protective factors at different stages of life and these are inextricably linked to the family and community environment. Certain populations are particularly at risk.
Substance misuse has wide-ranging and significant adverse effects on individuals, families and communities.

2. Size of the issue locally

Unfortunately, it is difficult to estimate how many people across Nottinghamshire are using substances, not least because of the clandestine nature of some substance misuse. The most reliable data comes from those in contact with treatment services, which does not necessarily reflect actual need in the community. It is possible however to:

a. Synthetically model local need based on national data (i.e. applying a percentage representative of Nottinghamshire to published national data on certain populations)
b. Analyse data from other public services (other than substance misuse treatment services) that are likely to come into contact with those who misuse substances. Substance misuse treatment service data will be considered separately in section 4.

2.1 Synthetic local estimates

Drugs:

The best available estimates indicate that:

- In Nottinghamshire **9,867** individuals use drugs frequently (Table 2).
- There is a cohort of **4,436** who use opiates and/or crack problematically (Table 2).
- It is estimated that 52% of the opiate/crack population is in treatment at some point in the year.
- It is also estimated that **665** 10 to 17 years olds misuse substances (http://beta.roi.nice.org.uk/CYP).

Table 2: Synthetic estimates of drug use in Nottinghamshire

	In their lifetime:	In the last year:	In the last month:	Use frequently
16-59 year olds (all drugs)				
Any drug	158,702	89,423	21,302	9,867
Class A drugs	70,957	14,662	6,223	---
Stimulant drugs	81,662	15,938	6,794	---
New Psychoactive Substances	13,112	3,905	---	---

15-64 year olds (estimated dependant drug users)				
Opiate and/or Crack users	---	---	---	4,436 (CI: 3,488 - 5,381)
Opiate users	---	---	---	4000 (CI: 3,179 - 4,793)
Crack users	---	---	---	2050 (CI: 1,103 - 2,955)
Of whom injecting				2,047 (CI: 1,425 – 2,692)

Utilising:
2014/15 Crime Survey for England and Wales
Problematic Drug Users (PDU) Glasgow Estimates

Alcohol:

The best available estimates indicate that:

- In Nottinghamshire **131,011** adults drink at levels that pose a risk to their health and **21,632** are dependent on alcohol (Table 3).
- It is estimated that around 19,310 of those drinking at levels that may harm their health are 60+ years old[17].
- It is also estimated that there are **5114** young people (10-17 year olds) who are drinking at increasing and higher risk levels (http://beta.roi.nice.org.uk/CYP).

Table 3: Synthetic estimates of alcohol use in Nottinghamshire (adults)

Drinking behaviour in adults:	Estimates:
Abstain	94,131
Lower risk Men who regularly drink no more than 3 to 4 units per day and women who regularly drink no more than 2 to 3 units per day.* Weekly limits are no more than 21 units per week for a man and 14 units per week for a woman	358,356
Increasing risk Men who regularly drink over 3 to 4 units per day and women who regularly drink over 2 to 3 units per day.* Weekly limits are more than 21 units to 50 units for a man and more than 14 units to 35 units for a women	98,563
Higher risk Men who regularly drink over 8 units per day or over 50 units per week and women who regularly drink over 6 units per day and over 35 units per week.	32,448
Dependency:	
Mild	18,171
Moderate	3,028
Severe	433

Utilising LAPE 2009 – "Topography of Drinking Behaviours in England", and local secondary analysis based on results reported in "Adult psychiatric morbidity in England, 2007",

Trends in drug and alcohol use have not been synthetically modelled.

These figures suggest that there could be in the region of at least 172,725 individuals in Nottinghamshire who use substances frequently and could benefit from a substance misuse intervention, with 26,068 dependent on substances (21% of the population of Nottinghamshire). Alcohol represents the greatest need (noting that a significant proportion of the drug using population are also likely to be drinking).

These figures are likely to be under-estimates due to the hidden nature of some substance misuse.

2.2 Where individuals with substance misuse issues come into contact with other local public services

The most reliable data is hospital admissions data. Substance misusers are also likely to come into contact with the following services:

- Local Authority:
  - Homeless and Housing services
  - Social Care services
- NHS:
  - Primary Care
  - Hospital Emergency Departments
  - Maternity services
  - Pharmacy services
  - Mental Health services
  - Ambulatory services
- Police and Police and Crime Commissioner:
  - Criminal justice services (including custody suites, prisons, probation and community rehabilitation companies)
- Other Public Sector and Voluntary Services
  - Fire and Rescue services
  - Social Security services
  - Community and voluntary sector services

Local substance misuse data is not collected comprehensively across these agencies. This is either due to historical reasons or to recent infrastructure and IT changes within organisations. Some information is known (such as of all recorded crimes, 8% are estimated to be alcohol related and 3.4% to be drug offences) but the picture is incomplete. A brief summary of what is known can be found in Appendix E.

For the following hospital admissions data, it cannot be ascertained whether the individuals involved are accessing substance misuse services or not. It does however help build a local picture of need and the impact this population has on local public services.

For the following hospital admissions data, county-level rates and trends are consistent with England and other comparator areas unless otherwise stated. District analysis identifies some differences. Headlines are given below and more comprehensive district level data can be found in Appendix F.

Alcohol-specific hospital admissions

- The latest data suggests that there has been a reduction in the rate of alcohol specific admissions in under 18s between 2006 and 2015. The rate in Ashfield is significantly higher than the England average.
- For adults (over 18s), there has been a steady increase in the rate of alcohol-specific admissions between 2008 and 2015. There are no significant gender or district differences.

Alcohol-related hospital admissions

- There have been 5,244 adult hospital admission *episodes* for alcohol-related conditions in 2014/15.
- Admission episodes in Mansfield and Ashfield are higher than the England average.

- By gender, admission episodes for females are higher than the England average and highest in Ashfield and Bassetlaw.
- 3513 *individuals* were admitted to hospital for alcohol-related conditions in 2014/15, representing a steady increase between 2008 and 2015.
- Rates in Mansfield and Ashfield are higher than the England average, with the highest rates for males in Mansfield and females in Ashfield.

Alcohol-related hospital admissions due to unintentional injuries:

- Nottinghamshire has higher rates than the England average for alcohol-related hospital admissions due to unintentional injuries, which include road or pedestrian traffic accidents, alcohol poisoning and fall and fire injuries.
- Nottinghamshire is the only area worse than England amongst its comparator areas.
- Rates are significantly worse for both males and females and also in the Mansfield and Ashfield and Newark and Sherwood districts.

Mortality and substance misuse

Alcohol:

The rate of alcohol-specific mortality has remained static nationally and locally at approximately 12 deaths per 100,000 of the population. Alcohol-related mortality in England and Nottinghamshire has remained relatively high notwithstanding a minor reduction in rate in 2006-08, with an increase seen between 2012 and 2014 (Table 4). Trends in Nottinghamshire are similar to England and comparator areas and there are no significant age, gender or district differences.

Table 4: Alcohol-related deaths in England and Nottinghamshire

Number of alcohol-related deaths:	2012	2013	2014
England	21,485	22,779	22,967
Notts	337	338	380

Drugs:

Nationally, between 2012 and 2014, there was a reported 42% increase in drug related deaths (from 1613 deaths to 2120)[18]. Since October 2014, comprehensive local Nottinghamshire data has been collected by the adult treatment provider. In Nottinghamshire in 2014/15 there were:

- 51 deaths due to long term health conditions. Substance misuse would have been a contributory factor as 26 of them were known to be primary drug users and 23 primary alcohol users.
- 12 drug-related deaths of service users in contact with the treatment service, representing a rate of 0.019% of all service users in treatment which is low compared to the national rate of 1%.
- Causes of deaths in Nottinghamshire follow national trends

There is an increasing population of long term in-treatment service users who are now suffering from other health complications as a result of their continued substance misuse. The local service provider has reported an increase in incidents in relation to service users on low opiate substitute methadone prescribing with high alcohol usage.

Reviews of all incidents are undertaken and reported through Nottinghamshire County Council's contract and quality meetings to identify themes, gaps or areas which require improvement and wider lessons or learning across the whole system. Good practice has



been identified and there has been significant improvement in the quality of service provision across the whole system, with a focus on addressing issues at a locality level to enable manageable and tailored quality improvements related to local need.

Hospital admissions data is the most reliable source of data. It is known that:

- Ashfield has a significantly higher rate of under 18 alcohol-specific hospital admissions
- Adult alcohol-related hospital admission *episodes* are higher than the national average in Mansfield and Ashfield. They are also higher for females, particularly in Ashfield and Bassetlaw.
- Alcohol-related hospital admissions *(individuals)* are higher than the national average for males in Mansfield and females in Ashfield
- Nottinghamshire is significantly worse than England and comparator areas for alcohol-related hospital admissions due to unintentional injuries.

(See Recommendation 10)

Local substance misuse data is not collected comprehensively across other public sector agencies. Some information is known but the picture is incomplete. It is known that:

- Nottinghamshire is significantly worse than England and comparator areas for alcohol related road traffic accidents
- 8% of all recorded crimes are estimated to be alcohol related
- 3.4% of all recorded crimes are estimated to be drug offences

Improved substance misuse-related data collection and sharing is required across public sector agencies (such as hospital Emergency Departments, Primary Care, maternity services and criminal justice agencies) if substance misuse is to be tackled strategically in a co-ordinated way.

(See Recommendations 11, 15 & 16)

3. Local targets and performance

Nottinghamshire works to 3 strategic themes of Reducing Demand, Restricting Supply and Reducing Harm (through the provision of effective services). There are currently no agreed targets or performance measures for the themes of Reducing Demand and Restricting Supply. For Reducing Harm, substance misuse treatment service targets are in place.

Adult substance misuse services now work to a new single countywide recovery-focussed, outcome-based contract. For more about the new model of delivery, see Appendix G. Baseline data was collected in contract Year 1 for the new service and used to set targets for future years. Performance is very good and the service is consistently exceeding its local contract targets. These targets are set locally and encapsulate all individuals who come into contact with the service and, as such, do not directly align with PHOF measures (which relate to only the structured care planned treatment cohort).

There has previously been no local formalised contract performance framework and outcomes for young peoples' substance misuse services. CGL have taken over the young peoples' substance misuse services as of 1st October 2018 and negotiations to agree a performance and outcome framework are currently taking place. CGL have a target to support 340 young people per year.

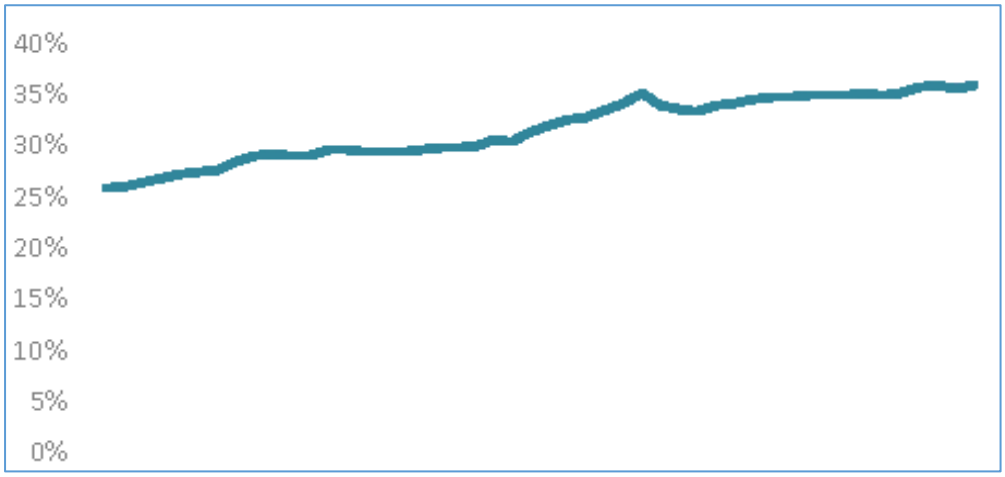
Table 5: Current adult substance misuse service performance

Outcome:	Contract Year 3 Target:	Current Performance:
1. Reaching into the community and 'pulling' people into the system	9954 unique individuals	11,788 unique individuals
2. Improving successful discharges from the service	15% (n = 632)	n = 939. There has been a significant reduction in unplanned discharges. Re-presentations remain low
3. Increasing engagement in education, training and employment (including volunteering)	23%	Averaging at 53%
4. Improving mental health and wellbeing	63%	Averaging at 85%
5. Improving housing situations	72%	Averaging at 95%

NOTE: 2,3,4 and 5 are measured via NDTMS and Treatment Outcome Profiles

In line with the national picture, there is an ageing opiate using cohort in treatment. As at June 2018 there were 744 individuals who have been in treatment for 4 years or more. There has been an increase in the number of opiate treatment clients who have been in treatment for over 6 years. Locally this is 36% (Figure 1). Nationally, it is 31.7%.

Figure 1: Trend of clients in treatment for over 6 years



Source: NDTMS Domes (2014/15 Q4 report)

It is essential that this cohort's needs are addressed either to:

- Move them through and out of treatment and achieve their recovery goals. The evidence suggests this could happen for approximately 10% of this population. Or;
- Improve their quality of life while they remain in treatment. For a large proportion of this cohort, they may never leave treatment. Whilst in treatment, many benefits are gained to the individual (e.g. improved physical health, mental health and social circumstances) and to the community (e.g. reduced crime). Improvements made whilst in treatment should be monitored for this cohort.

The system commissioned in Nottinghamshire has a focus on supporting this cohort. When the local system was commissioned in 2014, it was anticipated that supporting the 4 year plus cohort through and out of treatment would free up resource to do more preventative activity 'upstream'. However, in line with the national picture, a substantial proportion of this cohort may never leave treatment. Therefore, Public Health investment has largely funded (intensive) clinical support for these individuals, rather than an increase in preventative 'upstream' activity as was previously envisaged.

Local adult substance misuse services' performance is very good and exceeding contract targets.

A focus is needed on supporting those who have been in substance misuse treatment for 4 years or more to exit treatment successfully. For those who are unlikely to leave treatment, improvements made whilst in treatment should be monitored.

(See Recommendation 13)

4. Current activity, service provision and assets

The diagram below (figure 2) outlines the current provision across the domains of Reducing Demand, Restricting Supply and Reducing Harm (through the provision of effective services), all underpinned by the wider determinants of health. These 3 themes form the work streams of the Nottinghamshire Substance Misuse Strategy Group and the Framework for Action 2017-22.

Figure 2: Current Nottinghamshire provision and activity

Theme: Reducing demand	***Theme: Restricting supply***	***Theme: Reducing Harm***
Young People Education and Prevention programmes Early intervention: Healthy Family Programme Targeted Support & Youth Justice Early Help Unit Supporting national substance-related campaigns – e.g. Dry January/Alcohol Awareness Week/FRANK Supporting healthy lifestyle messages – e.g. One You/Making Every Contact Count (MECC)	Drug Seizures Alcohol Licensing Minimum Unit Pricing Trading Standards Night Time Economy Initiatives	Specialist Substance Misuse services – Young People Specialist Substance Misuse services – Adults Secondary Care – long term health conditions caused by substance misuse

Wider determinants of health (the social, economic and environmental conditions that influence health)

4.1 Education and Prevention – Young People

- There are currently a number of organisations providing education around substance misuse for young people in schools (sometimes via PSHE sessions) and other youth-centred services. However, the level and quality of this is varied at present as schools and academies commission programmes independently based on their own needs and there is no universal standard.

- The Nottinghamshire County Schools Health Hub (SHH) has been in place since January 2017 working as part of the Tackling Emerging Threats Team. The SHH co-ordinators quality assure substance misuse interventions offered to schools with a focus on the evidence-base, the impact on children and young people and cost effectiveness. Schools are supported to develop lesson plans, guidance and policies to support substance misuse prevention. Protection from and prevention of substance misuse as with all risk-taking behaviours and lifestyle choices, is underpinned by good mental health and wellbeing i.e. self-awareness, self-confidence, self-possession, self-esteem and ultimately self-efficacy.

- In January 2017, Public Health and Nottinghamshire CCGS commissioned a resilience programme to build emotional health and wellbeing for children and young people attending Nottinghamshire schools. The menu of evidence-based quality assured interventions is available to schools via the Schools Portal.

4.2 Early Intervention – Young People

Healthy Family Programme (0-19 years)
This service offers brief intervention and referral into open access (Tier 2) and specialist substance misuse services via schools and targeted school-based group work, community based holistic health and wellbeing drop-in sessions and following contact made by young people via CHATHEALTH (young peoples' texting service).

Targeted Support and Youth Justice
This service works with young people demonstrating signs of lower-level substance misuse. It provides advice and guidance on lifestyle choices and addresses issues for vulnerable adolescents such as homelessness, educational welfare as well as substance misuse.

CAMHS Head2Head
The Head2Head team has an early intervention role as well as a specialist substance misuse treatment role. The team works with young people across Nottinghamshire aged up to 18 (19 if they are working with a Youth Offending Team) who have significant issues with substance misuse. They work within the Targeted Support and Youth Justice Team supporting young people with lower level substance misuse issues and provide training and awareness raising for generic staff working with young people. Young people at risk of substance misuse issues aged 14-16 have been identified as a group particularly at risk of not accessing services or disengaging with them. These are a particularly vulnerable cohort as they move towards the transition from young people services to adulthood/adult services.

4.3 Substance Misuse Treatment - Young People

Although there is currently no local contract Performance Management Framework, data from the National Drug Treatment Monitoring System (NDTMS) can be used. Headlines are presented here. For more detailed information see Appendix H.

- As at March 2015 there were 173 young people in treatment for substance misuse, representing a decline throughout 2014/15 in line with national trends. In 2014/15 there were 255 fewer young people accessing specialist services than in 2011/12.
- Within Children and Families services, 91% of referrals were from Targeted Support. Within Youth Justice, 95% of referrals were from the Youth Offending Team. Over the year only 5 young people have self-referred.
- The majority of young people accessing treatment are 16-17 with the main substances of choice being cannabis and alcohol. The majority are male and 93% are white British.
- Those presenting to services demonstrate wider vulnerabilities such as domestic abuse, mental health problems and self-harm. In particular, Nottinghamshire has a large proportion of young people in treatment who are not in education, employment or training (NEET) (32%) when compared to national trends.
- 85% (114) had a planned exit from treatment. 15% (20) left in an unplanned way, which is lower than the national average (21%).

As of 1st October 2018, CGL are providing the Nottinghamshire Young Peoples' substance misuse services and a performance management framework is being negotiated.

4.4 Making Every Contact Count (MECC)

Nottinghamshire County Council is committed to adopting a MECC approach. Making Every Contact Count is an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. Staff across health, local authority and voluntary sectors have thousands of contacts every day with individuals and are ideally placed to promote health and healthy lifestyles. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

- *For organisations*: MECC means providing their staff with the leadership, environment, training and information that they need to deliver the MECC approach.

- *For staff*: MECC means having the competence and confidence to deliver healthy lifestyle messages, to help encourage people to change their behaviour and to direct them to local services that can support them.

- *For individuals*: MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking and looking after their wellbeing and mental health.

MECC focuses on the lifestyle issues that, when addressed, can make the greatest improvement to an individual's health:

- Stopping smoking
- Drinking alcohol only within the recommended limits
- Healthy eating
- Being physically active
- Keeping to a healthy weight
- Improving mental health and wellbeing

Where individuals are identified by frontline health and social care workers as drinking at increasing risk or high risk levels, identification and brief advice (IBA) should be provided with the aim of encouraging them to reduce their consumption to lower risk levels. This is a prevention (not treatment) approach aimed at helping at-risk drinkers to make informed choices about their drinking.

MECC and IBA are not currently systematically carried out or recorded across agencies in Nottinghamshire.

4.5 Prevention activities in the workplace

Nottinghamshire County Council delivers an integrated workplace health initiative across Nottinghamshire County: Wellbeing at Work. The initiative seeks to improve employee health and wellbeing by providing enhanced lifestyle advice and facilitating support for staff, whilst also promoting a culture of confidence, resilience amongst the workforce and positive manager-employee relationships.

This is done though workplace health champions who receive Royal Society for Public Health accredited training which equips them with the skills to support their colleagues in the workplace across a range of common health and lifestyle issues. Organisations can sign-up to a prestigious award scheme and work towards attaining a Wellbeing at Work Platinum Award.

The Health Champions act as a useful resource as a first point of reference for staff and are able to signpost to local health services, including substance misuse services.

Further rollout of the scheme is planned in order to engage with a wider range of organisations across the county.

4.6 Substance Misuse Treatment - Adults

For the first time in Nottinghamshire, local data on all individuals who come into contact with the community adult substance misuse service is now collected. Headlines are presented here. Further detail can be found in Appendix I. The data is from the providers own IT system and relates to the latest 2 years of data. It is not possible to benchmark with England or other areas as the key performance measures and outcomes have been locally determined and do not align directly with national (NDTMS) measures. The CGL contract is managed on the provider's own data system.

CGL have supported 11,788 unique individuals in the latest contract year. Current performance for successful completions and related outcomes and re-presentations exceeds targets (see section 3 above). Key data by phase are as follows (Table 6):

Table 6: CGL data – Key data by Phase

Phase:	No. unique individuals seen (linked to a district)	Referrals	Age & Gender	Parental Status
Phase 1: Low level advice and support, including Specialist Needle Programmes (Data: 2014/15)	747	64% self-referred Approx. 90% are from self, hospital and GPs	Mostly males aged 25-44	---
Phase 2: Substance misuse support (Data: 2016/18)	129	79% self-referred Approx. 90% are from self, GPs and criminal justice system	Mostly males aged 35-44	23% (30 clients) living with children
Phase 3: Structured care planned treatment (2016/18)	4,832	66% self-referred Approx. 90% are from self, GPs, other drug services and criminal justice system	Mostly males aged 35-44	54% (2610 clients) were parents with 20% (966 clients) living with children

22% of clients were also in the criminal justice system (1057 individuals). 46% were parents, with 18% living with children.

Broadly, levels of service activity by district correlate with deprivation levels.

<u>Education and Prevention:</u>
Agencies within Nottinghamshire should continue to support national and local initiatives aimed at reducing the supply of and demand for substances within the community.

(See Recommendations 2, 3 & 4)

Education and prevention programmes should be quality assured with a focus on the evidence base, the impact and cost effectiveness.

(See Recommendation 1)

<u>Treatment – Young People:</u>
The number of young people accessing specialist treatment is declining in line with national trends. Most referrals are from Targeted Support and Youth Justice services.

Young people present to treatment primarily for cannabis and alcohol misuse but also with a wide range of other vulnerabilities. There is a

large proportion of young people in treatment who are not in education, training or employment (32%).

Only 49% of young people received a specialist healthcare assessment whilst in treatment compared to the national average of 73%.

Only 50% of young people in treatment had a designated lead professional at the start of treatment.

There are high rates of successful completions of treatment.

<u>Treatment – Adults:</u>

Data on everyone who comes into contact with adult services is now collected for the first time. CGL have supported 11,778 individuals in the latest contract year. 22% of the in-service population are also in the criminal justice system.

There are high levels of self-referrals and 90% of referrals come from self, GPs and the criminal justice system.

(See Recommendations 11 & 12)

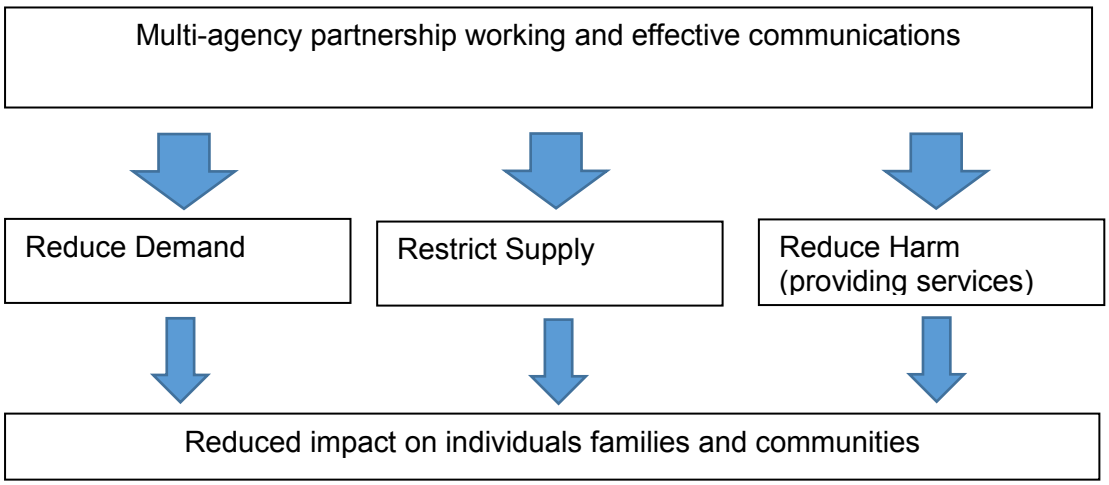
The in-service population is mostly male and aged 35-44. 996 individuals in substance misuse services were living with children.

Levels of service activity broadly correlate with deprivation levels across the county.

Successful completion rates are high and re-presentations are low.

5. Evidence of what works

The approach taken must be informed by what is known to work. Strategically, co-ordinated multi-agency partnership action is required in the following areas:



National drug and alcohol policy outlines the strategy and direction of substance misuse treatment focus and delivery. There is an extensive range of Public Health England and Department of Health/National Institute for Health and Care Excellence guidance summarising best practice in addressing and treating substance misuse issues ranging from prevention, pharmacological and psychosocial interventions, harm reduction measures and interventions for certain at risk and vulnerable populations, all across a range of settings. The key documents are identified in Appendix J.

In taking a life course approach to tackling substance misuse, the following is highlighted:

5.1 Prevention and Early Intervention

Preventing harmful substance use is central to a public health approach, which emphasises tackling the root causes of health, social harms and substance misuse. It can also help people avoid problems by providing opportunities for alternative, healthier life choices and developing better skills and decision making. Consistent and coordinated prevention activities delivered through a range of programmes and in a variety of settings (e.g. at home, in school, among peers, in the workplace, throughout the local community and in the media) seem most likely to lead to positive outcomes. Evidence also suggests that modifying the environment where risky behaviour takes place can reduce harmful outcomes – e.g. controlling alcohol sales, density of outlets and alcohol price – and that it is vital that people have access to accurate, relevant information about the health and social impacts of substance use. Although there is little to no evidence that information alone changes behaviour, it can help reduce harm and inform choice. It is most effective when delivered alongside interventions that help develop the skills and personal resources people need to avoid early initiation to substance use and developing harmful use.

Prevention interventions that influence substance use are often not drug and alcohol-specific and may already exist as broader interventions. For further detailed information on prevention interventions, what to do and when across the life course click here.

5.2 Promoting Resilience

Resilience is an individual's, family's or community's capacity to bounce back from adversity – i.e. a good outcome in the face of challenges (Masten 2001; Rutter 2012). It is important as it is part of achieving good health and wellbeing. This does not mean removing risk – it means shoring up the resources for dealing with it. Young people face a range of pressures and threats to their wellbeing from maltreatment and neglect to bullying and social media issues and also have to deal with major transitional life events. Both young people and adults will also have to face and overcome adverse life events. Resilience is not just about personal coping skills, but also ensures that conditions are in place to support relationships in the family and local community, and that services are available and appropriate for when they are needed. Promoting resilience is an important aspect of preventing and addressing health harming behaviours such as substance misuse and a prerequisite for good health and wellbeing.

The guide *'A public health approach to promoting young people's resilience 2016'* (Association for Young People's Health) references many resources that are available to promote resilience in young people. For more information, click here. Plans for Nottinghamshire have been outlined in section 4.1 above.

Adverse Childhood Experiences (ACEs):

Preventing ACEs can improve health across the whole life course, enhancing individuals' wellbeing and productivity while reducing pressure and costs on health and social care services. Preventing ACEs in a single generation or at least reducing their impacts can benefit both current and future generations. This growing body of evidence highlights the importance of remembering that the causes of substance misuse cannot be considered nor addressed in isolation of broader social and family issues and that to truly tackle health harming behaviours such as substance misuse, the co-ordination of investments, activities and assets across multiple organisations is essential. The research identifies the importance of:

- Improved awareness of the importance of early life experiences on the long-term health, social and economic prospects of children
- Information being available to a wide range of professionals (health, education, social, criminal justice and others) on ACEs, their consequences and how they can be prevented, as well as to the public and especially those planning or having children, with access to support services particularly in the early years. Support must conform to established and emerging evidence of what works in the prevention of ACEs and the successful development of resilience in children, with enhanced support for those in most need (often, but not exclusively, in deprived communities).

Wales is pioneering a range of policies and programmes aimed to identify and intervene where children may already be victims of abuse, neglect or living in adverse childhood environments, to better equip parents and care-givers with the necessary skills to avoid ACEs arising within the home environment and encourage the development of social and emotional wellbeing and resilience in children and also ensure that indirect harms (e.g. domestic violence, substance misuse, behavioural disorders) in the family setting are identified, addressed and their impact on children minimised.

For more information, see Welsh Adverse Childhood Experiences (ACE) study 2015.

A number of areas across the UK are exploring ways in which their public services can be more trauma informed and trauma smart, with areas of good practice being identified. Building on the latest Nottinghamshire Director of Public Health Reports, partners in Nottinghamshire are exploring a roll out of a trauma-smart programme across a range of front line services across the county. This programme will aim to equip professionals to routinely ask about service users' adverse childhood experiences when delivering services - empowering service users to gain an insight into what drives their behaviour, improve the therapeutic relationship and help the service user get access to the right services quicker. This programme will be formally evaluated to inform future commissioning activity.

5.3 Those requiring substance misuse support and treatment – building Recovery

Guidance for substance misuse treatment services is extensive[20 21 22]. The evidence is moving towards recovery-orientated interventions including maximising peer support opportunities, mobilising community assets and making recovery visible in communities.

Public Health England released guidance titled 'Improving access to mutual aid' in two documents in 2014 for commissioners and service managers[23]. This guidance highlights the importance of mutual aid in the recovery process especially regarding service users community integration, their social networks and recovery outcomes, along with the health and wellbeing of their families and relatives.

The new system commissioned in Nottinghamshire is a strength-based one and based on mobilising community assets to meet recovery needs and build recovery communities. Although the service commissioned is not a mental health service, improving health and wellbeing (both physical and mental) is a key outcome of the service. There is a body of evidence focused on wellbeing and community-centred approaches, including: *'Five Ways to Wellbeing'*[24], *'A Guide to Community-centred Approaches for Health and Wellbeing 2015'* (ref) and *'Building Recovery in Communities 2012'* [25].

5.4 The evidence on how effective substance misuse services meet other public health outcomes

The provision of effective substance misuse services contributes to other public health outcomes such as reducing premature mortality, reducing (re)offending, improving physical and psychological health, increasing employment and reducing homelessness. Appendix K summarises the available evidence on how the provision of effective substance misuse services meet other public health outcomes.

To strategically tackle substance misuse, co-ordinated partnership action is required to reduce demand and supply and to provide effective support and treatment services for those who require them.

Effective substance misuse services contribute towards many other public health outcomes.

There is strong evidence of the effectiveness of substance misuse treatment and emerging evidence around recovery-orientated interventions.

The evidence suggests that substance misuse does not exist in isolation and should be considered in the context of broader risk taking behaviour and the life and family circumstances of young people.

In line with the latest Director of Public Health Report, Nottinghamshire is exploring ways in which local frontline services can be more trauma smart. Any pilot will be formally evaluated to inform future commissioning (see Recommendation 14).

6. What is on the horizon?

There are a number of key issues that partners across Nottinghamshire are currently deciding on how to address most effectively going into 2019 and beyond.

6.1 Services for individuals who have co-existing mental health and substance misuse issues:

Co-existing mental health and substance use problems may affect between 30-70% of those presenting to health and social care settings. There has been national debate about how best to meet the needs of individuals with co-existing substance misuse and mental health issues and NICE Guidance was published in November 2017. This recommended that there should be no 'wrong door' for these individuals (i.e. an individual should not be excluded from a service on the basis of their substance misuse or mental health issues) and that mental health services should lead on care co-ordination, with substance misuse services providing the substance misuse element of that package of care. To bring local services in line with the latest NICE Guidance, CCGs across Nottinghamshire de-commissioned the specialist Dual Diagnosis service.

A new pathway has been designed for this cohort between Public Health, local CCGs, substance misuse service providers, Adult Mental Health and Improving Access to Psychological Therapies (IAPT) providers**.** This pathway is currently being implemented, led by the CCGs, and will monitored and audited through a Pathway Steering Group (see Recommendation 9).

6.2 New Psychoactive Substances:

Increasing numbers of new drugs are causing harm, have been linked to deaths, and are driving public and media concern. These drugs, known as new psychoactive substances (NPS), pose a challenge to government, local authorities, healthcare services and the criminal justice system.

Synthetic cannabinoids such as 'Mamba' and 'Spice' (which mimic the effects of cannabis) are increasingly prevalent in England, with widespread reports of severe mental and physical health problems associated with its use. Visible use in local communities and perceptions of increased substance misuse and related anti-social behaviour has prompted a focus on Local Authorities' responses to the problem and the support provision available across England.

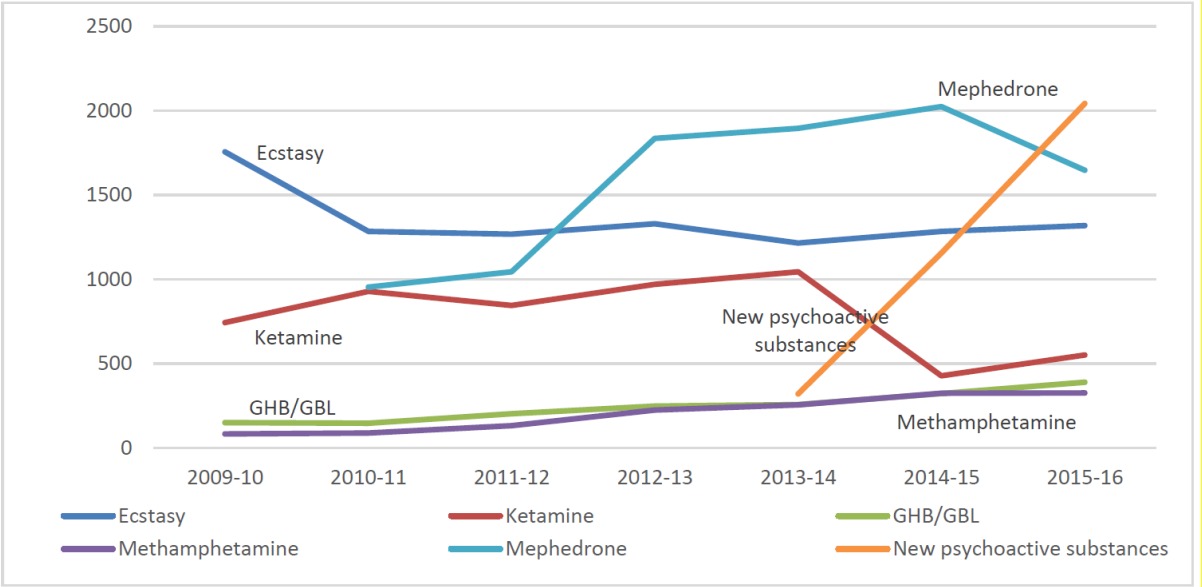
Unfortunately at present, robust data on the prevalence of NPS use in England is limited, as is evidence on long-term harms. Also, the consensus on optimal clinical management is developing.

According to 2016 statistics from the **Home Office on drug use in England and Wales in 2015:**

- The prevalence of NPS use is generally low among adults aged 16 to 59. Fewer than 1 in 100 (0.7%) adults had used an NPS in the last year. This equates to around 244,000 adults.
- Use of NPS in the last year is concentrated among young adults aged 16 to 24. Around 1 in 40 (2.6%) young adults took an NPS in the last year. This equates to around 162,000 people.

- Use of NPS in the last year was concentrated among young men.

The number of people who have entered substance misuse treatment services and reported NPS use as a problem increased significantly in 2015-16. The figure below shows the number of individuals presenting with problematic use of NPS or a so-called 'club drug':



Locally in Nottinghamshire, NPS use is a significant concern and has attracted much media and political interest, particularly in the Bassetlaw, Mansfield and Ashfield districts because the use of NPS is very visible in those local communities. This is distressing for both the public and also those vulnerable adults who are using NPS. They have multiple and typically complex health and social needs and an intensive and co-ordinated multi-agency response is required to support them. Most known NPS users are already known to substance misuse treatment services.

Local evidence demonstrates that the main areas of need are access to housing/suitable accommodation and access to mental health services, with substance misuse being a consequence of these problems. Initial work co-ordinated through Public Health and Community Safety identifies that rapid mental health assessments and support and supported living are the primary needs in working with these vulnerable adults, with harm reduction advice for substance misuse following. Once these interventions are implemented, then a structured substance misuse care plan can be implemented.

Local substance misuse service data shows the following referral numbers per district for the period April 2017-May 2018:

Districts	Number of referrals received, where NPS is listed in Drug 1, 2, 3 & other drug (April 2017 – May 2018)
Ashfield	14
Bassetlaw	40
Broxtowe	3

Gedling	4
Mansfield	48
Newark and Sherwood	14
Rushcliffe	3
Total	**126**

A county and city-wide NPS Professional Information Network is in place to monitor trends in NPS use and issues, and to share good practice across a range of partners, including substance misuse treatment services, health services, housing services, hospitals and educational establishments.

Nottinghamshire County Council is also engaging with partners including local NHS, the Police, the District Councils and the Police and Crime Commissioners Office through the Safer Nottinghamshire Board and the 3 local Community Safety Partnerships to provide an effective multi-agency response to these vulnerable adults.

The Safer Nottinghamshire Board has recently reviewed the role and contribution of 5 Assertive Outreach workers in place across Nottinghamshire. These outreach workers cover all districts, working with the most vulnerable adults in local communities, many of whom are living on the streets and visibly using NPS drugs. Assertive outreach is a specific (cost) effective way of working to engage vulnerable adults who do not traditionally engage with health and social support services. It focuses on finding and engaging with service users in their own community and working closely on an intensive one-to-one care co-ordination basis to address individual needs and proactively get them timely access to the critical services they need. Small scale evaluations across the UK have shown that assertive approaches can also deliver reductions in service use and considerable savings.

These posts are currently being funded through the Office of the Police and Crime Commissioner with additional funded provided by District Councils and Nottinghamshire County Council. Efforts are being focused in particular on those districts where NPS use is most visible. The Safer Nottinghamshire Board is currently exploring how this work will be configured, funded and co-ordinated in the future (see Recommendation 8).

6.3 Public health and alcohol licensing:

Whilst the promotion of public health is not specifically a licensing objective there is a role for Public Health to contribute towards how licensing policy and decision making may impact on the wider determinants of health within and between each Licensing Authority. Currently Public Health are working with Responsible Authorities in Nottinghamshire to produce a series of district level alcohol profiles by 2017 that relate to the four licensing objectives whilst considering the associated health impacts arising from alcohol consumption. These profiles will be a useful source of information to inform future policy and strategy relating to licensing decision making with a view to improving the health and wellbeing of local communities, for example through identifying a cumulative impact arising from a high concentration of licensed premises in a defined geographical area (see Recommendation 6).

6.4 Over the Counter and Prescription Medications:

The Nottinghamshire pathway for managing individuals who are dependent on over the counter or prescription medicines requires further clarity. There is variable practice as to how this is managed between substance misuse services and primary care across Nottinghamshire. As part of the process of re-commissioning Public Health services from April 2020, Public Health are engaging with CCGs and primary care to agree upon the most effective pathway for this cohort and to ensure lines of responsibility between agencies are contractually clear.

6.5 Individuals with long term conditions as a result of substance misuse:

There is an increasing population of individuals who are suffering from health complications as a result of their substance misuse. Clinical Commissioning Groups commission the healthcare support and substance misuse services contribute where the individual is substance misuse-treatment seeking.

7. Local Views

An extensive evaluation of the views of young people in treatment was undertaken by Nottingham Trent University in 2012. It is felt that much of the information gathered remains relevant. For details see the Nottinghamshire JSNA 2013: Children and young people.

More recently, the Integrated Commissioning Hub at Nottinghamshire County Council undertook a survey in 2014 to establish the key health and wellbeing priorities for young people. The survey received over 1200 responses and included questions about substance misuse. When asked what is the most important thing for being healthy 4.7% of the young people (aged 11-25) that responded highlighted the issue of substance use. This ranked higher than sexual health, education and access to health services. It was superseded by the importance of family and friends, diet and exercise and emotional health and wellbeing. Young people were also asked how they typically access information regarding their health with 46% suggesting they would search about it online. 9.3% of all respondents then identified accessing information on substance use online as a priority. It was suggested that a lot of information provided is designed to prevent young people from using substances, whereas they feel they are able to make educated decisions independently. This has been captured in the recommendations set out in the Young People's Health Strategy.

More broadly, Public Health have recently publicly consulted on the re-commissioning of local Nottinghamshire Public Health services as of April 2020. It is currently proposed that substance misuse services are kept separate to other Public Health services (which are currently planned to be integrated into a Wellbeing Service) and that adult and young peoples' substance misuse services are combined into an all-age service - but still ensuring age-appropriate and tailored interventions according to individual need. Public and stakeholder responses to the consultation will inform the development of the service model and service specification over coming months.

8. Unmet needs and service gaps

The prevalence of substance misuse in Nottinghamshire is difficult to establish, although synthetic modelling indicates that there is still substantial unmet need out there in terms of individuals who would benefit from a substance misuse intervention.

There needs to be a stronger focus and a more consistent approach to education and prevention across Nottinghamshire, with substance misuse being considered in the context of broader risk taking behaviour. Resilience programmes (including substance misuse) in schools and youth-centred venues are not currently quality assured.

More needs to be done by local partners across Nottinghamshire to reduce the supply of substances in communities, such as influencing the Licensing process and lobbying MPs on decisions that will positively influence the substance misuse agenda, support healthy behaviours and reduce health inequalities – e.g. minimum unit pricing and other alcohol-related measures (The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An Evidence Review – Public Health England 2016).

Lobbying is a powerful tool and is central to raising the profile of health issues and protecting and promoting health and wellbeing. Elective representatives such as MPs and councillors not only have the power to make decisions, they can be strong advocates in their own right and help influence others regarding national and local policy. Lobbying needs to be a co-ordinated and collective effort by all partners using up-to-date evidence (See Recommendation 5).

Clarity is required on the Nottinghamshire pathway for certain cohorts of substance misusers – i.e. those with co-existing mental health and substance misuse issues and those with dependence on over the counter or prescription medications.

Via the Safer Nottinghamshire Board governance structure, a longer term solution to meeting the complex needs of the most vulnerable individuals in local communities is required (e.g. NPS users – 126 individuals were supported by substance misuse services in 17/18).

9. Knowledge gaps

Reliable Nottinghamshire substance misuse prevalence data is difficult to establish. Little is known of substance misusers who come into contact with other services, such as hospital Emergency Departments, primary care, maternity services, mental health services, pharmacy services, fire and rescue services, criminal justice services, social security services, social care services, ambulatory services, homeless and housing services and community and voluntary sector services. Substance misuse data is not consistently or reliably collected due to historical reasons or recent infrastructure changes. An analysis of the sources of referrals to treatment may indicate that substance misusing individuals are not being identified and referred on as levels of self–referral are high. More needs to be known about substance misusers who come into contact with these services, particularly for groups identified as higher risk in section1.3 above.

There is no current systematic process for sharing existing data between partner agencies to provide an overview and basis for action to tackle substance misuse strategically.

What should we do next?

10. Recommendations for consideration by the local system partners

These recommendations should be considered by local partners in the context of having a stronger focus and more consistent approach to education and prevention across Nottinghamshire, with substance misuse being considered in the context of broader risk taking behaviour.

Reducing Demand:

1. Resilience programmes should be commissioned for delivery in targeted schools across the county where risk taking behaviour and problems are identified. Schools should be supported to identify substance misuse issues and should be advised as to quality evidence-based interventions that can be delivered.
2. Stakeholders and services should continue to engage in national campaigns and initiatives aimed at addressing substance misuse and promoting healthier lifestyles, such as Dry January, Sober in October and Stoptober.
3. A 'Making Every Contact Count' (MECC) approach should be systematically adopted within the delivery of all services, supported by the necessary staff training and IT infrastructure to record activity and outcomes.
4. Identification and Brief Advice (IBA) should be systematically offered by frontline workers to individuals who are drinking at increasing risk or high risk levels, supported by the necessary staff training and IT infrastructure to record activity and outcomes.

Reducing Supply:

5. Local partners should collectively take any opportunities to lobby at a national level on issues that will positively influence the substance misuse agenda. These efforts should be co-ordinated and make use of the best available up-to-date evidence.
6. Licensing Authorities (District Councils) should consider data presented in their local alcohol profile to inform future policy and decision making.
7. Closer partnership working with Trading Standards is required. This will align and join up activity between Nottinghamshire partners across the three strategic themes of Restricting Supply, Reducing Demand and Reducing Harm.

Providing Services:

8. Via the Safer Nottinghamshire Board governance structure, a long-term solution to meeting the complex needs of the most vulnerable individuals in local communities needs to be agreed. The main support needs of this cohort are mental health, housing and substance misuse (New Psychoactive Substances).

9. Commissioners and providers of mental health and substance misuse services should continue to implement the new Mental Health/Substance Misuse Pathway, including a process for reviewing the effectiveness of the pathway
10. Reasons should be explored as to why Nottinghamshire and some of its districts are doing significantly worse than England and comparator areas for certain types of alcohol-related hospital admissions and partnership plans should be developed to address this.
11. Services that come into contact with the at-risk and most vulnerable populations should routinely and systematically include substance misuse in the Risk Assessments they complete and referrals should be made as appropriate.
12. Reasons should be explored for the high levels of adult self-referrals to local services and whether there are any barriers to other agencies identifying substance misuse issues or making referrals.
13. Those who have been in substance misuse treatment for 4 years or more should continue to receive targeted support to move them through the system and exit successfully. For those who are unlikely to leave treatment, improvements made whilst in treatment should be monitored.
14. Nottinghamshire should explore ways in which local frontline services can be more trauma smart, in line with the latest Director of Public Health Report. Any pilots should be formally evaluated and inform future commissioning.

Data:

15. Data gaps identified across other services such as hospital Emergency Departments, primary care, maternity services and criminal justice services (including prisons, probation and community rehabilitation companies), should be addressed as these prevent a complete picture and strategic overview.
16. Along with improved data collection, data and information sharing amongst these agencies should be improved and co-ordinated via the Nottinghamshire Substance Misuse Strategy Group to improve strategic overview and also district-level action.

Key contacts

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APPENDIX A

National trends in substance misuse

Evidence suggests that substance misuse in the UK has reduced significantly over the last decade. Although national findings suggest that most young people will experiment with substances as part of natural curiosity, the proportion of young people who have ever drank alcohol or used drugs has been declining since 2001 (drugs) and 2003 (alcohol) (Smoking, Drinking and Drug Use Survey, 2014). Evidence suggests that substance misuse among young people in particular has reduced over the last decade by approximately one third (Her Majesty's Government 2010):

- ***11-17 year olds:*** In 2013, the proportion of 11-17 year olds who had used drugs frequently or in the last month in 2013 was 5.81%, compared to 7.85% in 2009. In 2014, 38% of 11-15 year olds had ever consumed alcohol, the lowest proportion since the survey began (approximately 60% in 1988). Of those who did drink, 8% reporting drinking in the last week, compared to 25% in 2003 (Fuller & Hawkins, 2013).

- ***16-24 year olds*****:** For 16-24 year olds it is estimated that 46% have consumed alcohol in the last week, with 2% having consumed alcohol on at least 5 days during the last week (Office for National Statistics, 2016).

- ***16-59 year olds:*** 36% of 16-59 year olds have used an illicit drug at least once during their lifetime (Public Health England, 2014), with 9% using them in the last year (Home Office, 2014) and 3.1% using drugs on a frequent basis (Home Office, 2014).

- ***Those presenting to treatment*****:** In 2013-14, 19,126 young people in England received help for substance misuse problems. This represents a 4.5% drop from 20,032 in 2012-13. Fewer young people have required specialist treatment over the past decade and there have been fewer convictions for drunk and disorderly behaviour. In 2015/16, 288,843 adults were in substance misuse treatment, a 2 % reduction on the previous year.

However, substance misuse remains a significant national challenge as:

- It is estimated that 4.5% of pregnant women are substance misusers, equating to 30,200 births.
- The reduction in young people's risk-taking behaviour, including substance misuse is debated.
- There was a significant increase in illicit drug use by adults in 2013/14 compared to the previous year.
- Alcohol consumption outside of the home reduced by 50% between 2002-12 but twice as much is consumed in the home and has only reduced by 4% between 2002-12)

- Over 10 million people in the UK consume alcohol at levels that can adversely affect their health, with 8.5 million drinking at increasing risk levels and 1.9 million at high risk levels. 7.3million people are estimated to binge drink
- 2 million adults are dependent on substances
- Between 2012 and 2014, there was a reported 42% increase in drug related deaths (from 1613 deaths to 2120) ((Corkery et al., 2013, PHE, 2016) and a 6.9% increase in alcohol-related deaths (from 21,485 deaths to 22,967) (http://fingertips.phe.org.uk/local-alcohol-profiles). Deaths involving heroin/morphine have increased by two-thirds in just 2 years, drug-poisoning deaths which included more than one drug increased by a third and 30% of drug-related deaths involved alcohol or long-term alcohol use. The rate of mortality in people aged under 75 from liver disease and liver disease that was considered preventable has risen by almost 14% (PHE, 2014c).
- In 2013-14, 13,659 under-18s presented to specialist services for issues with cannabis use - the highest number since records began in 2005-06.
- The number of 16-24 year olds using cannabis and some Class A drugs has risen over the past year.
- Overall, the use of club drugs has fallen but the use of ketamine and ecstasy has increased.
- The use of new psychoactive substances is a major concern - little is known about these drugs and their harmful effects. Young people are seen as being at particular risk as they are believed to be very easily accessible.
- Binge drinking is a major concern. Up to one-third of alcohol related A&E attendances are for those under 18. It has been reported that 59% of boys and 76% of girls are consuming more than the recommended daily amount of alcohol for adults. It is reported that an increased number of young people are obtaining alcohol from their parents.
- There are approximately 1 million alcohol-related hospital admissions in England per year and this figure has been increasing consistently (Public Health England, 2014b) with significant increases regarding alcohol-related cardiovascular disease conditions.
- Opiate users dominate current treatment systems. A number of factors have historically contributed to this, noticeably the focus on opiate-only testing on arrest and the criminal justice focus of previous drug strategies. Far more primary drug users than alcohol users are engaged in treatment.

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APPENDIX B

Substance Misuse Risk and Protective Factors across the Life Course

Preconception/Prenatal Stage:

Domain of influence	Risk Factors	Protective factors
Individual	Genetic disposition Prenatal substance exposure	No prenatal substance exposure
Family	N/A	N/A
School, Peers, Community	N/A	N/A

Infancy/Early Childhood Stage:

Persons	Risk Factors	Protective factors
Individual	Difficult temperament	Self-regulation Secure attachment Mastery of communication and language skills Ability to make friends and get along with others
Family	Cold and unresponsive mother behaviour Parental modelling of substance use/misuse	Reliable support and discipline from caregivers Responsiveness Protection from harm and fear Opportunities to resolve conflict Adequate socioeconomic resources for the family
School, Peers, Community	N/A	Support for early learning Access to high quality support services such as feeding, and screening for vision and hearing Stable, secure attachment to childcare provider Low ratio of caregivers to children

Middle School Stage:

Persons	Risk Factors	Protective factors
Individual	Poor impulse control Low harm avoidance Sensation seeking Lack of behavioural self-control/regulation Aggressiveness Anxiety Depression Hyperactivity/ADHD Antisocial behaviour Early persistent problem behaviours Early substance use	Mastery of academic skills (math, reading, writing) Following rules for behaviour at home, at school, and in public places Ability to make friends Good peer relationships
Family	Permissive parenting Parent–child conflict Inadequate supervision and monitoring Low parental warmth Lack of or inconsistent discipline Parental hostility Harsh discipline Low parental aspirations for child Child abuse/maltreatment Substance use/misuse among parents or siblings Parental favourable attitudes toward alcohol and/or drugs	Consistent discipline Language-based, rather than physical, discipline Extended family support
School, Peers, Community	School failure Low commitment to school Accessibility/ availability Peer rejection Laws and norms favourable toward use Deviant peer group	Healthy peer groups School engagement Positive teacher expectations Effective classroom management Positive partnering between school and family School policies and practices to reduce bullying

	Peer attitudes toward substances Interpersonal alienation Extreme poverty for those children antisocial in childhood	High academic standards

Adolescent Stage:

Persons	Risk Factors	Protective factors
Individual	Behavioural disengagement coping Negative emotionality Conduct disorder Favourable attitudes toward substances Rebelliousness Early substance use Antisocial behaviour	Positive physical development Emotional self-regulation High self-esteem Good coping and problem-solving skills and techniques Engagement and connections/participation in two or more of the following contexts: at school, with peers, in sports/leisure(extra-curricular activity), employment, religion, culture
Family	Substance use/misuse among parents Lack of adult supervision Poor attachment with parents	Family provides structure, limits, rules, monitoring, and predictability Supportive relationships with family members Clear expectations for behaviour and values
School, Peers, Community	School failure Low commitment to school Associating with substance-using peers Not college bound Aggression toward peers Norms (e.g., advertising) favourable toward alcohol use Accessibility/ availability	Presence of mentors and support for development of skills and interests Opportunities for engagement within school and community Positive norms Clear expectations for behaviour Physical and psychological safety

Young Adulthood Stage:

Persons	Risk Factors	Protective factors
Individual	Lack of commitment to conventional adult roles Antisocial behaviour	Identity exploration in love, work, and world view Subjective sense of adult status Subjective sense of self-sufficiency, making independent decisions, becoming financially independent Future orientation Achievement motivation
Family	Leaving home	Balance of autonomy and relatedness to family Behavioural and emotional autonomy
School, Peers, Community	Not attending college Substance-using peers	Opportunities for exploration in work and school Connectedness to adults outside of family

http://youth.gov/youth-topics/substance-abuse/risk-and-protective-factors-substance-use-abuse-and-dependence
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APPENDIX C

The evidence relating to certain populations most at risk of substance misuse

The existence of risk factors does not necessarily lead to substance misuse for most people. However, certain populations have been identified as having increased risk factors, ordered below by the strength of the evidence.

1. Young people: are more likely to participate in substance taking than older people[1]. Illicit drug use is most common in the 20-24 age group (Home Office, 2014). Factors such as enjoyment, curiosity, rebellion, cost and coping with problems have been cited as reasons for using substances. There is a growing body of evidence demonstrating that experiences during childhood can affect health throughout the life course (Adverse Childhood Experiences (ACEs))[2]. Children who experience stressful and poor quality childhoods are more likely to adopt health-harming behaviours such as substance misuse during adolescence and adulthood and the more ACEs a child is exposed to, the more likely they are to develop problems[3]. In addition, individuals who experience ACEs as children often end up trying to raise their own children in households where ACEs are more common.

The following specific vulnerable young groups have been identified as more at risk of substance misuse[4]:

- Children of substance misusing parents or where siblings or other family members misuse substances
- Young people who are or have been homeless, in care and/or who move home frequently
- Excluded pupils or frequent non-attenders or where there is low parental expectation regarding educational attainment
- Young people from marginalised and disadvantaged communities, including some black and minority ethnic groups
- Sexually exploited young people including those involved in commercial sex work
- Young offenders(Galahad SMS Ltd, 2009)
- Young people with mental health issues (e.g. low self-esteem, depression). This is perceived to be an increasing national concern
- Young people who have experienced forms of childhood trauma
- Young people experiencing other health, education or social problems at home, school and elsewhere
- New and emerging at-risk groups are young people who self-harm, have eating disorders, engage in limited physical activity and/or have a dependence on new technologies

Troubled family history: It is known that substance misuse follows families and generations. A genetic component to the risk of substance dependence has been demonstrated. There are increased health and developmental risks to a foetus when the mother uses substances during pregnancy. Substance misuse risks are increased in troubled households where neglect, drug misuse and/or physical and emotional abuse has taken place. Poor parental

discipline, a lack of family cohesion and traumatic family experiences have been identified as significant risk factors[5]. Throughout life, individuals can also learn from families and peer groups and copy patterns of substance use/misuse beliefs and behaviours.

3. Individuals living in deprived areas (environmental, cultural and socio-economic factors): There is a social gradient to substance misuse. Whilst it can affect all socio-economic groups, deprivation and social exclusion are likely to have an impact on the initiation and maintenance of substance misuse. People living in more deprived areas are more likely to have entrenched and complex needs and to be frequent substance users, as well as potentially lack access to resources and opportunities to help improve their personal and social capital[6 7].

People who live in urban surroundings have higher self-reported levels of drug taking compared to those living in rural areas. This may be a reflection of greater availability and accessibility of drugs in urban areas. A range of environmental and cultural factors predisposing toward the development of alcohol disorders have been reported, including the affordability and availability of alcohol, high consumption rates in the general population, occupational risk factors (such as working in the alcohol or hospitality industries), social pressure to drink, and religious and culturally attitudes related to alcohol. Unusually, although groups of lower deprivation report lower levels of alcohol consumption, increased deprivation is associated with increased alcohol-related mortality (Anderson & Baumberg, 2006).

4. Individuals with mental health issues: Co-existing mental health and substance use problems may affect 30-70% of those presenting to health and social care settings. A range of mental health issues such as attention deficit disorder, depression, anxiety, self-harm, schizophrenia and suicide are all commonly associated with substance misuse. However, although there are clear associations between mental health and substance misuse, causality is not always clear[8 9 10 11].

5. Offenders: Offenders and ex-offenders generally experience greater health inequalities, social exclusion and risk of substance misuse. Prisoners report higher levels of substance misuse: 44% report drug misuse and 31% report alcohol misuse, compared to 8.6% and 22% respectively in the general population. As the number of people who come into contact with the criminal justice sector increases, there will be an increasing number of ex-offenders in communities[12].

***6. Individuals in substance misuse recovery*:** While successful completion of treatment is an important outcome for individuals who have accessed substance misuse services, relapse is often a threat. Individuals in recovery post-treatment are at risk of relapse and other associated risks such as substance-related death[13].

***7. Domestic violence*:** As well as links to the perpetration of domestic violence, substance misuse can be a response to domestic violence and can increase vulnerability to violence, for example where substances are used as a coping mechanism for people in violent relationships[14]. Abused women are 15 times more likely to use alcohol and 9 times more likely to use drugs than non-abused women[15]. Alcohol misuse is associated with a fourfold risk of violence from a partner and is commonly present where sexual violence has occurred [16].

8. Men: are more likely than women to use substances and to die from using substances[17]. For example, approximately 62% of increasing and higher risk drinkers are male (Drinkaware, 2015b). In 2013/14, 76% of frequent drug users were male (Home Office, 2014). It has been suggested that men appear less likely to consider the risks associated

with substance misuse (Home Office, 2013). Amongst prisoners, males report more alcohol misuse than females (63% of males) [18], but more females are serving drug-related offences (24% of females compared to 15% of men) [19].

9. Older people: Over 75% of increasing and higher risk drinkers are over 35, with the highest rates in the 45-64 age group. . Alcohol is the substance most likely to affect individuals across their life course. Consumption amongst older people has increased over the last 20 years and many do exceed recommended levels. Older people have reduced tolerance, lower body weight, may take medications that interact with alcohol and are at greater risk of accidents e.g. falls.

10. Ethnicity: Adults from a mixed background are more likely to have participated in illicit substance taking in the last year compared to other ethnic groups. The ethnic group with the lowest level of drug taking is Asian or Asian British[20]. People from white backgrounds have lower rates of abstinence and higher levels of drinking compared to most black and minority ethnic groups (Hurcombe, Bayley & Goodman, 2010).

11. Sexual orientation: Lesbian, Gay, Bisexual and Transgender (LGBT) individuals have significantly higher rates of substance misuse than their heterosexual counterparts, with the highest rates amongst males. The higher levels of substance use is only partially explained by the younger age profile of those identifying themselves as being in this group[21 22 23.] It is estimated that binge drinking is twice as common in LGBT communities compared to the general population and have proven less likely to participate in health programmes (Williams et al, 2013).

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APPENDIX D
The impact of substance misuse on health and wellbeing

The harms arising from substance misuse are wide-ranging and vary depending on the substance used and the pattern and context of use, but it is well established that substance misuse represents a major public health burden. Substance misuse is linked to the development of a number of acute and chronic conditions, ranging from cancer to road traffic accidents.

Substance misuse is known to have an impact in the following domains:

The impact on:	The impact throughout life – key facts:
Physical health	Maternal substance misuse places a child's development at risk. Drug misuse can lead to low birth weight, premature delivery, sudden infant death syndrome and perinatal mortality. Structural damage is most likely between 4-12 weeks. Alcohol misuse increases the risk of miscarriage, the risk of foetal alcohol syndrome and foetal alcohol spectrum disorder and increases the risk of learning difficulties. The use of substances at an early age can have a significant impact on cognitive development. During adolescence the brain is still developing and the consumption of substances can have significant long-term effects including memory loss, decision-making capacity loss and reduced concentration levels. Using substances at an early age also increases the likelihood of sustained use, and therefore greater health harms, in later life. Substance misuse can be a contributing factor to many health conditions. Long-term substance use can lead to conditions of the vascular system (strokes and heart disease) and liver damage. Long term substance misusers can suffer from a poor nutritional state, which can exacerbate acute conditions such as wound infections and chest infections. There is no clear causal relationship between alcohol consumption and obesity but it has been identified that alcohol consumption can lead to an increase in food intake, many people are not aware of the calories contained in alcoholic drinks and the effects of alcohol on body weight may be more pronounced in overweight or obese people (National Obesity Observatory 2012). Most Hepatitis B viruses within the UK are acquired through adult risk taking behaviour associated with sexual practice and drug use. Hepatitis C is most commonly associated with past or current injecting drug users and is a major cause of the UKs rise in mortality from liver disease. There has been a recent outbreak of Hepatitis A amongst injecting drug users in the UK. Alcohol is the substance most likely to affect individuals across their life course. Patterns of drinking change with age and form over time. Younger people are more likely to drink larger amounts of alcohol on one or more occasions during a week. Older people are more likely to drink within recommended levels but more frequently within one week,

	although consumption amongst older people has increased over the last 20 years and many do exceed recommended levels. Older people have reduced tolerance, lower body weight, may take medications that interact with alcohol and are at greater risk of accidents e.g. falls.
Mortality	Substance misuse is a major cause of mortality. High rates of alcohol-specific mortality and mortality from chronic liver disease indicate a significant population who have been drinking heavily and persistently over the past 10 – 30 years, with deaths being the highest among men aged 60-64 and women aged 55-59. Drug-specific mortality rates are much lower but do not take into account other deaths that are related to illicit drug use such as those from blood borne infections, violent assaults and suicides, so figures are likely to be under-reported.
Mental health	Individuals who have previously had no mental health problems may develop symptoms as a direct result of the substances they have used. Heavy substance misuse often gives rise to increased anxiety levels and a range of other risky behaviours. Evidence suggests that prolonged substance misuse can lead to health concerns including psychotic symptoms, depression, anxiety, suicide and behavioural concerns. In serious cases, substance use may trigger serious conditions such as schizophrenia or long-term depression. Substances may also cause symptoms that are similar to those that lead to a psychiatric diagnosis. Some people who have a diagnosed mental health problem may take substances to help them cope with their symptoms or with the side effects of prescribed medication although, on balance, this is likely to make their problems worse. Substance misusers are more likely to commit suicide compared to the general population.
Sexual health	Substance use can lead to risky behaviours such as early sexual activity. Early use of substances is related to unprotected sex and teenage pregnancy. Injecting drug users have low rates of consistent contraception use, are more likely to frequently report multiple sexual partners and to face barriers in accessing STI and HIV testing and treatment. An estimated 2,200 injecting drug users were living with HIV in the UK in 2012, 300 of whom were unaware of their infection.
Relationships and families	Substance misuse is commonly associated with domestic violence, amongst both victims and perpetrators. It can be a response to domestic violence and increase vulnerability to violence. Substance misuse can reduce the capacity to parent effectively and children of parents or carers who are dependent on substances are at more risk of behavioural problems, low educational attainment and substance misuse problems themselves.

	Problematic substance use affects many people besides the person using the substance. For example, family members and close friends can experience significant stress and health problems as a result of being close to and concerned about the person with the substance misuse problem. The impact can also spread more widely, for example affecting family members' employment, their social lives and relationships, and the family finances. It is estimated that 1.4 million adults in the UK are affected by a relatives' drug misuse.
Crime and anti-social behaviour	There is a relationship between alcohol and drug use and crime rates and anti-social behaviour, with alcohol in particular being a driver of violent crime and anti-social behaviour. Higher levels of alcohol-related recorded crimes and violent crimes are likely to be significantly linked to binge drinking and the night-time economy. Alcohol is a common feature in sexual assault. Over a third of sexual assault offenders and a quarter of victims of serious sexual assaults are thought to have consumed alcohol prior to the incident It is widely reported that half of all serious acquisitive crimes is drug-related and around three quarters of heroin and crack cocaine users commit crime to fund their habit. The relationship between problematic drug use and crime is complex. As a direct consequence of the crime they commit, these substance misusers are highly likely to end up in the criminal justice system at some point and serve community or prison sentences. Prisoners report higher levels of substance misuse: 44% report drug misuse and 31% report alcohol misuse, compared to 8.6% and 22% respectively in the general population. As the number of people who come into contact with the criminal justice sector increases, there will be an increasing number of ex-offenders in communities.

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APPENDIX E
Substance misusers who come into contact with other services other than treatment services

Below is a summary of what is known in Nottinghamshire about substance misusers who access services other than substance misuse treatment services.

We know that:

1. Criminal justice services

- In 2015/16, 3.4% of all county crimes were drug offences – a decrease of 0.8% on the previous year. The number of recorded drug offences reduced by 14.8% compared with the previous year. This equated to 248 fewer drug offences. Drug supply offences decreased by 8.6% (30 fewer offences). Drug possession offences decreased by 16.5% (218 fewer offences). Overall, the positive outcomes rate (where the crime is dealt with by giving a disposal to the offender) dropped by 9.8% for possession offences and 5.7% for drug offences in those years. Overall outcomes have dropped by 15%. Tables 1 & 2 provides Community Safety Partnership (CSP) level performance.

Table 1: Possession of drugs offences and positive outcomes by county and by CSP:

	2015/16			2014/15				
	Crimes	Positive Outcomes	Rate	Crimes	Positive Outcomes	Rate	Vol change	% point change
County	1,106	907	82.0%	1,324	1,215	91.8%	-308	-9.8%
Mansfield & Ashfield	499	415	83.2%	560	520	92.9%	-105	-9.7%
Bassetlaw, Newark & Sherwood	302	247	81.8%	329	310	94.2%	-63	-12.4%
Broxtowe, Gedling & Rushcliffe	305	245	80.3%	435	385	88.5%	-140	-8.2%

Source: Nottinghamshire Police

Table 2: Supply of drugs offences and positive outcomes by county and by CSP:

	2015/16			2014/15				
	Crimes	Positive Outcomes	Rate	Crimes	Positive Outcomes	Rate	Vol change	% point change
County	318	244	76.7%	348	287	82.5%	-43	-5.7%
Mansfield & Ashfield	139	104	74.8%	155	130	83.9%	-26	-9.1%
Bassetlaw, Newark & Sherwood	67	53	79.1%	79	64	81.0%	-11	-1.9%
Broxtowe, Gedling & Rushcliffe	112	87	77.7%	114	93	81.6%	-6	-3.9%

Source: Nottinghamshire Police

- Between May and Oct 2016, 1515 individuals detained in custody suites stated they had consumed alcohol (figure 3), 486 required medical assistance for alcohol consumption (figure 4) and 823 stated they were dependent on drugs and/or alcohol (figure 5).

- 8% of all recorded crime is thought to be alcohol-related (equating to 2,951 offences). Anti-social behaviour is thought to account for 13.6% of all crime (2,744 offences). The proportion of alcohol-related violent crime is 19% (1,779 offences –

this is less than half the estimated national levels. 730 alcohol-related crimes have been associated with the night-time economy (63.9% of all night-time economy offences) http://www.nottinghamshire.pcc.police.uk/Document-Library/Public-Information/Performance/2016/Performance-and-Insight-Report-to-September-2016.pdf

- There are 3 adult male prisons in Nottinghamshire with a total prisoner population of approx. 2820 prisoners. Around 4000 people pass through these prisons each year. An analysis of 1,102 prisoners indicated that 44% had a drug misuse problem and 31% reported misusing alcohol. A further survey (n=593) indicated that 43% used cannabis, 12% used heroin and 36% reported misusing alcohol. HMP Ranby has the highest percentage of drug misusers (57%) and HMP Whatton the lowest (21.5%). In HMP Lowdham Grange, 30% had drug misuse needs, 3% had alcohol needs and 3.2% had a significant problem with binge drinking. 9.6% offenders were linked to alcohol-related violent behaviour.

- High rates of dependence are found amongst youth offenders. 11% demonstrate an alcohol problem and 20% a drug problem. 80% of 16-20 year old young offenders showed more than one mental disorder alongside substance misuse. Alcohol, cannabis and tobacco are most commonly used by this cohort. Although levels are significantly lower, increased use of cocaine, steroids and tranquilizers is evident (NCC - Summary of Asset data 2011-13).

- 60% of young people in custody were found to have regularly used illegal drugs to relieve anxiety, stress and depression or for other reasons linked to their emotional state suggesting a link between mental health needs and substance misuse (Youth Justice Board, 2009)

2. Alcohol-related Road Traffic Accidents

- These are significantly worse in Nottinghamshire when compared to England or comparator areas at a rate of 31.8 per 100,000 of the population. Rushcliffe has the highest rate (table 3). In 2015 there were 23 road traffic accidents that resulted in a death locally. Nationally it is estimated that 13% of road deaths are likely to be attributable to alcohol. This would mean approximately 3 deaths attributed to alcohol locally.

Table 3: Alcohol-related Road Traffic Accidents by district 2014-16

District	Rate per 100,000 (no. of incidents)
England	26.5
Nottinghamshire	31.8 (232)
Mansfield	31.9 (28)
Ashfield	31.8 (39)
Rushcliffe	59.2 (47)
Bassetlaw	40.4 (25)
Newark & Sherwood	28.3 (17)
Gedling	22.4 (59)
Broxtowe	31.7 (17)

http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938132848/pat/6/par/E12000004/ati/102/are/E10000024.

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3. Benefits claimants

- 610 people in 2016 were claiming benefits due to alcoholism (125.6 per 100,000) which is better than comparator areas and the England average of 132.8, with Rushcliffe, Bassetlaw and Broxtowe having the lowest rates (table 4). These rates and numbers are broadly consistent with the previous year.

Table 4: Benefits Claimants due to Alcoholism by district 2016

District	Rate per 100,000 (no. of individuals)
England	132.8
Mansfield	152.7 (100)
Ashfield	146.2 (110)
Newark & Sherwood	128.4 (90)
Bassetlaw	116.9 (80)
Gedling	129.2 (90)
Broxtowe	117.0 (80)
Rushcliffe	87.9 (60)
TOTAL	**610 individuals**

http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/1/gid/1938132848/pat/6/par/E12000004/ati/102/are/E10000024.

In 2016, there were 120 claimants of Disability Living Allowance for drug or alcohol addiction, a reduction from 160 in May 2015 (table 5).

Table 5: Claimants of DLA for substance addiction 2015/2016

	Total claimants	Claimants for DLA for substance addiction	Aged 25-49	Aged 50-64	Aged 65 and over
May 2015	42,460	160	50	80	30
May 2016	39,470	120	30	60	30

(https://www.nomisweb.co.uk)

4. Housing and homelessness

- In 2012/13, 368 people accessing County Council support services disclosed substance misuse problems (166 alcohol and 202 drug misuse). 20% of homeless people disclose substance misuse problems (Notts Homeless Watch Survey 2011). This equates to approximately 120 individuals, with alcohol mainly being a problem in Rushcliffe and drugs in Mansfield. They are mostly males.

5. Young People and families

- It is estimated that 4266 children and young people in Nottinghamshire are affected by parental illicit drug use and between 13,271 and 21,565 affected by parental problematic alcohol use. The majority of these children will be under 10 years.

- Nottinghamshire County Council supported 1580 'Troubled Families' between 2012 and 2015 and have a target to support a further 5190 between 2015 and 2020. Families experiencing substance misuse problems are included within this work: https://search3.openobjects.com/mediamanager/nottinghamshire/fsd/files/family_outcomes.pdf

- Of 313 Looked After Children referrals in Nottinghamshire in 09/10, 25 (8%) disclosed alcohol use (Notts Children in Care Health service 09/10 LAC referrals)

- 5 out of 40 permanent school exclusions in 2014/15 were due to drug and alcohol issues https://www.gov.uk/government/statistics/permanent-and-fixed-period-exclusions-in-england-2014-to-2015

6. Health services

- The completion rate of the Audit C alcohol screening tool by Primary Care as part of the NHS Health Check Programme is approximately 33% across the county, with wide variation between GP practices. It is not currently known whether this is a performance issue or a data recording issue.
- Individuals accessing Pharmacy Needle Programmes (clean injecting equipment) across the County are now captured by the adult treatment services data (2225 individuals during Oct 2014-Sept 2015). Previously, the size of this cohort was unknown.
- It is estimated that up to 70% of those accessing substance misuse services also have a mental health issue and 40% of those accessing mental health services have substance misuse issues (Weaver et al 2003). There is no local data on the prevalence of substance misuse issues within IAPT (Improving Access to Psychological Therapies) services

- The Long Term Conditions Team is commissioned by the Clinical Commissioning Groups (CCGs) to address the needs of those who have long term health conditions as a result of long term substance misuse. In 2015/16, the team supported 84 individuals. The majority were aged 41-60 and most referrals to the service were from GPs and the Hospital Drug and Alcohol Liaison Team. All individuals were white British. Split by CCG as follows:

CCG:	**Number of individuals (2015/16):**
Rushcliffe	25
Nottingham North and East	22
Nottingham West	21
Newark and Sherwood	16
Total:	**84**

- Little is known of substance misusers who come into contact with maternity services and this data is not routinely captured.
- No local data is collected regarding the elderly and injuries and falls relating to alcohol

7. Fire and rescue services

- A recent study in Nottinghamshire regarding deaths identified that drugs and alcohol were very common in the profile of people who died or were injured in fires. This is similar to the national picture. However, no local data is currently routinely collected.

8. Other services

- Little is known about substance misusers who come into contact with community and voluntary sector services, including domestic violence services.
- Closer partnership working with Trading Standards is required to join up their work on reducing supply with the work of other partner agencies on reducing demand and delivering effective services.

APPENDIX F
Hospital Admissions Data

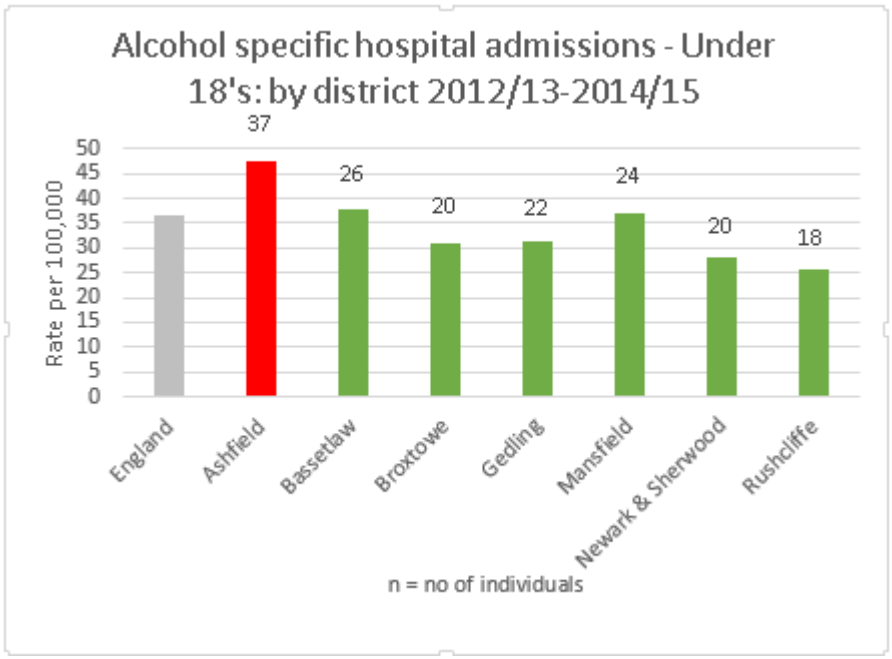
The following data is from Local Alcohol Profiles for England and can be found at: http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/0/gid/1938132833/pat/6/par/E12000004/ati/102/are/E10000024/iid/91384/age/1/sex/4

The latest data suggests that there has been a reduction in the rate of alcohol specific admissions in under 18s both nationally and locally between 2006 and 2015 (table 1). The Nottinghamshire rate and trend is similar to England and other areas that share similar demographics to Nottinghamshire. The rate in Ashfield is significantly higher than the England average (figure 1). Gender differences are not routinely reported nationally or locally.

Table 1: Alcohol specific hospital admissions – Under 18s: national and local 2006-15

	2006-09 rate per 100,000 (no. of individuals)	2012-15 rate per 100,000 (no. of individuals)
England	68.4	36.6
Nottinghamshire	52.5 (256)	34.2 (167)

Figure 1:



For adults, there has been a steady increase in the rate of alcohol-specific admissions between 2008 and 2015 both nationally and locally. The Nottinghamshire rate and trend is

similar to England and other comparator areas (table 2). There are no significant gender or district differences.

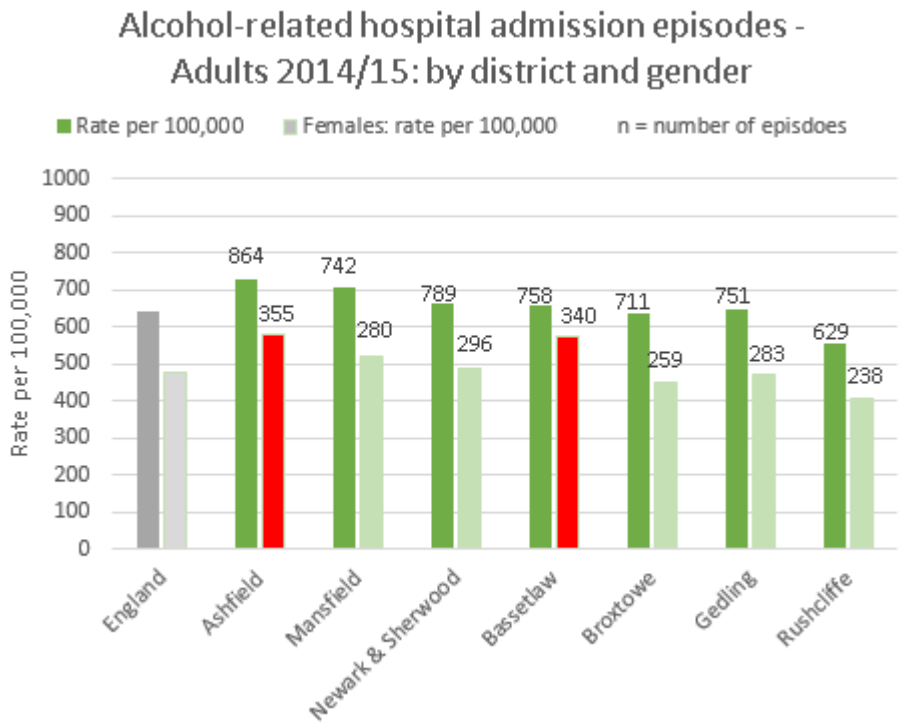
Table 2: Alcohol specific hospital admissions – Adults: national and local 2006-15

	2006-09 rate per 100,000 (no. of individuals)	2012-15 rate per 100,000 (no. of individuals)
England	316	364
Nottinghamshire	277 (2145)	310 (2470)

There have been 5,244 adult hospital admission episodes for alcohol-related conditions in 2014/15 (narrow definition). This represents 654 episodes per 100,000 residents. At County level, this is similar to the England average but when analysed in more detail:

- Admission episodes in Mansfield and Ashfield are higher than the England average.
- Admission episodes for females are higher than the England average and highest in Ashfield and Bassetlaw (figure 2)

Figure 2:



An age analysis identifies some groups as having higher rates of alcohol-related hospital admissions episodes than the national average (table 3):

Table 3: Alcohol-related hospital admission episodes – Adults 2014/15: by age group

Age Group	Local issue and rate per 100,000 (no. episodes)	National rate per 100,000
Under 40s	Higher in Ashfield for females = 166.1 (98)	120.4
Ages 40-64	Higher in Ashfield = 333.2 (413)	299.6
	Higher in Mansfield =344.8 (371)	299.6
	Higher in Broxtowe for men = 424.5 (237)	371.2
	Higher in Bassetlaw for women = 300.2 (182)	229.9
Over 65s	Higher in Gedling = 217.1 (255) No gender differences	190.5

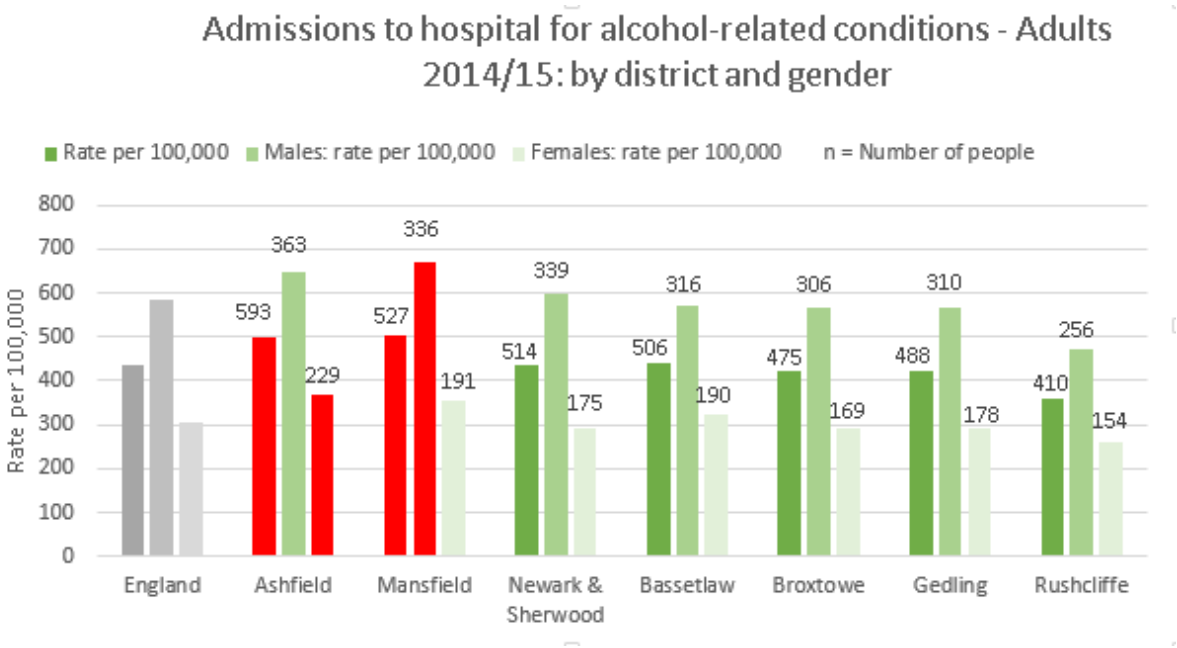
The above measure is based upon admission episodes (of which there were 5,244 in 2014/15) – not number of individuals. Further data indicates that 3513 individuals were admitted to hospital for alcohol-related conditions in 2014/15. There has been a steady increase between 2008 and 2015 both nationally and locally in this measure (table 4). The Nottinghamshire rate and trend is similar to England and other comparator areas.

Table 4: Admissions to hospital for alcohol-related conditions – Adults: national and local 2008-15

	2008-09 rate per 100,000 (no. of individuals)	2014-15 rate per 100,000 (no. of individuals)
England	421	438
Nottinghamshire	398 (3026)	439 (3513)

On further analysis, rates in Mansfield and Ashfield are higher than the England average, with the highest rates for males in Mansfield and females in Ashfield (figure 3):

Figure 3:



Regarding drug-related hospital admissions, national and local trends have been consistent for the past decade, with 72% of admissions being amongst the over 24s. In 2014, there were 331 admissions in Nottinghamshire, with gender differences between admission codes (table 5).

Table 5: Nottinghamshire drug-related hospital admissions 2014

2014	Male	Female	Total
Hospital admissions for drug-related mental health and behavioural disorders	104	36	140
Hospital admissions for poisoning by illicit drugs	87	104	191
Total			**331**

(National statistics UK – Health and Social Care Information, 2014)

For both drug and alcohol-related admissions, attendances at Emergency Departments are not included. Some local data from King's Mill Hospital indicates that during 2014/15 approximately 19% of all young people who presented at the Emergency Department with issues around substance misuse were admitted to hospital (153 presentations, 29 admitted).

Unintentional injuries:

Nottinghamshire has higher rates than the England average for alcohol-related hospital admissions due to unintentional injuries, which include road or pedestrian traffic accidents, alcohol poisoning and fall and fire injuries. Nottinghamshire is the only area worse than England amongst its comparator areas. Rates are significantly worse for both males and females and also in the Mansfield and Ashfield and Newark and Sherwood districts (figures 4 & 5).

Figure 4: Alcohol-related hospital admissions due to unintentional injuries 2014/15 by district

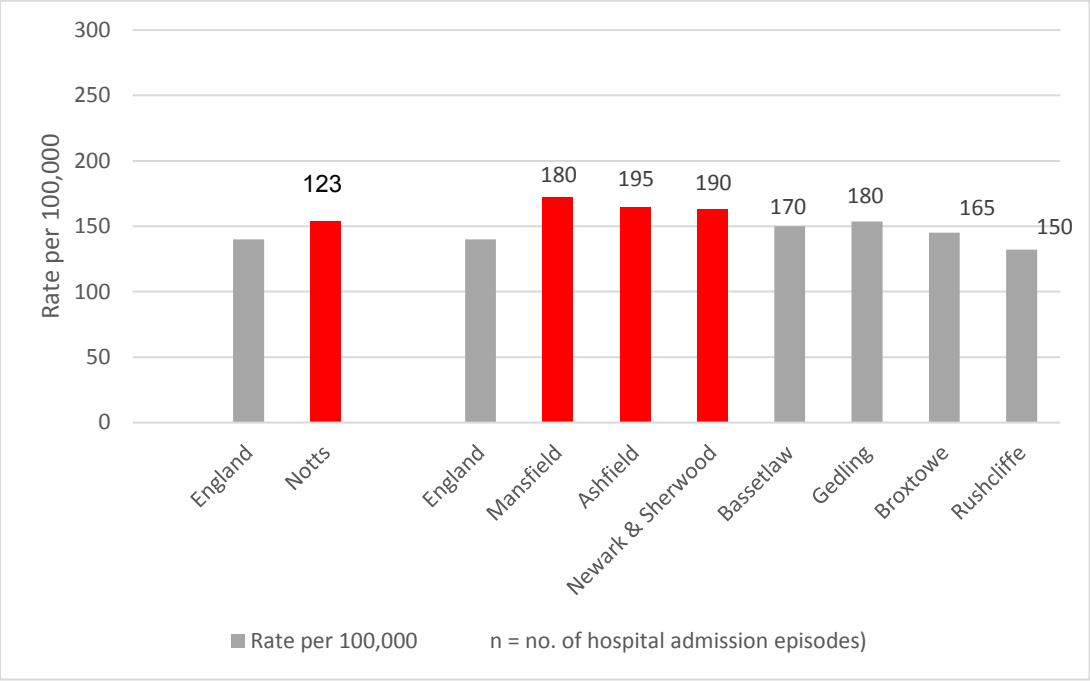
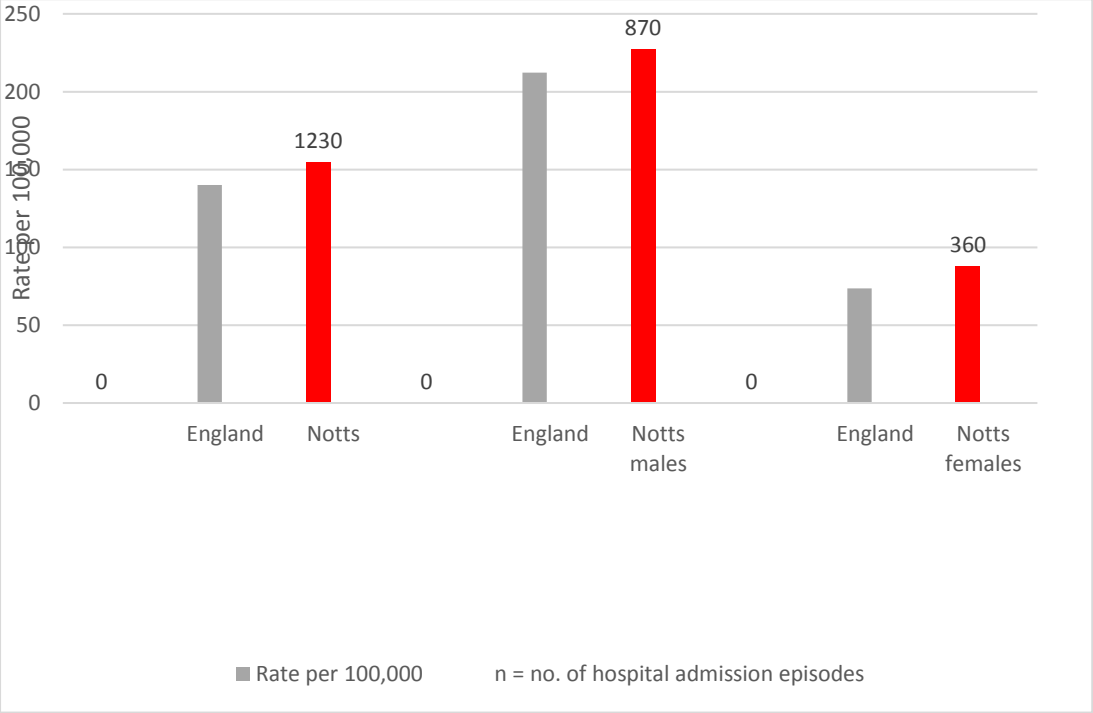


Figure 5: Alcohol-related hospital admissions due to unintentional injuries 2014/15 by gender



Mortality and substance misuse

Alcohol

The rate of alcohol-*specific* mortality has remained static nationally and locally at approximately 12 deaths per 100,000 of the population.

Alcohol-*related* mortality however has increased, particularly for liver disease which has seen a 400% increase since 1970, and this trend is in stark contrast to much of Western Europe. https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review. In recent years, alcohol-related mortality in England and Nottinghamshire has remained relatively high notwithstanding a minor reduction in rate in 2006-08, with an increase seen between 2012 and 2014. Nottinghamshire rates are similar to England and comparator areas, with no significant differences between districts or gender (table 6).

Table 6: Alcohol-related deaths (all ages) – national and local 2014-16

	2014 – No. individuals (rate per 100,000)	2015 – No. individuals (rate per 100,000)	2016 – No. individuals (rate per 100,000)
England	22,967 (45.5)	23, 836 (46.1)	23,839 (46.0)
Notts	380 (47.5)	386 (47.7)	359 (43.7)

The rate of mortality in people aged under 75 from liver disease and liver disease that was considered preventable has risen by almost 14% (Public Health England, 2014c). Alcohol-related liver disease deaths in under 75s have been rising in Nottinghamshire (table 7).

Table 7: Alcohol-related liver disease deaths (under 75s) – national and local 2010-15

	2010-12 – No. individuals (rate per 100,000)	2011-13 – No. individuals (rate per 100,000)	2012-14 – No. individuals (rate per 100,000)	2013-15 – No. individuals (rate per 100,000)
England	12,144 (8.9)	12,047 (8.7)	11,920 (8.6)	12,255 (8.7)
Notts	161 (7.3)	164 (7.4)	171 (7.7)	190 (8.6)

Drugs

Between 2012 and 2014, there was a reported 42% increase in drug related deaths between (from 1613 to 2120) ((Corkery et al., 2013, PHE, 2016). Since 2014, comprehensive local Nottinghamshire data has been collected by the adult treatment provider. In Nottinghamshire in 2014/15 there were:

- 51 deaths due to long term health conditions. Substance misuse would have been a secondary contributory factor as 26 of them were known to be primary drug users and 23 primary alcohol users. 85% were male and 95% white British.
- There were 12 drug-related deaths of service users in contact with the treatment service, representing a rate of 0.019% of all service users in treatment which is low compared to the national rate of 1%.
- Causes of deaths in Nottinghamshire follow national trends

There is an increasing population of long term in-treatment service users who are now suffering from other health complications as a result of their continued substance misuse. The local service provider has reported an increase in incidents in relation to service users on low opiate substitute methadone prescribing with high alcohol usage.

Reviews of all incidents are undertaken and reported through Nottinghamshire County Council's contract and quality meetings to identify themes, gaps or areas which require improvement and wider lessons or learning across the whole system. Good practice has been identified and there has been significant improvement in the quality of service provision across the whole system, with a focus on addressing issues at a locality level to enable manageable and tailored quality improvements related to local need.

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APPENDIX G
Substance Misuse Treatment for Adults

All Nottinghamshire County community substance misuse services were tendered in 2013/14 and Change Grow Live (CGL: http://www.changegrowlive.org) won the contract. As of 1st October 2018, CGL also hold the contract for young peoples' substance misuse services. Both contracts run until 31st March 2020.

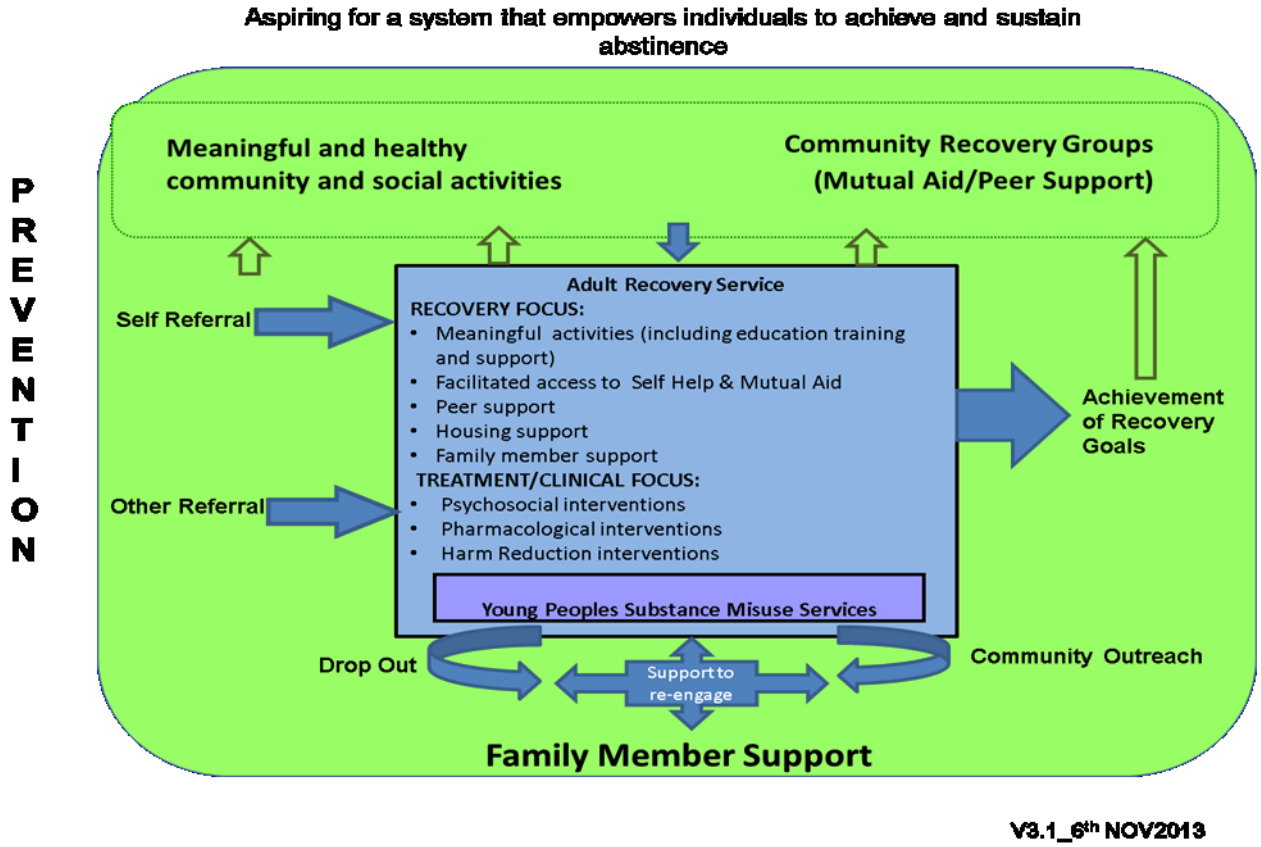
It is an outcome based contract and the provider has complete operational and financial flexibility to configure services as they see fit to meet the needs of the local population and the high level contract outcomes. CGL are the accountable care organisation for the local substance misuse population (http://www.kingsfund.org.uk/publications/accountable-care-organisations-united-states-and-england).

The new system aims to reduce illicit and other harmful substance misuse and increase the numbers recovering from dependence. It is:

- Focussed on recovery- recognising that this is not just a process of shedding symptoms but a process of growth and wellbeing; focussing on the potential, not the pathology
- Strengths and assets-based – which values the capacity, skills, knowledge, connections and potential in individuals, families and communities. The new system will utilise community assets to support individuals to achieve and sustain their recovery goals
- Improving and increasing access and engagement into the system for those needing support for their substance misuse. In particular, the new system will reach into communities and engage with more people year on year 'upstream' before they reach a stage of problematic substance misuse
- Integrates drug and alcohol services and focusses on behaviour change – seeing the substance(s) of choice as only the manifestation of an individual's problems
- Focussed on outcomes – empowering the provider to use the best evidence of what works, to innovate and develop staff and services to deliver outcomes that are meaningful for individuals, families and communities. The service will also be sensitive to the evolving nature of substance misuse over time and develop effective, timely responses based on evidenced need.

The service works with other agencies to support individuals who come into regular contact with public services (such as the Long Term Conditions Team for those with long-term health conditions as a result of their substance misuse and the Blue Light Project for street drinkers.

The Recovery Model:



The diagram demonstrates how at service entry point individuals are connected to meaningful and healthy community social activities and community recovery groups (including mutual aid and peer support). This makes recovery visible at the outset. Also, it is the connection to these community assets that will support an individuals in sustaining their recovery goals once they have been achieved.

Defining "recovery"

Nottinghamshire has adopted the UK Drug Policy Commission definition of recovery which is *'voluntarily sustained control over substance use which maximises health and well-being and participation in the rights, roles and responsibilities of society'* (UK Drug Policy Commission, 2008, p6). Recovery is the best word to summarise the positive benefits to physical, mental, and social health that can happen when substance-dependent individuals get the help they need. It is a concept based on principles of empowerment, choice and hope and focusses on strengths rather than weaknesses/pathologies.

Although recovery is a personal journey and varies between people and settings, it is not entirely unpredictable. Recovery is social in nature with recovery journeys involving other people and taking place in social settings. Recovery is also a social movement of change that helps to build and transform local communities and recovery successes should be visible to communities. Recovery does not occur in treatment, although treatment may be both a catalyst and a prerequisite for some people.

Service data:

The service offers 3 phases of support of increasing intensity and focusses on behaviour change. The pathways are not defined by the substance(s) of choice (see below).

For the first time in Nottinghamshire, local data on all individuals who come into contact with the substance misuse service is now collected (i.e. across all 3 phases). The CGL contract is managed on the data from the provider's own IT system. This does not always align with the national data for various reasons.

Broadly, the services delivered are categorised as follows:

Phase 1	Single brief intervention that offers screening, information, advice and guidance, with sign posting as required. This cohort includes needle exchange/harm reduction provision and anyone scoring 8 or under on audit C
Phase 2	Brief and extended brief interventions – triage & comprehensive assessment, with short term and intensive treatment and recovery support package. Treatment and recovery options include: pharmacological, psychosocial interventions (PSI), health & wellbeing interventions as required with additional peer support, 'Building Foundations of Life' programme (BFOL), access to family support, housing, education training and employment (ETE) and peer mentoring, links to mutual aid and asset based community capital/support. This cohort would typically include non-opiate and those scoring 19 or below on audit C. This pathway largely includes the traditional 'Tier 2' cohort.
Phase 3	Triage & comprehensive assessment with structured treatment and care co-ordination, longer term and often multi agency approach due to complexity of needs. Treatment and recovery options include: pharmacological, PSI, Foundations Of Recovery programme, health & wellbeing interventions as required with additional peer support, BFOL, access to family support, housing, ETE and peer mentoring, links to mutual aid and asset based community capital/support. This cohort would typically include opiate dependency, poly substance use, and those scoring 20 + on audit C. This pathway includes the traditional 'Tier 3' and 'Tier 4' cohorts.

Service user involvement underpins all phases and is integral to service design, quality development and improvement plans.

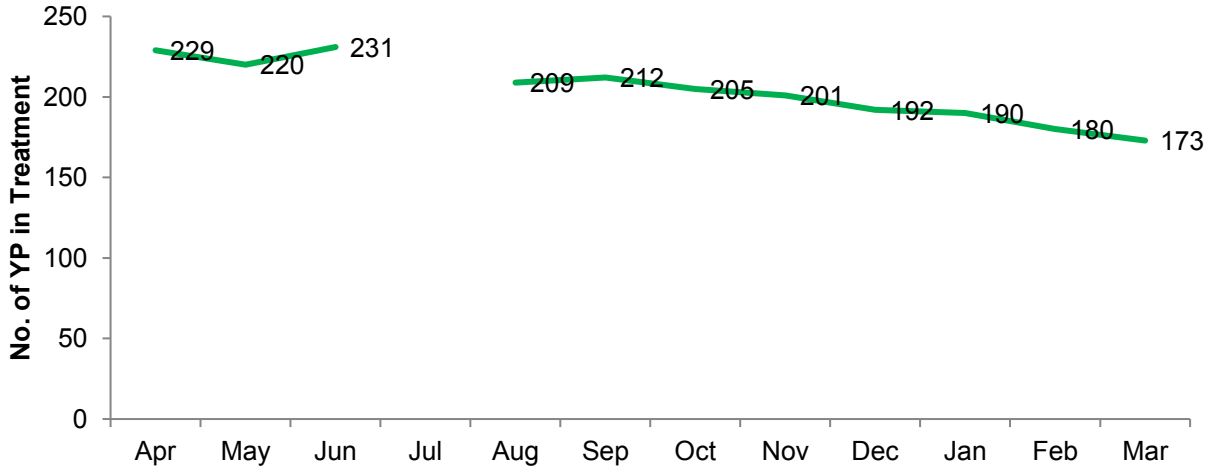
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APPENDIX H
Substance Misuse Treatment Services - Young People

Although there is no current local contract Performance Management Framework, data from the National Drug Treatment Monitoring System (NDTMS) can be analysed.
As at March 2015 there were 173 young people in treatment for substance misuse. The following data gives an idea of trends with regard to age, gender and district of residence as well as the most common reasons for presentation.

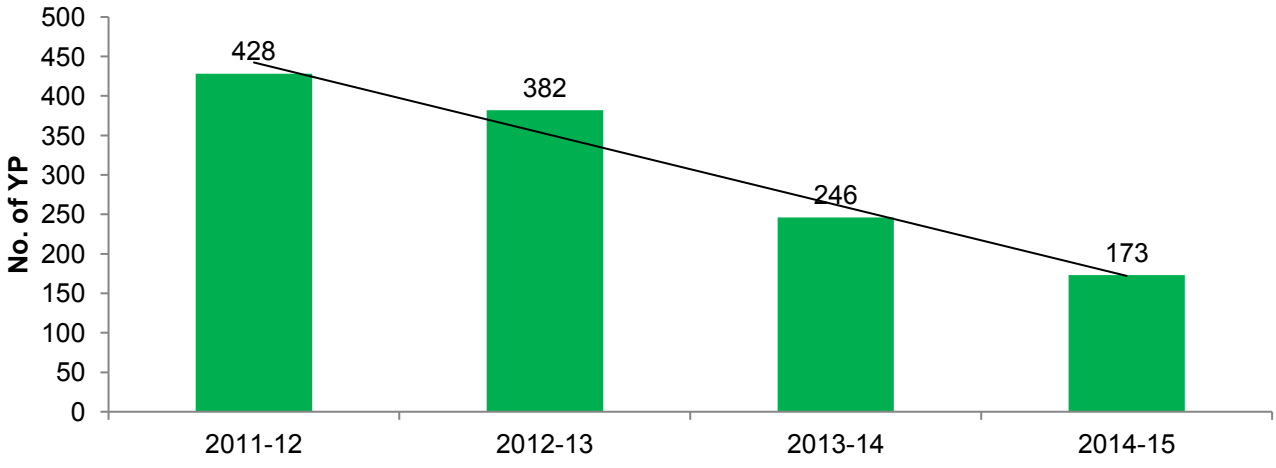
The number of young people accessing treatment for substance misuse has declined throughout 2014-15 (figure 1). This is in line with national trends. In 2014/15 there were 255 fewer YP accessing specialist services than in 2011/12.

Figure 1: Number of young people in treatment 2014-15 (rolling 12 months)



*Source: National Drug Treatment Monitoring Service (NDTMS)

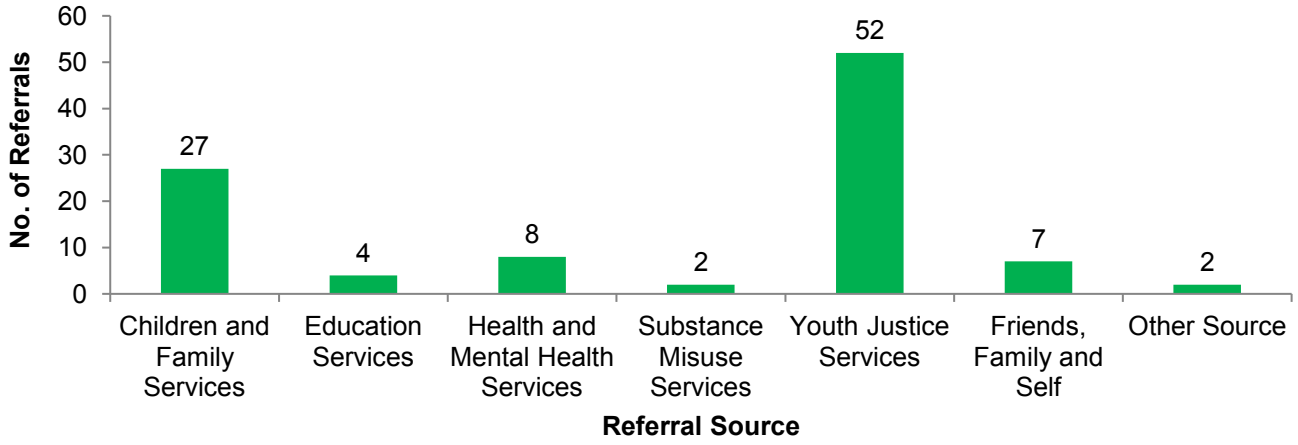
Figure 2: Number of young people in treatment 2011-15



*Source: National Drug Treatment Monitoring Service (NDTMS)

Within Children and Families services, 91% of referrals are from Targeted Support. Referrals are made using the Early Help Assessment Form which requires consent from a parent and/or carer. This is then processed by the Early Help service that enacts the appropriate referral process. Similarly, within Youth Justice, 95% of referrals this year are from the Youth Offending Team. Over the year only 5 young people have self-referred (figure 3).

Figure 3: Number and source of referrals for young peoples' substance misuse services 2014/15



*Source: National Drug Treatment Monitoring Service (NDTMS)

The majority of young people accessing treatment are age16-17 (figure 4) with main substances of choice being cannabis and alcohol (figure 5). Notable differences with national trends include Nottinghamshire having a lower proportion of young people with amphetamine, cocaine, ecstasy and nicotine use but a significantly higher proportion of young people using opiates. 93% of young people accessing services are of white British ethnicity.

Figure 4: Percentage of young people in services by age 2014-15

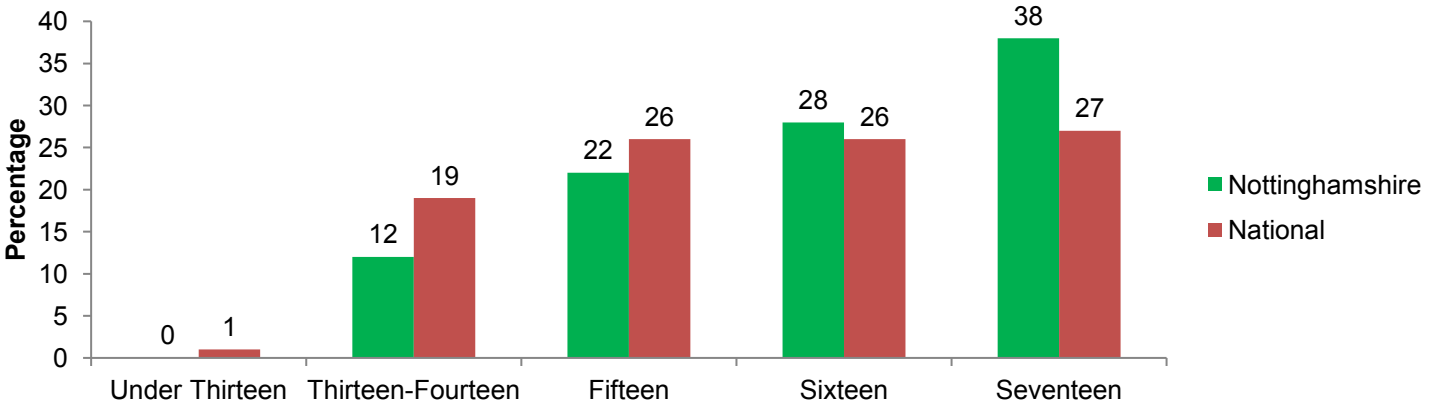
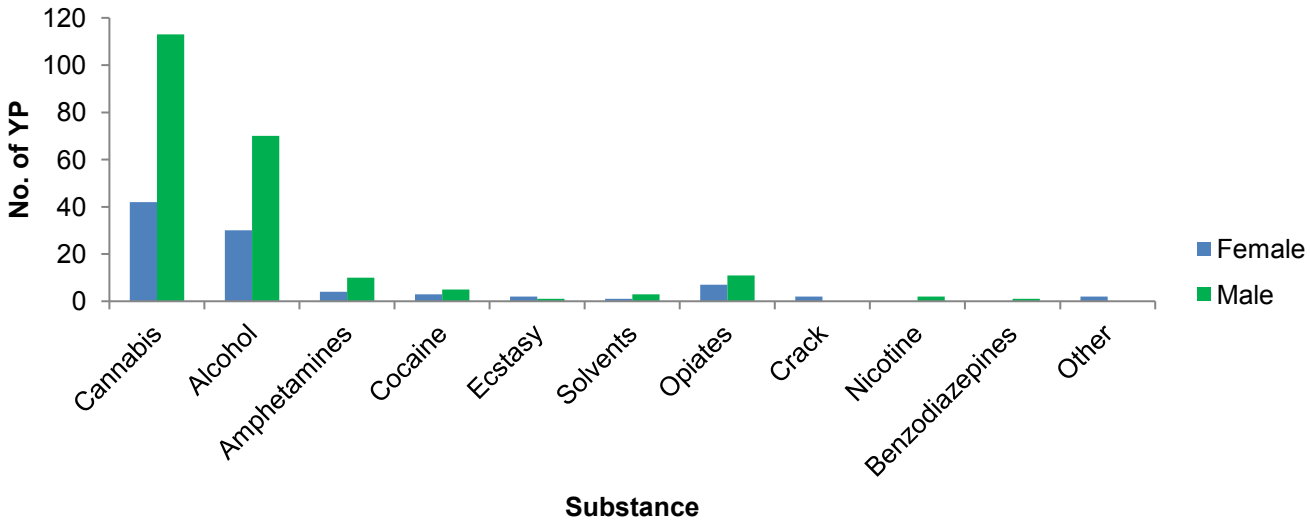


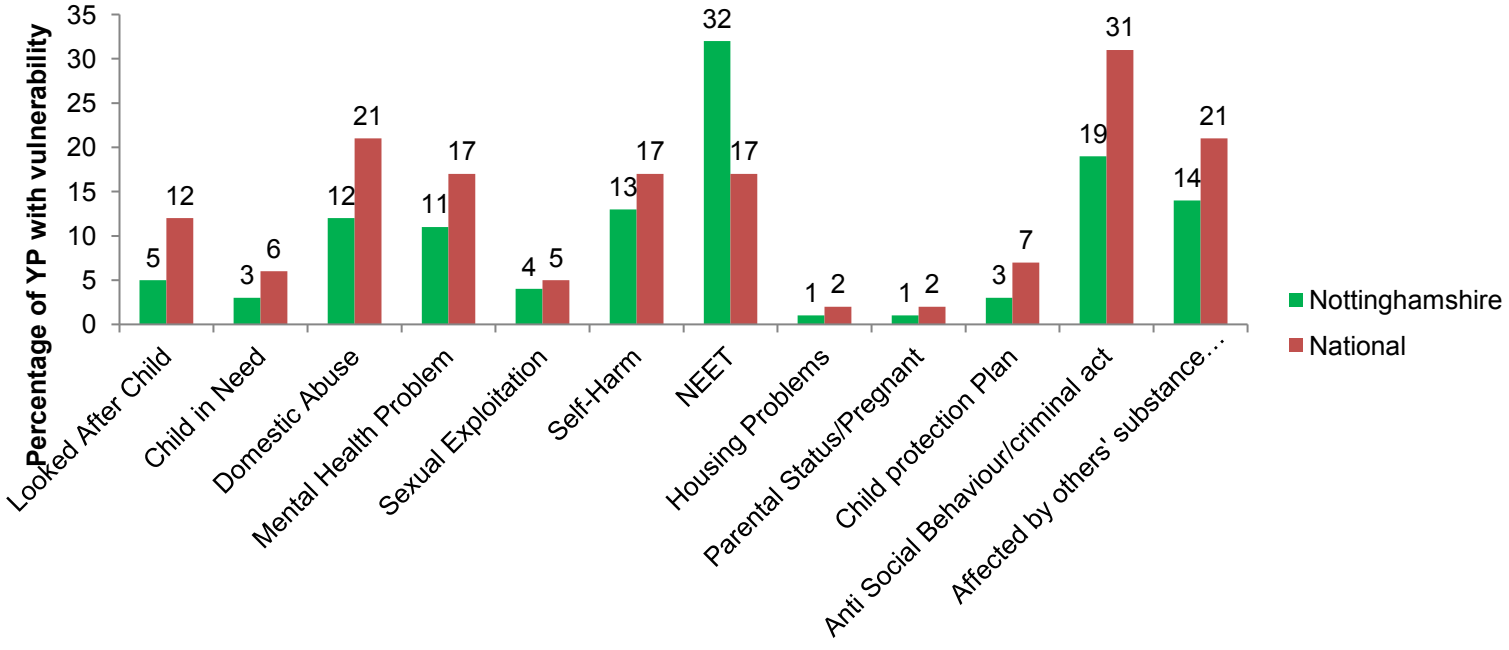
Figure 5: Substance of choice by gender for those in treatment



*Source: National Drug Treatment Monitoring Service (NDTMS)

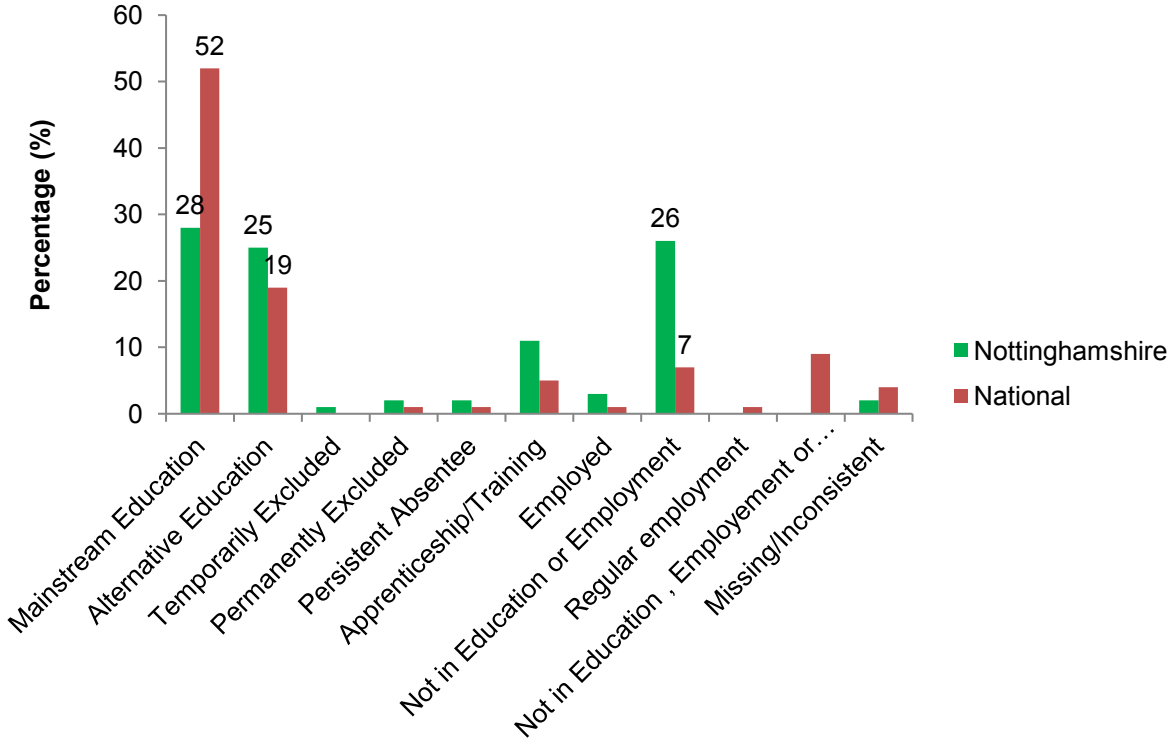
Substance misuse is often associated with a range of other risky behaviours. These include sexual exploitation, self-harm, housing problems, relationship breakdowns and a lack of engagement with education, training and employment opportunities. In Nottinghamshire, a large proportion of young people receiving treatment are not in education, employment or training (NEET) (32%) (figure 6 & 7). This is particularly significant given that Nottinghamshire has a relatively low proportion of young people that are NEET in comparison with national trends and the county's statistical neighbours (table 1).

Figure 6: Wider vulnerabilities of young people in treatment 2014-15



*Source: National Drug Treatment Monitoring Service (NDTMS)

Figure 7: Education, employment and training status of young people in treatment 2014/15



*Source: National Drug Treatment Monitoring Service (NDTMS)

Table 1: NEET Population in Nottinghamshire (2014) compared to East Midlands

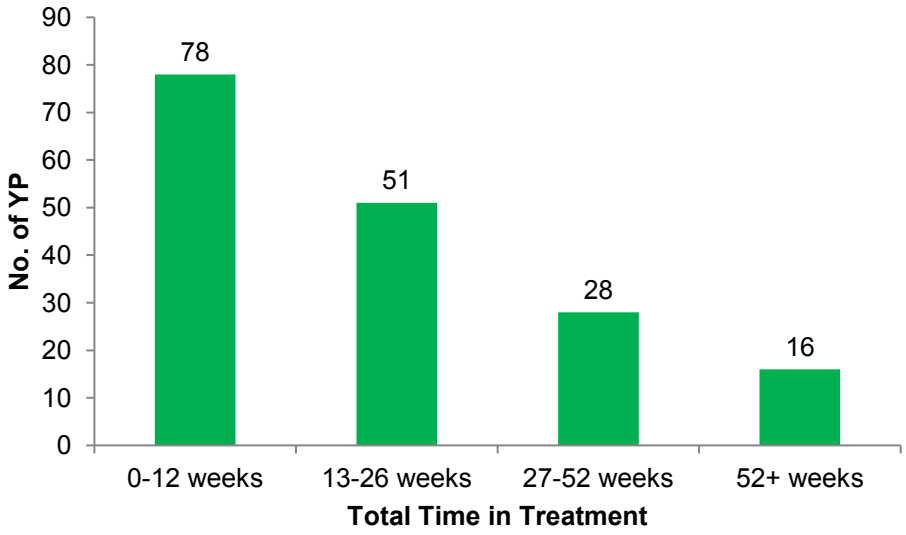
	16 yrs	17 yrs	18 yrs
East Midlands Average	2.0%	4.1%	7.1%
Nottinghamshire	1.3%	1.5%	1.9%

Source: NEET data by local authority. GOV.UK

Regarding waiting times, no young people are waiting more than three weeks for initial or subsequent assessments (the national standard for access to services).

The majority of treatment lasts between 0-12 weeks (45%). 16 young people (9%) remain in treatment for more than 1 year. The primary interventions undertaken with young people include harm reduction and psychosocial. These can take place on an individual basis or as part of group sessions (figure 8).

Figure 8: Total time in treatment 2014/15



*Source: National Drug Treatment Monitoring Service (NDTMS)

Assessment information collected for young people in treatment in Nottinghamshire highlights that only 49% received a specialist healthcare assessment at the start of treatment in comparison with the national average of 73%.

However, a greater percentage of young people were registered with a GP at the start of treatment. Nottinghamshire is also above average in terms of the percentage of young people who have a lead professional at the start of their treatment. However, this figure is only 50% which is relatively low.

When exiting treatment, 85% (114) of young people experienced a planned exit in 2014/15. However, 15% (20) left in an unplanned way. This figure is lower than the national average where 21% of young people leaving treatment in an unplanned way. In the majority of cases (approximately 80%), unplanned exits were due to the client dropping out of treatment. No reasons are given for this occurring. This is slightly higher than the national average of 79%. 3% of young people were transferred to other substance misuse services.

Clayfields House Secure Unit

Clayfields House is a Local Authority secure children's home located in Stapleford. It provides secure care, education and specialist interventions. Over the course of 2013/14, 2 Nottinghamshire young people received specialist interventions for substance misuse and continued service provision in the community.

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APPENDIX I

Substance Misuse Treatment and Recovery Services - Adults

The following CGL data relates to the time period June 2016 - June 2018 unless otherwise stated.

For a description of the services delivered in each phase, please see Appendix G.

Phase 1 – low level substance misuse advice and support (October 2014-Spetember 2015):

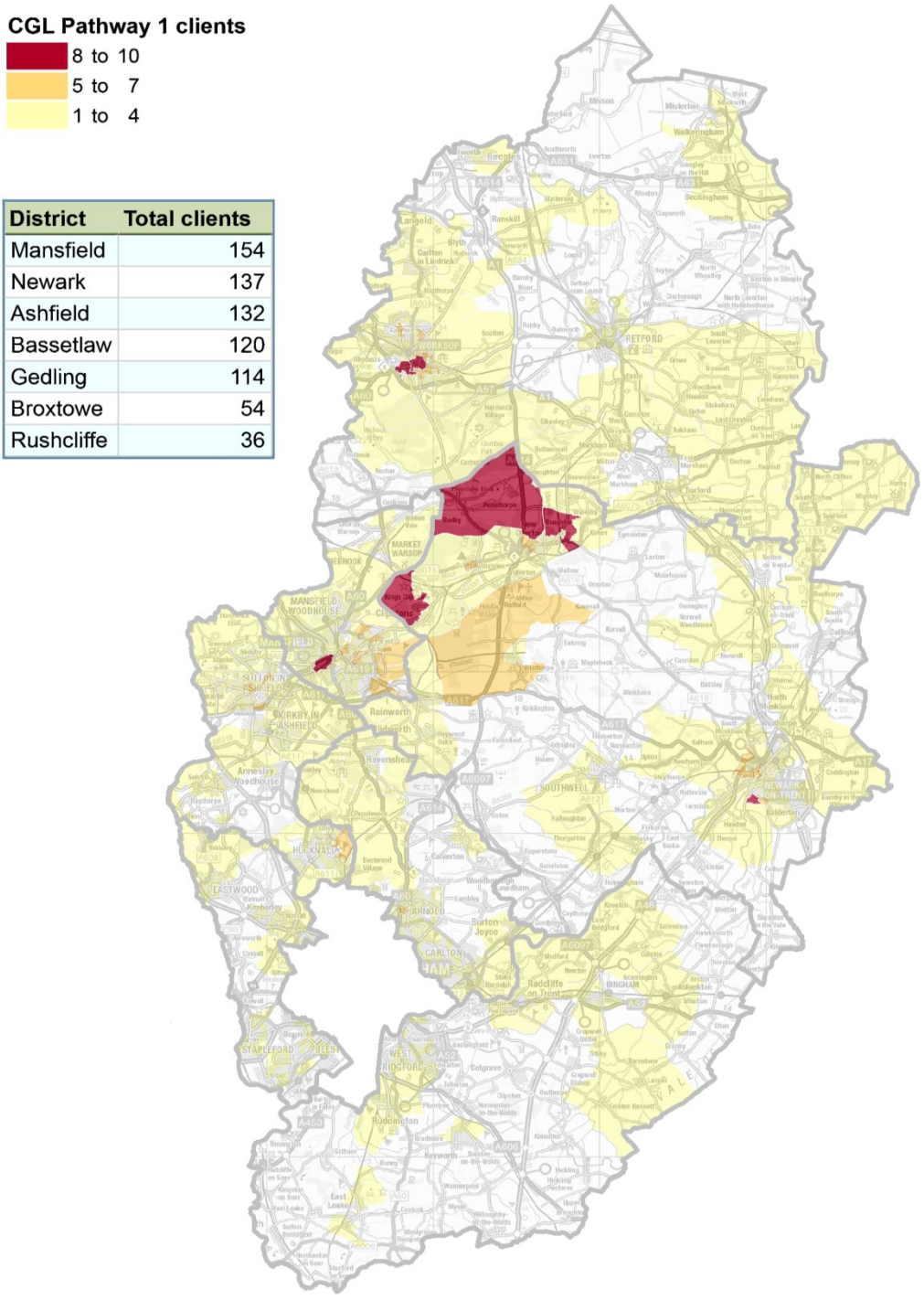
There were 747 individuals in phase 1. In addition to this, there were 10 of no fixed abode and 34 out of area. 121 were not matched to a district of residence. Numbers by district are detailed in Figure 1.

64% of individuals self-referred to the service. 90% of referrals were self-referrals, hospital or GP referrals (table 1). 82% were White British (table 2) and they were mostly males aged 25-44 (figure 2).

Figure 1: Number of adults in substance misuse services (Phase 1) by district

Nottinghamshire substance misuse service clients

Residence by small area (LSOA)



District	Total clients
Mansfield	154
Newark	137
Ashfield	132
Bassetlaw	120
Gedling	114
Broxtowe	54
Rushcliffe	36

Produced by the Nottinghamshire County Council Public Health Intelligence Team (NCCPHIT/IB)
Contains Ordnance Survey data © Crown copyright and database right 2016

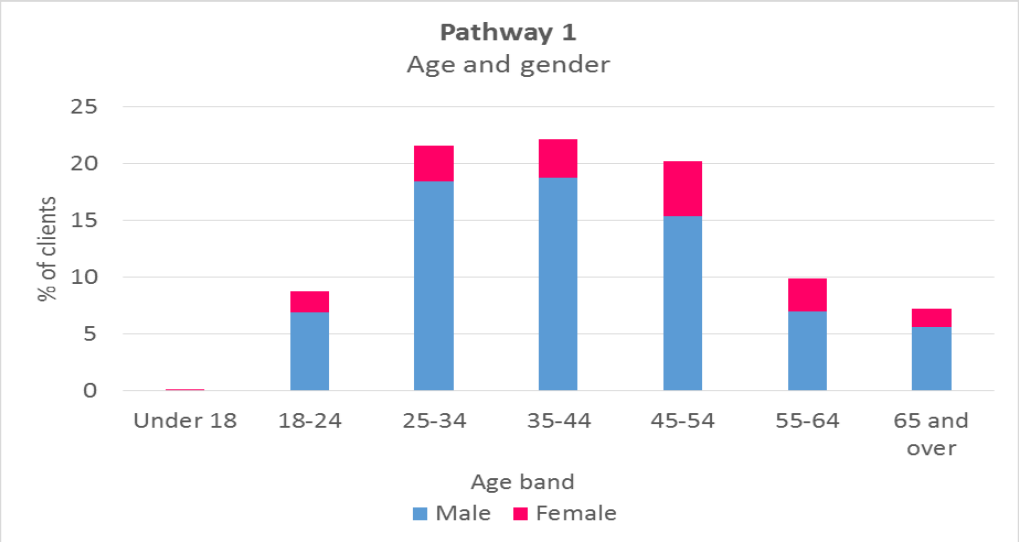
Table 1: Referral sources for Phase 1

Source	Number clients	Percentage	*Cumulative*	
Self	588	*64.5*	*64.5*	64% self- refer
Hospital	168	*18.4*	*82.9*	
GP	60	*6.6*	*89.5*	90% from 3 sources
	37	*4.1*	*93.5*	
Probation	12	*1.3*	*94.8*	
Alcohol	11	*1.2*	*96.1*	
DALT	10	*1.1*	*97.1*	
Treatment Agency	10	*1.1*	*98.2*	
CARAT/Prison	5	*0.5*	*98.8*	
Prison	5	*0.5*	*99.3*	
Social Services	4	*0.4*	*99.8*	
A&E	2	*0.2*	*100.0*	
Total	**912**	***100.0***		

Table 2: Adults in Phase 1 by ethnicity

Ethnicity	***Percentage***
Asian	*0.8*
Black	*1.0*
Mixed	*0.3*
White - other or Irish	*5.7*
White British	*82.2*
Other or not stated	*10.0*
Total	***100.0***

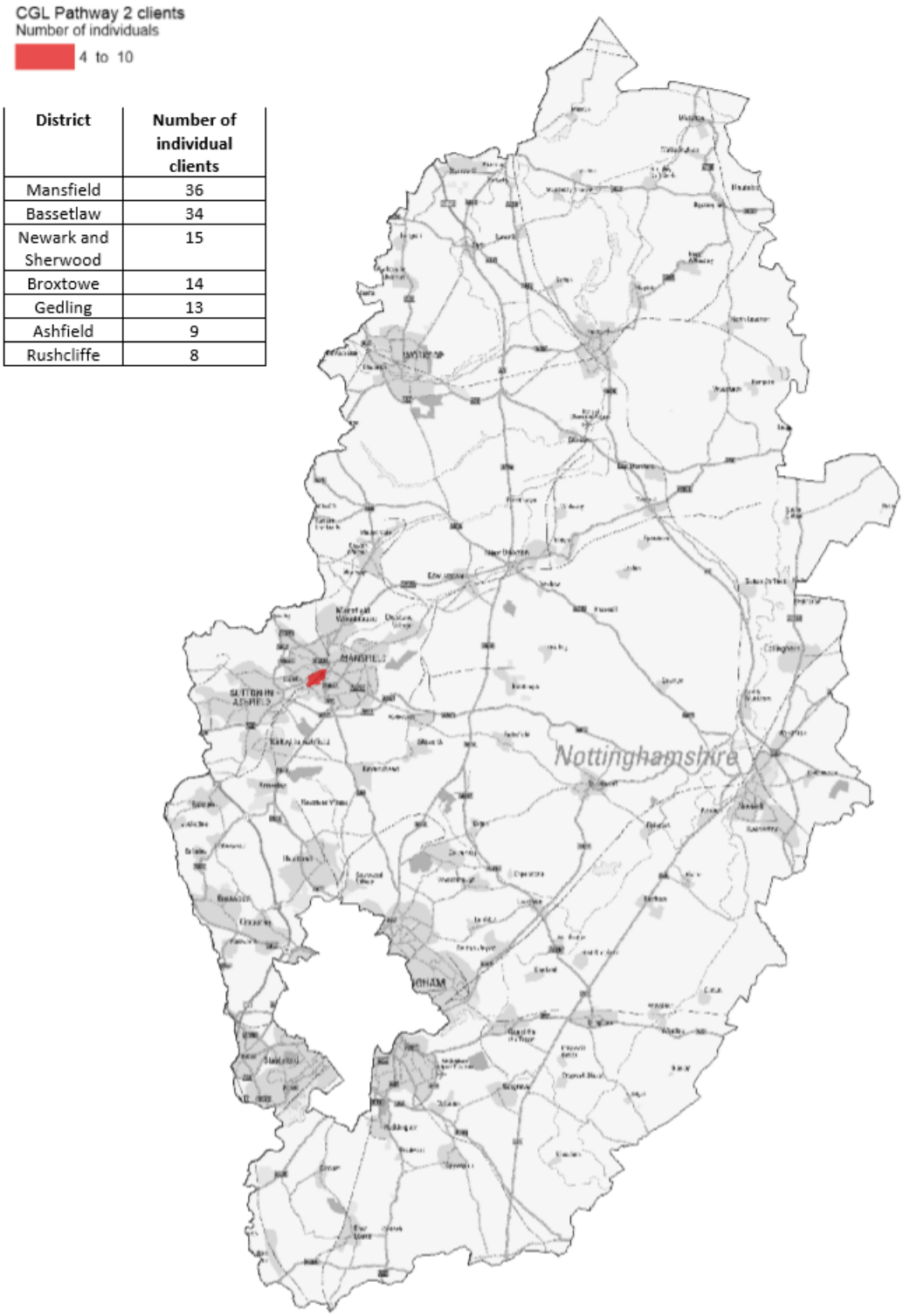
Figure 2: Adults in Phase 1 by gender



Phase 2 – non-structured substance misuse support

During June 2016 – June 2018 there were 129 new referrals (unique individuals) entering phase 2. Numbers by district are detailed in Figure 3. 79% self-referred, with 90% of referrals being from self-referrals, GPs and the criminal justice system (figure 3). They were mostly males aged 35-44 (figure 4). 23% (30 clients) were living with children (table 4). The hot spot ward is Portland Ward.

Figure 3: Number of adults in substance misuse services (Phase 2) by district



District	Number of individual clients
Mansfield	36
Bassetlaw	34
Newark and Sherwood	15
Broxtowe	14
Gedling	13
Ashfield	9
Rushcliffe	8

Table 3: Referral sources for Phase 2

Referral Source	Total	% of total	Cumulative %
Self	102	79%	79.1%
GP	9	7%	86.0%
DRR	4	3%	89.1%
ATR	3	2%	91.5%
Psychiatry services	2	2%	93.0%
Community Rehabilitation Company (CRC)	2	2%	94.6%
Hospital	2	2%	96.1%
Self-referred via health professional	1	1%	96.9%
Drug Service Non-Statutory	1	1%	97.7%
Social Services	1	1%	98.4%
Relative	1	1%	99.2%
National Probation Service	1	1%	100.0%
Total	129	100%	

Figure 4: Adults in phase 2 by gender

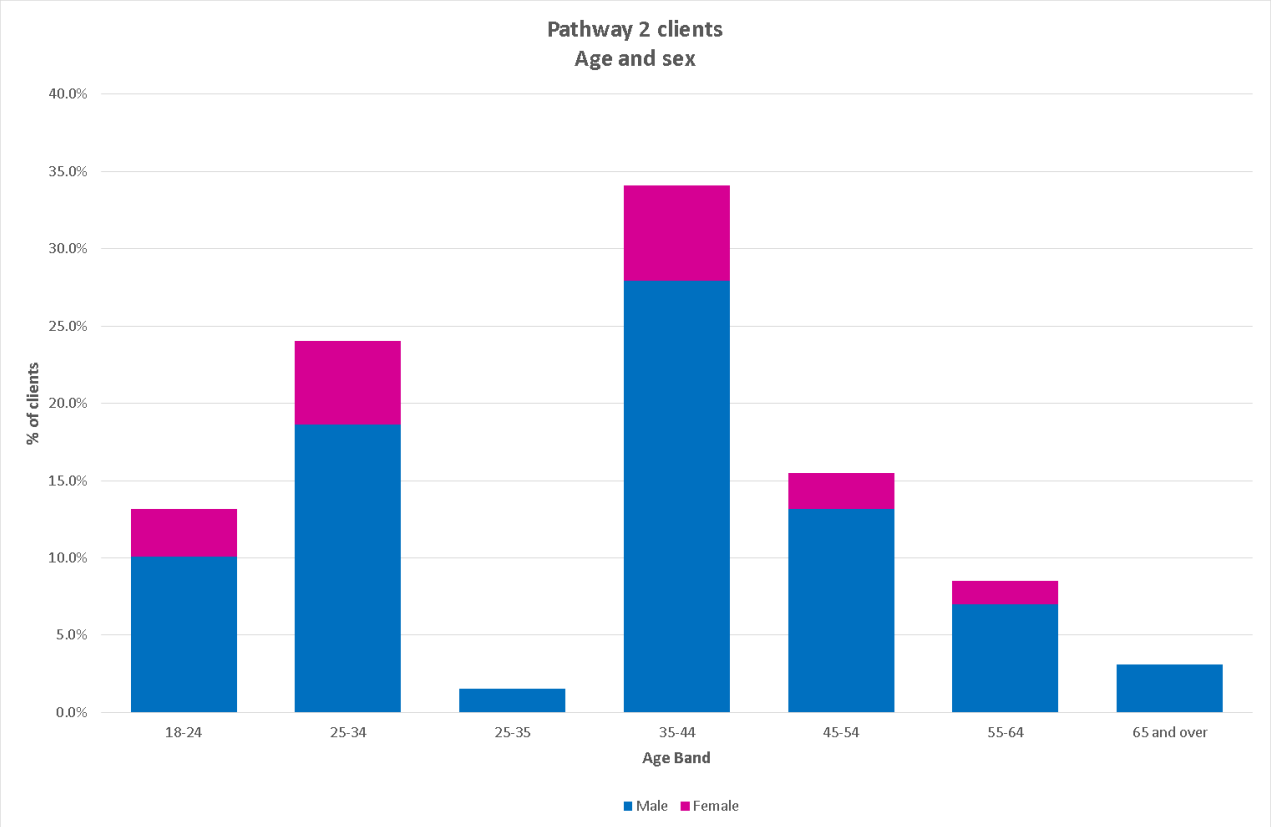


Table 4: Parental status of adults in Phase 2

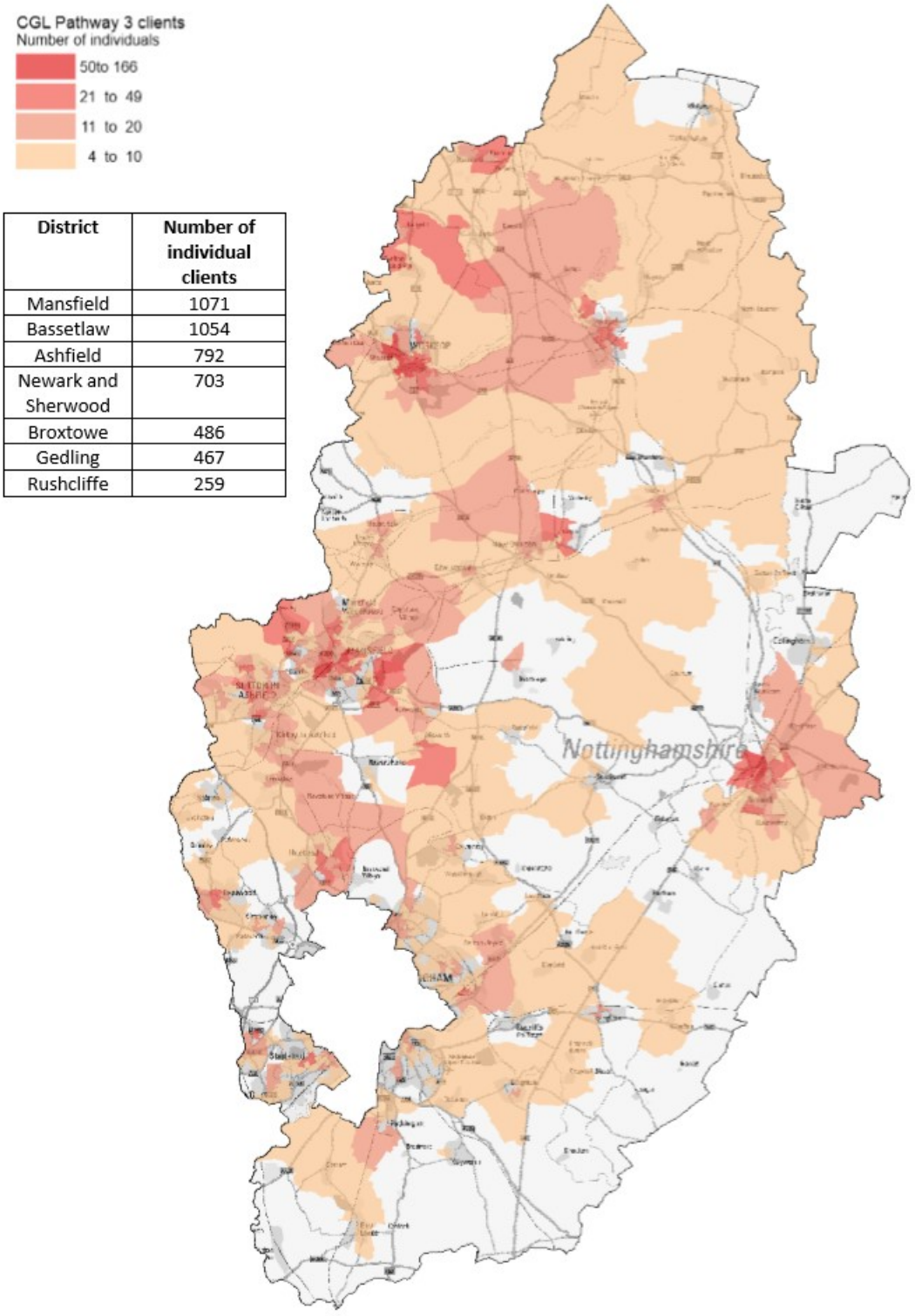
Parental Status	Total
All the children live with the client	19.38%
None of the children live with client	16.28%
Not a parent	60.47%
Some of the children live with client	3.88%
Grand Total	**100.00%**

Phase 3 – structured care planned substance misuse treatment

During June 2016 – June 2018 there were 4,832 new referrals (unique individuals) entering phase 3. 66% of referrals were self-referrals. Referrals from self, GP, other drug services and criminal justice services made up 90% of referrals (table 5). 54% (2,610 clients) were parents, with 20% (966 clients) living with children (table 7). Most were males aged 35-54. (table 6). The hotspot wards are:

- Worksop South
- Oak Tree
- Portland
- Bridge
- Newgate

Figure 5: Number of all adults in substance misuse services (Phase 3) by district



District	Number of individual clients
Mansfield	1071
Bassetlaw	1054
Ashfield	792
Newark and Sherwood	703
Broxtowe	486
Gedling	467
Rushcliffe	259

Table 5: Referral sources for Phase 3

Referral Source	Total	% of total	Cumulative %
Self	3171	65.6%	65.6%
Drug Service Statutory	429	8.9%	74.5%
GP	312	6.5%	81.0%
Prison	197	4.1%	85.0%
DRR	95	2.0%	87.0%
Criminal Justice - other	93	1.9%	88.9%
Drug Service Non-Statutory	87	1.8%	90.7%
Probation	80	1.7%	92.4%
Other	69	1.4%	93.8%
ATR	55	1.1%	95.0%
Hospital	51	1.1%	96.0%
Arrest Referral	45	0.9%	96.9%
Social Services	26	0.5%	97.5%
Self referred via health professional	20	0.4%	97.9%
National Probation Service	20	0.4%	98.3%
Relative	19	0.4%	98.7%
Psychiatry services	18	0.4%	99.1%
Concerned other	7	0.1%	99.2%
A&E	6	0.1%	99.3%
Psychological Services	5	0.1%	99.4%
Outreach	5	0.1%	99.5%
Community Alcohol team	4	0.1%	99.6%
DIP	4	0.1%	99.7%
Community Rehabilitation Company (CRC)	3	0.1%	99.8%
Peer (i.e. other service user) - Alcohol projects only	3	0.1%	99.8%
Employment Service	2	0.0%	99.9%
Job Centre Plus	2	0.0%	99.9%
Children's Social Services	1	0.0%	99.9%
Sex worker project	1	0.0%	100.0%
Community care assessment	1	0.0%	100.0%
Education service	1	0.0%	100.0%
Grand Total	4832	100.0%	

Table 6: Adults in Phase 3 by age and gender

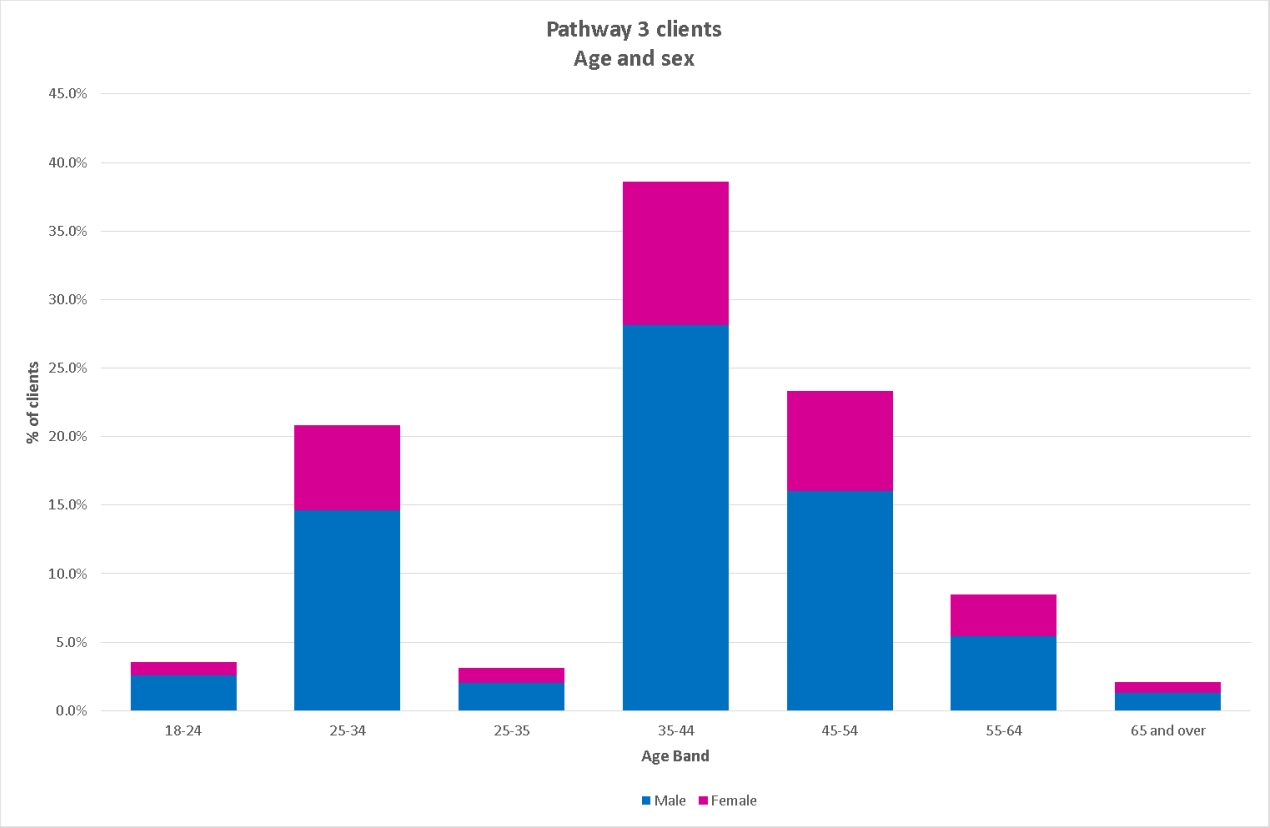


Table 7: Parental status of adults in Phase 3

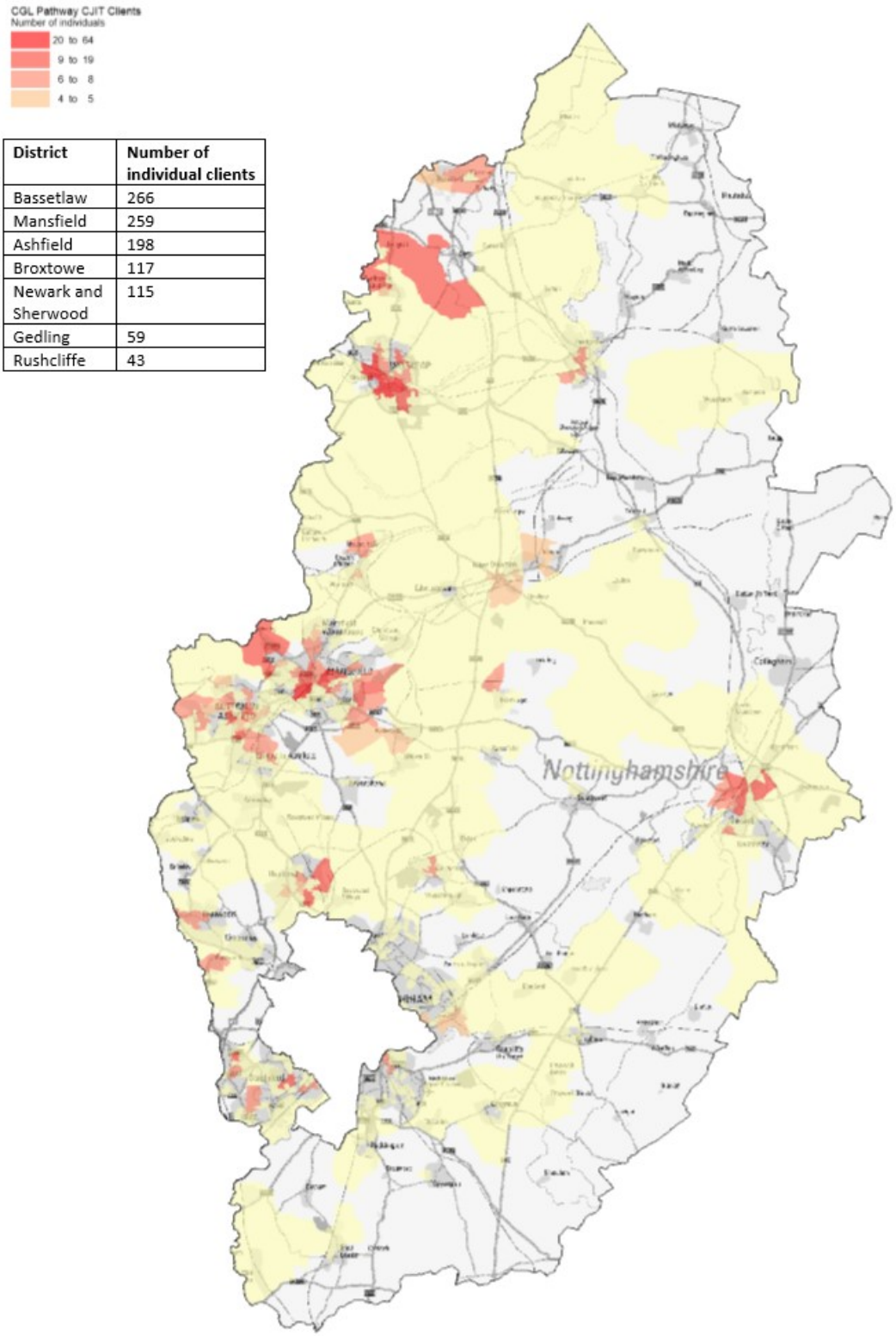
Parental Status	Total
All the children live with the client	16.33%
Client declined to answer	0.31%
None of the children live with client	25.51%
Not a parent	54.20%
Some of the children live with client	3.66%
Grand Total	**100.00%**

Individuals in substance misuse treatment who were also in the criminal justice system

22% of the in-service treatment population are also in the criminal justice system (1057 of 4832). Of those who have been in treatment for 4 years or more as at the end of June 2018, 48.5% were criminal justice clients. Numbers by district are detailed in Figure 6. 46% were parents, with 18% living with children (table 10). The hotspot wards are:

- Worksop North West
- Worksop South
- Worksop South East
- Portland Ward

Figure 6: Number of adults in substance misuse services who were also in the criminal justice system by district



District	Number of individual clients
Bassetlaw	266
Mansfield	259
Ashfield	198
Broxtowe	117
Newark and Sherwood	115
Gedling	59
Rushcliffe	43

Table 8: Referral sources for clients who are in substance misuse services and the criminal justice system

Referral Source	Total	% of total	Cumulative %
Drug Service Statutory	437	41.3%	41.3%
Prison	198	18.7%	60.1%
DRR	100	9.5%	69.5%
Criminal Justice - other	94	8.9%	78.4%
Probation	88	8.3%	86.8%
ATR	63	6.0%	92.7%
Arrest Referral	46	4.4%	97.1%
National Probation Service	22	2.1%	99.1%
Community Rehabilitation Company (CRC)	5	0.5%	99.6%
DIP	4	0.4%	100.0%
Grand Total	1057	100.0%	

Table 9: Adults in Phase 3 by age and gender

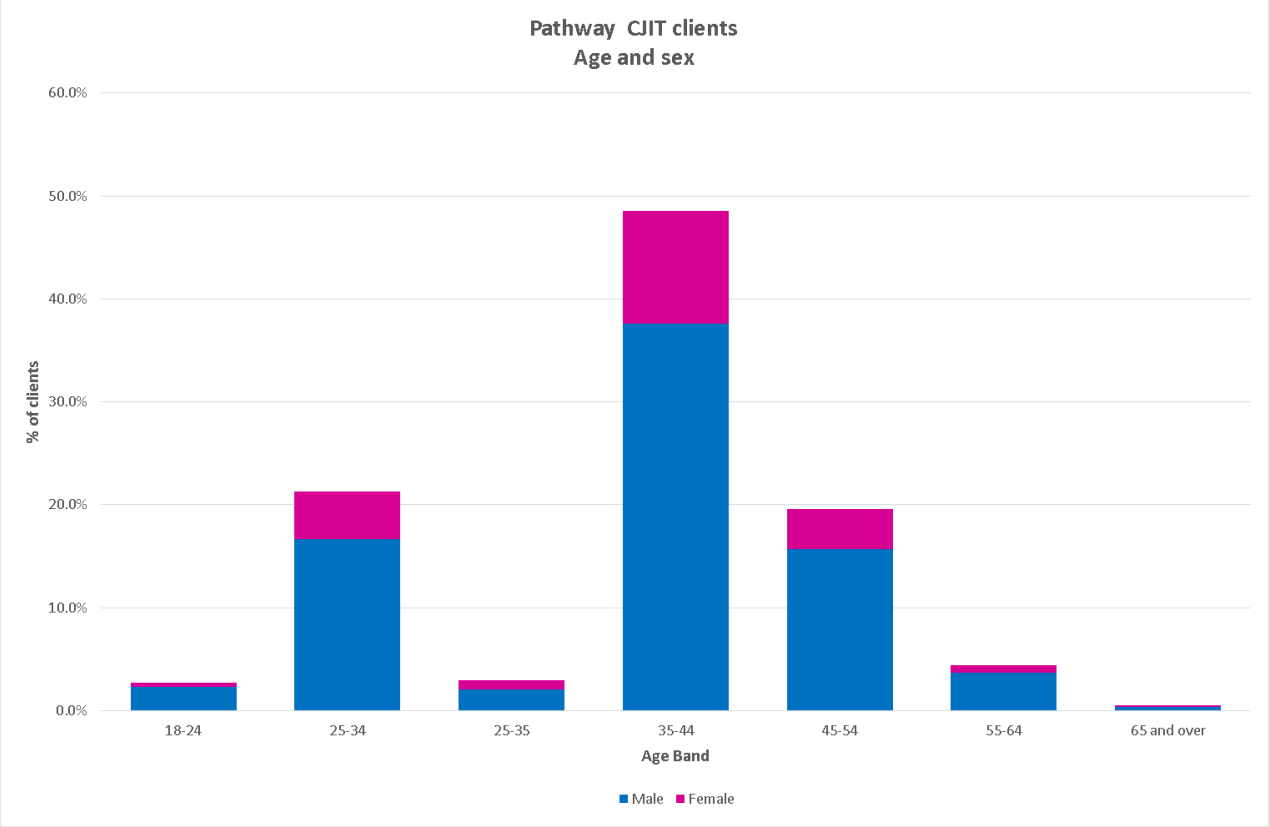


Table 10: Parental status of clients who are in substance misuse services and the criminal justice system

Parental Status	Total
All the children live with the client	14.29%
Client declined to answer	0.38%
None of the children live with client	28.10%
Not a parent	53.55%
Some of the children live with client	3.69%

APPENDIX J
Key documents regarding 'what works' for substance misuse

There is a large body of evidence and research relating to 'what works' for substance misuse treatment. National policy outlines the strategy and direction of substance misuse treatment focus and delivery, such as Drug Strategy 2010 - Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life (HM Government, 2010) and The Government's Alcohol Strategy (HM Government, 2012). Key documents are outlined below.

Young People:

- A public health approach to promoting young people's resilience 2016 (Association for Young People's Health 2016)

- International Standards on Drug Use Prevention (United Nations Office on Drugs and Crime 2015)

- You're Welcome - Quality criteria for young people friendly health services (DH, 2011): Specific guidance in relation to ensuring services are designed to be young people friendly, welcoming and accessible

- Practice standards for young people with substance misuse problems (CCQI, 2012): These standards bring together guidance based on the available evidence and emphasise the need for a sensitive, non-judgemental and collaborative approach to identifying risk, assessing all needs, and offering help and support.

- There is a strong evidence base for safeguarding and child protection, placing great emphasis on the importance of multi-agency working and information sharing and building upon existing individual and family strengths to increase resilience and protective factors. The below are key national safeguarding and child protection documents:
    - The Munro Review of Child Protection: A child-centred system (DfE, 2011)
    - Hidden harm report on children of drug users (ACMD, 2011)
    - Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children (HM Government, 2013)
    - Signs of Safety in England - An NSPCC commissioned report on the Signs of Safety model in child protection (NSPCC, 2013)
    -
- Evidence-based approaches to working with children and young people include:
    - Issues in Earlier Intervention - identifying and supporting children with additional needs (Department for children, schools and families, 2010)
    - Every child matters (HM Government Green Paper, 2003)
    - Five Ways to Wellbeing (the new economics foundation, 2008)

- College Centre for Quality Improvement – Practice Standards for Young People with Substance Misuse Problems (2012)
- Institute of Alcohol Studies – Children, adolescents and underage drinking factsheet (2013)
- National Treatment Agency for Substance Misuse – Moves to provide greater protection to children living with drug addicts (2009)

- National Treatment Agency for Substance Misuse – The Role of CAMHS and Addiction Psychiatry in Adolescent Substance Misuse Services
- NICE – Alcohol-use disorders: preventing harmful drinking (2010)
- NICE – Drug Use Disorders (2012)
- NICE – Interventions to reduce substance misuse amongst vulnerable young people (2007)
- NICE – Reducing Substance Misuse among Vulnerable Children and Young People Overview (2014)
- NICE – School based interventions on alcohol (2007)
- NICE – Tackling Drug Use (2014)
- Public Health England – Specialist Substance Misuse Treatment for Young People in England 2013-14 (2015)
- Public Health England – The International Evidence on the Prevention of Drug and Alcohol Use; summary and examples of implementation in England (2015)
- Public Health England – Young People's Hospital Alcohol Pathways; support pack for A&E departments (2014)
- Young People's Health Partnership – Young People and Substance Misuse (2015)

Alcohol

There is a body of evidence around effectiveness in alcohol interventions including new guidance published by the National Institute for Health and Clinical Excellence:

- NICE public health guidance 24 (2010): Alcohol-use disorders: preventing the development of hazardous and harmful drinking. This guidance covers the prevention and early identification of alcohol-use disorders among adults and adolescents. Its recommendations cover:
  - licensing practices
  - supporting children and young people aged 10-15
  - appropriate screening and treatment for 16-17 year olds
  - appropriate screening and treatment for adults

- NICE clinical guideline 100 (2010): Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications. This guidance covers key areas in the investigation and management of the following alcohol-related conditions in adults and young people (aged 10 years and older):
  - Acute alcohol withdrawal, including seizures and delirium tremens;
  - Wernicke's encephalopathy;
  - Liver disease;
  - Acute and chronic pancreatitis.

- NICE clinical guideline 115 (2011): Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. This guidance covers principles of care, identification and assessment and interventions for alcohol misuse.

- NICE Quality Standard for Alcohol (2011): The alcohol dependence and harmful alcohol use quality standard defines clinical best practice within this area. It covers the care of children (aged 10-15 years), young people (aged 16-17 years) and adults (aged 18 years and over) drinking in a harmful way and those with alcohol dependence in all NHS-funded settings. It also includes opportunistic screening and brief interventions for hazardous and harmful drinkers.

- Review of the effectiveness of treatment for alcohol problems *Raistrick et al 2006*: This outlines the evidence base for screening, brief interventions, less-intensive alcohol treatments, specialist treatment, detoxification and self-help.

- NICE guidance PH7 for alcohol: This guidance on school based interventions on alcohol describes the role of schools in education and brief advice to prevent alcohol misuse. It is currently being reviewed and is due to be published in August 2019.

Other key guidance documents include:

- Models of Care for Alcohol Misusers (DH 2006): This provides best practice guidance for health organisations in delivering an integrated local treatment system and sets out a tiered approach for alcohol interventions

- Signs for improvement: Commissioning interventions to reduce alcohol-related harm (DH 2009): This publication describes how organisations should be commissioning interventions to reduce alcohol-related harm. It includes some evidence base for the 7 high impact changes

- Alcohol Public Health Burden Evidence Review (Public Health England, 2016)

Drug Use (Adults)

- Commissioning for recovery: drug treatment, reintegration and recovery in the community and prisons (NTA, 2010)
- Department of Health guidance *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health, 2007)
- Building Recovery in Communities: Public Health England 2012
- A Summary of the Health Harms of Drugs, (Department of Health, 2011)
- Hepatitis C: guidance, data and analysis (PHE 2013)
- Improving Access to Mutual Aid: Public Health England 2014
- A Guide to Community-centred Approaches for Health and Wellbeing: Public Health England 2015
- Five Ways to Wellbeing (the new economics foundation, 2008)

NICE clinical guidelines such as:

- Drug Misuse: Psychosocial Interventions
- Drug Misuse: Opioid Detoxification
- Drug Misuse: methadone and Buprenorphine
- Public Health Guidance on Needle and Syringe Programmes *http://www.nice.org.uk/guidance/cg/published/index.jsp?p=off*

National policy and frameworks set the context within which substance misuse is tackled in Nottinghamshire. There is a focus on early intervention for young people and on achieving and sustaining recovery from substances for adults, with a strong focus locally on safeguarding and child protection. NICE guidelines are embedded within commissioned services and contracts.

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APPENDIX K
Substance misuse services and their contribution to other PHOF outcomes

There are many factors that influence public health over the course of a lifetime. They all need to be understood and acted upon. Integrating public health into local government is allowing that to happen – services will be planned and delivered in the context of the broader social determinants of health, like poverty, education, housing, employment, crime and pollution (ref). The framework focuses on two high-level outcomes which span across the whole public health system and beyond. These are:

- Outcome 1: increased healthy life expectancy;
- Outcome 2: reduced differences in life expectancy and healthy life expectancy between communities.

In addition, the PHOF comprises a set of supporting indicators to cover the full spectrum of what Public Health represents and work towards. These indicators are grouped into four domains:

- improving the wider determinants of health;
- health improvement;
- health protection;
- healthcare public health and preventing premature mortality.

In this context, timely access to substance misuse treatment is one way of reducing health inequalities across many of Public Health indicators because it:

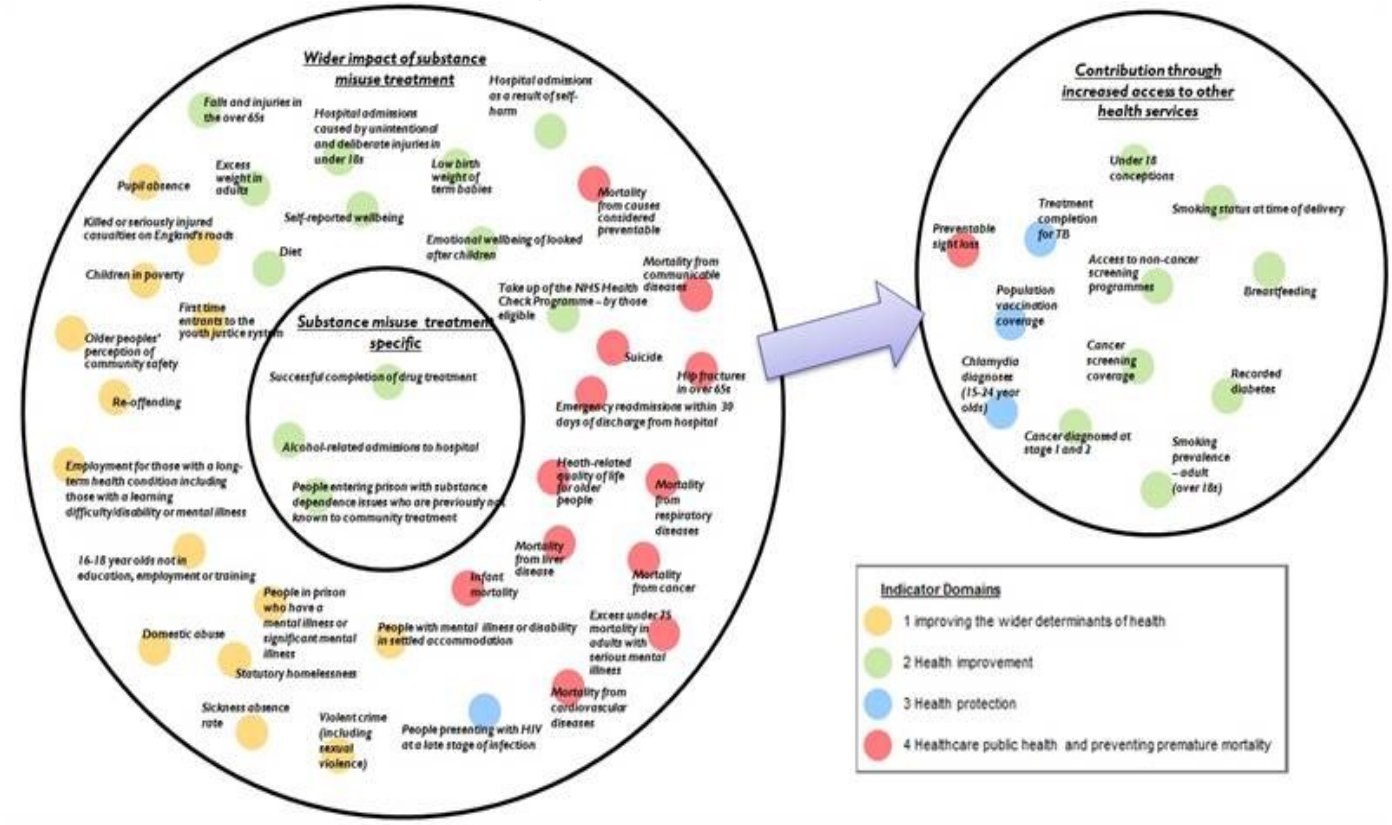
- Supports Public Health Outcomes Framework (PHOF) vision:
    - To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.

- Impacts directly on both of the PHOF outcomes:
    - Increased life expectancy
    - Reduced differences in life expectancy and healthy life expectancy between communities.

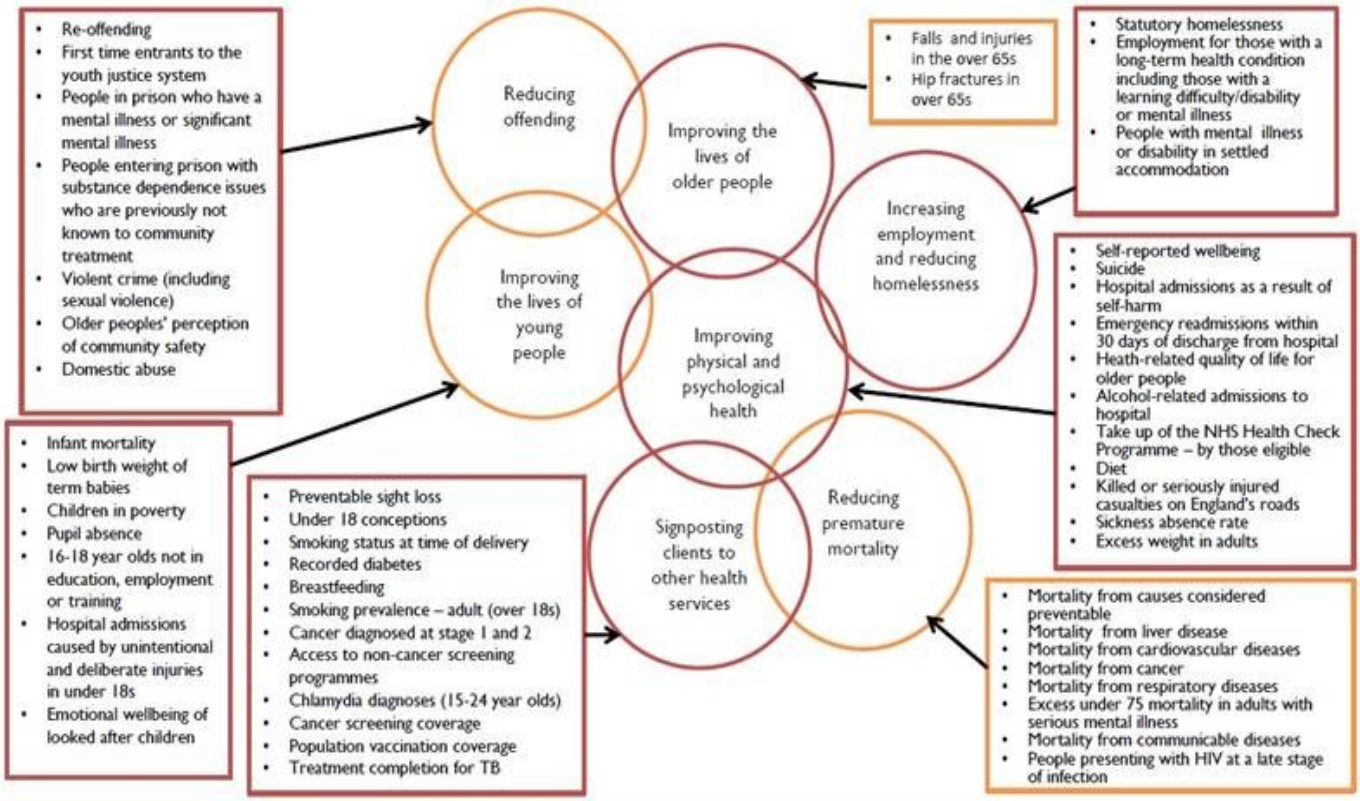
- Contributes to many of the outcome indicators:
    - Substance misuse treatment contributes to over half of the PHOF outcome indicators (ref).

In addition to the 3 substance misuse-specific PHOF indicators, effective substance misuse services contribute to the following non-substance misuse-specific PHOF indicators:

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The indicators to which substance misuse services contribute naturally cluster into 7 overlapping themes:



This demonstrates that commissioning effective substance misuse services contributes towards many positive health and wellbeing outcomes in the local community.

Evidence of how substance misuse impacts on other public health outcomes is detailed below:

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators	Evidence
1.5 16-18 year olds not in education, employment or training	16-18 year olds not in education, training and employment (NEET) are more likely to engage in drug abuse and have physical and mental health problems. Of those entering services in 2011-12, 20% were not in education or employment.[8] Data indicates that specialist interventions could potentially reduce the proportion of young people that are NEET by 6.5%. Using estimates of the lifetime cost of being NEET, a 6.5% reduction in the proportion that are NEET leads to a total lifetime benefit for young people of the equivalent to £6,590 per person. [9,10] For instance 13% of 16 to 18 year old non-participants in education and employment are dependent on alcohol compared with 5% of participants[11] and 77% of under 18s treated for substance misuse dependence in 2011-12 completed treatment and overcame their dependence.[12]
1.6 People with mental illness or disability in settled accommodation	A significant association between mental illness and drug addiction is well evidenced.[13] Many people come into drug treatment with no fixed abode , but the housing situation of those who receive drug treatment improves (see 1.15). [14,15,16]
1.7 People in prison who have a mental illness or a significant mental illness	A strong association between mental illness and drug addiction is well evidenced. [17] Treating someone's drug addiction and mental illness which can reduce the people's offending[18] which is a associated with their mental illness and/or drug use and therefore their likelihood of going to prison.
1.8 Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness	A significant association between mental illness and drug addiction is well evidenced. [19] Drug treatment is associated with an increase in the number of days worked. [20]
1.9 Sickness absence rate	Lost productivity due to alcohol is estimated to be £7.3bn a year.[21] The International Labour Organisation estimates that, globally, 3-5% of the average workforce are alcohol dependent, and up to 25% drink heavily enough to be at risk of Dependence.[22] Up to 17m working days are lost annually due to alcohol-related absence.[23] Effective alcohol treatment is known to reduce alcohol dependence which could then have a knock on effect on sickness absence.

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Indicators	Evidence
1.10 Killed or serious injured casualties on England's roads	There are 430 deaths and 1600 serious injuries every year which are attributable to drink driving [24] and in 2010, impairment by drugs (both illicit and medicinal) was reported as a contributory factor in 1,094 casualties, including 51 deaths. [25] Alcohol Related Road Traffic Mortality is part of the Local Alcohol Profiles for England.
1.11 Domestic abuse	There is a strong association between domestic violence and drug and alcohol abuse.[26,27] 92% of domestic abuse assailants reported use of alcohol or other drugs on the day of the assault, according to a recent JAMA report.[28] Some studies also suggest that people are more likely to be victims of domestic abuse if they use alcohol[29] and that victims of domestic abuse are more likely to misuse substances.[30] It makes sense therefore that substance misuse treatment can be one of the factors that help to reduce the incidents of domestic violence.
1.12 Violent crime (including sexual violence)	Violence connected to the drug market is significant, including gang related violence and robbery.[31,32] A minimum of 1 in 5 people arrested by police for violent crime test positive for alcohol.[33] An All Party Group of MPs investigating alcohol and crime[34] was advised by the British Medical Association that alcohol is a factor in: 60-70% of homicides; 75% of stabbings; 70% of beatings; and 50% of fights and domestic assaults . Treatment reduces offending behaviour and sustains this change.[35,36,37]
1.13 Re-offending	Drug and alcohol related crime is estimated to cost £25bn a year. [38,39] Structured treatment reduces offending behaviour and sustains this change. [40,41,42] Drug treatment prevented an estimated 4.9m crimes in 2010-11.[43,44]
1.15 Statutory homelessness	Between $^1/_3$ and $^2/_3$ of homeless people have a drug addiction.[45] Outcomes research has suggested that 64% of those entering drug treatment as NFA are housed during treatment.[46]
1.19 Older people's perception of community safety	Drug related acquisitive crime is a significant problem (see 1.13) which can potentially impact on older people's perception of community safety. Reductions in violence, burglary, robbery and other crimes as a result of drug treatment may improve older people's sense of security within their communities. As could the reduction in visible drugs markets, e.g. drug dealing and prostitution and alcohol related crime and anti social behaviour.

2 Health Improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators	Evidence
2.1 Low birth weight of term babies	Drug and alcohol use may be associated with risk factors for low birth weight of term babies.[47, 48] 10% of children of alcohol-dependent mothers suffer from foetal alcohol effects.[49] Effective alcohol treatment is known to reduce alcohol dependence which could in turn could prevent low birth weight of term babies.
2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s	There were 24,673 alcohol related admissions for under 18 years olds in 2010-11.[50] Treating young people can potentially reduce hospital admissions for under 18s. Of the 130 serious case reviews relating to children (some of which would involve injuries) under one in England and Wales (Jan 2008 – Sept 2011), substance misuse was a factor in at least 46 cases.[51] Treating parents can have an impact on family wellbeing which may reduce the likelihood of child abuse and accidents in children.
2.8 Emotional wellbeing of looked-after children	7% of all young people who are receiving young peoples' specialist substance misuse interventions are looked after children.[52] A CAMHS review suggested that parental substance misuse and criminality are a risk factor for looked-after children developing diagnosable mental health problems.[53] We know from the Treatment Outcomes Profile (TOP) that the mean psychological health score for young people increased by 22% during treatment.[54] From Oct 2013 changes in young peoples' emotional wellbeing will be collected on National Drug Treatment Monitoring System (NDTMS).
2.10 Hospital admissions as a result of self-harm	A significant proportion of self harm is associated with drug use[55] and alcohol use. Drug treatment improves wellbeing and reduces incidents of self harm.[56] RCPSYCH state that the risk of suicide is higher if people are depressed, or have a serious mental illness and use drugs or alcohol when they are upset. Intentional self harming is recorded as an alcohol related hospital admission - please see indicator 2.18.
2.15 Successful completion of drug treatment	The number of people successfully completing treatment is increasing year on year. [60,61]

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Indicators	Evidence
2.11 Diet	When people are regularly misusing drugs it can effect their diet. People may eat less often and eat more unhealthy food. Treatment can help people to recover from their dependency[57] and when they do so their interest in eating more frequently and healthily can increase. [58]
2.12 Excess weight in adults	Body Mass Index (BMI) of individuals who drink alcohol may be related to how much, and how often, they drink, according to a new study by researchers at the National Institutes of Health's National Institute on Alcohol Abuse and Alcoholism (NIAAA).[59] This can contribute to excess weight in adults. Alcohol treatment could therefore be associated with a reduction in excess weight in adults.
2.16 People entering prison with substance dependence issues who are previously not known to community treatment	Improved access to drug treatment ensures that an increased number of offenders entering prison and the secure estate are previously known to community treatment.
2.18 Alcohol related admissions to hospital	The evidence suggests that a dependent drinker costs the NHS twice as much other drinkers and that the largest and most immediate reduction in alcohol-related admissions can be delivered by intervening with this group through the provision of specialist treatment.[62,63]
2.22 Take up of the NHS Health Check programme - by those eligible	The Alcohol Strategy (2012) states: *The Department of Health will include alcohol identification and any subsequent brief advice needed within the NHS Health Check for adults from age 40 to 75 for the first time from April 2013.* This is direct identification of alcohol harm and provision of alcohol brief advice and onward referral where necessary.[64]

Indicators	Evidence
2.23 Self-reported wellbeing	Structured substance misuse treatment programmes and subsequent abstinence improves psychological wellbeing and reduces symptoms in those with psychiatric disorders.[65, 66] Accessing drug & alcohol treatment improves access to and effectiveness of mainstream mental health and psychological therapy services.[67]
2.24 Falls and injuries in the over 65s	RCPSYCH notes: balance gets worse with age - even a small amount of alcohol can make you more unsteady and more likely to fall. Alcohol and substance misuse appears to be on the increase in older adults and this may be a contributing factor to falls and injuries in this age group.[68] Effective alcohol treatment is known to reduce alcohol dependence which could then have a knock on effect in reducing falls and injuries in the over 65s.

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators	Evidence
3.4 People presenting with HIV at a late stage of infection	Substance misuse carries a risk of HIV infection.[69,70] This has been significantly reduced in the last 20 years due to harm reduction methods used during substance misuse treatment programmes, including needle and syringe provision and opioid substitution treatment.[71,72] HIV-positive injecting drug users who are aware of their status are known to report less risky behaviours than those untested or not infected. [73,74]

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities.

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Indicators	Evidence
4.1 Infant mortality	Among term infants, intake of at least 4 drinks of alcohol per week or binging on 3 or more occasions during pregnancy are associated with an increased risk of infant mortality, especially during the post neonatal period. Reducing alcohol consumption in pregnancy can reduce infant mortality.[75] Effective alcohol treatment is known to reduce alcohol dependence which could in turn reduce infant mortality.[76]
4.3 Mortality from causes considered preventable.	The majority of preventable causes of death (as considered by WHO) are associated with substance misuse.[77] Problematic alcohol use associated with many preventable chronic health problems (therefore treatment potentially lessens this) e.g. liver disease, cardio vascular illnesses, diabetes, gastric disorders. *Systematic reviews estimate annual death rates from opioid misuse of about 1%, which is more than 10 times that of the general population and contributes more than 10% of adult mortality.* Substance misuse treatment can reduce mortality risk. [78] For instance over 300 deaths were estimated to be prevented by drug treatment in 2010-11 with a value of life of over £500m.[79]
4.4 Mortality from all cardiovascular diseases (including heart disease and stroke)	Prolonged misuse of alcohol and other substances is thought to be a predictive factor associated with cardiovascular diseases. [80,81] Treatment may reduce this. Hypertension is recorded as an alcohol related hospital admission - please see indicator 2.18.
4.5 Mortality from cancer	Substance misuse, in particular alcohol, has been implicated as a causal factor associated with several types of cancer.[82] This figure may reduce with treatment. Certain cancers are recorded as an alcohol related hospital admission - please see indicator 2.18.
4.6 Mortality from liver disease	*Liver disease causes approximately 2% of all deaths in England. While other major causes of death are falling, the number of people who die from liver disease is rising and younger age groups are disproportionately affected.*[83] 37% liver disease deaths are alcohol induced and this is increasing in the UK,[84-89] 3% viral hepatitis.[90,91] Heroin, inhalants and steroids can also cause liver damage.[92] Substance misuse treatment can improve the health of patients and save the NHS money.[93] Alcoholic liver disease is recorded as an alcohol related hospital admission - please see indicator 2.18. Increasing treatment of hepatitis C positive current or ex-injectors is clinically effective and cost-effective[94,95], and so would be likely to impact on rates of end-stage liver disease related to hepatitis C, which are increasing.[96]

Indicators	Evidence
4.7 Mortality from respiratory diseases	Substance misuse can lead to a number of respiratory diseases and complications. [97,98] Treatment of drug addiction may reduce the effects on the respiratory system.
4.8 Mortality from communicable diseases.	Infectious diseases such as HIV, hepatitis B and C, and tuberculosis are associated with drug use. Blood-borne viruses are one of the primary causes of mortality in injectors. [99] Treatment services have well developed BBV screening which should mean more timely detection and treatment of HIV and Hep infections. Improved self-care and harm reduction education is likely to have an impact on the frequency of communicable diseases and the subsequent improved health may reduce mortality. [100]
4.9 Excess under 75 mortality in adults with serious mental illness	A significant association between mental illness and drug addiction is well evidenced. [101] Substance misuse treatment can reduce mortality risk. [102]
4.10 Suicide	41% of suicides are associated with alcohol misuse,[103] 7% with drug use.[104] RCPSYCH state that the risk of suicide is higher if a young person: is depressed, or has a serious mental illness is using drugs or alcohol when they are upset.[105] Accessing drug & alcohol treatment improves access to and effectiveness of mainstream mental health and psychological therapy services[106] and can therefore potentially reduce suicide.
4.11 Emergency readmissions within 30 days of discharge from hospital	Alcohol treatment, especially hospital based services should help reduce rates of readmissions for patients with alcohol related hospital admissions.[107] DH estimates that homeless people are often discharged too early and use 4 x more acute and 8 x more inpatient health services than the general population.[108,109] There is a strong association between homelessness and substance misuse. This may be reduced with substance misuse treatment.

Indicators	Evidence
4.13 Health related quality of life for older people	Structured substance misuse treatment programmes improve health and subsequent abstinence improves psychological wellbeing . It was estimated that the NHS saved £230m in 2010-11 due to substance misuse treatment.[110] The Drug Treatment Outcomes Research Study (DTORS) found clients' quality of life rating improved when they were in treatment. [111] If people's dependence on drugs and alcohol is addressed when they are younger, they will have better health related quality of life when they are older.
4.14 Hip fractures in over 65s	RCPSYCH notes: balance gets worse with age - even a small amount of alcohol can make you more unsteady and more likely to fall. Alcohol and substance misuse appears to be on the increase in older adults and this may be a contributing factor to falls and injuries in this age group.[112] Effective alcohol treatment is known to reduce alcohol dependence which could then have a knock on effect in reducing falls and injuries in the over 65s.