

Substance Misuse

Summary

- National surveys of school pupils have found that the proportion of 10-15 years olds who have ever taken drugs decreased to 27% in 2011 from 48% in 2001. The main drugs used by 10-15 years olds were cannabis and glue, gas aerosols and solvents.
- The crime survey for England and Wales suggests that the proportion of the adult population that has ever taken drugs is 36.5%, the proportion reporting taking drugs in the last year fell from 12% in 2001/02 to 8.9% in 2011/12.
- Nationally, mortality rates are higher in people addicted to heroin and people who inject heroin. Those that die are more likely to be white, over 35 years and male with a history of drug addiction.
- There were 13,268 admissions for substance misuse from 2009/10 to 2011/12 in Hampshire. The highest rates were seen in Rushmoor, Havant and Gosport districts and associated with deprivation.
- In 2011/12 2,134 people received structured treatment services in Hampshire; 80% of people in treatment stated that their main substance was heroin, methadone or other opiates. It is estimated that 55% (95% CI 38.6%, 95.9%) of opiate/crack drug users are in or know to treatment.
- There is good effectiveness to support prevention and treatment of drug dependence and NICE has published a set of quality standards for drug treatment services.

Recommendations

- Focus services for young people and schools in areas where there is a higher risk of people developing drug dependence.
- Undertake further analysis of hospital admissions for drug dependence to determine the reason for recent increases in admissions.
- Explore barriers to and opportunities for increasing the uptake of Hepatitis C testing to increase uptake to at least the national average.
- Consider the feasibility implementing Naloxone training for carers of people at risk of fatal overdose.
- Ascertain why there is still a significant proportion of people in treatment for >6 years locally with high frequency of re-attendance to services after discharge.
- Nationally the most popular drugs for 20-24 years olds are ecstasy, mephedrone and powder cocaine. The implications of this longer term change in drug use for treatment services should be explored to ensure that local services continue to address needs.
- Review emerging evidence and respond promptly to mitigate the harmful impact of the new psychoactive substances.

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1. Introduction

A recent review of the global burden of disease identified that deaths from drug use disorders and disability from drug dependence has risen greatly in the last twenty years in the UK and deaths from alcohol and drugs in the 20-54 year age group 'overshadowed' health gains made from cervical cancer screening and road injury reduction. Substance misuse was also cited as an important cause of years lived with disability in the UK population.¹

While people may take illicit substances without any effect on their health, this is not the case for a proportion of people for whom their drug use becomes problematic with negative physical, psychological, social and financial consequences for them and those around them.² Problematic drug use is most commonly seen with increased frequency and high dosage.³ In the UK problematic drug use is defined as the use of crack cocaine and/or opiates, as use of these drugs causes the most harm in terms of health and other social harms such as acquisitive crime and educational outcomes.⁴

In 2010 the government published a drugs strategy 'Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life.' This moved policy from reducing harm resulting from drug use to encouraging recovery. The strategy had two overarching aims: to reduce illicit and other harmful drug use and to increase the numbers recovering from their dependence.⁵

Substance misuse encompasses the misuse of alcohol, illegal drugs and prescription drugs. This chapter focuses on illicit drug use.

2. Level of need in the population

Estimating the prevalence of drug use and problematic drug use in the Hampshire, or indeed any population is difficult due to the illegality of possession and supply of illicit drugs and the social stigma attached to drug addiction. Much of the evidence is only available at a national level, therefore may be limited value when applied locally.

2.1 Use of illicit drugs and trends in young people aged 10-15 years

According to an annual survey of school pupils in England the proportion of 15 year olds who have ever taken drugs was 27% in 2011. The proportion of 10-15 year olds who have taken drugs in the last month or last year decreased over the last decade (Figure 1). At all

¹ Murray CJ, Richards MA, Newton JN et al. UK health performance: findings of the Global Burden of Disease Study 2010. The Lancet.

² Advisory Council on the Misuse of Drugs 2003, p.7

³ Bonomo Y, Proimos J. Substance misuse: alcohol, tobacco, inhalants, and other drugs. BMJ 2005: 330; 777-780.

⁴ Cave J, Hunt P, Ismail S et al. 2009. Tackling problem drug use. National Audit Office. 2009 Downloaded on 28th March 2013 http://www.nao.org.uk/wp-content/uploads/2010/03/0910297_reviews.pdf

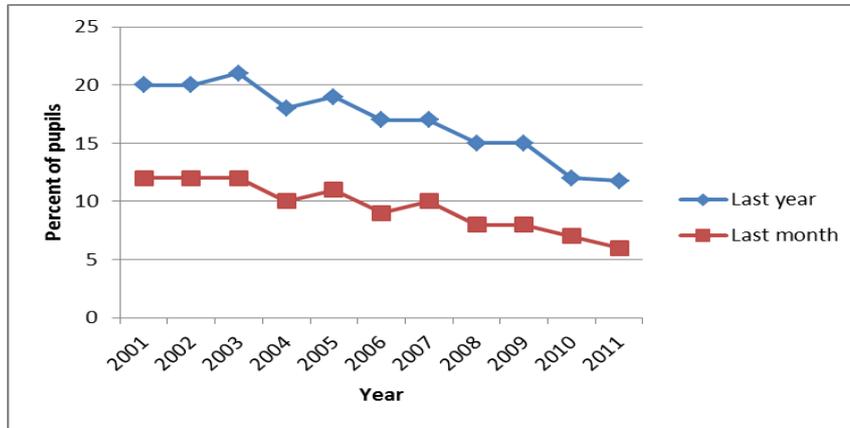
⁵ HM Government. Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life. HM Government 2010.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

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ages boys were more likely than girls to have ever taken drugs and taken drugs in the last year than girls although these differences were not statistically significant.⁶

Figure 1: Reported drug use in school pupils aged 10-15 years 2001-2011



The main drugs used by 10-15 year olds in the last year were cannabis (7.6%) and glue, gas aerosols and solvents (3.5%). Drug type was associated with age; pupils aged 11-13 were more likely to take glue, gas aerosols and solvents, with those aged 14-15 more likely to use cannabis. A small proportion (2.4%) of pupils reported using a class A drug in the last year.

The young people who reported frequent drug use of more than once a month were more likely to be using Class A drugs. Problematic drug use in this age group is uncommon. In 2011 only 0.2% of girls and 0.5% of boys reported using crack cocaine in the last year. These figures were 0.5% and 0.8% for opiates. Applying these figures to Hampshire, it can be estimated that 4,415 young people aged 11-15 years have taken drugs in the last month.

A smoking survey conducted on 11-16 year olds attending Hampshire schools asked pupils about cannabis use. This survey showed (Table 1) that the majority of pupils surveyed had never tried cannabis, but a small minority stated that they often smoked cannabis.⁷ It should be noted that there was some bias in the sampling.

⁶ Fuller E (ed). 2012. Smoking, drinking and drug use among young people in England in 2011. NHS Information Centre. Downloaded on 22nd March 2013 from <http://www.ic.nhs.uk/article/2021/Website-Search?productid=7911&q=drug+use&sort=Relevance&size=10&page=1&area=both#top>

⁷ Tyler, R, 2013, Tobacco and cannabis use among school-aged children in Hampshire 2012 – 2013, University of Portsmouth

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Table 1: Response to question ‘Which sentence about smoking cannabis describes you best

	Number and percent
I have never smoked, not even a puff	3670 (89.1%)
I have tried smoking once or twice but do not smoke now	196 (4.8%)
I smoke every now and then (less than once a week)	85 (2.1%)
I often smoke (once or more a week)	119 (2.9%)
Total	4117

2.2 Use of illicit drugs and trends overtime in adults

Figures from the annual Crime Survey for England and Wales give an indication of the use of illicit drug use in the adult population.⁸ The proportion of the population aged 16-59 years who reported ever taking drugs rose from 30.5% in 1996 to 36.5% in 2011/12.⁹ However, reported recent drug use fell over the last decade. Frequent drug use, defined as taking drugs more than once a month in the last year, was reported by 3.3% of respondents in 2011/12.

Recent drug use is strongly associated with age. Whilst 19.6% of 16-19 year olds reported taking drugs in the previous year, only 1.85% of 55-59 year olds did. Cannabis was the most used drug overall, however a higher proportion of 20-24 year olds reported taking other drugs such as powder cocaine, ecstasy and amphetamines than any other age group. Men are more likely to have ever taken drugs, to have taken drugs in the last year and last month than women.¹⁰ Pooled data from this survey showed that prevalence of Class A drug use was highest among White and Mixed ethnic groups. Adults from Asian or Asian British had the lowest levels of last year drug use, whereas levels of last year drug use were highest in those of White or Mixed groups.¹¹

⁸ This survey excludes people who are homeless or in temporary accommodation.

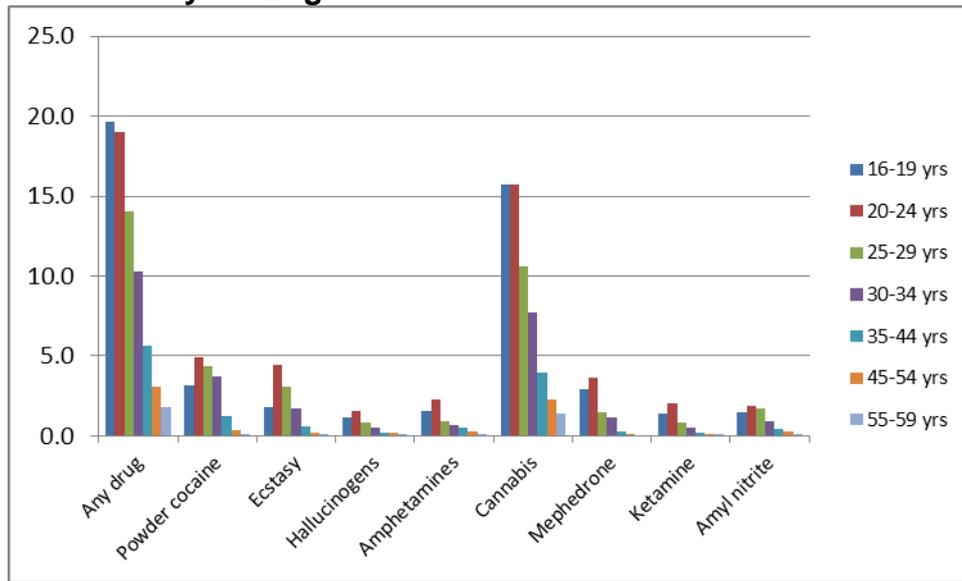
⁹ The Home Office. Illicit drug use among 16-59s tables Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales. Data table downloaded on 4th March 2013 from <http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/drugs-misuse-dec-1112-tabs/extent-adult-tabs>

¹⁰ The Home Office. Drug misuse declared: findings from the 2011 to 2012 Crime Survey for England and Wales (CSEW) (second edition). September 2012. <https://www.gov.uk/government/publications/drug-misuse-declared-findings-from-the-2011-to-2012-crime-survey-for-england-and-wales-csew-second-edition/drug-misuse-declared-findings-from-the-2011-to-2012-crime-survey-for-england-and-wales-csew-second-edition#extent-and-trends-in-illicit-drug-use-among-adults-aged-16-to-59>

¹¹ The Home Office. Illicit drug use among 16-59s tables Drug Misuse Declared: Findings from the 2009/10 Crime Survey for England and Wales. July 2010. <http://webarchive.nationalarchives.gov.uk/+http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/drugs-alcohol-research/hosb1310/hosb1310?view=Binary>

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Figure 2: Report drug use in previous year in adults aged 16-59 years 2011/12, by age and drug. Crime Survey for England & Wales



The latest Glasgow prevalence estimates suggest that there were 4,088 (95% CI 2344, 5815) people using opiates/and or crack cocaine in Hampshire in 2010/11. This is a slight decrease from the previous estimate of 4203 in 2008/09.

2.3 New psychoactive substances (NPSs)

New psychoactive substances (NPSs) are substances of abuse that are not controlled by existing legislation but which may pose a health threat. The development and use of these drugs signals a significant change to the drug market. There is an increasing range of NPSs that have diverse origins, effects and risk profiles.¹² In 2008 there were 12 types of NPS reported to be available which rose to 73 by 2012. The number of deaths attributed to NPS increased from 1 in 2001 to 28 in 2011.¹³ Some NPSs can be easily purchased from internet sites and shops and purport to be 'legal highs'. While data are lacking on the use of these substances, Mixmag in the UK has carried out internet surveys amongst clubbers. These show that the most prevalent NPS used are mephedrone and ketamine.¹⁴

It is difficult to estimate the use of these drugs locally; though anecdotal evidence suggests that in some areas their use is becoming problematic and use has been noted in the 14-18 year age group.

2.4 Risk factors for drug use in young people

There are diverse risk factors associated with drugs misuse in young people. The interaction between which is complex and makes separating out the additional risk posed by each factor difficult. Table 2 gives a summary of risk factors for drug use in young

¹² UNDOC. The Challenge of New Psychoactive Substances. The SMART programme: 2013. http://www.unodc.org/documents/scientific/NPS_2013_SMART.pdf

¹³ Personal communication, Glen Taylor, Head of Coroners and Scientific Services, Hampshire County Council. 12th July 2013

¹⁴ United Nations Office on Drugs and Crime. The challenge of new psychoactive substances. The Global SMART Programme. March 2013.

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people. It is not possible to predict which individuals will move from experimentation to dependent drug use.

Table 2: risk factors for illicit drug use in young people ^{15 16 17}

Demographic risk factors	Personal and family risk factors
Older age	Mental health issues
Male gender	Psychological traits e.g. poor self esteem
Deprivation (problematic drug use)	Early onset substance misuse
	Truancy, drop-out and poor attendance
	Aspects of interpersonal relationships
	Peer drug availability
	Familial substance misuse
	Family cohesion, low parental discipline

2.5 Other drivers and impacts of drugs misuse

2.5.1 Involvement in the criminal justice system

Problem drug use and crime is linked with problem drug users responsible for a large percentage of acquisitive crime. The government states that drug-related crime costs the UK £13.3 billion a year.¹⁸ Drug use in prison is an important public health issue with 51% of prisoners indicating that they are drug dependent and 35% admitting injecting behaviour. One survey reported that 19% of prisoners that had ever used heroine first used it in prison.¹⁹

2.5.2 Social exclusion, deprivation and poverty

There is a clear relationship between drug misuse, poverty and social exclusion. While not all marginalised people become dependent drug users, groups such as the homeless and those in care are at a higher risk. The reasons for this relationship are complex and relate to personal, family and community factors. In addition, changes in housing have led to a concentration of multiple social problems, and drug markets are found in areas with both strong and fragmented links.²⁰

2.5.3 Impact on families

A 2004 survey estimated that 42% of drug users using treatment services had dependent children and 47% of these children lived with their parents. Approximately 9% were in

¹⁵ Fuller E (ed). 2012. Smoking, drinking and drug use among young people in England in 2011. NHS Information Centre. Downloaded on 22nd March 2013 from <http://www.ic.nhs.uk/article/2021/Website-Search?productid=7911&q=drug+use&sort=Relevance&size=10&page=1&area=both#top>

¹⁶ Frisher M, Crome I, Macleod J et al. 2007. Predictive factors for illicit drug use among young people: a literature review. Home Office Online Report 05/07 Downloaded on 22nd March 2013 from <http://www.substancemisuserct.co.uk/staff/documents/rdsolr0507.pdf>

¹⁷ Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive

¹⁸ See <https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence>

¹⁹ Home Affairs Committee Ninth Report. Drugs: Breaking the cycle. December 2012.

²⁰ Shaw A, Egan J, Gillespie M. Drugs and Poverty: A literature review. March 2007. Scottish Drugs Forum.

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care.²¹ Problematic drug use can be associated with child neglect, chaotic home circumstances and exposure to drug use and criminal activity. Parental alcohol/drug problems are implicated in 23% of child protection cases that go to care proceedings and 33% of cases that result in serious injury or death nationally. A number of factors, including having a parent in treatment, can be protective.²² In Hampshire, 532 of 11,571 children in need cases opened by children's social services from July 2012 to June 2013 had the category 'Substance Misuse by Parent/carer' recorded. This is likely to be an underestimation of the true number of children in need where parental/carer substance misuse is an issue and changes in the data capture systems this year should allow a more accurate picture.

2.5.4 Impact of personal, physical and social capital on recovery

National Drug Treatment Monitoring Service Data (NDTMS) confirms that people receiving treatment for drug addiction who have higher levels of recovery capital are more likely to complete treatment successfully. Recover capital refers to social, physical, personal and cultural resources. In practical terms this means enabling clients to have access to secure housing, strong social networks and opportunities for education and employment.

2.5.5 Mortality

Drug related death can result from the acute effects of taking drugs, such as overdose, or from the effects of prolonged drug use. A long-term follow-up of people addicted to heroin found that they had a mortality risk nearly 12 times greater than the general population.²³ Approximately 1% of people who inject drugs die each year of an overdose.²⁴

In 2011 there were 1,605 drug misuse deaths recorded in England and Wales. The majority of these deaths were in males (74.3%). Age and sex specific mortality is highest in males aged 30-39 years, followed by males aged 40-49 years. Mortality rates in younger men are at their lowest levels since records began. The age related patterns of mortality are replicated in females.²⁵ The main drugs implicated in substance abuse deaths were heroin/morphine, methadone and opiates/opioid analgesics. Nearly 30% of deaths occurred in combination with alcohol.²⁶ Nineteen deaths were reported in 2010 and 16 deaths were reported in 2011 for residents in Hampshire. Nearly one-third of cases were attributable to heroin/morphine (n=10), 8 were attributed to methadone, 6 to hypnotics/sedatives and 5 to cocaine.

²¹ Meier et al 2004 in Clever H, Unell 1, Aldgate J. Children's needs parenting capacity. 2nd edition. 2011. London:TSO https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

²² Aldgate J. Children's needs parenting capacity. 2nd edition. 2011. London:TSO https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

²³ Oppenheimer et al, 1994 in Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive

²⁴ NICE.

²⁵ Office for National Statistics. Deaths related to drug poisoning in England and Wales, 2011. August 2012. Office for National Statistics. <http://www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2011/stb-deaths-related-to-drug-poisoning-2011.html>

²⁶ Ghodse H, Corkery J, Schifant F et al. Drug-related deaths in the UK. Annual Report 2011. 2012. International Centre for Drugs Policy: London

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2.5.6 Morbidity

Ill-health from substance misuse can arise from the immediate (acute) effects of drugs and from the longer term use of substances. The impact of drugs use on health depends on a number of factors, including the substance involved, route of administration, purity of the substance and duration of use. A comprehensive assessment of the health effects of individual drugs can be found in 'A summary of the health harms of drug use'.²⁷

2.5.7 Drug use during pregnancy

It has been estimated that 1% of babies are born each year to women with drug problems. Drug use during pregnancy can affect fetal growth and increases the risk of intra-uterine death. Health implications for the infant include severe neonatal drug withdrawal symptoms from exposure to opiates, cocaine and benzodiazepines. There is also a real risk of transmitting blood borne viruses to the infant. Following birth the child may be exposed to multiple risks and hazards, such as poverty, neglect and separation.²⁸

2.5.8 Injecting drug use

Sharing injecting equipment can transmit blood borne viruses and injecting drug use is the most important risk factor for infection with Hepatitis C. The virus causes fatal liver disease in approximately one quarter of people with chronic infections. Data from the Unlinked Anonymous Monitoring (UAM) survey of people who inject drugs (PWID) suggest that 45% were infected with Hepatitis C Virus in England in 2011. The same survey found that 16% of current and former injectors had evidence of a previous Hepatitis B infection and 1.2% of those surveyed were HIV positive. Levels of transmission of HCV have not changed over the last decade.²⁹ Injecting also increases the risk of other infections including localised wound and injecting site infections, systemic infections and sexually transmitted and respiratory infections.^{30 31}

2.5.9 Mental health problems and substance misuse

Dual diagnosis or the co-existence of substance misuse and mental health problems is relatively common.³² One study estimated that three quarters of drug service users had mental health problems and one third of the drug treatment population had multiple morbidity – the co-occurrence of several psychiatric disorders or substance misuse disorders. For people with psychiatric disorders, substance misuse is associated with significantly poorer outcomes than for individuals with a single disorder. These outcomes include worsening psychiatric symptoms, poorer physical health, poor medication

²⁷ Department of Health. A summary of the health harms of drugs. August 2011.

<https://www.gov.uk/government/publications/a-summary-of-the-health-harms-of-drugs>

²⁸ Advisory Council on the Misuse of Drugs. Hidden Harm – Responding to the needs of children of problematic drug users.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf

²⁹ Health Protection Agency. Shooting Up infections among people who inject drugs in the UK 2011. Health Protection Agency. November 2012. http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317136882198

³⁰ European Centre for Disease Prevention and Control and European Monitoring Centre for Drugs and Drug Addiction. Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC; 2011. http://bookshop.europa.eu/is-bin/INTERSHOP.enfinity/WFS/EU-Bookshop-Site/en_GB/-/EUR/ViewPublication-Start?PublicationKey=TQ3011263

³¹ Health Protection Agency. Shooting Up infections among people who inject drugs in the UK 2011. Health Protection Agency. November 2012. http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317136882198

³² Crome I, Chambers P et al. The relationship between dual diagnosis: substance misuse and dealing with mental health issues. Social Care Institute for Excellence. January 2009.

<http://www.scie.org.uk/publications/briefings/files/briefing30.pdf>

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adherence, homelessness, increased risk of HIV infection, greater dropout from services and higher overall treatment costs.³³ Of new clients entering drug treatment in Hampshire in 2012/13, 14% had a dual diagnosis.³⁴

3. Projected service use and outcome in 3-5 years and 5-10 years

It is acknowledged nationally that the population in treatment for opiate and or crack/cocaine use is ageing. A focus on recovery may see fewer clients representing for treatment.

The cohort of ageing drug dependent and ex-dependent people will experience an increase in illness and premature death as a result of their drug use. It is also likely that the effects of chronic Hepatitis C infection will lead to increased illness and the need for health and care services. It has been estimated that 15,840 individuals will be living with HCV-related cirrhosis or hepatocellular carcinoma in England by 2020 if left untreated.³⁵

Although the prevalence of recent drug use has declined in the general population, it is difficult to estimate the needs for health services that result from changes to the nature and type of drug use in younger people. Services will need to cater for clients requiring treatment for non-opiate drugs, including poly-substance misuse. These may represent a different cohort of people with different treatment needs, more stable lives and higher recovery capital.

The impact of the use of new psychoactive substances on healthcare needs is hard to predict and will depend on emerging trends in drug use as well as an assessment of the health risks attached to the use of NPSs both in terms of acute poisoning and longer-term effects.

4. Current services in relation to need

4.1 Primary prevention

Drug, smoking and alcohol education is part of the non-compulsory PHSE curriculum for primary and secondary schools. Some elements of alcohol and drugs education is also part of the compulsory science curriculum.

By March 2011 all schools in Hampshire had reached the National Healthy Schools Standard (NHSS), which included a requirement to have a school drugs misuse policy. Since the NHSS has been localised, only 58 schools have completed a whole school review. This means they will have a policy on drugs education and drugs misuse in school.

Hampshire County Council offers a range of services to support teachers and schools in delivering PHSE around substance misuse including PHSE planning support and training. Information on drugs is also available for young people online through the independent

³³ National Institute for Health and Care Excellence. Psychosis with coexisting substance misuse March 2011. <http://guidance.nice.org.uk/CG120/NICEGuidance/pdf/English>

³⁴ National Drug Treatment Monitoring System. Adult Partnership Performance Report. Quarter 4 Hampshire Partnership

³⁵ Health Protection Agency. Hepatitis C in the UK. 2012. http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317135237219

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government funded www.talktofrank.com and the Scottish government funded <http://choicesforlifeonline.org/>

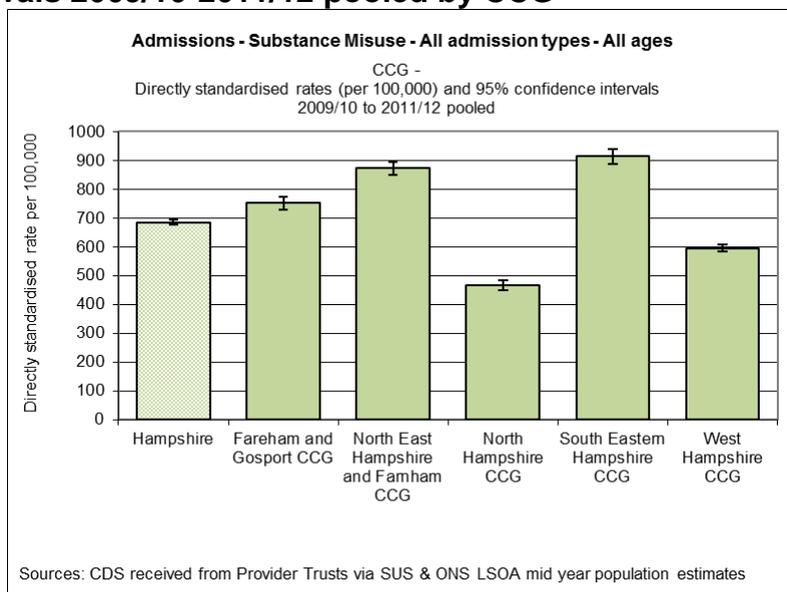
4.2 Health care services

There were 6,173 admissions to hospital for drug-related mental health or behavioural disorders in England in 2011/12. This represents a 23% decrease in the number of such admissions between 2000/01-2011/12. The 25-34 year age group had the largest proportion of admissions (33%) and nearly three times as many men were admitted as women. There were 110 admissions to hospital for drug-related mental health disorder in Hampshire in 2010/11.

There were 12,344 admissions to hospital with primary diagnosis related to drug poisoning in England in 2011/12. This represents an increase of 585 from 2000/01 when there were 7,814 admissions. The highest number of admissions for drug poisoning is found in the 16-24 year age group. There were 241 admissions with a primary diagnosis related to drug poisoning in Hampshire in 2011/12.

Figure 3 shows the rates of admission for substance misuse by CCG for Hampshire.³⁶ There were 13,268 admissions from 2009/10-2011/12 in Hampshire. The highest rates of admission were for people resident in Fareham and Gosport, North East Hampshire and Farnham and South Eastern Hampshire CCGs. The rate of admission has risen substantially between 2010/11 and 2011/12. This will require further analysis but may be due to changes in coding of admissions.

Figure 3: Directly standardised rate of admissions for substance misuse and 95% confidence intervals 2009/10-2011/12 pooled by CCG

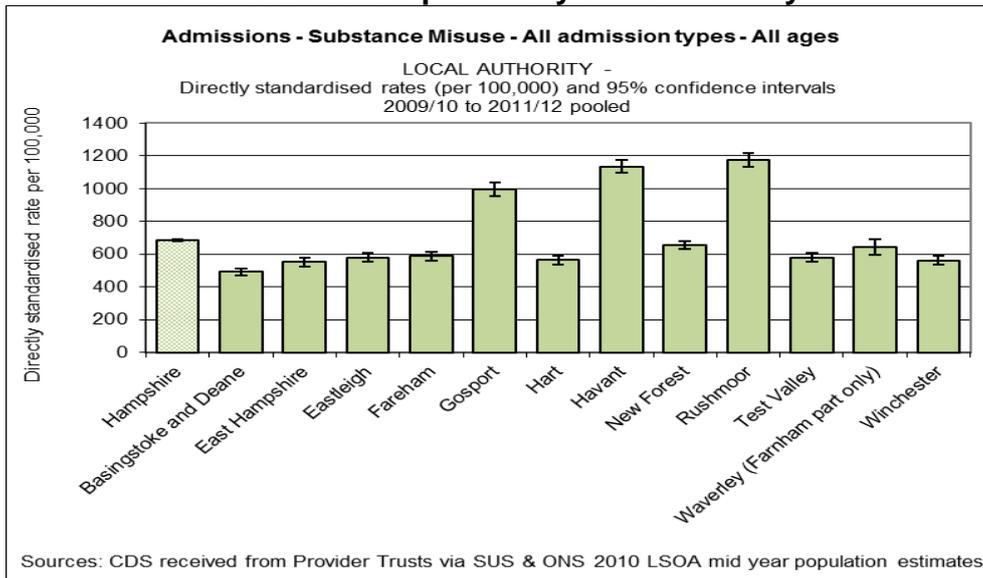


Some of the observed difference may be partly explained by relative deprivation. When admissions are attributed to areas of deprivation there is a linear relationship between rate of admission and deprivation quintile.

³⁶ These data include admissions with a primary or secondary diagnosis of drug poisoning, mental health and behavioural disorders related to substance misuse and poisoning of undetermined intent and is a broader definition than poisoning alone.

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Figure 4: Directly standardise rate of admissions for substance misuse and 95% confidence intervals 2009/10-2011/12 pooled by local authority



4.3 Community drug treatment services – children and young people

Drug treatment services for young people aged 18 or under are currently provided in Hampshire by Catch22. A new model of care has been implemented since April 2013 with one point of referral to ensure that young people can be supported with their substance misuse issues and receive a targeted service in an educational setting and specialist support in the community, (according to need), without the need for further referral. Catch22 is also building capacity through multi-agency training and also provides substance misuse services in Swanwick Lodge secure children’s home. In the year 2012/13, 195 young people entered the specialist treatment service. The largest age group represented is the 15-17 year cohort. The main substance misuse problems cited were cannabis (94%), alcohol (55%) and amphetamines (21%). It has been noted that there has been a rise in the use of ecstasy with 18% of clients reporting use. Less than five young people entered residential rehabilitation.

4.4 Community drug treatment services - adults

Specialist community drug and alcohol treatment services are provided in 8 HOMER (Hampshire Operational Model for Effective Recovery) one stop shops with satellite bases across Hampshire by Solent NHS Trust working in partnership with CRI, a voluntary agency. The service delivers an integrated recovery pathway that addresses the holistic needs of the individual. It is staffed by multi-disciplinary locality teams. In-patient detoxification services are available at Solent NHS Trust’s Baytrees Unit in Portsmouth and rehabilitation is available through a number of providers. There is an increasingly strong focus on using peer groups and mentoring to increase support for clients and provide support networks as people enter recovery

In 2011/12 2,133 clients received structured treatment. Of people in treatment 73% were male, and 27% female. Figure 5 shows the treatment population by age group. There has been a notable change in the proportion of people in different age groups with more in the older age groups, most notably the 40-44 year age group. Of those entering treatment 93.7% were recorded as White ethnicity, 2.3% were Asian/Asian British and for 2.2% of

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clients their ethnicity was unknown. Less than one percent of clients were in the Black/Black British, Mixed or Other ethnicity categories. There is variation by treatment centre, with 20% of clients using the Aldershot service being of an ethnicity other than White British. Of those entering treatment in 2011/12, 22% had at least one child living with them.

Figure 5: Age distribution of clients receiving treatment in the HOMER service by financial year

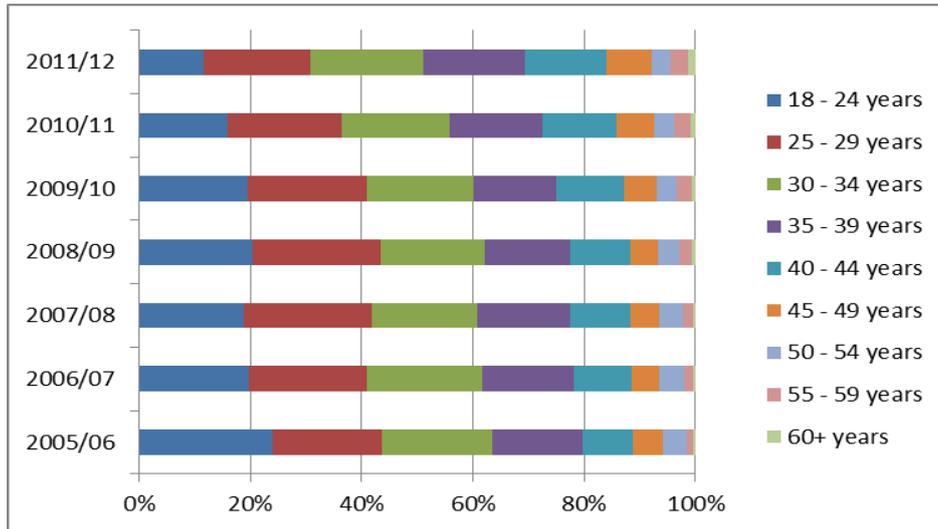
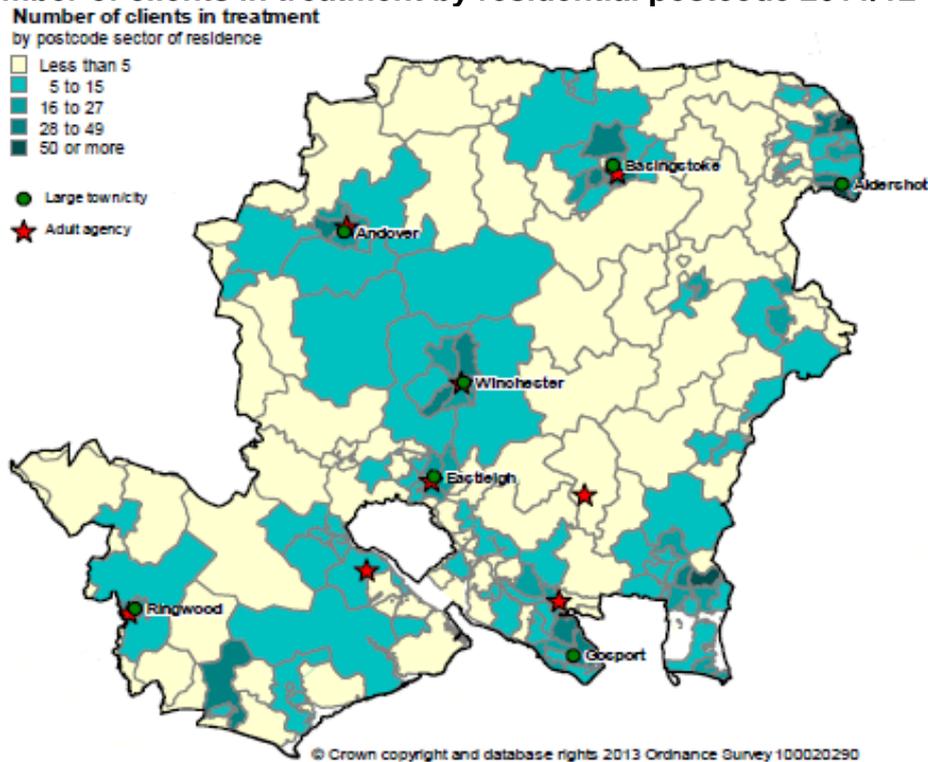


Figure 6 shows the distribution of clients in treatment by postcode. This shows that the highest concentration of clients in treatment live in the main conurbations including Andover, Aldershot, Basingstoke, Eastleigh, Gosport, Ringwood and Winchester. The highest numbers of clients are seen in the Fareham, Havant and Basingstoke HOMER centres.

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Figure 6: Number of clients in treatment by residential postcode 2011/12³⁷



The main source of referral for clients entering treatment in 2011/12 was self-referral (74%), drug services (8%) prison drug services (5%) and the criminal justice service (5%). Only 2% of referrals were from GPs.³⁸

Sixty-two percent of people in treatment stated their main substance was opiates followed by opiate and crack users. Whilst the proportion of people in treatment for opiates only has remained relatively stable over the last six years, the proportion of opiate and crack users has increased from 9.3% to 20.6% of those in treatment.

Prevalence estimates of opiate/crack drug users (OCUs) enable us to consider the level of engagement in treatment services by this group. It is estimated that there were 4,088 (95% CI 2344, 5815) OCUs in Hampshire in 2010/11 of whom, 2,250 (55%, 95% CI 38.6%, 95.9%) are in, or known to treatment services.

Of the 2139 clients in treatment in 2012/12, 1196 cited second drug use. The most prevalent second drug was crack (n=340), followed by alcohol (284) and cannabis (177). Eighty-eight percent of people citing crack as their primary drug also reported secondary drug use, followed by 77% of cocaine users and 58% of heroin users.

Clients that have previously or are currently injecting drugs should be offered Hepatitis B vaccine (HBV) and a dried spot blood test for Hepatitis C. Figures for 2012/13 showed that 46% of eligible clients accepted a HBV vaccine compared to a national average of 47% and 60% of clients received a Hepatitis C test compared to 70.6% nationally.

³⁷ Drug Treatment Monitoring Unit. Drug and alcohol action team profile: Adult April 2011 – March 2012. Hampshire. http://www.dtmu.org.uk/sph-files/2011-12-team-profiles/adults/J15B_DAAT%20Profile.pdf

³⁸ National Drug Treatment Monitoring System. Treatment Map Summary 2011/12.

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4.5 Duration of treatment and treatment outcomes

In 2012/13, 11.0% of opiate clients and 51.3% of non opiate clients successfully completed treatment, placing the Hampshire service in the top quartile for the relevant cluster.³⁹ This represents a growth of 72.4% in opiate clients and 54.7% in non opiate clients in successful treatments as compared with 2011/12.

However, analysis shows that those clients who have been in treatment for over 6 years, have less successful outcomes and have a low completion rate. In 2011/12, 18% of the opiate and 4% of non-opiate clients had been in treatment for six years or more with completion rates of 2% and 9% respectively,^{40 41} compared to completion rates of 9% and 46% respectively for clients who had been in treatment for less than one year. These figures were similar to the national picture.

Eighty-seven percent (n=102) of drug and alcohol clients who had a planned exit in 2011/12 completed treatment outcome profiles. There was an improvement in scores for physical health, psychological health and quality of life. On entry to treatment 16.7% were in paid employment which had increased to 24.5% on exit. Similarly, the proportion reporting an acute housing need fell from 15.7% on entry to 2.9% on exit.

Only 1% of clients entering drug treatment in 2011/12 had residential rehabilitation. This figure has remained the same since 2008/09 with a large national variation in the proportion of clients entering residential rehabilitation, the national average being 2.04%.

4.6 Prison drug treatment services

In 2012/13 2238 people entered Winchester prison, of whom 446 (20%) entered drug treatment. Of these, 217 were opiate users and the remaining 68 were non-opiate users. Twenty-three percent were currently injecting. Whilst all clients in this time period had a planned discharge, this was mainly due to transfer, either out of custody 175 (63%) or to another custodial unit 89 (33%). Only 3% completed treatment and were free of drugs;⁴² the service has advised that this is due to the relatively short length of stay at the prison. Of those released, 51 (21%) did not have a record of onward referral. This highlights the transient nature of this population and the need to ensure continuity of treatment.

A 2012 inspection of Winchester prison by Her Majesty's Prison Inspectorate reported that one third of prisoners questioned said that drugs were easily available, while 1 in 10 said they had developed a drug problem in the prison. The inspectorate stated that these findings were supported by a high drug testing failure rate. The inspection report highlighted that clinical services were of high quality but lacked psychosocial interventions and the prisoners requiring the service were not always located on the dedicated wing.⁴³ The Hampshire DAAT understands that considerable work has been done in the prison to rectify the issues highlighted.

³⁹ Explain cluster

⁴⁰ National Treatment Agency for Substance Misuse. Recovery Diagnostic Report. Opiate Clients. 2012

⁴¹ National Treatment Agency for Substance Misuse. Recovery Diagnostic Report. Non-opiate Clients. 2012

⁴² Data from NTDMS database.

⁴³ HM Chief Inspector of Prisons. Report on an announced inspection of HMP Winchester. 15–19 October 2012. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/prison-and-yoi-inspections/winchester/winchester-2012.pdf>

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4.7 Needle & Syringe Programmes (NSPs)

Needle and syringe programmes are offered in HOMER one-stop shops and 59 pharmacies across Hampshire. Pharmacies provide a Level 2 NSP service offering face-to-face harm minimisation interventions, self-selection injecting paraphernalia and receipt and disposal of used injecting equipment. They also present an opportunity to contact people injecting drugs who have not had contact with treatment services. 24,000 needle exchange transactions took place in 2012/13.

5. User and provider views

5.1 User views

A small scale questionnaire was undertaken for the HOMER service (n=60) across Hampshire in 2012. Service users were generally positive about the service with most reporting that they were treated well, were welcomed and respected. They felt that staff had a shared understanding of recovery.

The majority of respondents said they had care plans and mentioned their keyworker when asked what was positive about the service. Other positive aspects included stability and support, having someone to talk to/a support network and access to prescription substitutes. Ideas for improvements included having more staff and more structure, having more 1:1 time with the keyworker having more access to rehab and detox and a night time needle exchange. Respondents also wanted support around employment, independent living and housing.

5.2 Provider views

A survey was completed by 54 people working in substance misuse teams across Hampshire for the National Treatment Agency (NTA). The majority of staff felt that the treatments they were providing were effective and that they had a recovery focus.

6. Evidence of what works

6.1 Primary prevention

Evidence from a systematic review shows that skills based health promotion programmes delivered in schools can reduce early stage drug use.⁴⁴ For children and young people misusing or at higher risk of misusing drugs, NICE recommends that motivational interviews, group based therapies, group-based parent skills training and family based structured support should be offered.⁴⁵

6.2 Harm reduction

Harm reduction seeks to reduce drug related deaths and the transmission of blood borne viruses (BBV). NICE published guidance on needle and syringe programmes provides evidence that they reduce injecting risk behaviour and the risk of transmitting HIV.⁴⁶

⁴⁴ Faggiano F, Vigna-Taglianti F, Versino E, Zambon A, Borraccino A, Lemma P. School-based prevention for illicit drugs' use. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD003020. DOI: 10.1002/14651858.CD003020.pub2.

⁴⁵ National Institute for Health and Care Excellence. Interventions to reduce substance misuse among vulnerable young people (PH4). March 2007. <http://www.nice.org.uk/PHI004>

⁴⁶ NICE. Needle and syringe exchange programmes. February 2009
<http://www.nice.org.uk/nicemedia/live/12130/43301/43301.pdf>

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Methadone maintenance therapy has been shown to lower illicit opioid use and lower risk of death compared to those not taking methadone and both methadone and buprenorphine are recommended by NICE.⁴⁷ NTA guidelines provide interventions that providers can take to help reduce injecting drug use.⁴⁸ A recent pilot of Naloxone training for families and carers at 16 sites in England found that the antidote had been used for 18 overdoses.⁴⁹

Testing for Hepatitis B and C and Hepatitis B vaccination for eligible clients in drug treatment services is recommended by NICE. Service providers should ensure their staff have the knowledge and skills to promote and undertake pre and post test discussions. NICE recommends that commissioners should agree local pathways to testing and treatment services.⁵⁰

6.3 Treatment for substance misuse

UK and international evidence shows that drug treatment impacts positively on levels of drug use, offending, overdose risk and the spread of blood borne viruses. The national evaluation of drug treatment in England found that drug treatment is effective in reducing the harmful behaviours associated with problem drug use and is cost effective. The authors estimated that for every £1 spent, an estimated £2.50 was saved.⁵¹

There are comprehensive national evidence based clinical guidelines on the clinical management of drug misuse dependence.⁵² NICE has produced evidence based technology appraisals and guidelines for specific treatments^{53 54 55 56} and for patients with other diagnosis such as psychosis.⁵⁷

NICE has published a set of quality standards for drug treatment services for adults especially those in inpatient and specialist residential and community-based treatment

⁴⁷ National Institute for Health and Care Excellence. NICE technology appraisal guidance 115 Methadone and buprenorphine for the management of opioid dependence. January 2007.

<http://www.nice.org.uk/nicemedia/live/11606/33833/33833.pdf>

⁴⁸ National Treatment Agency for Substance Misuse. Reducing drug-related deaths. National Treatment Agency 2004

⁴⁹ National Treatment Agency for Substance Misuse. The NTA overdose and naloxone training programme for families and carers. August 2011.

⁵⁰ National Institute for Health and Clinical Excellence. Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection. December 2012.

⁵¹ Donmall M, Jones A, Davies L & Barnard M. Summary of key findings from the Drug Treatment Outcomes Research Study (DTORS). December 2009. The Home Office.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116599/horr23.pdf

⁵² Department of Health (England) and the devolved administrations (2007). *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive

http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

⁵³ National Institute for Health and Care Excellence. NICE clinical guideline 52: Drug misuse: opioid detoxification. July 2007 <http://www.nice.org.uk/nicemedia/live/11813/35997/35997.pdf>

⁵⁴ National Institute for Health and Care Excellence. NICE technology appraisal guidance 115 Methadone and buprenorphine for the management of opioid dependence. January 2007.

<http://www.nice.org.uk/nicemedia/live/11606/33833/33833.pdf>

⁵⁵ National Institute for Health and Care Excellence. NICE technology appraisal guidance 115 Naltrexone for the management of opioid dependence

⁵⁶ National Institute for Health and Care Excellence Drug misuse: Psychosocial interventions. July 2007.

<http://www.nice.org.uk/nicemedia/live/11812/35973/35973.pdf>

⁵⁷ National Institute for Health and Care Excellence. Psychosis with coexisting substance misuse March 2011.

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settings. The quality standard gives markers of high-quality and cost-effective care that will contribute to improving health outcomes. The quality statements are detailed in box a.⁵⁸

Box a: NICE quality standards for drug use disorders

1. People who inject drugs have access to needle and syringe programmes in accordance with NICE guidance.
2. People in drug treatment are offered a comprehensive assessment.
3. Families and carers of people with drug use disorders are offered an assessment of their needs.
4. People accessing drug treatment services which are offered testing and referral for treatment for hepatitis B, hepatitis C and HIV and vaccination for hepatitis B.
5. People in drug treatment are given information and advice about the following treatment options: harm-reduction, maintenance, detoxification and abstinence.
6. People in drug treatment are offered appropriate psychosocial interventions by their key worker.
7. People in drug treatment are offered support to access services that promote recovery and reintegration including housing, education, employment, personal finance, healthcare and mutual aid.
8. People in drug treatment are offered appropriate formal psychosocial interventions and/or psychosocial treatments.
9. People who have achieved abstinence are offered continued treatment or support for at least 6 months.
10. People in drug treatment are given information and advice on the NICE eligibility criteria for residential rehabilitative treatment.

⁵⁸ National Institute for Health and Care Excellence. QS23 Quality standard for drug use disorders. November 2012. <http://publications.nice.org.uk/quality-standard-for-drug-use-disorders-gs23/introduction-and-overview>