

# CAMBRIDGESHIRE DRUG AND ALCOHOL JOINT STRATEGIC NEEDS ASSESSMENT

2016



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## **CONTENTS**

### **Acknowledgements**

- 1. Introduction**
- 2. Executive Summary**
- 3. Scope and Themes**
- 4. The National Picture for Drugs and Alcohol**
- 5. Investing in the Prevention and Treatment of Drug and Alcohol Misuse**
- 6. Prevention**
- 7. Substance misuse across the life course**

**7.1 Children and Young People**

**7.2 Adults**

**7.3 Older People**

### **8. Changing Patterns of Substance Misuse and Emerging Issues**

**8.1 Changing patterns of drug misuse**

- Novel Psychoactive Substances
- Prescribed Drugs

**8.2 Emerging Issues**

- Alcohol Related Brain Damage
- Complex Cases

### **9 Dual Diagnosis**

### **10 Criminal Justice System**

### **11 Housing and Homelessness**

**Appendix 1: Homelessness Schemes in Cambridgeshire and Peterborough as at June 2016**

**Appendix 2: – Profile of Homelessness Accommodation in Cambridgeshire and  
Peterborough as at June 2016**

**Appendix 3: Consultation Summary**

**Appendix 4: Glossary**

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## 1. INTRODUCTION

The scope of this JSNA is broad capturing the needs of children, young people, adults and older people in relation to the misuse of both legal and illegal substances. It addresses prevention, treatment and recovery presenting a wide range of data that includes local service information. This information is considered alongside the perceptions of local stakeholders regarding their views on needs and how they are being addressed. Misuse of drugs and alcohol is closely associated with mental health, the criminal justice system, housing and other socio-economic factors. The interface between these factors, the complex needs that they create and the challenges in addressing them are reflected in the document. Also factored in the assessment are the wider social and economic factors which play an important part in prevention, effective treatment and recovery. The inequalities associated with substance misuse are described which often reflect the multiple disadvantages experienced by those misusing substances. There is glossary at the end of the document.

The overarching aim of the JSNA is to provide an overview of the current drug and alcohol misuse needs in Cambridgeshire with the following specific objectives.

- Identify the preventative and treatment services and pathways throughout the life course.
- Identify how the pathways, treatment and recovery options in Cambridgeshire are addressing needs in Cambridgeshire.
- Describe the changing patterns of drug misuse and emerging issues along with their implications for services.
- Describe how mental health, the criminal justice system and housing interface with substance misuse and the challenges and opportunities that this presents.
- Present an overview of the evidence and economic evidence for supporting the prevention and treatment of drug and alcohol misuse

The document is divided into separate chapters. Some of the chapters where there is substantial robust quantitative data have headlines and data detail sections. Other chapters are more descriptive and use locally collected data. There will be some duplication of the data because of the cross cutting themes in the JSNA.

Each individual chapter also provides evidence for interventions and where appropriate case studies are included to illustrate any issues. Each chapter concludes with “What is this telling us?” which summarises the key issues and implications.

The executive summary provides an overview of the issues and presents a number of strategic and action based recommendations for specific areas in the JSNA.

## 2. EXECUTIVE SUMMARY

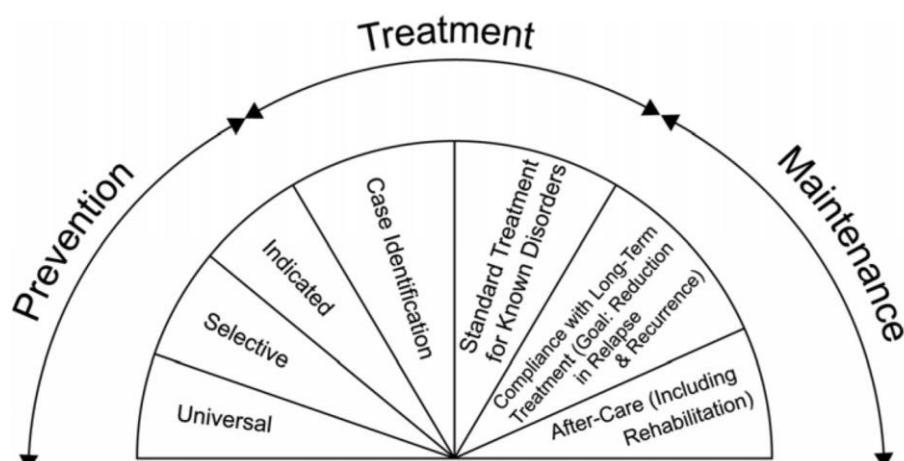
### Key Themes and Concepts in Scope

The scope of this JSNA is broad and some key concepts are used to indicate how the prevention and treatment of substance misuse is understood and addressed.

#### Classification of Substance Misuse Interventions

Figure 1 is the United States Institute of Medicine's prevention classification system<sup>1</sup>, validated in 2009 and it is used here to capture the scope and complexity of this JSNA. It has been applied<sup>2</sup> to the substance misuse field to illustrate the continuum of services/interventions between prevention, treatment, recovery and harm reduction and is a useful tool for describing a conceptually unified and evidence-based continuum of services. This taxonomy also provides a common language to describe prevention and assist in the planning, delivery, and evaluation of activities.

**Figure 1: The Institute of Medicine model of prevention (1994; 2009)**



The JSNA addresses prevention through universal interventions which includes media campaigns through to environmental interventions such as licensing regulations.

<sup>1</sup>Institute of Medicine (1994) Reducing the Risks for Mental Disorders: Frontiers for Preventative Intervention Research. In Meazak PJ, Haggerty RJ, editors. Committee on Prevention of Mental Disorder, Division of Biobehavioural Sciences and Mental Disorders. Washington DC. National Academy Press

<sup>2</sup> Advisory Council on the Misuse of Drugs. Prevention of drug and alcohol dependence. 2015



The terms 'selective' and 'indicated' are terms now increasingly applied to substance misuse and are explained more fully in the prevention section. They, to some extent, reflect the traditional models of prevention: primary, secondary and tertiary. However selective refers to the targeting of those at risk and indicated to those who are misusing substances but not yet dependent.

The local prevention and treatment services are described along with any supporting evidence. The current thinking on abstinence, recovery and harm reduction alongside the long term management of substance misuse is described.

How the cross cutting themes of mental health, the criminal justice system and housing impact on the prevention and treatment outcomes is considered

## Life Course Approach

Throughout the JSNA the impact of substance misuse is addressed throughout the life course. This allows consideration of key transition periods for prevention and treatment.

Drug prevention and treatment are commonly thought of as being most relevant to young people and most research and activity is concentrated on this age group. However, prevention is relevant across the lifespan, for example, in reducing prescription drug misuse or alcohol use in older adults.

There are many factors associated with an increased risk of the misuse of drugs and alcohol among young people and adults. These factors often lead to risk taking behaviours and poor health outcomes such as mental health problems and offending. The aim of preventative interventions is to tackle risk factors and build resilience to developing drug and alcohol problems

## Risk and Resilience

Intervention, whether preventative or treatment, focuses on reducing risk and building resilience in individuals and communities, especially those most at risk. Developed primarily for use with children and young people but applicable to all ages the approach is based on risk and resilience theory.

Resiliency Theory<sup>3</sup> provides a conceptual framework for considering a strengths-based approach to understanding child and adolescent development and informing intervention design. It provides a conceptual framework for studying and understanding why some young people grow up to be healthy adults in spite of risks exposure. Resilience focuses attention on positive contextual, social, and individual variables that interfere or disrupt development from risk to problem behaviors, mental distress, and poor health outcomes. These positive contextual, social, and individual variables work in opposition to risk factors, and help young people overcome any negative effects of risk exposure. The objective is to identify the assets and resources which are positive factors. Assets include for example self-efficacy and self-esteem. Resources refer to factors outside individuals such as parental support and programmes that provide opportunities to learn and practice skills. The children and young people section includes discussion of those individuals who are less likely to have

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<sup>3</sup> Zimmerman M, Resiliency Theory: A Strengths-Based Approach to Research and Practice for Adolescent Health Health Education Behaviour 2013 Aug 40(4) 381-383

the assets and resources to develop resilience. The theory and concepts can also be applied to adults and older people.

## Key findings and recommendations

The aim of this JSNA is to provide an overview of legal and illicit drug and alcohol misuse needs in the Cambridgeshire population. It is a complex area and consequently the scope and scale of the document is substantial. It includes prevention and treatment throughout the life course.

However, it is possible to identify some key themes throughout the different sections of the document that demonstrate the interconnectivity of the needs and interventions relating to drug and alcohol misuse. These are described below along with a number of recommendations for each section that reflect these key themes.

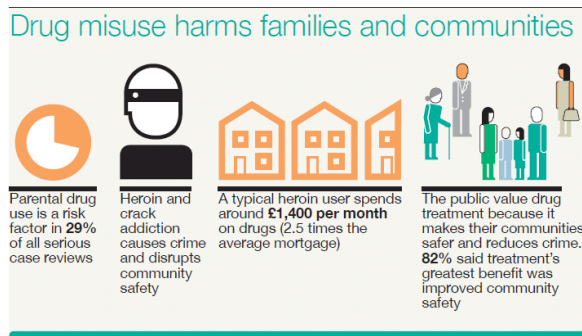
### The cost of drug and alcohol misuse

There are far ranging effects upon the physical and mental health of those who misuse drugs and alcohol which impact upon their families and communities and across wider aspects of their lives that are captured in Figures 2 and 3.

**Figure 2: Alcohol harms for families and communities**



**Figure 3: Drug misuse harms for families and communities**

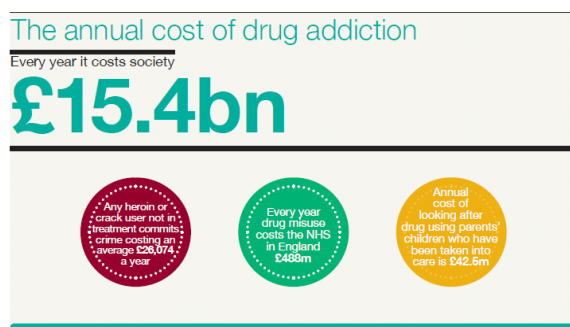


There are socio-economic costs to society and services which includes health services, social care, the criminal justice system, employers and housing services. The harms of drug and alcohol misuse have been modelled to show the costs of treating and addressing them. (Figures 4 and 5)

**Figure 4: Annual cost of alcohol to society**



**Figure 5: Annual cost of drug addiction to society**



## Key Themes

Against this context a number of key themes were identified in the JSNA which inform the recommendations found in the document.

### What is the need?

Cambridgeshire has a consistent record of having relatively good health outcomes but with pockets of poorer health associated with areas of deprivation. This picture is replicated when looking at the misuse of drugs and alcohol where most indicators demonstrate that as a county Cambridgeshire is either similar or better than national or comparator areas. In addition, the usual patterns of intra-county variation are found across many of the indicators with poorer outcomes generally being found in Fenland and Cambridge City.

In terms of prevalence there has been a consistent fall in alcohol and drug misuse amongst young people. In 2014 the Cambridgeshire Health Related Behaviour Survey that is undertaken in secondary schools found that 36% of 15 years olds reported drinking alcohol in the past seven days. A drop from 50% in 2008. The 2014 Public Health England (PHE) Survey "What about YOUTH" indicated that Cambridgeshire had similar rates of regular and "drunk in the last four weeks" as national and comparator areas. The same PHE Survey found 12.1% of 15 year olds in the county reported that they had tried cannabis, similar to national rates. The Health Related Behaviour Survey in 2014 found that nearly 17% of Year 10 pupils reported ever having taken drugs with a statistically significant higher rate in Cambridge City.

There is no recent data for adult alcohol misuse prevalence in Cambridgeshire but new figures are expected in 2016. The 2009 figures estimated that 85.8% of over 16 year olds in Cambridgeshire were estimated to be drinkers of alcohol. Of these 21% of drinkers (18% of all over 16s) were estimated to be increasing risk drinkers and 6.8% of drinkers (5.9% of all over 16s) are estimated to be higher risk drinkers. There was an estimated 32,190 people aged between 16-59 years who used illicit drugs in 2014, 8.6% of this age group, with 47% aged between 16 and 24 years.

These figures suggest that there are, despite comparing favourably with national and comparator figures, a substantial number of people in Cambridgeshire who are starting to or continuing to misuse these substances and consequently will have a range of treatment and wider needs. This ongoing level of need calls for sustained prevention interventions across the life course.

### High Risk and High Treatment Need Groups

There is a clear message throughout the JSNA that there are certain groups that have a higher risk for misusing substances. Many of those in treatment have multiple complex needs in terms of misuse and vulnerabilities.

For example children of substance misusing parents/carers or looked after children face particular challenges that may make them more susceptible to drug or alcohol misuse. All ages who find themselves in the criminal justice system or who have mental health concerns have a higher risk. The risks of substance misuse especially alcohol in older people are becoming more apparent and their prevention and treatment needs require a more flexible approach.

The relationship between substance misuse and mental ill-health leading to dual diagnosis is well established. It is a cyclical relationship with mental health issues presenting a risk for substance misuse and vice versa and it presents a complex treatment challenge. A similar relationship is found between those experiencing socio-economic pressures who have a higher risk of substance misuse and these issues also may undermine recovery. Homelessness is a particular high risk factor that can have a negative effect on treatment outcomes as well as creating risks for misuse.

The approach that is embedded both in prevention and treatment interventions is the risk and resilience concepts. These focus on reducing the risks that individuals have for misusing substances by increasing their resilience through strengthening personal assets such as self-esteem and securing resources such as employment opportunities.

This poses opportunities especially for prevention using both universal population and targeted approaches to support known to be most at risk. Although the concepts are mostly used in terms of children and young people they also resonate with all ages.

### **Abstinence and Harm Reduction**

The widely accepted aim of treatment of both drug and alcohol misuse is abstinence at six months, yet this is challenged by data both at national and local levels. Generally the age profile of people in treatment for drugs and alcohol is rising.

Nationally the overall numbers accessing treatment for alcohol have increased by 3% since 2009-10, however the number aged 40 and over accessing services has risen by 21% and the number aged 50 and over by 44%. This is reflected in the 2014/15 Cambridgeshire figures when 33% of those in treatment were aged between 40-49, 23% between 50-59 years and 12.1% were over 60 years.

Similarly nationally (2014/15) 44% people in treatment for opiates were aged 40 and over. This is an increase of 21% since 2009-10. Locally in the same period figures indicate for clients being treated for drug misuse 46% had been in treatment for over two years with the figure for opiate users rising to 60%.

The issues that this presents is that many of these people will have been drinking at high-risk levels or misusing drugs for some time and are likely to be experiencing complex health issues alongside long term dependence which makes abstinence at six month especially challenging.

In addition, a recent analysis by Public Health England (2016) of current drug clients in treatment has identified the increasing complexity of their needs in terms of multiple drug misuse. For Cambridgeshire and Peterborough of the high complexity patients 83% had been in treatment previously compared to 27% of very low complexity patients. A similar index for alcohol was not available.

The current model of a successful six month abstinence treatment intervention is at variance with the complexity and length of treatment time along with clinical experience. These indicate that although some individuals can be successfully treated within an acute care framework, many patients need multiple episodes of treatment over several years to achieve and sustain recovery. The progress of many patients is marked by cycles of recovery, relapse, and repeated treatments,

often spanning many years before eventuating in stable recovery, permanent disability or death. A model of long-term, active care management for substance use disorders is comparable to the way treatments for other chronic conditions are managed in medicine.

A long-term care approach to treatment is associated with harm reduction approaches. In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs. It recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse. This is by a range of measures such as reducing the sharing of injecting equipment, providing support for stopping injecting, and providing substitution opioid drugs for heroin misusers as support for abstinence from illegal drugs.

## Integration

Every section references integration either through informal partnership arrangements, joint project working or more formal pathways envisioned in the Dual Diagnosis Strategy. Although there is limited academic evidence for the integration of drug and alcohol services or wider integration involving other services there are examples across the country where integration of services has been established. However evaluation information is very limited. Locally projects like the Blue Light initiative which is described in this document indicate a move towards a more integrated working. However, the Cambridgeshire Blue Light model is not a formal partnership arrangement as it is in other areas but based on informal arrangements.

The varied and multiple needs of those at risk and those in treatment cannot be addressed by one organisation. For example, for effective working with at risk deprived vulnerable children a number of agencies that includes social and health care, schools and informal networks, are required to work collaboratively. Treatment services cannot just treat, for example with therapies, as a wider range of services that include employment and housing is critical for building resilience and ensuring recovery.

There is evidence that suggests that integration is most effective when it is system wide and all organisations are fully engaged strategically along with, where possible, joint commissioning arrangements. Any integration of services requires evaluation and monitoring for improvement in outcomes and patient experience.

## Emerging Issues

The document describes the new patterns of drug misuse and other emerging challenges. Novel Psychoactive Substances and the misuse of prescribed and over the counter drugs have been emerging in recent years and presenting new challenges for service delivery. New approaches are required that will involve a greater understanding amongst the public and professionals to make them aware of the risks and their roles in preventing harm associated with their use. Another challenge identified by local stakeholders is the lack of appropriate services for the management of Alcohol Related Brain Damage (ARBD)

## Recommendations

### Children and Young People

As indicated above overall substance misuse in Cambridgeshire amongst children is not dissimilar to national figures or its comparator areas. There has been a downward trend in substance misuse in recent years however there are still substantial numbers of children and young people starting and continuing to misuse substances.

Amongst young people admission to hospital for alcohol and drug misuse are statistically significantly lower than the national figures. However in line with national figures the number and rate of admissions have doubled over the last five years. The number of young people in treatment fell in 2014/15 to 200 from 245 in 2013/14 and over 90% of the planned exits from treatment did not re-present within six months. The majority of children and young people have one or more vulnerabilities, the most common being mental health and self-harming. Service data estimates that of the young people who re-present only 5% require treatment. In 2014/15 5% of young people in the service transitioned to adult services, the figure was 1% for 2015/16.

Treatment is provided by the Cambridgeshire Child and Adolescent Substance Use Service (CASUS) which is part of Cambridgeshire and Peterborough Foundation Trust. It provides a comprehensive treatment service and also capacity allowing, delivers prevention interventions in a number of settings and with different groups.

Prevention interventions are also provided by Cambridgeshire County Council Personal, Social and Health Education Service (PSHE) which includes policy and other training or information giving interventions. Cambridgeshire County Council also undertakes checks for under age sales through its Trading Standards Department.

A key concern is the needs of children and young people in vulnerable groups who are at a higher risk of misusing substances for example looked after children and children who live with parents/carers who misuse. This includes those who have not started and those who are using but are not yet dependent on substances.

The numbers of children and young people estimated to be misusing substances and the multiple needs of many of the children and young people in the treatment services requires working across organisations to ensure that there are effective prevention activities and supportive pathways that can address their needs effectively.

## Recommendations

1. Although Cambridgeshire compares well in terms of substance misuse in young people there are still substantial numbers who misuse substances. Prevention interventions need to be maintained and developed at a universal or population level and also more targeted interventions in high risk areas and with high risk groups.
2. Many of the children and young people in the treatment services have different vulnerabilities. Looked after children, those with mental ill-health or who are self-harming are examples of common vulnerabilities. There is evidence for early “selective” (targeted) and “indicated” (early interventions) for these groups. These could be more fully developed locally before children and young people enter the treatment services. Interventions for these groups need to be wide-ranging and focus upon developing resilience and resistance to risk factors for drug and alcohol misuse.
3. Children living with parents who are misusing are at high risk of poorer health and wellbeing outcomes. The work that is currently being piloted needs to be fully evaluated to identify learning that can be applied to all the vulnerable groups.
4. Local Safeguarding Children Boards (LSCB) are now the key for organisations to come together to agree on how they will co-operate with one another to safeguard and promote the welfare of children. They often encounter cases which involve an element of substance misuse in parents or carers. The lessons learned from these cases should be used more explicitly to improve interagency working.
5. Any targeted interventions need to be part of an integrated approach with different organisations supporting the development of resilience in children and young people most at risk of misusing substances. This includes the small number of those who transition into adult services.

## Adults

As indicated above prevalence relating to alcohol and drug misuse in Cambridgeshire is generally similar to national and comparator areas. However as with children and young people there are still substantial numbers starting and continuing to misuse substances.

Overall in line with national figures hospital admissions for conditions totally attributable to alcohol (specific) and related conditions have increased and they fall within the top 25% of local authorities. In 2013/14 1,890 people in Cambridgeshire were admitted to hospital for conditions totally attributable (specific) to alcohol. In the same year there were around 6,650 people who were admitted to hospital for alcohol related conditions. Taking into account that a person may be admitted to hospital on multiple occasions there were around 12,200 alcohol related admissions in the same time period. Hospital admission rates are generally higher in Fenland and Cambridge. In 2014/15 there were 2,125 hospital admissions due to alcohol related mental and behavioural disorders in Cambridgeshire. Generally these rates are lower than national figures but are



statistically significantly higher in Cambridge along with an apparent increasing trend more widely among men.

There were 211 deaths in Cambridgeshire due to alcohol related causes in 2014. Alcohol specific mortality rates are generally higher in the more disadvantaged areas and average life expectancy is reduced from alcohol related conditions in Fenland. The rate of alcohol related liver disease has increased amongst women in 2012/14 to a level similar to the national figure.

The number of adults in alcohol treatment increased in 2014/15 to 841 from 571 in 2013/14 with most clients being between the ages of 30 and 59 years. The total number in treatment represents 3.8% of the estimated number of high risk drinkers. This is higher than the comparator area (Oxfordshire) but lower than the national figure. 36% of clients completed alcohol treatment and did not re-present within six months, similar to national and comparator figures. The percentage of those in treatment that were also receiving mental health care was 6%, this is lower than the national figure (20%) and lower than the comparator area (15%). There were 36% unemployed or economically inactive and 5% had a known housing problem. These figures refer to those treated by the Cambridgeshire County Council countywide commissioned service Inclusion and exclude the numbers treated by the Gainsborough Foundation (the Service commissioned by GPs for the Huntingdonshire area. Data for this service is not comparable).

In terms of illicit drugs there were 143 hospital admissions with a primary diagnosis of illicit drug poisoning, with rates lower in men and similar in women to national figures. 732 admissions were with a primary or secondary diagnosis of drug-related mental health and behavioral disorders. In Cambridgeshire the annual rate of drug related deaths has been stable for over the past 10 years but they are statistically significantly higher in the more deprived wards.

In 2014/15 there were 1,564 clients who received treatment for drug misuse; nearly 75% were opiate users. Those using opiates spent a longer time in treatment with 60%, higher than the national figure, remaining there for over two years compared with non-opiate users where the figure was 46%. Treatment completion for non-opiates is 34.4% compared to 7% for opiate users, with rates of abstinence for most types of drugs being lower than the national figure. Of those in treatment 23% of newly presenting patients (126 individuals) were also receiving treatment from mental health services. This is higher than the national level of 21%. In addition 63% were known to be unemployed higher than the national and comparator figures. In terms of housing 29% had problems compared to 23% nationally and 35% for the comparator area.

Testing and vaccinating for blood borne viruses is an important element of harm reduction. However in Cambridgeshire the levels of testing and vaccination for blood borne viruses compares particularly unfavourably with national and comparator areas.

As indicated above, there is evidence that the complexity and age profile of people using drug treatment services is changing. A recent report by Public Health England indicates that that nearly one third of clients in treatment have complex treatment needs with over 80% of them having had previous treatment episodes. In addition Treatment Service data has also highlighted the ageing opiate user clients with around 270 clients in the Tier 3 services (more complex clients) being over the age of 50. This mirrors the national trend.

This picture of the long term use of drugs with multiple treatment attempts and an aging profile also suggest that there is a higher risk of wider health issues that substance misuse could exacerbate. Poor mental health is often a key challenge for those misusing substances along with housing and other wider socio-economic factors that are associated with substance misuse.

## Recommendations

### Prevention

1. There is evidence for environmental interventions for alcohol misuse. These include outlet density, reduced licensing hours and minimum pricing; the latter has the strongest cost-effectiveness evidence. Local authorities have the potential to develop local policies that would affect both prevention and treatment outcomes.
2. Formalise and expand identification, brief and extended interventions for alcohol misuse that are evidence based and have cost benefits. Target those who are not dependent and focus on these with high risks e.g. unemployed, those with mental health issues, poor housing or homeless.
3. Identify options for funding brief and extended interventions in areas where they are most effective and have the greatest cost benefits i.e. primary care and Accident and Emergency Departments.
4. Cambridgeshire's low uptake and incomplete vaccination for Hepatitis B and low testing for Hepatitis C will require an innovative approach. There are a number of innovative approaches being utilised across the country that for example provide incentives to clients, these require evaluation. A different commissioning approach could be utilised where incentives are used for providers to increase uptake rates.

## Service improvements

1. Hospital liaison services have evaluated well nationally. In Cambridgeshire only Cambridgeshire University Hospitals has a Hospital Liaison Service. Hinchingsbrooke Hospital does not have any formalised system for supporting those who are misusing substances who present at the hospital. Some preliminary data indicates that there is a cohort of people who present on numerous occasions i.e. 'frequent fliers'. More investigation is required to identify who these are and the most appropriate intervention. A cost-effective approach would be the development of joint mental health and substance misuse interventions at centres where individuals are presenting.
2. Community detoxification is effective and cost effective. The expansion of provision through greater engagement of GP practices would enable this to increase. Although not all patients are suitable for community detoxification.
3. Develop and expand recovery services that strengthen support from the community and address the complex socio-economic issues with the aim of securing a sustained recovery. This could include expanding the length of time that a person receives recovery support to reflect client need with the objective of reducing the high number of re-presentations within six months.
4. A very common and frequent opinion amongst users and recovery workers who took part in the consultation was that there is limited support during times of crisis especially when they occur outside of service hours. Further development would help prevent relapses or presentations at Accident and Emergency departments. There was a strongly held view that a crisis telephone triage line, similar to that established for mental health services could prevent many relapses. The option of developing a shared crisis management service for mental health and substance misuse could be explored in terms of effectiveness and cost benefits.
5. Maintain the aim of abstinence but acknowledge that many clients require multiple courses of treatment to achieve recovery and may never achieve abstinence, and adopt a model of long-term, active care management for substance misuse.
6. A long-term model of care would require both strengthened recovery services and an increase in harm reduction approaches. Existing schemes such as supervised consumption and needle exchange schemes would require further development and expansion. New commissioning approaches are required to engage more community pharmacists and GPs to undertake shared care. Greater GP involvement would assist in the management also of any physical health co-morbidities.
7. The complex needs of substance misuse clients requires an integrated approach with clear pathways to support from a range of different services. Many of these exist and there are some examples of good practice but some client needs are not fully addressed and this undermines treatment outcomes or care management. A more strategic approach to the development of pathways is required that would use resources more efficiently and could involve joint commissioning approaches. There are particular opportunities for integrating elements of the mental health and substance misuse pathways but in addition with criminal justice and housing services (see later). Any integration of services should include evaluation of patient outcomes, experience and cost benefits in the absence of academic and high quality evaluations.

## Services and cost benefits

The JSNA provides information about the evidence of effectiveness and also the cost benefits of interventions. The headline figures are as follows and sourced from Public Health England (Alcohol and drugs prevention, treatment and recovery: Why invest? 2014)

- Every £1 spent on interventions on young people's drug and alcohol services brings benefits of £5-£8.
- For every 100 alcohol dependent people treated at a cost of £40,000, £60,000 is saved on 18 Accident & Emergency visits and 22 hospital admissions.
- Every 5,000 patients screened in primary care may prevent 67 Accident and Emergency visits and 61 hospital admissions - costs of £25,000 saves £90,000.
- One alcohol liaison nurse can prevent 97 Accident & Emergency visits and 57 hospital admissions so costs of £60,000 saves £90,000.
- For every £1 spent on drug treatment £2.50 is saved through averting costs to society.
- Drug treatment prevents an estimated 4.9 million crimes every year.
- Treatment saves an estimated £960 million of costs to the public, businesses, criminal justice and the NHS.

Through analysis using Public Health England's Spend and Outcome Tool (SPOT) it is possible to compare Cambridgeshire's spend on drug and alcohol services and a range of outcomes found in the Public Health Outcomes Framework against other areas. Both Cambridgeshire's spend and outcomes are below the mean, as is overall public health spend in Cambridgeshire.

## Recommendations

1. The SPOT tool does not assess the relative cost-effectiveness of different interventions or assess how to get the best value for money.
2. The SPOT analysis can be considered alongside evidence from the alcohol and drugs Value for Money tools (the Commissioning Tool) and with the evidence that investment in treatment is associated with immediate and long-term savings.
3. It would be useful to apply the Commissioning Tool to identify the spend and outcomes of different types of treatments accessed by opiate users, non-opiate users and alcohol only for the development of evidence based services that are cost-effective and cost saving.

## Older People and Substance Misuse

There is an increasing awareness that substance misuse, especially alcohol, is more prevalent in the older population (greater than 65 years) than previously thought. Many of those who misuse alcohol may have started earlier in life but some commence in response to traumatic life events such as loss of a partner. Key factors are loneliness and life changes. In addition professionals often find it difficult to ask 'embarrassing' questions of older people but there are warning signs.

### Recommendations

1. Integrate substance misuse amongst older people into the wider work relating to prevention interventions and the development of older people's services.
2. Raise awareness/education about substance misuse amongst older people with statutory and voluntary sector older people's services.
3. Align local clinical pathways for the identification and diagnosis of substance misuse in older people to reflect national guidelines.
4. Scope the service options for developing substance misuse services for older people that will integrate their care into other older people's services to improve identification and management.
5. There are opportunities to adopt a harm reduction approach by addressing their wider issues of isolation, mental and physical health issues.

## Changing Patterns of Substance Misuse and Emerging issues

### *Novel Psychoactive Substances (NPS)*

It is estimated that there are nearly 3,400 (aged 16-59) users of NPS in the local population. These are mostly (63%) in the younger age group (16-24 years). 83% of those who have used NPS have previously used illicit drugs.

### Recommendations

1. More publicity about the harms associated with the use of NPS that targets high risk young people and those known to have used illicit drugs.
2. Provide statutory and voluntary organisations with information for their staff to provide information and advice both for young people but also parents/carers.

### *Prescription drugs and over the counter drugs*

The broadest definition of this type of substance misuse is the “use of medications for other purposes or ways prescribed or intended”. This includes prescription-only medicines (POMs), Over the Counter (OTCs) and pharmacy only medicines for sale under the supervision of a pharmacist.

Based on national prevalence estimates in 2014, 20,212 people in Cambridgeshire aged 16-59 are misusing prescription only painkillers (5.4% of this population). 27% were aged 16-24 years. 25% of those misusing prescription only painkillers reported using an illicit drug in the last year.

It has been found to be more generally spread across the population than illicit drugs. Those at risk of misusing include those using painkillers especially those in the older age groups and those with long standing illness or disability.

### **Recommendations**

There are national guidelines produced by the Royal College of General Practitioners that include the following recommendations for reducing the misuse of POMs and OTCs.

1. Better training of staff across all agencies especially GPs for the identification and management of the misuse.
2. Close working between GPs and substance misuse services to provide GPs with expert advice and support.
3. Further develop the work undertaken by the Cambridgeshire and Peterborough Clinical Commissioning Group Medicines Management Team that undertake audits to identify potential misuse.
4. Ensure local prescribers, pharmacists and dispensers have undertaken training available for their professional bodies and to establish a structured pathway or care approach for identifying and managing POM and OTC misuse. In some areas, community pharmacists are commissioned to proactively work with patients to identify and work with patients to address their misuse.

### *Alcohol related brain damage (ARBD)*

ARBD is an umbrella term for the alcohol related conditions that affects brain function. This includes Wernicke-Korsakoff syndrome, alcohol related dementia and other forms of cognitive impairment. It has been raised by clinicians as an area of concern as there are no local services or pathways in place to manage people with the condition. Case studies and information from the voluntary sector support this picture.

There is no clear picture of the numbers affected in Cambridgeshire. In other parts of the country there have been scoping studies and most notably a specific service has been established on The Wirral.

### **Recommendations**

1. More information should be collected relating to need and current local provision of services to understand how ARBD could be addressed locally.
2. This would include identifying service gaps in terms of pathways and referrals and in the eligibility criteria for third sector provision and the opportunities within existing services for further support.

### **Dual diagnosis**

The term dual diagnosis is generally used to describe individuals who have co-existing substance misuse and mental illness, although the severity of these conditions may vary and the point at which a dual diagnosis is made will vary. Locally the Dual Diagnosis Strategy specifically refers to those individuals who have severe mental illness and who also experience a high level of problematic substance misuse. In 2014/15, 23% of newly presenting clients in substance misuse services were also in contact with mental health services and of those in alcohol treatment 51 (6%) were also receiving care from mental health services. The most common vulnerabilities in children and young people in treatment are mental health problems and involvement in self-harm. This may be underestimated as it does not include those not in treatment and stigma may prevent clients from disclosing this information.

As indicated above in 2013/14 there were 732 hospital admissions where there was a secondary or primary diagnosis of drug related mental health and behavioural disorders and in 2014/15 2,125 hospital admissions due to alcohol related mental or behavioural disorders in Cambridgeshire. The percentage of those in alcohol treatment that were also receiving mental health care was 6% (51 individuals) this is lower than the national figure (20%) and lower than the comparator area (15%). Of those in drug treatment 23% of newly presenting patients (126 individuals) were also receiving treatment from mental health services. This is higher than the national level of 21%.

In addition, suicide is associated with dual diagnosis, as indicated by national studies. A current audit of suicides in Cambridgeshire and Peterborough is also identifying dual diagnosis in some of the reviewed suicide cases.

The management of dual diagnosis is challenging as it requires an integrated approach across different treatment services. The academic evidence for integrating substance misuse and mental health services is limited but there are examples of integrated services across the country each with their own model of service delivery and differing levels of integration. However there are few evaluations of these services.

In Cambridgeshire in both adult and children and young people services there is some joint working but issues identified by providers are as follows.

- Lack of data sharing that prohibits a good understanding of the extent of dual diagnosis.
- The Improving Access to Psychology Therapies (IAPT) service is for those with mild to moderate mental health issues. It will accept those who misuse substances but not those who have moderate to severe substance misuse problems. Similarly the personality disorder service that treats clients with both personality disorders and substance misuse has a long waiting list which can impact on an individual's care plan.
- Children and Young People's Mental Health Services (CAMHS) cite transition between services as being problematic as Child and Adolescent Mental Health Services work with those aged under 17 and CASUS with those under 18. There is not any follow on service for discharged clients who have their substance misuse issues under control but whose mental health issues are not managed.
- The rural areas have poor transport links and although CASUS offers home visits the time involved impacts on capacity. CASUS and the Youth Offending Service have found difficulties with academies engaging with the services.
- The Dual Diagnosis Strategy was developed to enhance joint working and enable the efficient and effective use of resources. However there is a lack of awareness of the strategy and there has been little demand for the training.



## Recommendations

1. Collaboration between services – there is currently no strong evidence base for the integration of services or a particular model that is favoured, but collaboration between substance misuse and mental health services is clearly a strong theme. There is an on-going need to build collaboration and overcome the organisational challenges between services. Integrated service models that other areas are implementing have not been evaluated in terms of outcomes and cost-benefits.
2. Data collection and sharing are two areas that could benefit from increased collaboration. Sharing data held by substance misuse and mental health service providers could usefully help in estimating the number of people with a dual diagnosis in services. Establishing a standardised practice for collecting data across all services would ensure there is greater recording of dual diagnosis, as well as greater consistency in how this is recorded.
3. One of the key gaps identified is in terms of service provision for those with moderate to severe substance misuse problems and mild to moderate mental health problems. Currently there is not a statutory service that these individuals can access to address their mental health needs. The service pathway and options for addressing this gap need consideration.
4. The Cambridgeshire & Peterborough Suicide Audit will be published in autumn 2016 and it is clear that substance misuse will be highlighted as part of this work. It will be important for the local suicide prevention work to recognise the role of substance misuse as a risk factor locally, and consider the local action plan in light of this.
5. It is important to recognise the importance of engaging the education system in drug and alcohol issues as a whole as initial signs from those working with schools suggest that attitudes are changing as schools change.
6. In terms of dual diagnosis training, it is important to ensure that new or changing services are accessing the training.
7. There is a clear need for more research specific to dual diagnosis including service models, particularly in adolescents. Currently it is difficult to say which interventions are better than mainstream treatment for those with multiple needs. This should be a consideration when looking at local service models, ensuring that there is adequate evaluation in place, which may require consideration of data sharing agreements.
8. The Dual Diagnosis Strategy addresses some of the challenges for the identification and management of this condition. However, there are still many areas that require implementation. This could be accelerated through a dedicated resource to identify and progress the practical steps that need to be undertaken to establish the required changes.

## Substance misuse and the criminal justice system

There is a significant relationship between substance misuse and the criminal justice system. Drug or alcohol addiction may fuel or exacerbate criminal activity, for example through theft to meet the cost of purchasing supplies. Managing the care of those who misuse substances and are involved in the criminal justice system presents a challenge similar to that of dual diagnosis, in that it calls for effective working across different organisation. There is also a tension between the needs of the criminal justice system to ensure that the appropriate penalties are enforced that might include a requirement to involvement in treatment, with the ethos of the treatment services where issues like confidentiality are central to care. There is however evidence that it is important to identify individuals misusing substances in the Criminal Justice System and provide treatment in terms of the prevention of further criminal activity and an opportunity to treat the misuse.

Drug users are estimated to be responsible for between a third and a half of acquisitive crime. According to the 2013/14 Crime Survey for England, 53% of violent incidents were alcohol-related. Alcohol and drug misuse related offences are associated with driving with excess alcohol, assault or criminal damage and partner abuse.

Substance misuse is known to be particularly prevalent amongst the prison population. HM Chief Inspectorate Annual Report for 2014-15 surveyed samples from 49 adult prisons found that on arrival at prison 41% of women and 28% of men had problems with drugs and for alcohol the figures were 30% and 19%.

There are difficulties with data collection in these areas both nationally and locally and under-reporting is considered to be an issue. There are local studies and for example data collected between 2011 and 2013 in Cambridge City found that of the 100 crimes studied over 50% were linked with alcohol misuse.

In December 2015, in Cambridgeshire the Criminal Justice Intervention Team had 149 clients on its caseload with the majority being in structured treatment. Of the 149 clients in the caseload, 123 were using opiates, 20 a combination of alcohol and non-opiates and six were using alcohol. Being in treatment and on release transferring to the care of the local treatment service is considered to be important in terms of crime prevention. In Cambridgeshire 43% of users transfer to external services on release compared to 29% nationally.

In addition, it is recognised that there is a high percentage of prisoners who have mental health issues with studies indicating the figure to be as high as 90%. A large proportion of these will also have substance misuse issues especially drug abuse.

There are various pathways in the Criminal Justice System with the route taken dependent on the severity of the crime, whether a community sentence or custodial sentence is imposed and which services are accessed on release from prison.

Substance misuse services within prisons are commissioned by NHS England and delivered by prison in-reach teams. The local Drug and Alcohol Treatment Service, Inclusion, provides the Substance Treatment Action and Recovery Team (START) which provides support to substance misusers on release from prison. For those who misuse substances that are identified within the prison setting,

there is a requirement for those working within the prisons to notify the local START team of clients prior to release. The key concerns are that prisons are only required to inform START of the release of prisoners who misuse opiates and that there is a need to increase engagement and with prisoners prior to release and improving the general level of communication.

In addition there are schemes that focus upon those with complex needs which often includes substance misuse. There is the Integrated Offender Management team where the most problematic offenders are identified and jointly managed by partner agencies working together with the aim of ensuring the most effective release from prison. The Chronically Excluded Adult Service caters for particularly chaotic high need individuals, with a high proportion having links to the criminal justice system. This has evaluated well and found to be cost-effective, demonstrating a fall in arrests and contact with the criminal justice system post intervention. Liaison and Diversion Services are now in place ensuring that those with mental health problems have appropriate support on discharge from prison.

The Cambridgeshire County Council Youth Offending (YOS) Substance Misuse Team delivers substance misuse interventions to young people (10-18 years). The Substance Misuse Team that is part of Cambridgeshire County Council delivers Tier 3 (for those with higher misuse issues) interventions and advises YOS Officers on their delivery of Tier 1 and 2 interventions (less complex clients). Individuals that require higher level Tier 3 interventions and complex cases are referred to the Cambridgeshire Child and Adolescent Substance Use Service (CASUS), which is part of the Cambridgeshire and Peterborough Foundation Trust.

As part of a review (2015) into the provision of specialist substance misuse treatment in Cambridgeshire YOS and CASUS the following data was captured:

- 1/3 of young people working with the YOS have substance misuse issues requiring Tier 3 support from the specialist team.
- 1/3 had substance misuse issues that require Tier 1 and 2 interventions that are delivered by YOS Officers supported by the specialist team.
- 1/3 did not present with substance misuse issues, but at any point, this could become evident.

Between 1 January and 30 June 2015, 176 young people started interventions with the YOS, 35% (62) of these young people were referred to the substance misuse team. Of these individuals 41 required Tier 3 (specialist substance misuse) treatment, 10 required Tier 2 (targeted) treatment and 11 required no further action. There are issues however in particular confidentiality and timeliness, related to the data sharing between the YOS Substance Misuse Service and CASUS that affects the overall management of the clients.

Other issues were identified.

- Some individuals may have a short court order which means that their time in the YOS or prison is limited but they may have complex needs. Linking the individual to community services within the short timeframe can be challenging.

- There can be challenges in sharing information between services. For example some children that are looked after by the local authority may come into contact with a number of services and find themselves relaying information to each organisation.
- Schools: A challenge identified by both CASUS and the YOS Substance Misuse Team was working with different school policies. Both services identified that increasingly schools were implementing zero tolerance policies where a pupil that was found to be in possession of drugs is automatically excluded. This type of action could be considered to be detrimental to the motivation of an individual academically. Both providers reported there was an increase in this type of policy or that schools were becoming increasingly less engaged in substance misuse support as there was a change towards academy status.

## Recommendations

1. There are a number of challenges relating to communication or information sharing barriers. In particular in relation to the START team receiving timely notification of potential clients prior to release from prison, and widening these notifications beyond opioid users. There is also a challenge in terms of communication between the YOS and CASUS with issues of confidentiality and timeliness adding barriers. A formal information sharing agreement may help with this process.
2. There is a need to ensure that there are effective pathways between services. The criminal justice system is an area where there are multiple stages and organisations involved, with care being commissioned and provided by different organisations along the pathway.
3. There is little evidence of effective interventions for those beyond that of mainstream services for those in contact with the criminal justice system. A lot of the research that is available is American based and often prison based too, therefore it is important to ensure that local interventions are evaluated in terms of outcomes, patient experience and cost effectiveness where possible to contribute to the growing evidence base.
4. It is key to recognise the importance of engaging the education system as initial signs from those working with schools suggest that attitudes are changing as schools change. It is important to consider this issue as a whole in terms of drugs and alcohol, not just those with a dual diagnosis or engaging with the criminal justice system. This will require engagement with schools to understand the best way to address this issue.
5. It was not possible to access data for the county that identified alcohol misuse hotspots. This information is developed through pooling hospital, ambulance, police and licensing authority information. This information could help understand the causes and shape prevention interventions

## Housing and Homelessness

There is well documented evidence of the impact of inappropriate housing and homelessness on mental health and substance misuse. Many people may be misusing substances and will not experience any housing issues. However, vulnerable people who become homeless may be exposed to drug and alcohol cultures that can lead to starting to misuse substances. Substance misuse can increase the risk of homelessness that reflects unemployment, relationship breakdown and other socio-economic issues. It is a cyclical issue, with appropriate housing, support and the avoidance of rough sleeping both preventing substance misuse and improving treatment outcomes.

Cambridgeshire was the fastest growing county authority between 2001 and 2011 and is expected to continue to grow and this growth has created pressures on the housing market. In particular affordability and consequent homelessness are concerns with the most acute pressures in the south of the county. The rates of statutory homeless are statistically higher in Cambridge City and Huntingdon than the figure for England, and have increased since 2010/11 when the situation was relatively stable.

Recent surveys (of homeless people) indicate that around a third of homeless people reported misuse of drugs and alcohol. In one audit 39% of participants said they take drugs or are recovering from a drug problem, and 36% had taken drugs in the month before completing the audit. By comparison, national figures at that time indicated that only 5% of the general public took drugs in the past month. Cannabis appears to be the most commonly used drug however 25% of survey respondents said they had used heroin prescription drugs not prescribed for them.

27% of homeless people taking part in the same audit reported that they have or are recovering from an alcohol problem. 39% of homeless men and 25% of women drink twice or more a week, and around two-thirds of homeless men and women drink more than the recommended amount each time they drink. By comparison, one-third of the general public drink more than the recommended amount on at least one day each week.

There are barriers to accessing housing. Feedback from District Council Housing leads and housing providers indicate that throughout the county there are issues related to homelessness and substance misuse along with the level of support that people involved in misusing substances receive. The issues differ to some degree across the county and there is concern that changes to housing benefits will exacerbate the issues.

There is a range of accommodation options in Cambridgeshire for the homeless. Some of these offer additional support for substance misuse and/or mental health issues. There are examples where services are trying innovative approaches that range from abstinence projects and interventions to prevent street drinking, through to projects which focus on addressing the wider socio-economic issues experienced by these clients.

Data from many of the accommodation providers and projects for the homeless is not consistent but that which is available - and reports from staff - clearly reflect that their clients have substance misuse and often dual diagnosis. Staff expressed concern about the need for increased support for the wide range of needs, more joint working and collaboration across the services.

## Recommendations

1. The accommodation options for the homeless report that a large proportion of their clients have a known substance misuse issue. However there is limited and varied data collection or capacity to collect information and an associated possible under reporting of the issues. Improvement and standardisation of data collecting across many providers could improve the strategic planning of services.
2. In Cambridgeshire there is a range of housing options available including additional support from different services including Inclusion. Support plays an important part in preventing relapse, promoting recovery and tenancy sustainment. This approach could be further bolstered with clear pathways and referral criteria.
3. There are a number of innovative partnership projects across the county that should be evaluated and inform on-going service development. The impact of these interventions on treatment outcomes, mental health services, Accident & Emergency attendances and involvement in the criminal justice system needs to be captured and cost benefits identified.
4. There is an on-going pressure on the available housing/hostels available for those with substance misuse issues. There are barriers that prevent many clients securing accommodation from housing providers including the definition of statutory homeless. These require further exploration working with statutory and voluntary sector providers and commissioners, substance misuse services, mental health services and the criminal justice system.

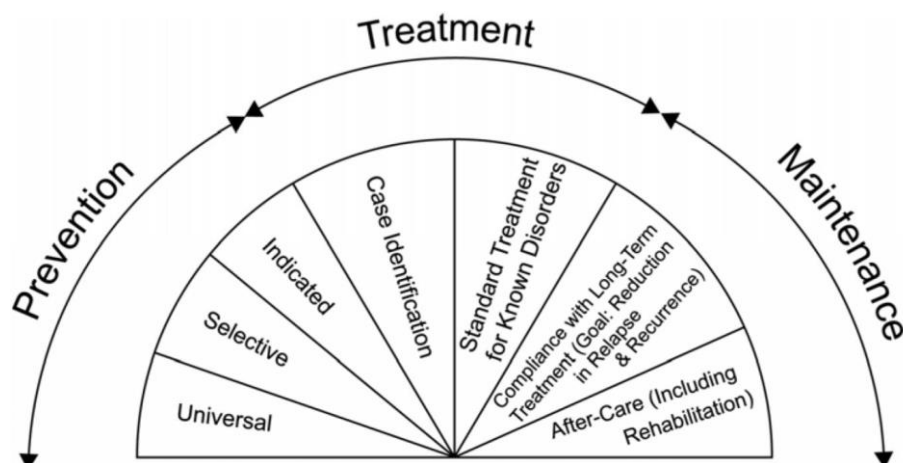
## CHAPTER 1: Key Themes and Concepts in Scope

The scope of this JSNA is broad and some key concepts are used to indicate how the prevention and treatment of substance misuse is understood and addressed.

### Classification of Substance Misuse Interventions

Figure 6 is the United States Institute of Medicine's prevention classification system<sup>4</sup>, validated in 2009 and it is used here to capture the scope and complexity of this JSNA. It has been applied<sup>5</sup> to the substance misuse field to illustrate the continuum of services/interventions between prevention, treatment, recovery and harm reduction and is a useful tool for describing a conceptually unified and evidence-based continuum of services. This taxonomy also provides a common language to describe prevention and assist in the planning, delivery, and evaluation of activities.

**Figure 6: The Institute of Medicine model of prevention (1994; 2009)**



The JSNA addresses prevention through universal interventions which includes media campaigns through to environmental interventions such as licensing regulations.

The terms 'selective' and 'indicated' are terms now increasingly applied to substance misuse and are explained more fully in the prevention section. They to some extent reflect the traditional models of prevention: primary, secondary and tertiary. However selective refers to the targeting of those at risk and indicated to those who are misusing substances but not yet dependent.

<sup>4</sup>Institute of Medicine (1994) Reducing the Risks for Mental Disorders: Frontiers for Preventative Intervention Research. In Meazak PJ, Haggerty RJ, editors. Committee on Prevention of Mental Disorder, Division of Biobehavioural Sciences and Mental Disorders. Washington DC. National Academy Press

<sup>5</sup> Advisory Council on the Misuse of Drugs. Prevention of drug and alcohol dependence. 2015

The local prevention and treatment services are described along with any supporting evidence. The current thinking on abstinence, recovery and harm reduction alongside the long term management of substance misuse is described.

How the cross cutting themes of mental health, the criminal justice system and housing impact on the prevention and treatment outcomes is considered

## Life Course Approach

Throughout the JSNA the impact of substance misuse is addressed throughout the life course. This allows consideration of key transition periods for prevention and treatment.

Drug prevention and treatment are commonly thought of as being most relevant to young people and most research and activity is concentrated on this age group. However, prevention is relevant across the lifespan, for example, in reducing prescription drug misuse or alcohol use in older adults.

There are many factors associated with an increased risk of the misuse of drugs and alcohol among young people and adults. These factors often lead to risk taking behaviours and poor health outcomes such as mental health problems and offending. The aim of preventative interventions is to tackle risk factors and build resilience to developing drug and alcohol problems

## Risk and Resilience

Intervention whether preventative or treatment focuses on reducing risk and building resilience in individuals and communities, especially those most at risk. Developed primarily for use with children and young people but applicable to all ages the approach is based on risk and resilience theory.

Resiliency Theory<sup>6</sup> provides a conceptual framework for considering a strengths-based approach to understanding child and adolescent development and informing intervention design. It provides a conceptual framework for studying and understanding why some young people grow up to be healthy adults in spite of risks exposure. Resiliency focuses attention on positive contextual, social, and individual variables that interfere or disrupt development from risk to problem behaviors, mental distress, and poor health outcomes. These positive contextual, social, and individual variables work in opposition to risk factors, and help young people overcome any negative effects of risk exposure. The objective is to identify the assets and resources which are positive factors. Assets include for example self-efficacy and self-esteem. Resources refer to factors outside individuals such parental support and programmes that provide opportunities to learn and practice skills.

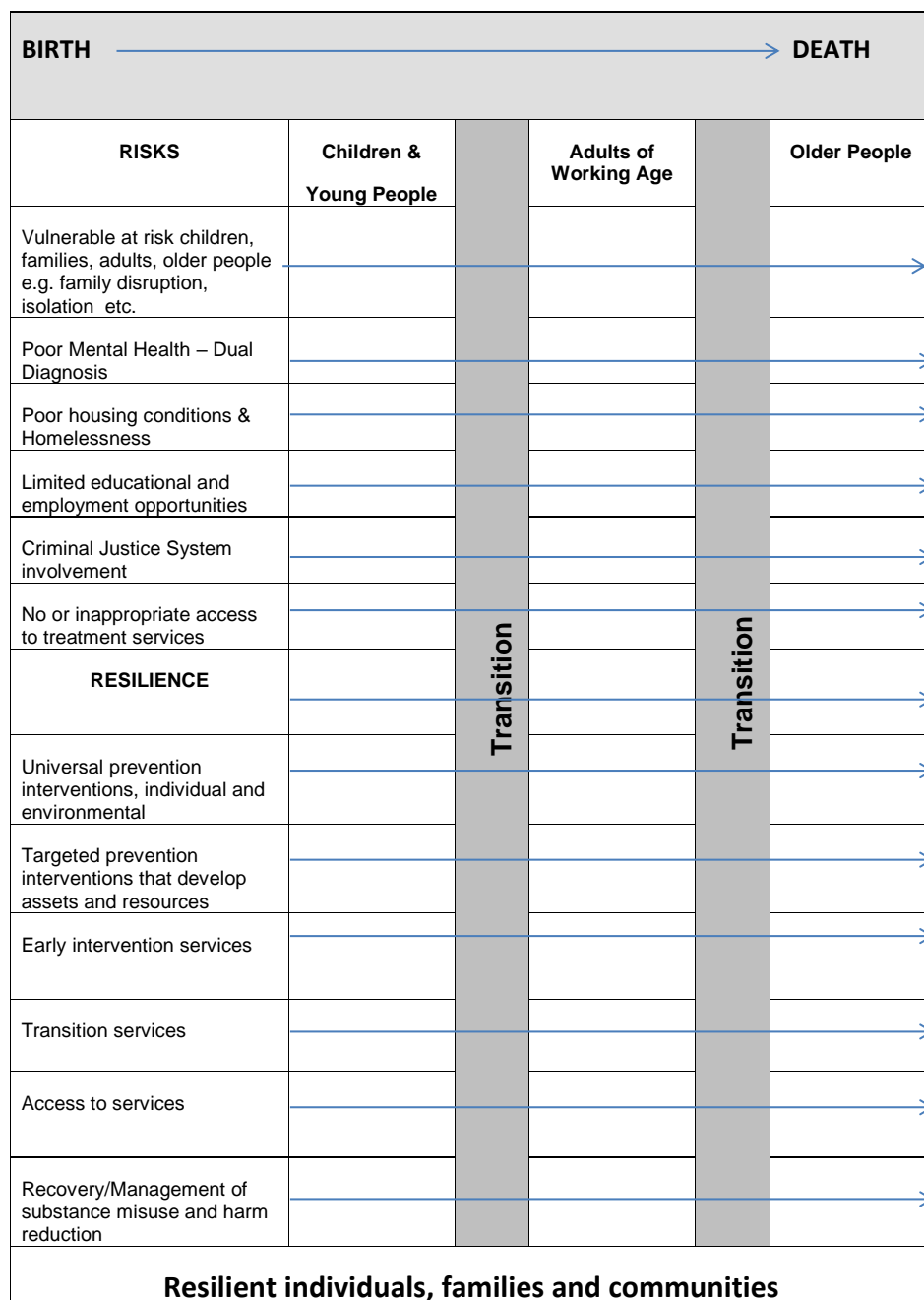
The children and young people section includes discussion of those individuals who are less likely to have the assets and resources to develop resilience. The theory and concepts can also be applied to adults and older people.

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<sup>6</sup> Zimmerman M, Resiliency Theory: A Strengths-Based Approach to Research and Practice for Adolescent Health Health Education Behaviour 2013 Aug 40(4) 381-383



Figure 7: Risk and Resilience throughout the life course



## CHAPTER 2: The National Picture

### 2014-15 Data Headlines

The following are some of the national headlines from the National Drug Treatment Monitoring System (NDTMS) which indicate some of the changing patterns of drug and alcohol misuse that are reflected in the local themes found in this JSNA.

- The age profile of people in treatment is rising. For example, 44% of the 152,964 people in treatment for opiates are now 40 and over. Since 2009-10, the number of opiate users aged 40 and over starting treatment has risen by 21% (12,761 to 15,487).
- This ageing cohort is often in poor health, with a range of vulnerabilities associated with long-term drug use. These people require a wide range of support, including social care. When considering all ages, presentations to treatment for opiates have been falling over the last six years (55,494 to 44,356), reflecting the downward trend in prevalence of heroin use.
- The number of people presenting for alcohol problems in 2014-15 was 150,640. Of these, 89,107 were treated for problematic drinking alone, and 61,533 for alcohol alongside other substances. Alcohol only clients had an older age profile than opiate users (68% aged 40 and over).
- While the overall numbers accessing treatment for alcohol have increased by 3% since 2009-10 (86,385 to 88,904), the number aged 40 and over accessing services has risen by 21% and the number aged 50 and over by 44% (42,128 to 50,786, 21%, 16,627 to 24,017, 44%). Many of these people will have been drinking at high-risk levels for some time and are likely to be experiencing health harm such as liver disease and hypertension.
- The majority of younger people (18-24) presenting to treatment in 2014-15 cited problems with either cannabis or cocaine (7,369, 52%, and 3,272, 23%).
- Most presentations for new psychoactive substances (NPS) are also in the younger age groups, though the total number accessing treatment for NPS remains relatively low (1,370, 0.5%).
- Overall, the number of under-25s accessing treatment has fallen by 33% since 2009-10, with the largest decrease in opiates (mainly heroin) where the numbers presenting to treatment have fallen by 60%. This reflects a shift in the type of drug use among young adults.
- Men made up 70% of the entire treatment population in 2014-15. The gender split varied depending on the presenting substances – 73% of people using drugs were male compared to 62% presenting with alcohol only.
- Individuals recorded as white British made up the largest ethnic group in treatment, (85%, 245,380) with a further 4% from other white groups.
- Since 2013 the overall rate of people exiting treatment successfully has slowed. This is mainly because the rate of opiate clients' successfully completing treatment has fallen, which is likely to be a result of those now in treatment having more entrenched drug use and long-standing and complex problems.

- In all, 130,609 people exited the drug and alcohol treatment system in 2014-15, with 52% (67,788) having successfully completed their treatment free of dependence. Non-opiate-only clients had the highest rates of successful exits with almost two thirds (64%) completing treatment, followed by 61% of alcohol clients. Opiate clients had a completion rate of 30%.
- The recovery rates for non-opiates and alcohol have remained higher and stable largely because users of these substances are more likely to have access to the personal and social resources that can aid recovery, such as employment and stable housing.
- The number of people who died while in contact with services in 2014-15 was 2,360. Most of these (61%, 1,428) were opiate clients who tended to be over 40 (median age 43) and were likely to have been using heroin for a long time.
- While not all deaths in treatment will be attributable to an individual's substance use, the use of drugs is a significant cause of premature mortality in the UK.<sup>1</sup> Drug misuse deaths registered in England and Wales between 2012 and 2014 increased by 42%, with the number now 2,120 per year, the highest since records began in 1993. The number of deaths involving heroin in 2014 increased by 64% from 2012.
- The drug-related death rate among people in treatment is significantly lower than among those who are not in treatment.
- Among those accessing treatment for alcohol only problems, there were 792 deaths. Again the majority were aged 40 and over, (median age 49). Users of other substances made up the remaining deaths, with the lowest number of deaths seen among users of non-opiates (39 deaths), the lowest median age (35 years) was also seen in this population.

## Drug and Alcohol Misuse and Health and Wellbeing

Please note that where references are not cited the information sources are the following Public Health England documents.

*Guidance: Health matters: harmful drinking and alcohol dependence 2016.*

*Public Health England Alcohol and drugs prevention, treatment and recovery: Why Invest? 2014.*

Drug and Alcohol dependence can be a long-term condition, which may involve relapses even after good quality treatment. Dependent individuals also experience many health problems and are frequent users of health services.

An analysis of 67 risk factors and risk factor clusters for death and disability found that alcohol is the third leading risk factor for death and disability after smoking and obesity.<sup>7</sup> It is associated with 60 different medical conditions.<sup>8</sup>

<sup>7</sup> Lim S.S. et al A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study Lancet. 2012 Dec 15;380(9859):2224-60. doi: 10.1016/S0140-6736(12)61766-8.

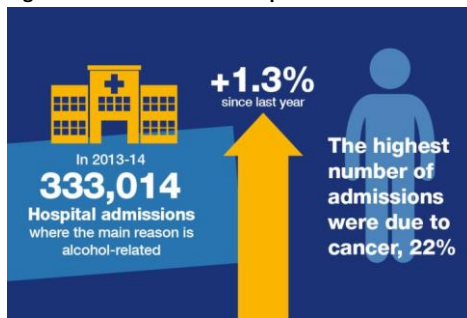
<sup>8</sup> Health and Social Care Information Centre Report 2012. Chapter 6 Alcohol Consumption

**Figure 8: Health outcomes associated with Alcohol misuse**



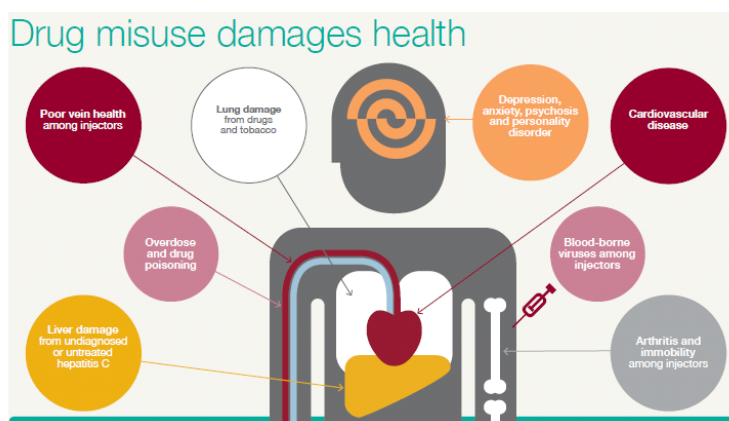
In addition recent evidence has identified a strong link with several cancers including mouth, bowel, stomach, liver and breast. There is a high cost to healthcare associated with these impacts upon health.

**Figure 9: Alcohol related hospital admissions**



The effects of misusing legal or illegal drugs on health are also wide ranging.

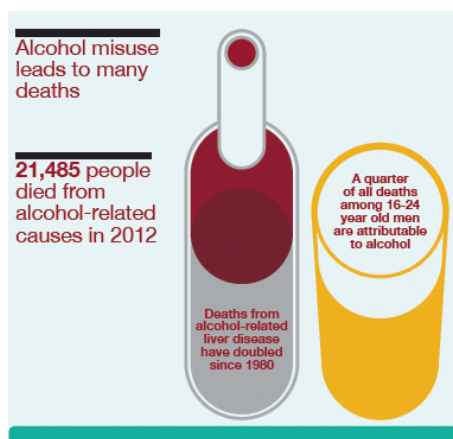
**Figure 10: Health outcomes associated with drug misuse**



## Drug and alcohol related mortality

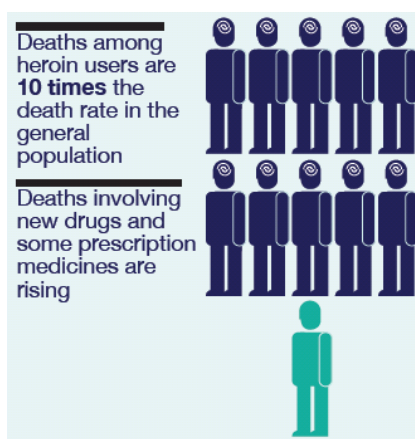
Excessive alcohol consumption is a major cause of preventable premature death. It accounts for 1.4% of all deaths registered in England and Wales in 2012. The number of alcohol-related deaths in England has increased in recent years.

**Figure 11: Mortality and alcohol misuse**



High mortality rates are also associated with drug misuse. More recently the increase in the misuse of prescribing drugs is also being associated with a rising number of deaths.

**Figure 12: Mortality associated with drug misuse**

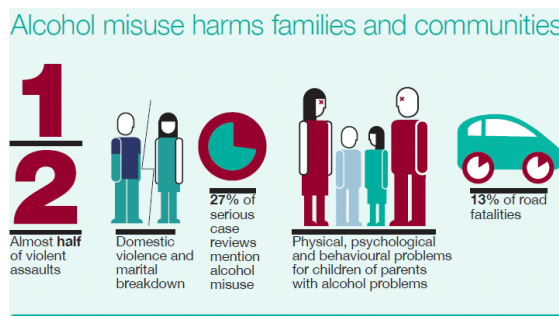


### Impact of drug and alcohol misuse on children and families

There are wide ranging effects of alcohol misuse upon families and communities. Some headlines demonstrate its impact:

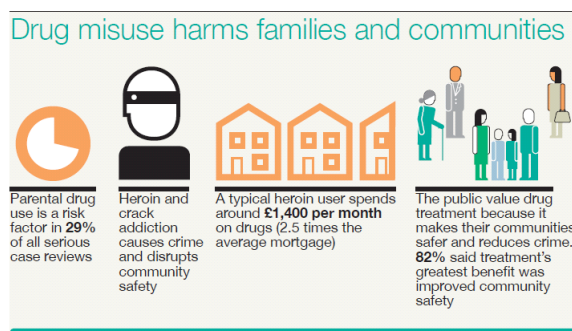
- Alcohol plays a part in 25 to 33% of known cases of child abuse.
- In a study of four London boroughs, almost two-thirds of all children subject to care proceedings had parents who misused substances including alcohol.
- In a study of young offending cases where the young person was also misusing alcohol, 78% had a history of parental alcohol abuse or domestic abuse within the family.

**Figure 13: Alcohol harms for families and communities**



The misuse of drugs has a similar impact of families and communities

**Figure 14: Drug misuse harms for families and communities**

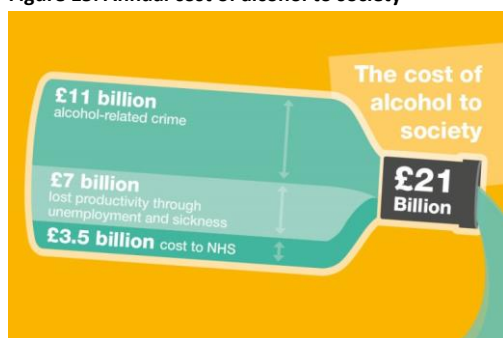


Drug and alcohol misuse also affects carers and family members, a group that is often overlooked. The Care Act 2014 recognises this and recommends an assessment of their own needs.

## The Costs of Drug and Alcohol Misuse

Given the scale of drug and alcohol misuse, its impact is not just upon health but on wider social and economic issues. Alcohol misuse is associated with recorded crimes in England and seen as a contributory factor in over 50% of assaults and domestic violence. Alcohol-related harm is now estimated by the Government to cost society £21 billion annually, covering health-related costs, criminal justice, social care, housing and social care.<sup>9</sup>

Figure 15: Annual cost of alcohol to society



Similarly drug misuse is associated with crime, health and social care costs with a total cost to society of £15.4 billion annually. The cost of looking after children whose parents or carers misuse drugs is now estimated to be £42.5 million annually.

Figure 16: Annual cost of drug addiction to society

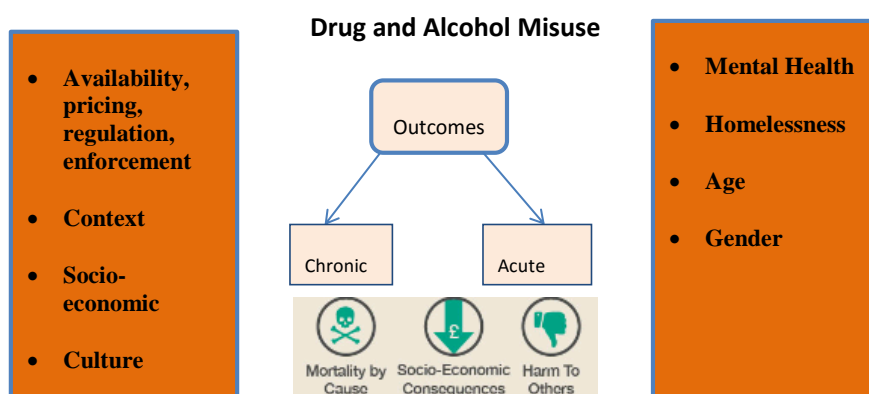


<sup>9</sup> The Government's Alcohol Strategy, March 2012

## Inequalities in drug and alcohol misuse

There is a range of factors associated with drug and alcohol misuse. The relationships are complex with differences in misuse between different groups and inequalities in impacts.

**Figure 17: Key factors in drug and alcohol misuse**



Key differences in substance misuse are gender and socio-economic deprivation. In England, there are gender differences for drug and alcohol misuse. This gender difference is found to be the case all over the world and is one of only a few key gender differences in social behaviour.

The impact of drug misuse, harmful drinking and alcohol dependence is much greater for those in the lowest income bracket and those experiencing the highest levels of deprivation. The reasons for this are not fully understood especially in relation to alcohol misuse. People on a low income do not tend to consume more alcohol than people from higher socio-economic groups. It is thought that increased risk is likely to relate to the effects of other issues affecting people in lower socio-economic groups.

Significant negative health impacts can arise as a result of unemployment and homelessness, both for the individual and their families but this impact worsens when it involves drug and alcohol misuse. Studies from Europe and the US conclude that misuse is more likely to start or escalate after unemployment begins.

A number of large epidemiological surveys demonstrate the high prevalence of co-morbidity in those attending mental health services and both drug and alcohol treatment services. An estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year. There is a strong association between alcohol misuse and suicide. The [National confidential inquiry into suicide and homicide by people with mental illness](#) found that there was a history of alcohol misuse in 45% of suicides among the patient population during period 2002 to 2011.



## Reducing the costs of drug and alcohol misuse – Why should we invest in the prevention and treatment of drug and alcohol misuse?

Clearly there are wide ranging costs to individuals, families, communities and society in general. This JSNA indicates a number of evidence based interventions that provide cost benefits which mitigate the costs of drug and alcohol misuse. The following are those that have a strong evidence base.

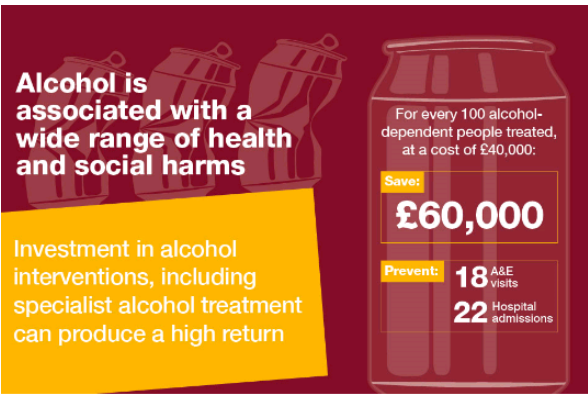
The JSNA identifies that the majority of drug and alcohol misuse starts amongst people in the young age groups. In 2014/15 73% of 15 year olds report that they have had an alcoholic drink and over 7% reported having a drink in the last week. 12% reported that they have tried cannabis with nearly 6% reporting that they had used cannabis in the last month. Although many do not go on to regular harmful use, some do, with harmful and costly consequences for themselves, families and communities. There is evidence that interventions young people to increase resilience and resistance to involvement in risk taking behaviour can bring benefits.

Figure 18: Investing in prevention



Investment in alcohol interventions and treatment services can produce savings for the NHS.

Figure 19: Investing in alcohol interventions



The JSNA recommends the wider use of brief interventions as an early intervention for the identification and prevention of any escalation of alcohol misuse. This has been found to be most effective and cost effective in Accident and Emergency settings and primary care. In addition a Hospital Liaison Service also has strong evidence base and has been found to be cost-effective and a cost saving intervention. See Evidence base and Recommendation sections.

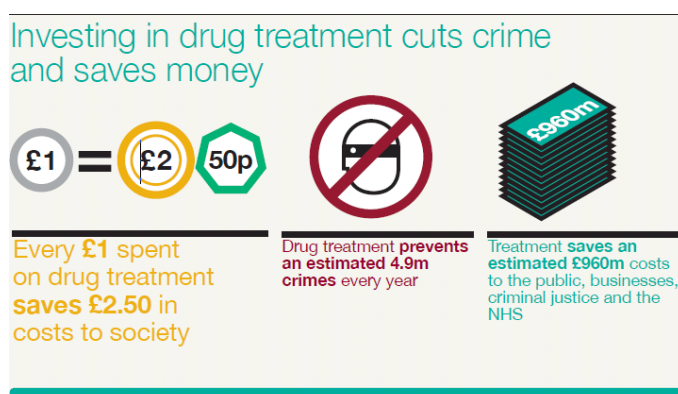
Figure 20: Investing in alcohol interventions



There is also evidence and economic evidence for the use of environmental factors which are described in detail in the Prevention section. The areas with the strongest evidence base are related to alcohol, licensing hours, outlet density and minimum pricing. Minimum pricing has the strongest economic evidence with figures modelled in 2010 indicating that a price limit of 40p per unit of alcohol could produce savings of £100 million over 10 years to the NHS, criminal justice and employers.

Investment in drug misuse interventions impact on a wide range of organisations and have been found to deliver savings against the wider societal costs.

**Figure 21: Investment in drug treatment**



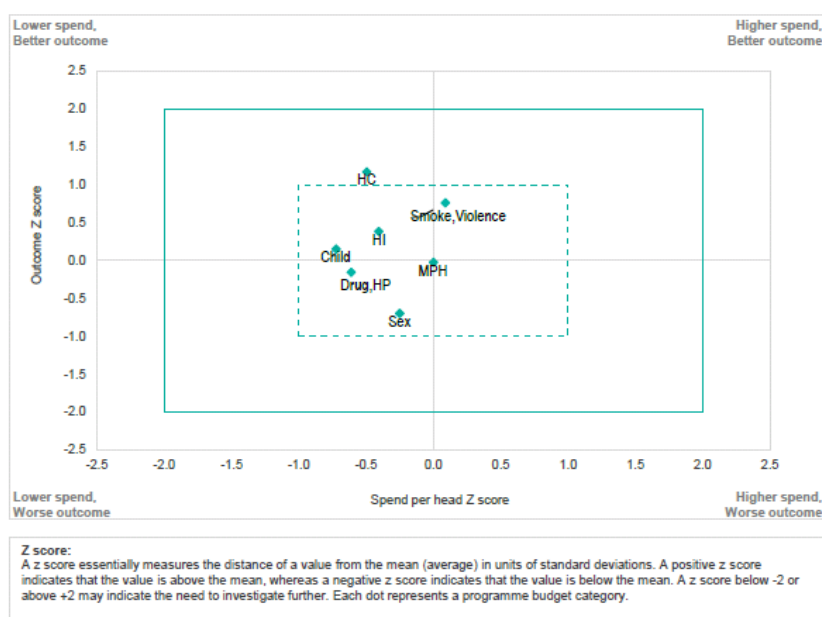
### Cambridgeshire's Investment in Alcohol and Drugs Services

Public Health England has developed a number of tools to help understand cost and health outcomes and value for money.

The Spend and Outcome Tool (SPOT) gives an overview of spend and outcomes at local authority level. It includes several measures from different outcome frameworks, including the Public Health Outcomes Framework (PHOF). It allows comparison across different local authority areas.

Adult alcohol

**Figure 22: Cambridgeshire's Public Health Spend and Outcomes<sup>10</sup>**



The “Drug” category in Figure 22 includes drugs and alcohol i.e. adult alcohol, adult drugs and young peoples’ alcohol and drugs services expenditure are considered. The spend per head and a range of outcomes found in the Public Health Outcomes Framework can be compared to other areas.

In Cambridgeshire spend on services and desired outcomes are both below the national mean, as is overall public health spend in Cambridgeshire.

However the SPOT tool does not assess the relative cost-effectiveness of different interventions or how to get the best value for money. The SPOT analysis can be considered alongside evidence from the alcohol and drugs Value for Money tools (the Commissioning Tool) and with the evidence that investment in treatment is associated with immediate and long-term savings.

The aim of the Commissioning Tool<sup>11</sup> is the same as the SPOT, though specifically relating to spend and outcomes of different types of treatments accessed by opiate users, non-opiate users and alcohol only.

<sup>10</sup> Public Health England Spend and Outcome Tool 2016 <http://www.yhpho.org.uk/LASPO/SPOT2016v361/E10000003%20Cambs%20SPOT%202016%20Full%20Briefing.pdf>

<sup>11</sup> Public Health England SPOT the differences between PHE Economic Tools 2016 <http://www.yhpho.org.uk/LASPO/SPOT2016v361/E10000003%20Cambs%20SPOT%202016%20Full%20Briefing.pdf>

## CHAPTER 3: Prevention

### A Framework for Prevention.

Prevention is usually conceptualised into three levels.

- Primary prevention is aimed at people who have no particular care needs or signs of illness. The focus is on maintaining good health, independence and resilience.
- Secondary prevention is aimed at identifying people existing health problems and aims to improve their situation or slow down any deterioration.
- Tertiary prevention is aimed at minimising disability or deterioration from established health problems or complex social care needs.

As described in the Key Themes and Scope section, the US Institute of Medicine<sup>12</sup> uses a specific classification system for different types of interventions for drug and alcohol misuse. This is now widely used in the drug and alcohol misuse field as it captures the need to differentiate between those at high risk but not yet misusing drugs or alcohol and those who have started to misuse but are not yet dependent. The “**universal**” interventions are for primary prevention and are usually adopted to address the whole population and aims to prevent initiation of substance misuse. It is appropriate when risk factors for the problem are not easy to identify, are diffused amongst the population and targeting is not easy. Whereas “**selective**” (or targeted) interventions are for those groups that are known to be at high risk.<sup>13</sup> The term “**indicated**” or secondary prevention aims to limit the harm in the early stages of substance misuse. This terminology therefore brings new dimension to primary prevention.

The 2010 UK Drugs Strategy<sup>14</sup> proposed a “whole life course” approach to break through inter-generational substance misuse behaviours. Figure ? indicates how this has also been adopted by the United Nations Office of Drug Control (UNODC).<sup>15</sup> This reflects the importance attached to the health and social influences, both positive and negative, that accumulate and change over time with the early years interventions having the most impact.

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<sup>12</sup> Institute of Medicine Reducing the risk for Mental Disorders: Frontiers for Preventative Intervention Research in Mrazek PJ, Haggerty RJ, Committee on Prevention of Mental Disorders, Division of Biobehavioral Sciences and Mental disorders. Washington DC. National Academy Press (1994 validated 2009)

<sup>13</sup> United Nations Office of Drug Control (UNODC) International Standards of Drug Use Prevention 2013

<sup>14</sup> Home Office Reducing Demand, restricting supply, building recovery: supporting people to live a drug free life (2010)

<sup>15</sup> United Nations Office on Drugs and Crime. International Standards on Drug Use prevention (2013)

Figure 23: Life Course Interventions for Drug and Alcohol Prevention (UNODC)

	Prenatal & infancy	Early childhood	Middle childhood	Early adolescence	Adolescence	Adulthood
<b>Family</b>	Prenatal and infancy visitation (Selective) ** Interventions targeting pregnant women with substance abuse disorders (Selective) *		Parenting skills (Universal & selective) ****			
<b>School</b>		Early childhood education (Selective) ****	Personal & social skills (Universal) *** Classroom management (Universal) *** Policies to keep children in school (Selective) ** Addressing individual vulnerabilities (Indicated) **	Prevention education based on personal & social skills & social influences (Universal & selective) *** School policies and culture (Universal) **		
<b>Community</b>				Alcohol & tobacco policies (Universal) ***** Community-based multi-component initiatives (Universal & selective) *** Media campaigns (Universal and selective) * Mentoring (Selective) *	Entertainment venues (Universal) ** Workplace prevention (Universal, selective & indicated) *** Brief intervention (Indicated) ****	

Source: UNODC prevention standards

Key: Indication of efficacy (\* limited/ \*\* adequate/ \*\*\* good/ \*\*\*\* very good/ \*\*\*\*\* excellent).

The next section describes the evidence relating to universal primary prevention interventions wider environment interventions. Information on prevention, which includes selective (targeted) and indicated (secondary) prevention interventions throughout the life course are addressed in the relevant chapters.

## Universal Prevention

Figure ? Public Health England has identified some key areas that are required if there is to be an effective population prevention programme.

The section addresses some specific policies relating to alcohol. Other primary prevention interventions such as community programmes and campaigns and how they affect different age groups are addressed in the relevant chapters. The key point is that to effectively address primary prevention there needs to be interventions across the system that includes individuals, communities and organisations.

**Figure 24: Public Health England: Population Level Prevention**



### Environmental Interventions – Alcohol Related Policies

The Advisory Council of the Misuse of Drugs (ACMD)<sup>16</sup> has observed that prevention is not just about what activities or programmes deliver but how prevention is organised and implemented which it terms as environmental interventions.

Environmental prevention includes interventions that aim to limit the availability of drug and alcohol opportunities through system wide policies, restrictions and actions. They are designed to affect the immediate cultural, social, physical and economic environment in which people make their choices about drug and alcohol misuse.

The rationale that is often given for this is that limiting the opportunities for action results in behaviour change. There are more examples of interventions designed to impact on alcohol than drug misuse. With illegal drugs, policy interventions reflect the enforcement context. The Misuse of Drugs Act in 1971 is an example of environmental prevention for illegal drug misuse. Drug driving and workplace policies could also be considered as examples.

Alcohol is a legal substance and policies therefore focus upon interventions that limit opportunity for its use. The policies are well researched and focus upon outlet density, minimum pricing and taxation. Advertising and campaigns are also cited by some commentators as environmental interventions and these are picked up in later chapters.

<sup>16</sup> Advisory Council on the Misuse of Drugs Prevention of drug and alcohol dependence 2015

## The Evidence

The majority of systematic reviews on this specific topic were utilising evidence and research from the United States, Canada, Australia and Netherlands which have very different policy and legislative controls around alcohol that makes the transferability of some of the findings problematic e.g. in the United States individual states have varying controls over licensing, pricing and outlet density.

Numerous primary studies and systematic reviews have assessed the effectiveness of alcohol interventions but evaluating the strength of evidence remains challenging due to the diversity of the outcome measures recorded (e.g. defining alcohol related harm, alcohol consumption). Also there are context dependent interventions (measure of outlet type, club, bar, off-licence, supermarket) which are often distinguished in the literature as “on and off” premises, which relates to sales of alcohol on or off site premises. The definition of alcohol related harm varies across the research studies and is difficult to quantify as studies will include differing measures e.g. consumption, injury outcomes, motor-vehicle crashes, domestic violence, anti-social behaviour, crime, etc.

## The UK policy context

In the UK the Licensing Act of 2003 established the powers to control local alcohol supply and consumption. Local governments are directly responsible for controlling alcohol provision through licensing, planning and trading standards. Their powers are limited to activity within the National Legal Framework of licensing objectives.

- Prevention of crime and disorder
- Public Safety
- Prevention of public nuisance
- Protection of children from harm

All licensing decisions about specific premises must promote the four statutory licensing objectives.

Licensing Authorities are responsible for issuing “Statements of Licensing Policy” which have the option to designate special policies or establish local relevance to particular licensing approaches. These special policies allow for the introduction of designated Cumulative Impact Zones (CIZs) Early Morning Restriction Orders (EMRO) and Late Night Levies (LNL) as additional mechanisms to control alcohol sales.

Licensing authorities can only consider health-related evidence that directly links the premises in question to a threat to one of the named licensing objectives. An issue is that routine health data is rarely collected in a way that can be linked to individual premises. The Local Government Association has observed that health data is not likely to be considered relevant.<sup>17</sup> Martineau et al (2013) argue that repeated submissions based on health evidence that is unrelated to the licensing objectives and not deemed “relevant” to the specific applicant may weaken the credibility of future representations.

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<sup>17</sup> Local Government Association Public Health and alcohol licensing in England. LGA Research UK briefing (2013)



The Police Reform and Social Responsibility Act (2011) granted health organisation leads a statutory role in the licensing process and the right to comment on any health impacts relating to local licensing applications.

### Outlet density

Outlet density refers to the number of physical locations in which alcoholic beverages are available for purchase either per area or per population. Reducing the number of alcohol outlets aims to decrease access to alcoholic beverages and increase social cohesion in and around premises resulting in a decrease of excessive alcohol consumption and alcohol related harms.<sup>18</sup>

The limitation in the literature on the effectiveness of the interventions on consumption is that there is not always a distinction between outlets for either off-premises or on-premises consumption. On-premises settings may include restaurants, bars and pubs and off-premises settings may include supermarkets, grocery stores and convenience stores. In relation to alcohol related harms studies on off-premise alcohol outlets are strongly associated with drinking problems, crime and injuries than on premise alcohol outlets which has a stronger association with night time violence.

In addition to outlet density the following seven characteristics<sup>19</sup> have been identified in the literature that also influence consumption and alcohol related harms. Observers have commented that this makes it difficult to formulate policy

1. Outlet size (volume of sales)
2. Clustering (level of aggregation)
3. Location (proximity to school)
4. Neighbouring environmental factors
5. Size of the community
6. Type and number of alcohol outlets
7. Association with illegal activities (e.g. illicit tobacco and alcohol sales)

One systematic review examined how alcohol outlet density related to long-term health outcomes and the extent to which this differs for those living in disadvantaged neighbourhoods.<sup>20</sup> This review reported that a large body of evidence has shown more disadvantaged neighbourhoods have greater densities of alcohol outlets. The review suggested that the presence of alcohol outlets has a *“disproportionately deleterious effect for those living in more disadvantaged area”*. The conclusion of the review was that applying more restrictive alcohol licensing requirements may be protective of health and support the reduction of inequities.

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<sup>18</sup> Campbell C, Hahn R, Elder R, et al The effectiveness of limiting outlet alcohol density as a means of reducing excessive alcohol consumption and alcohol related harms. *American Journal of Preventative medicine* 37 96) 556-569 (2009)

<sup>19</sup> Campbell C, Hahn R, Elder R, et al The effectiveness of limiting outlet alcohol density as a means of reducing excessive alcohol consumption and alcohol related harms. *American Journal of Preventative medicine* 37 96) 556-569 (2009)

<sup>20</sup> Badland H, Mavoa S, Livingston M, David S & Giles-corti B (2015) Testing spatial measures of alcohol density with self-rated health in the Australian context: Implications for policy and practice. *Drug & Alcohol Review* 1-9 2015

Outlet density has also been found to be associated with alcohol related harm. Ludbrook found that accidents and violence are more likely to occur in areas with high density outlets and called for more economic evaluations of outlet density interventions.<sup>21</sup>

In summary there is evidence found in a number of studies that outlet density control is a means of controlling alcohol related harms.<sup>22 23 24 25</sup>

- Increased density was associated with increased consumption and visa versa.
- Whilst evidence of effectiveness on reducing outlet density exists it is not outlet specific which could restrict local implementation
- Negative health effects exist for alcohol outlet density in those living in more disadvantaged neighbourhoods.
- There is an association between outlet density and interpersonal violence (inferred due to social aggregation) in and around alcohol outlets and that the density of outlets in a given locality can influence the probability of assaults.

The evidence in the NICE<sup>26</sup> Guidance in 2010 was undertaken by the Sheffield School of Health and Related Research (SchHARR) Public Health Collaborating Centre found a clear positive association between increases in alcohol outlet density and increases in alcohol consumption among both adults and young people. Further limited evidence also identified a positive relationship between alcohol outlet density and alcohol-related harms. This research from Sheffield still provides some of best evidence for policy interventions upon alcohol consumption.

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<sup>21</sup> Ludbrook A. (2004) Effective and Cost-Effective measures to reduce alcohol misuse in Scotland: An update to the literature review. Health Economics Research Unit: University of Aberdeen. <http://www.scotland.gov.uk/health/alcoholproblems/docs/liire-00.asp>.

<sup>22</sup> Campbell C, Hahn R, Elder R, et al The effectiveness of limiting outlet alcohol density as a means of reducing excessive alcohol consumption and alcohol related harms. *American Journal of Preventative medicine* 37 96) 556-569 (2009)

<sup>23</sup> Gmel G, Holmes J & Studer J (2016) Are alcohol outlet densities strongly associated with alcohol-related outcomes? A critical review of recent evidence. *Drug & Alcohol Review* January 2016), 35, 40-54

<sup>24</sup> Badland H, Mavoa S, Livingston M, David S & Giles-corti B (2015) Testing spatial measures of alcohol density with self-rated health in the Australian context: Implications for policy and practice. *Drug & Alcohol Review* 1-9 2015

<sup>25</sup> Holmes J, Guo y, Maheswaran R, Nicholls J, Meier P & Brennan A (2014) The impact of spatial and temporal availability of alcohol on its consumption and related harms: A critical review in the context of UK licensing policies. *Drug & Alcohol Review* (September 2014) 33,515-525

<sup>26</sup> Sheffield School of Health and Related Research SchHARR in NICE 2010 Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People

## Reduction in licensing hours

In some countries, state and national laws limit the days and hours of the week alcohol may be sold as a means to reducing excessive alcohol consumption and related harms. In the UK a relaxing of licensing restrictions in 2013 has removed any national restrictions on the days and hours when alcohol can be served. Local licensing authorities can impose restrictions on premises but often will require good local evidence that it will reduce harm and that the licensing objectives are at threat e.g. prevention of crime and disorder, promotion of public safety etc.

One systematic review of the effectiveness of policies maintaining and restricting days of alcohol sales on excessive alcohol consumption and related harms<sup>27</sup> found evidence to support restrictions on days of sales. It was found that limiting alcohol availability by maintaining existing limits on the days of sale is an effective strategy for preventing excessive alcohol consumption and related harms. There was some direct evidence that the imposition of increased limits on days of sales may reduce alcohol-related harms by reducing consumption and reduced levels of public disorder.

UK and international evidence from a systematic review also found in NICE (2010)<sup>28</sup> that increases in licensing hours were typically associated with increased consumption and/or harms. Examples from abroad most notably from the city of Newcastle in Australia<sup>29</sup> reported a sustained lower assault rate following the introduction of restrictions.

## Policy options for alcohol price regulation

International alcohol pricing policies have expanded to include targeted taxation, inflation-linked taxation, taxation based on alcohol by volume (ABV), minimum pricing policies, bans of below-cost selling and restricting price-based promotions. The effectiveness of alcohol tax policies for reducing excessive alcohol consumption and health related harms is based on economic theory that increasing the price of alcohol would be expected to lower alcohol consumption.

A policy option briefing for the UK government in 2009<sup>30</sup> considered purchasing preferences in terms of the types and volumes of alcoholic beverages, prices paid and the balance between on premise and off premise consumption. They concluded that pricing policies vary in their impact on different product types with different effects on population subgroups. As with outlet density, studies do not always account for every variable, which excludes the complicating factors that the effects of taxation and pricing policies differ for different types of drinkers i.e. heavy/abusive drinkers and moderate drinkers and different policy initiatives i.e. minimum pricing, off trade discounting etc.

Pricing policies are known to be effective but few studies focus on how the specific interventions affect health-care costs and quality of life outcomes for different drinkers. Primary research<sup>31</sup> found

<sup>27</sup> Middleton J, Hahn R, Kuzara J, Elder R et al (2010) Effectiveness of Policies Maintaining or Restricting Days of Alcohol Sales on Excessive Alcohol Consumption and Related Harms. *American Journal of Preventative Medicine* (2010) 39 (6) 575-589

<sup>28</sup> NICE, Sheffield School of Health and Related Research SCHARR in NICE 2010 Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People 2010

<sup>29</sup> Kypros K et al Restrictions in pub closing times and lock outs in Newcastle Australia five years on Drug and Alcohol Review 2014

<sup>30</sup> Meir P, Purshouse R & Brennan A (2009) Policy options for alcohol price regulation: the importance of modelling population heterogeneity. *Addiction*, 105, 383-393

<sup>31</sup> Brennan A., Meier P., Purshouse R., Meng Y., Rafia R., Hill-Macmanus D. Health Economic Modeling of Alcohol Harm Reduction. [http://eprints.whiterose.ac.uk/43755/1/HEDS\\_DP\\_12-03.pdf](http://eprints.whiterose.ac.uk/43755/1/HEDS_DP_12-03.pdf)

health economic outcomes both reduced admission and that health care savings are strongly related to the extent of consumption reduction achieved by the policy. Consumption reduction would also lead to reductions in mortality, disease prevalence and hospital admissions.

Alcohol pricing policy options are more complex than simple duty increases. Some evidence from systematic reviews<sup>32</sup> would advise caution in generalisations that higher taxes and prices significantly reduce consumption. Commentators recommend that population heterogeneity must be taken into account to interpret what policy options have implications for which population subgroups.<sup>33 34</sup>

The research again found in the NICE Guidance in 2010 provides considerable evidence relating to the impact of price/taxation on alcohol consumption. This demonstrates a clear relationship between price/tax increases and reductions in the demand for alcohol. A positive relationship between alcohol affordability and alcohol consumption was reported as operating across the European Union. The evidence base also showed a relationship between price/tax increases and reductions in alcohol-related harms. A positive relationship between alcohol consumption and liver cirrhosis, traffic injuries, and traffic deaths was also observed.

## Minimum Pricing

The 2010 NICE research suggested that there was limited evidence that minimum pricing may be an effective approach in reducing overall alcohol consumption but there was some evidence of it having an impact on young people and more disadvantaged groups.

NICE (2014)<sup>35</sup> reported on a Lancet study that demonstrated that minimum pricing would have the greatest impact on people whose drinking is considered to be harmful, which was defined as consumption over 50 units per week for men and more than 35 units per week for women. Around three-quarters of the total reduction in alcohol consumption from minimum pricing would occur among such drinkers, leading to an estimated 860 fewer alcohol related deaths per year, and a reduction of 29,900 hospital admissions per year. The effect of minimum pricing around moderate drinkers was found to be very small. The group most affected by minimum pricing was found to be harmful drinkers on low incomes, reducing their alcohol intake by an estimated 300 units per year, with reductions in mortality much greater than for drinkers in any other group. The differential effect arose because minimum price policies target cheap alcohol products, which make up higher proportion of the average selection of alcohol purchases for heavier drinkers than those of moderate drinkers.

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<sup>32</sup> Nelson J (2014) Gender Differences in Alcohol Demand: A systematic Review of the role of prices & taxes. Health Economics 23: 1260-1280 (2014)

<sup>33</sup> Meir P, Purshouse R & Brennan A (2009) Policy options for alcohol price regulation: the importance of modelling population heterogeneity. Addiction, 105, 383-393

<sup>34</sup> Nelson J (2014) Gender Differences in Alcohol Demand: A systematic Review of the role of prices & taxes. Health Economics 23: 1260-1280 (2014)

<sup>35</sup> NICE (2014) Minimum pricing for alcohol <https://www.nice.org.uk/news/article/minimum-pricing-for-alcohol-effectively-targets-harmful-drinkers>

England has not adopted minimum pricing but has introduced alternative pricing regulation which bans the sale of alcohol “below cost”. This ban came into force in England and Wales in May 2014. In Scotland a minimum price per unit of alcohol became law in the form of the Alcohol Minimum Pricing Scotland Act 2012. In 2012 60% of the volume of alcohol sold in Scotland in the off-trade was sold below 50p per unit, the recommended minimum price for Scotland was to be set at 50p. However the law is still facing legal challenges.

### Advertising and Alcohol Misuse

NICE 2010 also provides evidence for the impact of advertising on alcohol consumption and related harms. A systematic review of longitudinal studies found that exposure to alcohol advertising and promotion was associated with the onset of adolescent alcohol consumption and with increased consumption amongst adolescents who were already drinking at baseline assessment. One review presented evidence of a small but consistent relationship between advertising and alcohol consumption among young people at an individual level. Another concluded that the evidence base suggested the existence of an association between exposure to alcohol advertising and promotion and alcohol consumption among young people. Other reviews were also indicative of alcohol advertising having an impact among young people, with evidence of awareness, familiarity and appreciation of alcohol advertisements among this age group.

### Economic Evidence

The NICE (2010)<sup>36</sup> costing report, concluded that only minimum pricing per unit of alcohol had significant resource implications. The benefits of setting a minimum price of 40 per unit of alcohol were calculated in an economic modelling report produced for NICE in 2009. It estimated that national savings of £100 million would be achieved after one year by the NHS, criminal justice system and employers, as follows:

- £80.3 million (NHS)
- £6.8 million (criminal justice system)
- £13.2 million (employers)

A detailed overview (Ubido et al) of the cost benefits of these alcohol prevention interventions from reviewing evidence from 1995 onwards until 2010.<sup>37</sup> The authors do note that in cost-effectiveness analysis there is often considerable uncertainty associated with the findings as a result of the assumptions and parameters used, therefore a degree of caution is required when reading the results. The most cost effective intervention was the introduction of minimum pricing.

<sup>36</sup> NICE 2010 <https://www.nice.org.uk/advice/LGB6/chapter/Costs-and-savings>

<sup>37</sup> Ubido J, Lewis C, Holford R & Scott-Samuel A (2010) Prevention Programmes Cost-Effectiveness Review: Alcohol. Liverpool Public Health Observatory 2010

**Table 1: Minimum Pricing Cost benefits - Adapted from Prevention Programmes Cost-Effectiveness Review: Ubido et al**

Study	Intervention	Cost-effectiveness /savings
NICE (2010) review <sup>38</sup>	Minimum price per unit of alcohol	<p>Potential health savings are £80.3m, as a result of reduced hospital admissions. Total <b>savings</b> including criminal justice and workplace savings are estimated at <b>£100m over a 10 year period</b> (based on 40p per unit minimum price).</p> <p>Costs of implementation were not quantified, but should be nil to the NHS, with costs likely to involve expenses incurred by trading standards and local licensing agencies.</p>
University of Sheffield (2008) <sup>39</sup>	50p minimum price per unit of alcohol.	<p>Costs are minimal, involving lobbying national government and supporting local authorities to take local action.</p> <p><b>In England</b>, a 50p minimum price would result in an estimated 98,000 fewer hospital admissions each year (12.4% fewer).</p>
WHO (2009) <sup>40</sup>	Increase excise taxation by 20%	<p>Tax increases of 20% are highly cost-effective, resulting in a cost <b>1\$472 for each healthy year of life restored*</b></p> <p>(*Cost-effectiveness ratio, expressed in terms of international dollars per DALY saved).</p>

<sup>38</sup> NICE (2010) Alcohol-use disorders: preventing harmful drinking. Costing report. National Institute for Health & Clinical Excellence. <http://www.nice.org.uk/PH24/costingreport/pdf/English>

<sup>39</sup> University of Sheffield (2008) Independent review of the effects of alcohol pricing and promotion, Part B. Modelling the potential impact of pricing for alcohol in England. [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_091364.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_091364.pdf)

<sup>40</sup> WHO (2009) Evidence for the effectiveness and cost effectiveness of interventions to reduce alcohol related harm. World Health Organisation Europe. <http://www.euro.who.int/data/assets/pdf>

Ubido also analysed the economic evidence for licensing controls

**Table 2: Licensing controls cost benefits - Adapted from Prevention Programmes Cost-Effectiveness Review: Ubido et al**

Study	Intervention	Cost-effectiveness/ savings
University of Sheffield <sup>41</sup> (2009) Report to the NICE Public Health Programme Development Group	Outlet Density Reduction	A 10% decrease in the number of both off-trade and on-trade outlets could result in public sector cumulative 10 year harm reductions of between £0.4b and £5.1b.  <b>Potential health savings in year 1 range from £3.5m to £49m</b> (including 5,800 fewer hospital admissions in the first year, rising to 23,000 annually with the full effect of the policy).
University of Sheffield (2009) (as above)  Report to the NICE Public Health Programme Development Group	Reduction in Licensing Hours	A 10% reduction in hours could result in cumulative 10 year savings for the public sector, ranging from a loss of £0.36b to a gain of £5.2b.  <b>Potential healthcare cost reduction in year 1 range from a loss of £2.9m to gains of £45,</b> (including at least 3,600 fewer hospital admissions in the first year, rising to 14,100 annually with the full effect of the policy).
WHO (2009) <sup>42</sup> cost effectiveness modelling study	Reduced access to retail outlets plus comprehensive advertising ban	<b>Each healthy year of life restored costs around I\$2,509*</b>  (*I\$ = international dollars)

## The Local Picture

The current local process for using policy for reducing alcohol consumption utilises Cumulative Impact Policies. Where a district licensing authority has an identified Cumulative Impact Policy the responsible authorities can make a representation against approving the licence for the area. Cumulative Impact Policies operate under a “rebuttal presumptive” i.e. the burden of proof is

<sup>41</sup> University of Sheffield (2009) Modelling to assess the effectiveness and cost effectiveness of public health related strategies and interventions to reduce alcohol attributable to harm in England using the Sheffield alcohol policy model version 2.0  
<https://www.ias.org.uk/resources/ukreports/uni-sheffield/univ-sheffield-am.pdf>

<sup>42</sup> WHO (2009) Evidence for the effectiveness and cost effectiveness of interventions to reduce alcohol related harm. World Health Organisation Europe.  
<http://www.euro.who.int/data/assets/pdf>

reversed and it is the applicant who must demonstrate how they will avoid threatening the licensing objectives.

In Cambridgeshire there are two Cumulative impact areas, in Cambridge City and Wisbech. Peterborough City Council also has a designated area within the city where a Cumulative Impact Zone exists. Working with the following partners; Cambridgeshire Constabulary, Trading Standards, Cambridgeshire County Council Drug & Alcohol Team, Community Safety Partnership and Licensing teams work together to responding to license applications falling with any of the Cumulative Action Zones. Cambridgeshire Constabulary and Trading Standards along with Public Health are responsible authorities in their own right and each organisation puts in a separate representation from the differing perspectives but also referencing each other's representations.

Representations have been assessed by partners and tend to be prioritised for those premises that provide off-site consumption of alcohol. In the last year, four representations have been made each being Public Health England by the licensing committee resulting in no new license being granted for premises within the Cumulative Impact Zone. There is some local concern that with the recent successes of the Cumulative Impact policy that applicants are looking just outside the restricted area for licensed premises which would not be subject to Cumulative Action Zone restrictions. Further work on reviewing Cumulative Action Zone licensing applications will be required in the next year.

### What is this telling us?

- There is some evidence that pricing, licensing policies and advertising influences alcohol consumption and its related harms. The majority of these interventions are determined by national policy. If the evidence is to be applied local collaborative agreements require development.
- Different groups are affected by alternative policies in different ways and there is no robust evidence that identified the different impacts.
- Local processes could be developed for collecting health evidence that link anonymised data on alcohol-related injuries with the precise location of where the injury occurred providing evidence that could support challenges to licensing applications. Through developing profiles that indicate high risk areas interventions could be targeted, including the development of designated special policies in areas where problematic drinking occurs (i.e. Cumulative Impact Zones, EMRO)
- Collaborative working between Cambridgeshire Constabulary, Trading Standards and Community Safety Partnerships, Licensing authorities could support the development of a more consistent evidence based approach to licensing.
- Planning Authorities have the authority to shape planning conditions and restrictions that have an impact on opening times and regulate the concentration of outlets.



## CHAPTER 4: Children and Young People

**Please note that in all Chapters the local comparator area cited is Oxfordshire**

This section addresses both alcohol and drugs misuse in children and young people.

### What the data tell us: Prevalence of Alcohol and Drug Misuse in Children and Young People

**HEADLINES:** Overall, alcohol and drug misuse among young people in Cambridgeshire is not dissimilar to national figures or its nearest statistical neighbour (Oxfordshire) but there is still a proportion of children and young people who are starting and continuing to misuse drugs and alcohol and continuing

#### Alcohol

- The “What About Youth” survey in 2014/15 found that around 73% of 15 year olds report trying an alcoholic drink, around 7% had a drink at least once per week.
- The Cambridgeshire Health Related Behaviour Survey found that alcohol use amongst young people has fallen since 2008. In 2014 the percentage of Year 10 pupils reporting drinking alcohol in the seven days prior to the survey fell from 50% in 2008 to 36% in 2014.
- Cambridge has a lower percentage reporting recent drinking than the other districts (29%) and is statistically significantly below the Cambridgeshire average.

#### Drugs

- The “What About YOUth” survey in 2014/15 found that around 12% of 15 year olds had tried cannabis and around 6% reported using cannabis in the last months and 0.7% had used other drugs.
- The Cambridgeshire Health Related Behaviour Survey found that nearly 17% of Year 10 pupils reported taking drugs.
- The percentage reporting ever taking drugs was statistically significantly higher than the county average in Cambridge at 22% and statistically significantly lower than the county average in Huntingdonshire at 14.4%.

## Data in Detail

### Drinking prevalence

Among 15 year olds in Cambridgeshire, 72.4% reported having ever had an alcoholic drink in the Public Health England What About YOUth survey, statistically significantly higher than the England average of 62.4% (Table ??, Figure ??); the county's nearest neighbour Oxfordshire also has a percentage statistically significantly higher than England average. 7.2% reported having a drink at least once a week and 16.4% reported being drunk in the last four weeks.

**Table 3: Drinking behaviours among 15 year olds, Cambridgeshire, 2014/15**

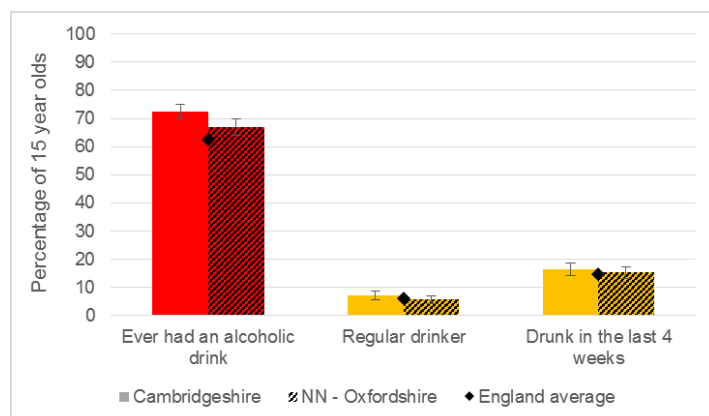
Local Authority	Ever had an alcoholic drink				Regular drinkers (drink at least once a week)				Drunk in the last 4 weeks			
	%	Lower 95% CI	Upper 95% CI	Significance*	%	Lower 95% CI	Upper 95% CI	Significance*	%	Lower 95% CI	Upper 95% CI	Significance*
Cambridgeshire	72.4	69.7	75.1	Worse	7.2	5.7	8.7	Similar	16.4	14.2	18.6	Similar
NN - Oxfordshire	66.9	64.0	69.7	Worse	5.7	4.4	7.0	Similar	15.4	13.3	17.5	Similar
England	62.4	62.1	62.6	-	6.2	6.0	6.4	-	14.6	14.4	14.8	-

\* Significance in comparison to the England average

NN - CIPFA nearest neighbour for Cambridgeshire

Source: What About YOUth survey, Public Health England

**Figure 25: Drinking behaviours among 15 year olds, Cambridgeshire, 2014/15**



■ Statistically significantly higher than the England average  
▨ Statistically similar to the England average  
■ Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire

Error bars represent 95% confidence intervals

Source: What About YOUth survey, Public Health England

Data from Cambridgeshire's Health Related Behaviour Survey show that 36% of Year 10 pupils in Cambridgeshire reported drinking alcohol in the previous seven days (Table ??). By district of school location, this ranged from 28.6% of pupils in Cambridge to 39.2% of pupils in Fenland. The percentage reporting that they drank alcohol in the previous seven days was statistically significantly

lower than the county average in Cambridge (Figure ??). At county level, the percentage has fallen from 50% in the 2008 survey (Figure ??), and falls have been seen across all districts (see Data Supplement).

**Table 4: Percentage of Year 10 pupils reporting they had drank alcohol within the last 7 days, Cambridgeshire, 2014**

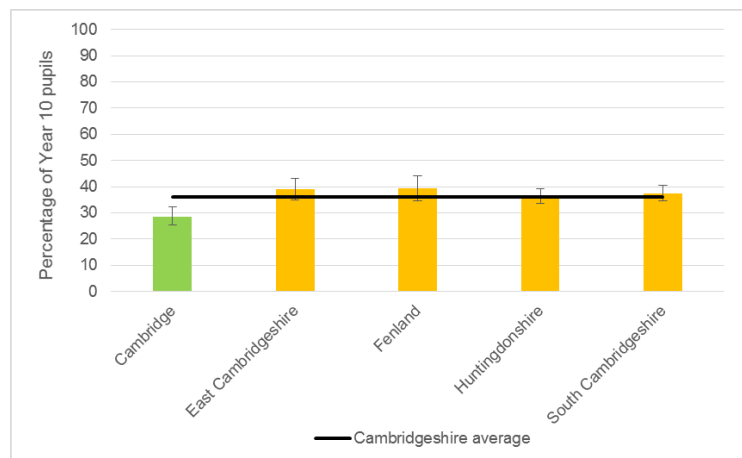
Local Authority	Numerator	Denominator	Percentage	Lower 95% CI	Upper 95% CI
Cambridge	185	647	28.6	25.2	32.2
East Cambridgeshire	224	575	39.0	35.1	43.0
Fenland	155	395	39.2	34.6	44.1
Huntingdonshire	452	1243	36.4	33.7	39.1
South Cambridgeshire	377	1006	37.5	34.5	40.5
Cambridgeshire	1393	3866	36.0	34.5	37.6

Note: 1 of the 2 Fenland schools did not take part in the survey

Data by school location rather than residence (postcode only 76% complete)

Source: The Health Related Behaviour Survey, Schools Health Education Unit

**Figure 26: Percentage of Year 10 pupils reporting they had drank alcohol within the last 7 days, Cambridgeshire, 2014**



■ Statistically significantly higher than the Cambridgeshire average  
■ Not statistically significantly different to the Cambridgeshire average  
■ Statistically significantly lower than the Cambridgeshire average

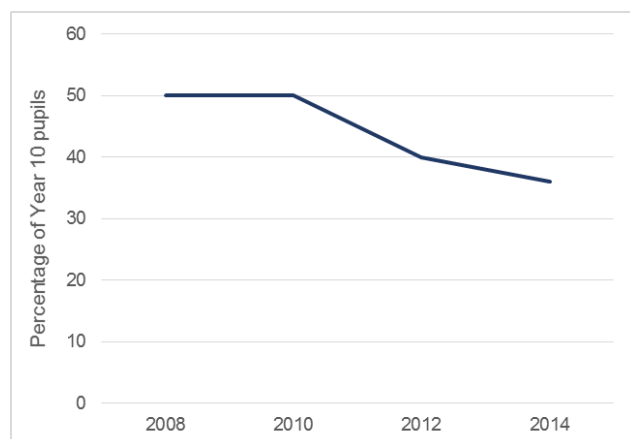
Note: 1 of the 2 Fenland schools did not take part in the survey

Data by school location rather than residence (postcode only 76% complete)

Error bars represent 95% confidence intervals

Source: The Health Related Behaviour Survey, Schools Health Education Unit

**Figure 27: Percentage of Year 10 pupils reporting they had drank alcohol within the last 7 days, Cambridgeshire, 2008-2014**



Source: The Health Related Behaviour Survey, Schools Health Education Unit  
Data by school location rather than residence (postcode only 76% complete)

### *Prevalence of drug use*

Among 15 year olds in Cambridgeshire, 12.1% reported having ever tried cannabis in the Public Health England What About YOUTH survey, statistically similar to the England average of 10.7% (Table ??, Figure ??). 5.8% reported using cannabis in the last month and 0.7% reported taking other drugs in the last month. In Oxfordshire, percentages were statistically significantly higher than the national average for cannabis use.

**Table 5: Drug use among 15 year olds, Cambridgeshire, 2014/15**

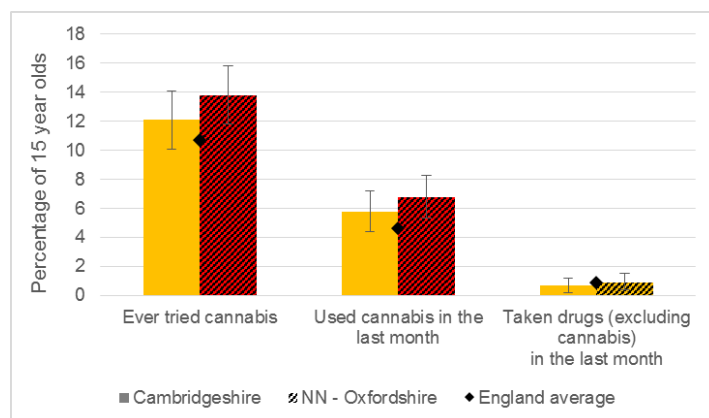
Local Authority	Ever tried cannabis				Used cannabis in the last month				Taken drugs (excluding cannabis) in the last month			
	%	Lower 95% CI	Upper 95% CI	Significance*	%	Lower 95% CI	Upper 95% CI	Significance*	%	Lower 95% CI	Upper 95% CI	Significance*
Cambridgeshire	12.1	10.1	14.1	Similar	5.8	4.4	7.2	Similar	0.7	0.2	1.2	Similar
NN - Oxfordshire	13.8	11.8	15.8	Worse	6.8	5.3	8.3	Worse	0.9	0.4	1.5	Similar
England	10.7	10.6	10.9	-	4.6	4.5	4.8	-	0.9	0.8	0.9	-

\* Significance in comparison to the England average

NN - CIPFA nearest neighbour for Cambridgeshire

Source: What About YOUTH survey, Public Health England

**Figure 28: Drug use among 15 year olds, Cambridgeshire, 2014/15**



Statistically significantly higher than the England average  
 Statistically similar to the England average  
 Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire  
 Error bars represent 95% confidence intervals  
 Source: What About YOUth survey, Public Health England

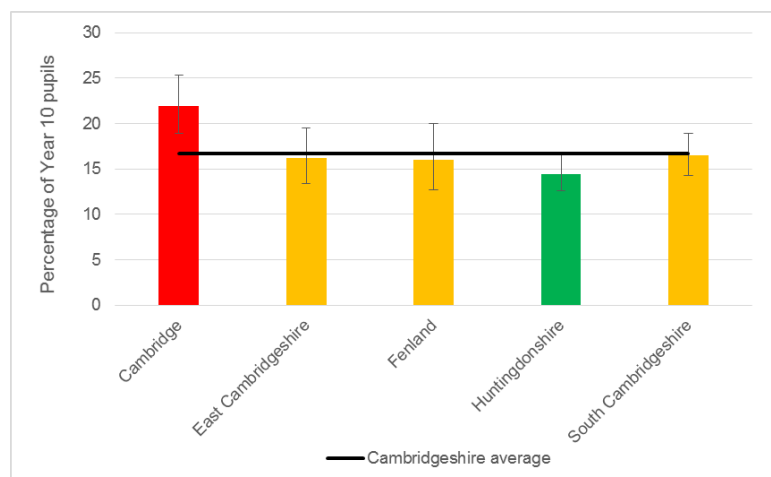
Data from Cambridgeshire's Health Related Behaviour Survey show that 16.7% of Year 10 pupils in Cambridgeshire reported ever taking drugs (Table ??). The percentage reporting ever taking drugs was statistically significantly higher than the county average in Cambridge at 22% and statistically significantly lower than the county average in Huntingdonshire at 14.4% (Figure ??).

**Table 6: Percentage of Year 10 pupils reporting they had ever taken drugs, Cambridgeshire, 2014**

Local Authority	Numerator	Denominator	Percentage	Lower 95% CI	Upper 95% CI
Cambridge	138	628	22.0	18.9	25.4
East Cambridgeshire	91	560	16.3	13.4	19.5
Fenland	61	381	16.0	12.7	20.0
Huntingdonshire	175	1213	14.4	12.6	16.5
South Cambridgeshire	163	987	16.5	14.3	19.0
Cambridgeshire	628	3769	16.7	15.5	17.9

Note: 1 of the 2 Fenland schools did not take part in the survey  
 Data by school location rather than residence (postcode only 76% complete)  
 Source: The Health Related Behaviour Survey, Schools Health Education Unit

**Figure 29: Percentage of Year 10 pupils reporting they had ever taken drugs, Cambridgeshire, 2014**



■ Statistically significantly higher than the Cambridgeshire average  
■ Not statistically significantly different to the Cambridgeshire average  
■ Statistically significantly lower than the Cambridgeshire average

Note: 1 of the 2 Fenland schools did not take part in the survey  
 Data by school location rather than residence (postcode only 76% complete)  
 Error bars represent 95% confidence intervals  
 Source: The Health Related Behaviour Survey, Schools Health Education Unit

National data for England indicate that the percentage of Year 7-10 pupils having ever taken drugs has reduced over the last ten years, from 28% in 2005 to 15% in 2014.<sup>43</sup>

## Vulnerable and high risk children and young people

The report 'Silent Voices'<sup>44</sup> suggests that the groups that are particularly vulnerable or misuse substances include children with parents/carers who drugs and alcohol, young carers, children from Black, Asian and Minority Ethnic (BAME) groups, children who experience substance related bereavement, children of prisoners, children cared for by others, children with foetal alcohol syndrome, those in the criminal justice system and the young homeless. In Cambridgeshire, pathways and services are starting to be put in place that will systematically identify the needs of children wherever they present.

<sup>43</sup> Health and Social Care Information Centre. Smoking, Drinking and Drug Use Among Young People in England – 2014

<sup>44</sup> Cuthbert 2011. Cited in 'Silent Voices' Adamson J, Templeton L, (2012) Silent Voices. Supporting children and young people affected by parental alcohol misuse. Children's Commissioner/ Community Research Company

## What the data tells us: Drug and alcohol misuse in pregnancy.

**Headlines:** It is difficult to have certainty over numbers however estimates suggest parental alcohol misuse is far more prevalent than parental drug misuse.

- National data estimates indicated in 2007 high numbers of babies under the age of one who live with parents who misuse drugs or alcohol.
- In 2014 a survey showed that out of 15,000 women 40% drank alcohol during pregnancy.
- Locally there is limited data. Maternity units have specialist midwives who receive referrals for drug and alcohol misuse during pregnancy.
- The Rosie, Cambridge: In 2015/16 there were 46 referrals of Cambridgeshire residents. The most frequent substances reported were cannabis (29/46 for cannabis and 8/46 for alcohol).
- Hinchingsbrooke Hospital: In 2015/16 there were 8 referrals.
- Queen Elizabeth Hospital in Kings Lynn. In 2015/16 there were 12 referrals for Wisbech women.

The last Adult Psychiatric Morbidity Survey undertaken in England in 2007 suggested that

- Around 79,000 babies under one in England are living with a parent who is classified as a 'harmful' or 'hazardous' drinker.
- Around 43,000 babies under one are living with a parent who has used an illegal drug in the past year. This is equivalent to 51,000 across the UK.
- Around 16,500 babies under one are living with a parent who has used Class A drugs in the past year. This is equivalent to 19,500 across the UK.<sup>45</sup>

According to the UK Health Survey 2011, 52% of women of childbearing age who drink exceed two to three units per day. Results from the most recent UK Infant Feeding Survey (IFS) which included data from over 15 000 women, showed that 40% drank alcohol during pregnancy but only 3% drank more than two units per week.<sup>46</sup>

### Local service data

The local maternity units have specialist midwives who work with vulnerable groups. If a mother is identified who is misusing substances she receives additional clinical and social support from the midwives. Referrals are made to Social Care and to the Substance Misuse Treatment Services.

<sup>45</sup> Rayns G., Dawe S., Cuthbert C., ALL BABIES COUNT Spotlight on Drugs and Alcohol, NSPCC

<sup>46</sup> Maternal alcohol intake prior to and during pregnancy and risk of adverse birth outcomes: evidence from a British cohort Camilla Nykjaer et al JECH 2014

The data relating to substance misuse in pregnancy is provided by the different maternity units. The Rosie in Cambridge covers the highest proportion of births in Cambridgeshire, with the highest number of referrals to the specialist midwife. There were 64 referrals to the substance abuse midwife between 1 April 2015 and 31 March 2016 with 46 being Cambridgeshire residents. The most frequent substance reported within Cambridgeshire residents was cannabis (29/46 for cannabis and 8/46 for alcohol).

Other centres include Hinchingsbrooke Hospital, where between 1 April and 31 March 2016 there were 8 referrals. The Queen Elizabeth Hospital in Kings Lynn, where most Wisbech women deliver had 12 referrals in the same period.

### **Risks of Alcohol Misuse during Pregnancy and Early Years**

Parental substance misuse can harm children's development both *directly* – through exposure to substances in utero – and *indirectly* – through its impact on parenting capacity. Women who are dependent on alcohol during pregnancy have poorer maternity outcomes for mother and baby (higher rates of pregnancy loss, higher rates of antepartum haemorrhage (APH), lower birth weight, higher incidence of admission to neonatal unit/special care, higher rates of Social Care involvement)

Extensive research indicates that prenatal alcohol abuse is clearly linked to brain development.<sup>47 48</sup> The riskiest period for drinking in pregnancy is around the time of conception and during the first trimester<sup>49</sup> when the foetal central nervous system is developing. Foetal Alcohol Spectrum Disorder (FASD) – including its most severe manifestation, Foetal Alcohol Syndrome (FAS) – is a direct consequence of prenatal exposure to alcohol.

A baby exposed to alcohol before birth has a higher risk of physical, learning and behavioural problems. These include poor growth while in the womb and after birth, so the baby is shorter and smaller than average, sometimes with deformed limbs, small head and jawsize along with distinctive facial features, cerebral palsy, autistic like behaviour, epilepsy, poor immune system, major organ problems, sight and hearing problems. FASD is a spectrum of these disorders and reflects the link between the damage caused by alcohol on the developing foetus and the level of maternal alcohol consumption, the pattern of alcohol exposure and the stage of pregnancy during which alcohol is consumed. This is confounded by a number of other risk factors including the genetic makeup of the mother and the foetus, the nutritional status of the mother, hormonal interactions, polydrug use (including tobacco use), general health of the mother, stress, maternal age and low socioeconomic status.

Problematic drinking by parents is associated with negative parenting practice (such as low warmth and high criticism) and parenting capacity can be compromised when parents become increasingly focused on drinking.

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<sup>47</sup> National Scientific Council on the Developing Child (2006) Early exposure to toxic substances damages brain architecture.

<sup>48</sup> 16 Welch-Caerre E. (2005) The neurodevelopmental consequences of prenatal alcohol exposure, *Advances in neonatal care* 5(4): 217–229.

<sup>49</sup> Coles C. (1994) Critical periods for prenatal alcohol exposure: evidence from animal and human studies, *Alcohol health research world*, 18: 22–29.



## Risks for Drug Use in Pregnancy

As many as 90% of women who are drug dependent are of childbearing age. The National Institute for Clinical Excellence (NICE) in 2010 estimated that around 4.5% of pregnancies will involve a substance abusing mother.<sup>50</sup>

Illicit drug use during pregnancy affects both the mother and the developing foetus, due to the fact most drugs cross the placenta. Research has shown there to be a range of adverse consequences associated with drug misuse in pregnancy, including spontaneous abortion, congenital malformations, low birth weight, poor growth and premature delivery.<sup>51</sup>

Neonatal Abstinence Syndrome is the most commonly reported adverse effect and refers to drug withdrawal symptoms displayed by babies exposed to substances in utero. These include irritability (high pitched crying, inability to sleep) and gastrointestinal symptoms (poor feeding, regurgitation, poor weight gain). There have been relatively few longitudinal studies investigating the developmental outcomes associated with prenatal exposure to illicit substances and findings are inconclusive.

## What the data tells us: Children and young people who live with parents/carers who misuse drugs and alcohol

**Headlines:** There are estimates of substantial numbers of children and young people who live with parents/carers who misuse substances, however due national studies and difficulties in identification there is an acknowledgement the number is under reported and there is considerable unmet.

- In 2014-15 it was estimated that the proportion of parents/carers in treatment (data from Adult Treatment Service Provider- Inclusion) who live with children under the age of 18 was 24.2% for opiate users, 32.2% for non-opiate users, 29.2% for alcohol users and 22.8% for alcohol and non-opiate users similar to the national averages.
- A snapshot undertaken in 2015 of social care teams estimated that there were at least 836 children in contact with parents receiving treatment from the Substance Misuse Treatment Services.

79

<sup>50</sup> National Institute for Clinical Excellence (2010) Guidance on Pregnancy and Complex Social Factors CG110.

<sup>51</sup> Greenough A. et al (2005) Effects of substance misuse during pregnancy, The Journal of the Royal Society for the Promotion of Health 125(5): 212–213.

<sup>52</sup> Manning, Best, Faulkner and Titherington (2009) "New estimates of the numbers of children living with substance misusing parents: results from UK national household survey", BMC Public Health 9, <http://www.biomedcentral.com/1471-2458/9/377>

<sup>53</sup> Cuthbert 2011. Cited in 'Silent Voices' Adamson J, Templeton L, (2012) Silent Voices. Supporting children and young people affected by parental alcohol misuse. Children's Commissioner/ Community Research Company [http://www.childrenscommissioner.gov.uk/content/publications/content\\_619](http://www.childrenscommissioner.gov.uk/content/publications/content_619)

A study of nearly 300 social work cases going across three London Boroughs found that there were concerns about parental substance misuse in 100 (a third) of the families (involving 186 children). In a study of 338 social work files from six English Local Authorities, parental substance misuse in just over half (52%) of cases, and both issues were present in a fifth (20%) of cases. There was evidence of parental substance misuse in 57% of serious case reviews and parental alcohol misuse was identified in a study of 22% of serious case reviews. Between 1999 and 2009 nearly 40,000 children calling ChildLine raised the issue of parental (or other significant person) drinking. Data from ChildLine (April 2008-March 2009) showed that: 4,028 children were concerned about parental alcohol misuse (21% of all callers) – 71% were girls, 60% aged 12-15 years and 20% aged 5-11 years.<sup>54</sup>

Research suggests alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings.<sup>55</sup> A study in Ireland found that almost one-in-ten children (9%) reported that “their parents’ alcohol use affects them hugely in a negative way”.<sup>56</sup>

### The impact on children and young people

There is a considerable body of literature on the potentially negative impact on children of growing up with a parent who has an alcohol or drug problem, the risk factors that can exacerbate this effect, and resilience and the protective factors that can reduce it.<sup>57 58 59</sup> The evidence was acknowledged in two key government publications in 2003.<sup>60 61</sup> There are common structures and functions within the family that are often disrupted by alcohol or drug misuse that can result in many problems for the children into adolescence and adulthood including a high number of referrals to safeguarding services. The issues outlined below relate to both alcohol and drug misuse, but additional problems can arise when the parent misuses illicit drugs. These include the illegal nature of drug misuse, the modes of ingestion, the links to crime, the use of the family home for groups of people to take drugs (drug misuse is more likely to be a home-based activity), and the even stronger links with poverty, unemployment and social deprivation. Velleman and Templeman<sup>62</sup> reviewed the large body of literature and identified an extensive list of the high risk outcomes (found below) that are associated with children and young people with parents/carers who are substance misusers

<sup>54</sup> Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services. PHE Published December 2013

<sup>55</sup> Supporting information for developing local joint protocols between drug and alcohol partnerships and children and family services. Public Health England Published December 2013

<sup>56</sup> ISPC Always here For Children Annual Report 2010

<sup>57</sup> Cleaver, H., Unell, I. & Aldgate, J. (1999) *Children's Needs – Parenting Capacity*. TSO (The Stationery Office).

<sup>58</sup> Kroll, B. & Taylor, A. (2003) *Parental Substance Misuse and Child Welfare*. Jessica Kingsley

<sup>59</sup> Velleman, R. & Templeton, L. (2005a) *Alcohol use and misuse*. In *Key Topics in Public Health* (ed. L. Ewles), pp. 177–196. Elsevier.

<sup>60</sup> *Advisory Council on the Misuse of Drugs (2003) Hidden Harm: Responding to the Needs of Children of Problem Drug Users. The report of an Inquiry by the Advisory Council on the Misuse of Drugs*. TSO (The Stationery Office).

<sup>61</sup> *Prime Minister's Strategy Unit (2004) Alcohol Harm Reduction Strategy for England (NAHRSE)*. Strategy Unit.

<http://image.guardian.co.uk/sys-files/Society/documents/2004/03/15/alcoholstrategy.pdf>

<sup>62</sup> Velleman R., Templeton L., Understanding and modifying the impact of parents’ substance misuse on children. *Advances in Psychiatric Treatment* (2007), vol. 13, 79–89 doi: 10.1192/apt.bp.106.002386

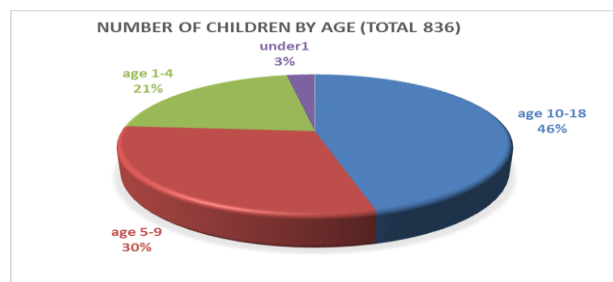
## The Cambridgeshire picture

### Parents in treatment

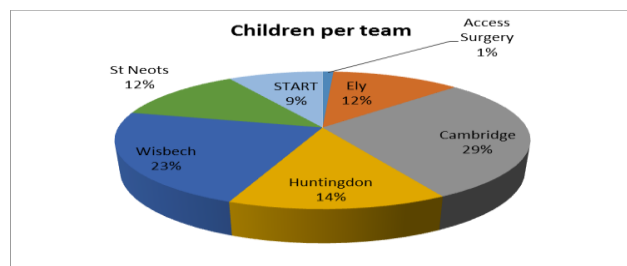
2014-15 data estimated that the proportion of parents/carers in treatment (data from Adult Treatment Service Provider- Inclusion) who live with children under the age of 18 was 24.2% for opiate users, 32.2% for non-opiate users, 29.2% for alcohol users and 22.8% for alcohol and non-opiate users similar to the national averages.<sup>63</sup>

A snapshot undertaken in 2015 of social care teams estimated that at least 836 children in contact with parents receiving treatment from the Substance Misuse Treatment Services. The age distribution, team source and recorded previous interventions of these 836 children are shown below.

**Figure 30: Number of Children by Age**



**Figure 31: Percent of Children living with a Parent/Carer who misuses substances per team**

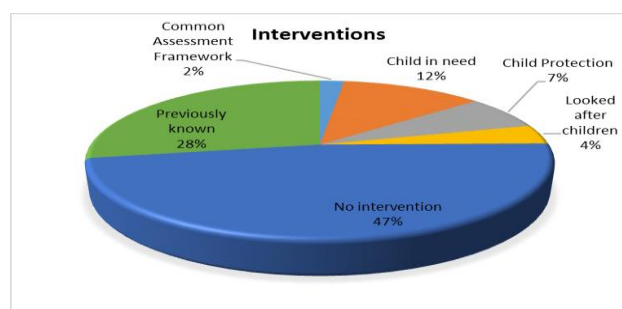


<sup>63</sup> Cambridgeshire - Adult Q4 DOMES 14-15

## Interventions

Currently interventions are being developed collaboratively between the Adult Treatment Services and Cambridgeshire County Council Children's Services. Joint home visits will help determine how an integrated approach could best suit the family's needs. The home visit model was developed in response to the tension that can be created through asking a parent who has come for treatment for his or hers substance misuse about the safety of their children. This pilot will be monitored.

**Figure 32: Interventions**



## Children known to a wide range of targeted and specialist children's services

These children are identified through assessments that are undertaken to assess family needs but their parents/carers are not known to the Substance Misuse Services. They are undertaken by a wide range of children's services including the Family Intervention Partnership, County Council's Locality teams, Children's Centres, Children's Social Care, health services such as health visitors and Voluntary Organizations including Young Carers.

The different agencies carry out these assessments in different ways. However a screening tool has recently been launched to improve identification of children in this group (Appendix).<sup>64</sup> However the total number of children in this group is not currently recorded locally.

## Unmet need

There are children who live with parents who misuse substances but they are not known to targeted or specialist services. (They are likely to be known to universal services such as school and GP but they do not receive any active interventions)

A proportion of older children in this group present to agencies; for example children present to ChildLine concerned about parental alcohol abuse. The 'Hidden Harms' project carried out in 2003 by the Advisory Council on the Misuse of Drugs<sup>65</sup> recommended that the voices of the children of problem drug and alcohol users should be heard and listened to.

<sup>64</sup> <http://www.cambridgeshire.gov.uk/thinkfamily>. Professional support pack, page 5

<sup>65</sup> Advisory Council on the misuse of drugs: Hidden Harms

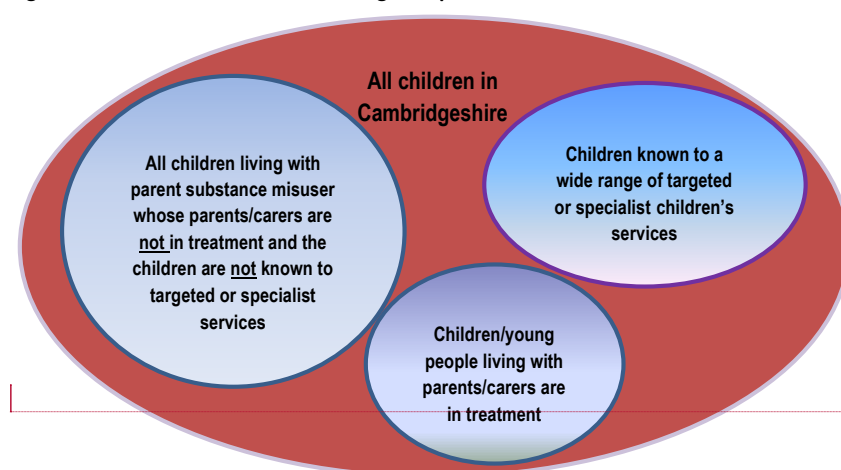
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/120620/hidden-harm-full.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf) 2003

Cambridge Adolescent Substance Use Service (CASUS) has allocated a part time worker to work with children and young people who are affected by parental substance misuse. Those young people who are known to Centre 33's Young Carers programme benefit from a joint initiative called the Stepping Stone program where specialist substance misuse workers alongside Young Carers workers deliver a tailored programme for young carers affected by parents with substance misuse. Part of this work is funded from young people's substance misuse treatment budget

### Pathways in Cambridgeshire for identification and support for children with parents/carers who misuse substances

There are three routes to identification of children affected by parental substance misuse. Figure ? below illustrates these groups diagrammatically, and the groups are detailed individually.

Figure 33: Identification of children living with parental substance misuse



Commented [JM1]:

### Key issues for children and young people who live with parents or carers who misuse substances

- The extent of the need is hidden. Children living with parental alcohol misusers are likely to come to the attention of social care services later than children living with drug misusers. In addition, boys are less likely than girls to ask for help, but more likely to come to the attention of services due to behaviour issues – for example through youth offending services.
- There is evidence that interventions that support the development of protective factors provide children and young people with the resilience to mitigate the effects of having parents/carers who misuse substances. Flexibility of services that provides support that is not time limited, and allows children to receive support on their own as well as in family units is beneficial.
- Although pathways and interventions are being developed these require strengthening and staff training is also required to ensure that identification and support with referral to services can be provided.

## Other vulnerable groups of children and young people

The following indicates the numbers of vulnerable children and young people in different risk groups that have been identified drugs and alcohol issues. Data is sourced from Cambridgeshire County Council Children's Social Care Services.

### What the data tells us:

**Headlines:** There are a number of groups of vulnerable young people where although percentages of those with drug and alcohol are not high there is still substantial numbers affected.

### School Exclusions

Between 2011/12 and 2015/16 the percentage of fixed-term alcohol/drug related school exclusions across all schools in Cambridgeshire remained stable and similar to the England rate (Table ??).

**Table 7: Fixed-term exclusions from school for drug/alcohol incidents, Cambridgeshire, 2011/12 to 2015/16**

Year	Cambridgeshire					England		
	Total exclusions	Of which drug/alcohol related				Total exclusions	Of which drug/alcohol related	
		Number	%	Lower 95% CI	Upper 95% CI		Number	%
2011/12	2,010	49	2.4	1.8	3.2	304,370	7,740	2.5
2012/13	2,040	68	3.3	2.6	4.2	267,520	7,040	2.6
2013/14	2,500	59	2.4	1.8	3.0	269,480	7,660	2.8
2014/15	2,730	60	2.2	1.7	2.8	302,980	8,240	2.7
2015/16	2,941	73	2.5	2.0	3.1	n/a	n/a	n/a

CI - confidence interval, n/a - Not available

Sources: Department for Education (2011/12-2014/15), Cambridgeshire County Council (2015/16)

### Not in education, employment or training (NEET)

On average during 2015/16, 637 young people aged 16-18 were recorded by Cambridgeshire Youth Support Service as being NEET, 3.2% of young people known to the service. 35 young people known to the service were substance misusers, 13 of which (36.2%) were NEET.

### Children's social care

During 2014/15, 45,865 social care contacts were received in total by Cambridgeshire County Council (Table ??). This figure includes multiple contacts on the same individual throughout the year, by a variety of sources.

From the records of these contacts, 484 (1.1%) were related to alcohol issues, and 737 (1.6%) were related to drug misuse issues. 447 contacts related to both drug and alcohol misuse issues. There are indications that there are higher numbers of contacts with parental misuse issues. In 2014/15

2,012 contacts (4.4%) indicated parental alcohol misuse concerns, and 1842 (4.0%) indicated drug misuse concerns, with 447 showing both concerns. For those contacts with children with both alcohol and substance misuse concerns, 378 also indicated parental alcohol and substance misuse.

Although these figures do not indicate an absolute number of children and families with drug and alcohol issues they do indicate the level of activity in social care that is linked to drug and alcohol misuse among children young people.

**Table 8: Children's social care contacts relating to alcohol and substance misuse, Cambridgeshire, 2014/15**

<b>Total number of contacts</b>	45,865	
<b>Of which involving:</b>	<b>Number</b>	<b>%</b>
Alcohol issues	484	1.1
Drug issues	737	1.6
Alcohol and drug issues	447	1.0
Parental alcohol misuse	2,012	4.4
Parental drug misuse	1,842	4.0
Parental alcohol and drug misuse	447	1.0
Child and parental alcohol and drug misuse	378	0.8

Numbers relate to contacts and not numbers of children - children may receive multiple contacts throughout the year  
Categories are not mutually exclusive

#### *Referrals to Children's Social Care*

In 2014/15, the above contacts resulted in 4,481 referrals to Children's Social Care. Of these referrals 79 children (1.8%) had alcohol issues, 149 (3.3%) had issues with drug misuse; 51 had issues with both. There were 496 referrals (11.1%) where there were concerns of parental alcohol abuse, and 406 (9.1%) with concerns about drug misuse. 129 showed concerns for both alcohol and substance misuse. For those referrals of children showing both drug and alcohol misuse concerns, 32 also indicated parental alcohol and drug misuse

**Table 9: Children's social care referrals relating to alcohol and substance misuse, Cambridgeshire, 2014/15**

<b>Total number of referrals</b>	4,481	
<b>Of which involving:</b>	<b>Number</b>	<b>%</b>
Alcohol issues	79	1.8
Drug issues	149	3.3
Alcohol and drug issues	51	1.1
Parental alcohol misuse	496	11.1
Parental drug misuse	406	9.1
Parental alcohol and drug misuse	129	2.9
Child and parental alcohol and drug misuse	32	0.7

Categories are not mutually exclusive  
Source: Cambridgeshire County Council

### ***Looked After Children***

As at 31/03/2015, there were 337 children looked after who had been looked after continuously for at least 12 months. Eight (2.4%) of these children were identified as having alcohol issues, five (1.5%) had drug misuse issues.

## **What the data tell us: Hospital Admissions**

**Headlines:** Hospital admissions generally below or similar to national and Oxfordshire figures. The increase in hospital admissions among young people is associated with the misuse of New Psychoactive Substances (NPS) with young people being unaware of the potential harms of these drugs.

### **Hospital admissions for children and young people**

- Admission rates (under 18s) for conditions wholly attributable (specific) to alcohol use in Cambridgeshire are statistically significantly lower than the national average and have fallen in line with national trends, but are higher than in Oxfordshire. (2011/12 to 2013/14).
- Admission rates for drug use (aged 15-24) have remained statistically significantly below the national average since 2008/09-10/11. However, both the number and rate of admissions have approximately doubled over the last five years, similar to increasing trends nationally and in the county's statistical neighbour Oxfordshire (Around 63 admissions per year).

## **Data in Detail**

### **Hospital admissions – alcohol (under 18s)**

On average, 42 children in Cambridgeshire aged under 18 are admitted to hospital each year with conditions wholly attributable to alcohol use (Table ??). Admission rates in Cambridgeshire are statistically significantly lower than the national average (Figure ??) and have fallen, in line with national trends, but are higher than in Oxfordshire (Figure ??, Data Supplement).



**Table 10: Alcohol-specific hospital admissions in under 18s, Cambridgeshire, 2011/12 to 2013/14**

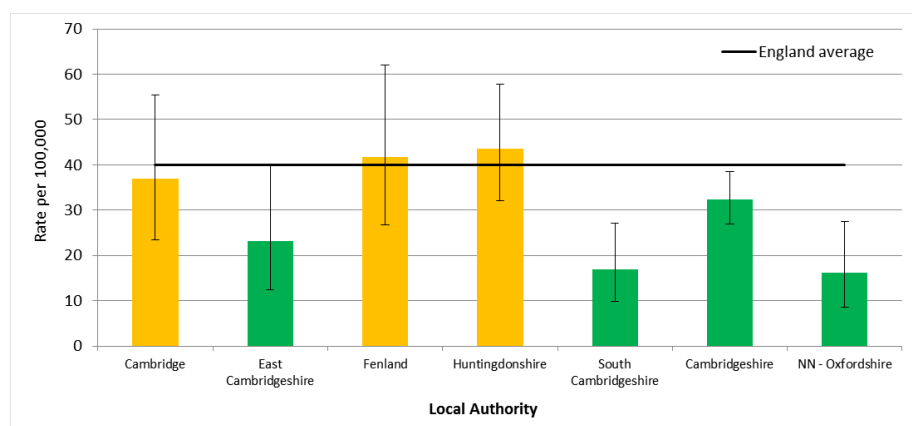
Local Authority	Number	Rate per 100,000	Lower 95% CI	Upper 95% CI
Cambridge	25	36.9	23.4	55.3
East Cambridgeshire	15	23.2	12.4	39.7
Fenland	25	41.6	26.7	62.0
Huntingdonshire	50	43.5	32.1	57.7
South Cambridgeshire	15	16.9	9.9	27.1
Cambridgeshire	125	32.3	26.9	38.5
NN - Oxfordshire	15	16.1	8.6	27.5
England	13,725	40.1	39.4	40.7

NN - CIPFA nearest neighbour for Cambridgeshire

CI – Confidence interval

Source: Local Alcohol Profiles for England, Public Health England

**Figure 34: Alcohol-specific hospital admissions in under 18s by district, Cambridgeshire, 2011/12 to 2013/14**

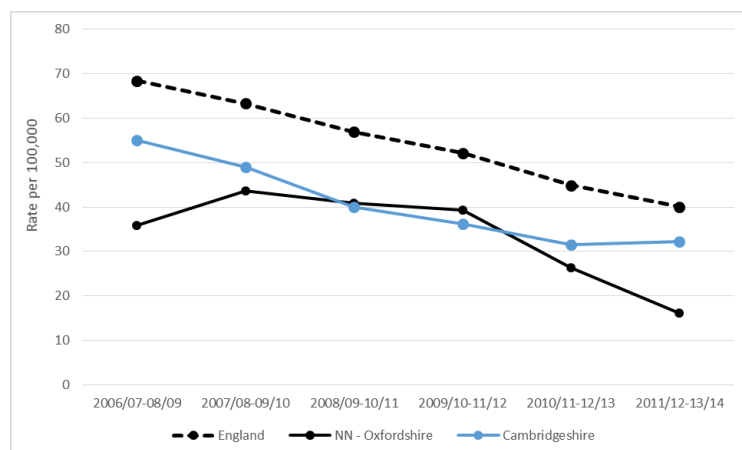


NN - CIPFA nearest neighbour for Cambridgeshire

Error bars represent 95% confidence intervals

Source: Local Alcohol Profiles for England, Public Health England

**Figure 35: Alcohol-specific hospital admissions in under 18s, Cambridgeshire, 2006/07-08/09 to 2011/12-13/14**



NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

### Hospital admissions – drug use (aged 15-24)

Around 63 young people aged 15-24 years are admitted to hospital due to drug use each year in Cambridgeshire, a rate statistically significantly below the national average (Table ??). Rates are similar to Oxfordshire.

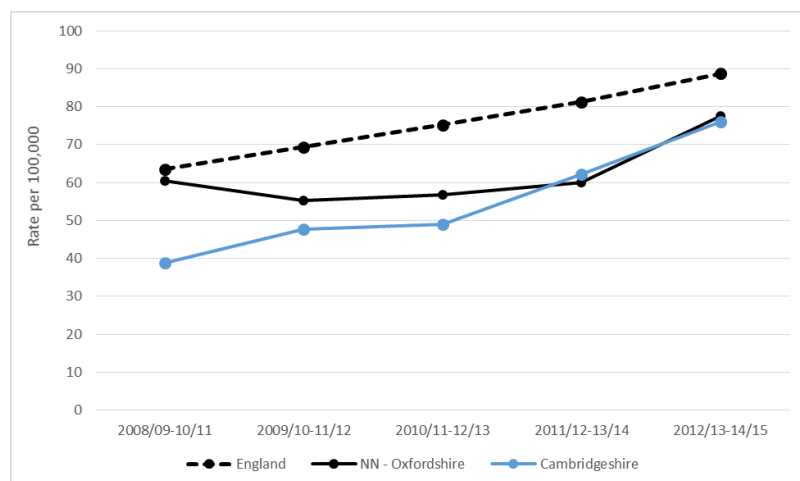
**Table 11: Hospital admissions due to drug use in young people (15-24 years), Cambridgeshire, 2012/13-14/15**

Local authority	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI
Cambridgeshire	189	76.0	65.6	87.7
NN - Oxfordshire	208	77.5	67.4	88.8
Peterborough	75	108.6	85.4	136.2
England	18,317	88.8	87.6	90.1

NN - CIPFA nearest neighbour for Cambridgeshire, DASR – Directly age-standardised rate, CI - Confidence interval  
Based on ICD-10 codes F11-F19, T40, T52, T59, T436, Y12, Y16 and Y19  
Source: Child Health Profiles, Public Health England

The rate of admissions for drug use has remained statistically significantly below the national average since 2008/09-10/11 (Data Supplement). However, both the number and rate of admissions have approximately doubled over the last five years, similar to increasing trends nationally and in the county's statistical neighbour Oxfordshire (Figure ??).

**Figure 36: Hospital admissions due to drug use in young people (15-24 years) (directly age-standardised rates per 100,000 population), Cambridgeshire, 2008/09-10/11 to 2012/13-14/15**



NN - CIPFA nearest neighbour for Cambridgeshire  
Based on ICD-10 codes F11-F19, T40, T52, T59, T436, Y12, Y16 and Y19  
Source: Child Health Profiles, Public Health England

## What the data tells us: Children and young people in Treatment

**Headlines:** Children and young people in treatment figures are generally below or similar to national and Oxfordshire figures. Positive treatment outcomes were at a high level but around one third were in treatment for longer than six months. There was a high level of planned treatment exits along with a low representation rate.

- In 2014/15 200 young people aged under 18 in Cambridgeshire were receiving specialist substance misuse treatment in the community. This number has fallen from 245 people in 2012/13. The rate of under 18's in treatment within the population in Cambridgeshire is statistically significantly below the national average but notably higher than the rate for Oxfordshire.
- 99% of young people in treatment in 2014/15 began their substance misuse before the age of 15
- The majority in 2014/15 were aged 16-17 but the proportion under 15 was lower than the English average.
- Cambridgeshire is similar to England in that cannabis and alcohol were the most commonly used substances.
- The most common vulnerabilities of those in treatment in 2014/15 were mental health problems and involvement in self-harm. These vulnerabilities were more common in females.
- 32% of the clients in 2014/15 were in treatment for longer than six months with around 77% exiting treatment in a planned way
- Of the planned exits from treatment around 92% did not re-present within 6 months

### Re-presentations

Service data estimates that 10% of young people re-present but only 5% require treatment

### Transition

In 2014/15 5% of young people in the Service transitioned to adult services, the figure was 1% for 2015/16.

## Data in detail: Young people in treatment

[Sources unless otherwise stated: Public Health England. Young people's substance misuse data: JSNA support pack – Key data to support planning for effective young people's substance misuse interventions in 2016-17: Cambridgeshire. Data relate to those aged under 18 receiving specialist substance misuse interventions, which can be for any substance for which they are receiving help.]

200 young people aged under 18 in Cambridgeshire were receiving specialist substance misuse treatment in the community in 2014/15 (Table ??). This number has fallen from 245 people in 2012/13. The rate of under 18's in treatment within the population in Cambridgeshire is statistically significantly below the national average but notably higher than the rate for Oxfordshire. An additional 26 young people aged 18-24 were also receiving treatment in specialist 'young people only' services.

**Table 12: Number and rate of young people (aged under 18) in specialist substance misuse services, Cambridgeshire, 2014/15**

Local authority	Number	Rate per 100,000	Lower 95% CI	Upper 95% CI
Cambridgeshire	200	152.1	131.8	174.7
NN - Oxfordshire	58	41.1	31.2	53.1
England	22,008	189.9	187.4	192.4

NN - CIPFA nearest neighbour for Cambridgeshire, CI – Confidence interval  
Additional source: Office for National Statistics mid-2014 population estimates.

The majority (55%) of young people in treatment were aged 16-17 years in Cambridgeshire (Table ??). The proportion aged 15 or under in the county was lower than the England average (33% v. 41%).

**Table 13: Number of young people in specialist substance misuse services by age group, Cambridgeshire, 2014/15**

Age group (years)	Cambridgeshire		England
	Number	Percentage	Percentage
<15	75	33	41
16-17	125	55	45
18-24	26	12	14
Total	226	100	100

Data not routinely available for Oxfordshire

The substance most commonly used by young people in treatment in Cambridgeshire was cannabis (89%) followed by alcohol (51%) (Table ??). The patterns were fairly similar to the England averages.

**Table 14: Substances used by young people in specialist substance misuse services, Cambridgeshire, 2014/15**

Substance	Cambridgeshire		England
	Number	Percentage	Percentage
Alcohol	116	51	52
Cannabis	202	89	85
Stimulants	63	28	22
Tobacco	29	13	11
Others	18	8	9

Data not routinely available for Oxfordshire

Young people in community substance misuse service in 2014/15 were predominately referred from the Youth Justice Service (38%), Education services (18%), self/family/friend referral (12%), Children and family services (10%) and Health/mental health services (8%). The majority of young people (99%) began their main drug misuse before the age of 15 years and most (73%) used 2 or more substances.

Almost all young people received psychosocial interventions (96%) but only 2 (1%) also received pharmacological intervention.

99% of young people in treatment began their main problem substance use before the age of 15 (Table ??). Vulnerabilities notably more common among clients in Cambridgeshire compared with the England average include using two or more substances, identified mental health problems and involvement in self-harm. A lower percentage is involved in offending/antisocial behaviour.

The identification of mental health problems is more common in females than males (47% v. 29%), as was involvement in self-harm (44% v. 20%). These patterns by sex are similar to those seen for England (data not shown).

There is a strong association between the misuse of alcohol and drugs and mental health issues amongst children. Although comorbid depressive and anxiety symptoms are common in adults, the extent and severity of the comorbidities often found in children is greater. Comorbid disorders such as conduct disorder and attention deficit and hyperactivity disorder significantly complicate the management of substance misuse, and concurrent treatment of them is to be considered. NICE recommends a multisystem, multi-level approach to deliver integrated care such as family interventions as the most effective form of intervention. See Dual Diagnosis chapter.

**Table 15: Top ten vulnerabilities among young people in specialist substance misuse services, Cambridgeshire, 2014/15**

Vulnerability	Number	Percentage	NN - Oxfordshire percentage	England percentage
Began main problem substance under 15	131	99	88	93
Using two or more substances	97	73	71	61
Identified mental health problem	46	35	10	18
Involved in self-harm	37	28	13	17
Affected by domestic abuse	29	22	15	21
Affected by others' substance misuse	24	18	29	21
Involved in offending/antisocial behaviour	24	18	13	32
Not in education, employment or training	23	17	21	17
Looked after child	22	17	15	12
Child in need	16	12	*	6

NN - CIPFA nearest neighbour for Cambridgeshire

\* Value suppressed due to risk of deductive disclosure

Length of treatment appeared to be slightly longer compared with national averages, but the majority (40%) of young people had treatment that lasted more than 12 weeks. 32% of young clients in Cambridgeshire were in treatment for longer than 26 weeks, slightly higher than the England average of 26%. No data was available for abstinence rates for young people in substance misuse services following treatment.

76.9% of young people exited treatment in a planned way in 2014/15, similar to the England average of 79%. 92.3% of planned exits in 2014 did not re-present within six months, similar to the national average of 94% (Table ??).

**Table 16: Young people with planned exits from treatment by re-presentation status, Cambridgeshire, 2014**

Re-presented within 6 months	Cambridgeshire		NN - Oxfordshire		England
	Number	Percentage	Number	Percentage	Percentage
Yes	9	7.7	0	0.0	6
No	108	92.3	27	100.0	94
Total	117	100.0	27	100.0	100

NN - CIPFA nearest neighbour for Cambridgeshire

Additional Information from The Cambridgeshire Child and Adolescent Substance Use Service (CASUS - part of Cambridgeshire and Peterborough Foundation Trust) estimated that only 5% of these require specialist treatment again. This is attributed to difficulty with a different substance, relapse (top up sessions) or request for interventions to avoid relapse or help with another difficulty i.e. mental health or housing.

Again data from CASUS indicates that in 2014-15 5% clients were transitioned or referred to adult services. However in 2015-16, 1% of clients transitioned to adult services, which is the national average. CASUS has a small 18-21 provision which means that it can continue to support the most vulnerable young people and this service saw 14 individuals for drug and alcohol treatment aged 18-21 in the 2015-16 period.

## **Prevention Interventions in Cambridgeshire - Children and Young People**

Specific preventative interventions focusing on children and young people in Cambridgeshire include universal interventions in schools, with retailers and some targeted interventions with high risk children and young people along with their families.

### **Cambridgeshire County Council Personal Social and Health Education (PSHE)**

The Personal Social and Health Education (PSHE) Service at Cambridgeshire County Council support schools with universal programmes that include policy work but the focus is upon developing resilience through addressing emotional skills development and self-esteem. The Service offers the following interventions.

#### **Policy Guidance**

- Primary schools – as part of Primary Personal Development (which schools can subscribe to through the Wellbeing Programme), full policy toolkit and guidance available – includes model policy, guidance on working with governors and parents/carers, responding to drug related situations, assessing children's knowledge and perceptions.
- Model policy and guidance on personalising it were distributed to all Cambridgeshire schools in 2015 through Public Health commissioned funding.
- Secondary schools – model policy available for purchase.

#### **Whole school approach (Healthy Schools)**

- The whole school review process and tools available to primary schools as part of wellbeing subscription, plus support with action planning for theme based work on drug and alcohol education.

#### **Curriculum Guidance**

- Units of work are continually being developed and updated as part of Primary Personal Development Programme for subscribing primary schools.
- Secondary entitlement frameworks were reviewed and developed in 2015. This will be incorporated into mental health work in secondary being undertaken in 2016.
- The Understanding and Managing Risk programme for Key Stages 3 and 4. This covers assessing attitudes to risk, and also includes curriculum activities relating to smoking, and units of work on drug education. This was distributed to all secondary schools in 2014 and training and support is still available.



- Occasional sessions working with children in primary schools as demonstrations/to support teachers.

#### **Staff Training**

- In 2015 a course was offered to primary schools as part of PSHE Service course programme, however this was cancelled last year due to lack of take up.
- In school training for groups of staff is offered but there is limited take up.

#### **Parent/carer information sessions**

- After school/evening sessions for parent/carers raising awareness about drug education and to support parents in considering children's needs and how to support them is offered.

#### **Life Education**

- Two mobile classrooms delivering interactive drug and alcohol education and Life skills to primary schools in Cambridgeshire and Peterborough. In 2015 the classrooms visited 60 schools, reached 14,000 pupils and visited by 500 parents/carers and 500 teachers and school staff. Pupil and school evaluations demonstrate the positive impact on pupils learning.

### **Cambridgeshire County Council Trading Standards**

Cambridgeshire Trading Standards and community protection officers focus on preventing underage sales of alcohol by working with all new alcohol licence holders and their collective networks to inform, educate and support those businesses to maximise compliance with age restricted sales legislation. Test purchasing is carried out by officers and our partners when intelligence shows there is a need for concern, with a view to taking subsequent enforcement action taken against those who do not comply.

### **Cambridgeshire Child and Adolescent Substance Use Service (CASUS)**

The Cambridgeshire Child and Adolescent Substance Use Service (CASUS - part of Cambridgeshire and Peterborough Foundation Trust) CASUS is the drug and alcohol treatment service in Cambridgeshire for children and young people. Although a treatment service CASUS does provide universal and targeted preventative interventions mainly in schools and colleges. Table ? provides figures for CASUS in 2015-16. Staff from CASUS undertake community events, PSHE and targeted Interventions but the Service stresses that this is based on capacity of the team rather than need. In addition the staff provide structured consultation to children's workforce professionals to support their inventions with young people around drugs and alcohol.

**Table 17: CASUS - Range and Numbers of Preventative Universal and Selective (Target) Interventions 2015/16**

Community Events- Drug and Alcohol Prevention			PSHE (CASUS INC)			YP Targeted Drug Interventions			Training for Professionals	
Fresher Fayres			Drug and Alcohol Education in Mainstream Education Settings (Secondary Schools, Sixth Form Colleges, Independent Secondary Schools).			Group sessions and individual interventions for young people identified as at risk of substance misuse.			Drugs, Alcohol, NPS, LSD, Mentalizing, Safeguarding.	
Young driver Events			National Citizenship Programmes.			Baby Group – teenagers at risk early pregnancy.			Children’s Workforce eg school nurses, teachers, foster carers , child minders	
Alcohol Awareness Events						Inpatient Adolescent Units.				
						Alternative educations settings – specialist and within schools.				
CH & YP	Pa.	Pr.	CH & YP	Pa.	Pr.	CH & YP	Pa.	Pr.	Sessions	Attending
570	293	26	52	2095	47	40	289	71	48	635

**Date from CASUS Key: CH & YP – Children and Young People, Pa. – Parents, Pr. Professionals**

Overall the majority of interventions focus upon high risk vulnerable groups (see Children of Parents who Misuse Substances).

### Substance Misuse Services during Pregnancy

All women have alcohol intake and other substance abuse discussed at booking either by the midwife or medic. Since it is not known at what level of alcohol the baby will be affected the recommendation is to avoid alcohol completely. Otherwise drinking patterns (frequency, alcohol type, number of units etc.) are assessed. If high or frequent alcohol intake is identified then the woman is offered referral to specialist midwives and to consultant review for surveillance of foetal development support. Similar advice is given with regard to drug misuse.

The specialist midwife works in close liaison with the multiagency team (e.g. Primary Care, Substance Misuse Treatment Services, Social Care). Referrals as appropriate are made such as to support groups. The local Common Assessment Framework (CAF) tool is used to assess the wider context of their parenting needs and involve support workers and referral to social care if the parenting capacity is considered to be compromised. Paediatric follow-up is also activated.

## Treatment Services for Children and Young People

Specialist substance misuse services for children and young people are distinct from adult services because young people's alcohol and drug problems tend to be different to adults and need a different response. Specialist substance misuse services aim to support young people to address their alcohol and drug use, reduce the harm it causes and prevent it from becoming a greater problem as they get older.

In Cambridgeshire children up to the age of 19 (exceptions are made and a patient might continue with the service until 21 years of age) are referred into the Cambridgeshire Child and Adolescent Substance Use Service (CASUS - part of Cambridgeshire and Peterborough Foundation Trust). The Trust operates across Cambridgeshire in a variety of locations and settings including school, home, community settings as well as at Cambridge and Peterborough Foundation Trust bases. It is an integrated service, providing wide ranging interventions for drug and alcohol problems. Referrals are made from Child and Family Services, Health and Mental Health Services, Education Services Substance Misuse Services and Criminal Justice and referrals. Self-referral can also be made directly by a child or young person ) or their family and friends via text, email or the website. The service is publicised across Cambridgeshire (distribution of leaflets, attendance at local events) and also involves training of professionals.

The main service aims are to promote universal and targeted interventions in response to substance misuse issues, to treat children and young people with substance misuse problems and to support those with parents who have substance misuse problems.

Treatment commonly involves psychosocial and/or family Interventions, pharmacological treatments and in some cases access to Tier 4 Interventions (residential care). The service is specified to provide specialist harm reduction initiatives for children and young people injecting drugs, to reduce risk from blood-borne disease (advice and needle exchange and blood borne virus testing), and encourage safe needle disposal. The Service includes aspects of care for those with alcohol addition, such as community or inpatient detoxification.

## Working with Other Services

Children and young people substance misuse services aim to link with a number of other services, such as Child and Adolescent Mental Health Services (CAMHS), Social Care, Housing agencies/Homeless hostels, Accident and Emergency, Multisystemic Family Therapy services and adult Alcohol treatment services. The service aims to identify need, and implement interventions, in relation to sexual health, such as facilitating access to condoms and Chlamydia screening and encouraging attendance at sexual health appointments. The CASUS also is commissioned to prioritise Lesbian/Gay/Bisexual and Transgendered young people.

The service aims to incorporate 'targeted intervention', where non-referred CYP are identified as high risk and intervention is coordinated between the CYP SM service and the relevant agency e.g. police or housing association. This linking with a wide network of universal and targeted services is

to facilitate securing support for young people with a range of issues and help them to build their resilience.<sup>66</sup>

## Youth Offending Service (YOS)

There is a well documented high prevalence of substance misuse amongst young offenders. Addressing the substance misuse is associated with reducing the risk of re-offending.<sup>67 68</sup>

In Cambridgeshire, CASUS works in partnership with the Youth Offending Service (YOS), where YOS substance misuse workers employed by the Local Authority deliver universal, targeted and specialist interventions to children and young people who are offenders. Casus also provides a more specialised service for Young Offenders where there is more complex substance misuse. Where children and young people have finished their YOS order, their case may be transferred to the Cambridgeshire CYP Drug misuse service (See criminal justice system for further details regarding the YOS and CASUS).

## Prevention Evidence for Children and Young People

This section describes the evidence for universal, selective and indicated prevention.

### Scope of the Evidence

A recent review of the evidence by Public Health England<sup>69</sup> identified from the research the following factors and types of intervention that are linked to positive outcomes. The underlying evidence for this summary is explored below.

- Early interventions, particularly generic pre-school programmes, improving literacy and numeracy, have a long-term effect.
- Personal and social skills education.
- Links to school interventions including school environment improvement programmes: positive ethos; disaffection; truancy; participation; academic and social-emotional learning.
- A focus on 'risk and resilience' factors.
- Multi-component programmes involving parenting interventions and support for individuals and families, which may require joined up commissioning and planning.
- Staff who are qualified and competent to deliver the interventions they provide.

The Public health England briefing also indicates interventions that result in **no or negative outcomes**:

- Scare tactics and images.
- Knowledge-only approaches.

<sup>66</sup> Substance misuse interventions for vulnerable under 25s NICE Public Health Guideline 4 (2007) <https://www.nice.org.uk/guidance/ph4>

<sup>67</sup> McMurren M., Systematic Review What works in substance misuse treatment for offenders. Criminal Behaviour and Mental Health Vol 17 Issue 4 p 225-233 2007

<sup>68</sup> Leam A.C., Dixon L., Garron TA., Weekes JR., Moser AE., Wheatley M., Matheson.; What works in reducing substance misuse related offending (In What works in Offender Rehabilitation. An evidence based approach Assessment and Treatment Wiley & Sons 2013

<sup>69</sup> Public Health England The international evidence on the prevention of drug and alcohol use 2015

- Ex-users and the police as drug educators where their input is not part of a wider prevention programme.
- Peer mentoring schemes that are not evidence-based.

## Pregnancy and Substance Misuse

Addressing substance misuse in pregnancy has a number of objectives that address the prevention of harm to the child and also the provision of early interventions and treatment to the mother. Preventative interventions, therefore, need to address increasing awareness of the risks of substance misuse in pregnancy in the general population as well as targeting those considering pregnancy or already pregnant, identification of those at risk and an appropriate intervention.

In the USA, a number of specific universal strategies aimed at preventing FASD have been used. These have focused on media advertising campaigns, school and community-based programmes, warning posters, and labelling of alcohol beverages. Universal strategies for preventing FASD include the implementation of effective public health policies that raise awareness of the risks of maternal alcohol consumption and alter drinking behaviour, both prior to conception and during pregnancy. One controlled study in the USA found that those pregnant women provided with bespoke information materials in different media talked more about the effects of alcohol in pregnancy and had an increased levels of knowledge of the issues.<sup>70</sup>

A number of studies have assessed approaches aimed at preventing alcohol exposure during pregnancy in high-risk women have found that a brief intervention during a pregnancy led to a reduction in alcohol consumption during subsequent pregnancies.<sup>71 72</sup> The “Protecting the next pregnancy” project targeted women who drank at risk levels during a pregnancy, and provided them with an intensive brief intervention following the birth of a child exposed to alcohol during the pregnancy. In comparison to a control group, the use of intensive brief interventions was found to reduce alcohol consumption during further pregnancies and subsequently resulted in improved birth outcomes.

Another study in 2014 in Dublin found following identification and brief interventions 60% of those who drank alcohol prior to pregnancy stopped and 9% cut down consumption. 57% of those who drank were binge drinkers, this dropped to 4.8% following the intervention.<sup>73</sup> However the study did conclude that the most powerful factor in decreasing alcohol consumption was the pregnancy itself.

There is less evidence for effective interventions for women using drugs prior to or during pregnancy. However there are some studies that indicate that additional support in the form of home visits by midwives have been effective in reducing drug use during pregnancy.<sup>74 75</sup>

<sup>70</sup> Lowe JB, Baxter L, Hirokawa R, Pearce E, Peterson JJ Description of a media campaign about alcohol use during pregnancy *Journal of studies on alcohol and drugs* 2010

<sup>71</sup> Chang, G.; McNamara, T.K.; Orav, E.J.; et al. Brief intervention for prenatal alcohol use: A randomized trial. *Obstetrics and Gynecology* 105:991–998 2005.

<sup>72</sup> Chang, G.; Goetz, M.A.; Wilkins-Haug, L.; et al. A brief intervention for prenatal alcohol use: An in-depth look. *Journal of Substance Abuse Treatment* 18:365–369, 2000.

<sup>73</sup> Sheehan J, Gill A and Kelly BD, The effectiveness of a brief intervention to reduce alcohol consumption in pregnancy: A controlled trial *Irish journal of psychological medicine*, 2014, 31(3), 175

<sup>74</sup> Bartu A, Sharp J, Ludlow J, Doherty DA Postnatal home visiting for illicit drug-using mothers and their infants: a randomised controlled trial. *The Australian & New Zealand journal of obstetrics & gynaecology* 2006, 46(5), 419 2006

Overall, most researchers including NICE Guidance<sup>76</sup> recommend that in addition to identification and brief interventions women who misuse alcohol or drugs during pregnancy require additional support and many maternity units have specialist midwives who work with a range of agencies to ensure that all appropriate support is provided. This includes ensuring that women are provided with parenting skills and help finding support for issues such as housing which should continue during the first two years of baby's life. NICE also recommends that pregnant women who are substance misusers should receive multi-disciplinary ante-natal care tailored to addressing their dependence.

## Children and Young People: Universal Interventions (Primary Prevention)

Evidence from a review of systematic reviews (9 reviews 471 studies) of preventative interventions targeting children and young people focus upon family based and school based interventions.<sup>77</sup>

### Family Programmes

Two reviews of family and parental support programmes provide evidence that these interventions can reduce substance misuse through strengthening personal resilience. One of the reviews concluded that universal family based programmes with educational and psycho-social components showed positive effects across multiple outcomes of alcohol and drug misuse.<sup>78</sup> This includes work in the pre-natal and infancy period where visits by trained nurses/midwife/social workers to mothers to be or new mothers will help them deal with risk factors such as housing, employment etc. and provide parenting skills.<sup>79</sup> Another systematic review (20 studies) found that the most effective parenting programmes required active parental participation, developed social competence, self-regulation and overall parenting skills.<sup>80</sup>

### School Based Programmes

Systematic reviews of school based programmes have been used to evaluate school based programmes.<sup>81</sup> They found that the key effective interventions were those that developed life skills and psycho-social skills. The evidence was strongest for general programmes targeting multiple factors including misuse of drugs, tobacco, alcohol and anti-social behaviour. Skills focused school programmes also showed statistically significant reductions in drug use compared to the usual curriculum.

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<sup>75</sup> Schuler ME, Nair P, Kettinger L. Drug-exposed infants and developmental outcome: effects of a home intervention and ongoing maternal drug use. *Archives of pediatrics & adolescent medicine*, 2003, 157(2), 133-2003

<sup>76</sup> NICE Guidance (CG10) Pregnancy and complex social factors. A model for service provision for pregnant women with complex social factors.

<sup>77</sup> Canadian Agency for Drugs and Technologies in Health. Prevention Strategies for Substance Misuse: A review of the clinical evidence. 2012

<sup>78</sup> Foxcroft DR, Tsersvadze A. A Universal family-based prevention programs for alcohol misuse in young people. *Cochrane Database Systematic Review*. 2011; 9 CD009308

<sup>79</sup> NICE Guidance (CG10) Pregnancy and complex social factors. A model for service provision for pregnant women with complex social factors.

<sup>80</sup> Petrie J., Bunn F. Byrne G. Parenting programmes for preventing tobacco, alcohol or drug misuse in children<18: a systematic review. *Health Education research* 2007; 22(2) 177-91

<sup>81</sup> Foxcroft DR, Tsersvadze A. A universal school based prevention programs for alcohol misuse in young people. *Cochrane database Systematic Review*. 2011; (5): Cd009113

Skills based prevention programmes train teachers to engage students in interactive activities to give them the opportunity to learn and practice a range of personal and social skills. They focus on encouraging peer refusal abilities that support young people to counter social pressures. However another systematic review concluded that there is limited data on long term effectiveness of school based interventions and called for more formal studies and trials.<sup>82</sup>

### Selective (Targeted) Interventions for Vulnerable and Disadvantaged Groups (Secondary Prevention)

These interventions target those individuals, groups, families and communities whose risk of substance misuse is known to be higher than average. Building resilience through providing protective interventions is a key theme for preventing substance misuse amongst vulnerable, disadvantaged or marginalised children and young people.

A review originally undertaken in 2006 (then reviewed again in 2013) by Jones et al provides a comprehensive overview of the evidence for interventions to reduce substance misuse amongst vulnerable and disadvantaged young people.<sup>83</sup> The review classifies intervention into those valid for young people with multiple risk factors and those that have particular relevance for those with specific risk factors such as black and minority groups.

The main findings are summarised below. However it should be noted that some of the studies in the review were small or of poor quality. The interventions focus on building resilience through strengthening families, developing skills and providing support.

**Multi component interventions** have been found to be effective in reducing substance use in the short term; there is inconsistent evidence about effectiveness in the long term.

**Multicomponent community interventions** across different settings (rather than school and community projects alone) prevent, delay or reduce drug use.

**Community Case Management Interventions** have been found to increase substance use knowledge and increase positive parenting skills.

**Employment skills programs:** Comprehensive employment programs to increase participation in employment and training, reduce arrest and conviction rates and time spent in jail. They have not been found to be an effective intervention for reducing substance use.

**Individual counselling** produced significant reduction in delinquent and criminal behaviour in the medium term.

**Family based interventions** have been found to prevent alcohol misuse when focused upon improving parenting skills.

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<sup>82</sup> Faggionato F, Vigna-Taglianti FD, Versino E., Zambon A., Borroccino A., Lemma P. School based prevention for illicit drug use : a systematic review. Rev med. 2008 May; 46 (5): 385-96

<sup>83</sup> Jones L., Sumnall H., Witty K., Wareing M., Mcveigh J., A review of community based interventions to reduce substance misuse interventions among vulnerable and disadvantaged young people. PHIC Report 5. 3a Liverpool U.K.: National Collaborating Centre for Drug Prevention, Centre for Public Health, Liverpool John Moores University. (2006)

**School based educational and skills programs** have been found to be associated with improving educational skills and positive behaviours and parents' family based caring.

**School based counselling and therapy** such as brief single substance misuse interventions and group counselling have resulted in changing attitudes to alcohol.

### **Children and Young People in Families with Substance Misusing Members**

Key protective factors of this group that lead to more resilience have been identified in a number of studies, both general and specific to parental substance misuse.<sup>84 85</sup> These included support from school, immediate and extended family, and individuals and services outside of the family. Although the studies identified the difficulties in maintaining this support.

The systematic review by Jones et al<sup>86</sup> concluded that there were no effects from multi-component interventions that target parental drug abuse and parenting practices in combination with drug treatment on children's drug use, behavioural outcomes or school and family factors.

Parenting programs combined with drug treatment (parental) that improve parental problem solving, parenting practices and depression were found to stabilise or reduce parental drug use in the short to medium term.

There is a general call in the literature for more research into the factors that will protect children with substance misusing parents.

### **Indicated (Secondary prevention)**

The interventions described here are for those who are already misusing substances but not yet dependent.

### **Brief/extended interventions and motivational interviewing**

Interventions commonly use one or two sessions of motivational interviewing (MI) and feedback in young people identified as high risk of drug and alcohol misuse through schools, colleges and emergency departments. NICE<sup>87</sup> in 2010 recommended the use of extended brief interventions with young people aged 16-21 but not for young people under the age of 17.

A number of systematic reviews have concluded that motivational interviewing is an effective intervention for young people. However there is little evidence for its use with those under the age of 16. The authors of one systematic review of effectiveness of motivational interviewing

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<sup>84</sup> Beinart, S., Anderson, B., Lee, S., et al (2002) *Youth at Risk? A National Survey of Risk Factors, Protective Factors and Problem Behaviour among Young People in England, Scotland and Wales* (JRF Findings 432). Joseph Rowntree Foundation.

<sup>85</sup> Bancroft, A., Wilson, S., Backett-Milburn, K., et al (2004) *Risk and Resilience: Older Children of Drug and Alcohol Misusing Parents*. Joseph Rowntree Foundation.

<sup>86</sup> Jones L., Sumnall H., Witty K., Wareing M., Mcveigh J., A review of community based interventions to reduce substance misuse interventions among vulnerable and disadvantaged young people. PHIC Report 5. 3a Liverpool U.K.: National Collaborating Centre for Drug Prevention, Centre for Public Health, Liverpool John Moores University. (2006)

<sup>87</sup> NICE PH Guidance 24 Alcohol-use disorders: preventing harmful drinking (2010)



interventions for adolescent substance misuse<sup>88</sup> concluded that it had a positive effect upon substance misuse with small effects over time.

Another systematic review of brief interventions (BASICS) with college students for alcohol misuse was found to effective in reducing alcohol consumption.<sup>89</sup>

A review in 2014<sup>90</sup> of the evidence for the recommendations found in the 2010 NICE Guidelines that said they did not find any new evidence to warrant a change in the recommendations for interventions for the prevention of alcohol misuse. It supported the use of extended brief interventions with young people aged 16-21 for reducing drinking and that the level of effectiveness with young people under the age of 17 remains limited.

The 2014 Review also presented evidence that supported the recommendations that workers judge the level of misuse and the ability to consent and referral to specialist services for children and young people aged 10 to 15 years.

However there are trials that present more ambivalent evidence for brief/extended interventions. Two trials showed a positive effect but they lacked robustness<sup>91 92</sup> and the findings could be unreliable. Four other trials have focused upon cannabis use and it could be concluded that likely that brief interventions have minimal effect in reducing cannabis misuse in young people.<sup>93 94 95 96</sup>

A recent review (2016) of brief intervention following an alcohol related admission to accident and emergency departments<sup>97</sup> concluded that the variety of study designs and effects limit conclusions on effectiveness of brief interventions for young Accident and Emergency patients following an alcohol-related event. Furthermore it stated that the number of practice projects in Europe indicates a need perceived by practitioners to address this population and a requirement for ongoing research.

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<sup>88</sup> Jenson CD, Cushing CC, Aylward BS, Craig JT, Sorell DM, Steele RG. Effectiveness of motivational interviewing interventions for adolescent substance use behaviour change. A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 79(4), 433-440 (2011)

<sup>89</sup> Fachini A, Aliane PP, Martinez EZ, Furtado EF Efficacy of brief alcohol screening interventions for college students (BASICS): A meta-analysis of randomized controlled trials. *Substance Abuse Treatment, Prevention and Policy*, 7,40 (2012)

<sup>90</sup> NICE Alcohol – use disorders: preventing harmful drinking. Evidence Update 2014

<sup>91</sup> Winters KC, Leitten Willia Brief intervention for drug-abusing adolescents in a school setting. *Psychology of Addictive Behaviors*, Vol 21(2), 249-254(2007)

<sup>92</sup> MaCambridge J, Strang J. The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: results from a multi-site cluster randomized trial. Volume 99, Issue 1 Pages 39–52 ( 2004)

<sup>93</sup> Bernstein ED, Edwards E, Dorfman D, Heeran T, Bliss C, Bernstein J. Screening and Brief Intervention to Reduce Marijuana Use Among Youth and Young Adults in a Pediatric Emergency Department Volume 16, Issue 11 Pages 1174–1185 (2009)

<sup>94</sup> Christoff A. Boerngan R. Reducing substance involvement in college students: A three-arm parallel-group randomized controlled trial of a computer-based intervention *Addictive Behaviors*, Volume 45, Issue null, Pages 164-171 (2015)

<sup>95</sup> Fischer B, Jones W, Shuer P, Rehm J. 12-month follow-up of an exploratory 'brief intervention' for high-frequency cannabis users among Canadian university students *Substance Abuse Treatment, Prevention, and Policy* 7:15 (2012)

<sup>96</sup> MaCambridge J, Day M, Thomas BA, Strang J. Fidelity to Motivational Interviewing and subsequent cannabis cessation among adolescents. *Addictive Behaviors*, Volume 36, Issue 7, Pages 749-754 (2008)

<sup>97</sup> Diestelkamp S, Drechsel M, Baldus C, Wartberg L, Arnaud N, & Thomasius R. (2016). Brief in person interventions for adolescents and young adults following alcohol-related events in emergency care: A systematic review and European evidence synthesis. *European Addiction Research*, 22(1), 17-35.

## **Identification, brief/extended interventions and motivational interviewing: disadvantaged and vulnerable children and young people**

NICE (2007) recommends tools for identifying vulnerable and disadvantaged children and young people under 25<sup>98</sup> who are known to be already or at very high risk of misusing substances. It also recommends targeted interventions which include structured family based support and children with behavioural problems group-based behavioural therapy before and during the transition to secondary school.

In 2014 NICE<sup>99</sup> reviewed the evidence for its recommendations found in the 2007 Guidelines and concluded that there is evidence for motivational interventions being effective for reducing substance misuse for young people at risk of delinquent or criminal behaviour, personality targeted interventions may be effective with children and young people with a psychological disposition towards substance misuse. However there was inconclusive evidence for interventions with children with mental health issues or those with a parent or carer who misuses substances.

There are caveats relating to the evidence for work with children and young people. Children enrolled and interviewed in many of the research settings; where reporting of illegal drug use might lead to discipline (or perceived discipline, from parents, teachers or the police) may be more likely to report positive outcomes.

## **Evidence for Treatment Interventions**

### **Cognitive Behavioural Therapy**

There is some evidence that cognitive behavioural approaches to drug and alcohol misuse disorders may be effective in reducing substance misuse as well as other related problems for the individual. However, much of the evidence base is from approaches dealing with comorbidity such as conduct disorders, and anxiety and affective disorders where information on the extent and severity of alcohol misuse specifically is lacking. Adaptations of cognitive behavioural approaches to young people, address developmental stages and levels of maturity.

In a controlled trial<sup>100</sup> participants were randomised to cognitive behavioural therapy or a psychoeducational intervention. At three months substance misuse had significantly improved, and up to nine months showed continued improvement.

Although the primary focus of studies of comorbidity has been on individuals with conduct disorder, a few studies have also examined the problems presented by co-occurring common mental health disorders such as depression and anxiety. One study evaluated the efficacy of an integrated 20-week programme of cognitive behavioural therapy with case management in a population of drug and alcohol misusing young people (aged between 15 and 25 years). Sixty-three per cent of the sample met the criteria for alcohol dependence. Treatment resulted in a significant improvement in

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<sup>98</sup> NICE Guidelines (PH4) Substance misuse interventions for vulnerable under 25s (2007)

<sup>99</sup> NICE Interventions to reduce substance misuse among vulnerable young people Evidence Update (2014)

<sup>100</sup> Kaminer and colleagues (2002),

abstinence rates as well as a reduction in the number of participants meeting diagnostic thresholds for dependence. These positive effects were also observed at 44-week follow-up.

## Family interventions

Functional family therapy is a psychological intervention that is behavioural in focus. The main elements of the intervention include engagement and motivation of the family in treatment, problem solving and behaviour change through parent training and communication training, and seeking to generalise change from specific behaviours to have an impact on interactions both within the family and with community agencies such as schools.

Brief strategic family therapy is a psychological intervention and is influenced by other approaches such as structural family therapy. The main elements of this intervention include engaging and supporting the family, identifying maladaptive family interactions, and seeking to promote new and more adaptive family interactions.

Multi-Dimensional Family Therapy (MDFT) is a family-focused treatment for individual adolescents and their families. MDFT targets the psychosocial functioning of individual family members, the family members' relationships, and influential social systems outside the family. It uses strategies from family therapy and behavioural therapy to intervene directly in systems and processes related to antisocial behaviour (for example, parental discipline, family affective relations, peer associations and school performances) for children or young people.

A meta-analysis<sup>101</sup>, evaluated sixteen trials of multicomponent and family-based interventions for alcohol misuse. It was reported that multicomponent family therapies were effective in reducing alcohol misuse in young people and in reducing criminal activity outcomes. Types of family therapies evaluated included: multi-systemic therapy, multidimensional therapy, brief family therapy, functional family therapy and strength-oriented family therapy. However due to variation in the studies included no particular family therapy was identified as being especially effective

Six trials of family therapy for child drug abuse were identified and all used 'Multidimensional Family Therapy' (MDFT) in an outpatient setting as the intervention. MDFT commonly included sessions with the young person, their parents or any other family and contact with school, courts and any other relevant organisations. MDFT was commonly compared with another form of active treatment e.g. individual or group CBT, family or peer group discussion groups or parent training. Across studies, MDFT showed a small and reasonably consistent positive effect compared with control treatments suggesting that MDFT is an effective treatment for drug and alcohol misuse in children and young people

Many of the trials that evaluate the efficacy of these interventions involved participants with conduct disorder or psychiatric disorder, polydrug and alcohol misuse. The studies of multicomponent interventions demonstrate benefits on offending behaviour and promising results for the reduction of alcohol and drug misuse.

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<sup>101</sup> (2010) *StePublic Health England* N. J. Tripodi, S.J., Bender K., Litschge C., Vaughn M.G., *Interventions for Reducing Adolescent Alcohol Abuse, A Meta-analytic Review Arch Pediatr Adolesc Med.* 2010;164(1):85-91

## **Assisted Withdrawal for Young People**

NICE recommendations are that assisted withdrawal should be offered as inpatient care for children and young people aged 10–17 years, otherwise recommendations follow those of adults taking into account age, height and body mass, and stage of development of the child or young person

## **Pharmacological Interventions**

There is a limited evidence base using the results of three small pilot randomised controlled trials, to assess the efficacy of pharmacological interventions in young people for alcohol misuse. The three studies do, however, provide some preliminary data indicating positive responses in young people to pharmacological interventions when compared with placebo. Due to the poor methodological quality of these studies, however, results should be interpreted with very considerable caution.

## **Summary of the treatment evidence**

There is good evidence for the effectiveness of family therapy (Multidimensional Family Therapy) in young people and this appears to be an effective form of treatment for substance misuse and offending behaviour. For CBT there is some evidence especially when there are co-morbidities. Limited evidence was found for the effectiveness of brief interventions in young people.

Although assisted withdrawal for young people is recommended by NICE there is limited evidence due to the size of the trials and that the recommendations are based on extrapolation from adult data.

## **What is this telling us?**

### **Overview**

Generally in Cambridgeshire the prevalence of drug and alcohol misuse is comparable to national and local comparator areas. Although there are some differences within the county with Cambridge City having higher drug use and lower alcohol use than the rest of the county. A similar picture can be applied for hospital admissions and treatment services. There is a high rate of successful treatment outcomes with a low number of representations along a low percentage, between 1-5% transitioning into adult services. However there are concerns for high risk vulnerable children and young people who need to be identified and targeted with interventions to reduce their risks and build resilience.

- Locally pathways and services are starting have been developing that will systematically identify the needs of vulnerable children wherever they present. However workforce training is required to streamline and improve identification of children affected by parental substance misuse along with Improvement in inter-agency sharing of information.
- There is evidence for early “selective” interventions for these high risk groups which could be more fully developed locally. Interventions for these groups should be wide –ranging and focus upon developing resilience and resistance to risk factors for drug and alcohol misuse.

- Many of the children and young people in the treatment services have different vulnerabilities which includes high levels of mental ill-health and self-harming, looked after children and involvement in the criminal justice system.
- Children living with parents who are misusing are at high risk. The work that is currently being piloted needs to be fully evaluated to identify learning that can be applied to all the vulnerable groups.
- Local Safeguarding Children Boards (LSCB) are now the key for organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. They often encounter cases which involve an element of substance misuse in parents or carers. The lessons learned from these cases should be used more explicitly to improve inter-agency working
- Any selective interventions need to be part of an integrated approach with different organisations supporting the development of resilience in children and young people most at risk of misusing substances. This includes the small number of those who transition into adult services.

## CHAPTER 5: Adult Alcohol and Drug Misuse

***Please note that in all Chapters the local comparator area cited is Oxfordshire***

This next two sections look at drug and alcohol misuse amongst adults. Each is initially described separately but service delivery is considered for both in one section.

### What the data tell us: Prevalence of alcohol misuse

**Headlines** (Please note data are based on models from 2009 - new data is expected at the end of 2016)

- 85.8% of over 16 year olds in Cambridgeshire are estimated to be drinkers of alcohol.
- 21% of drinkers (18% of all over 16s) are estimated to be increasing risk drinkers.
- 6.8% of drinkers (5.9% of all over 16s) are estimated to be higher risk drinkers.

### Data in Detail

#### Prevalence estimates

Prevalence estimates are based on 2009 models applied to 2014 population estimates and so may not accurately reflect current drinking levels, and updates to the definitions were published in 2016.<sup>102</sup> Updated estimates are expected from Public Health England later in 2016.

85.8% of over 16 year olds in Cambridgeshire are estimated to be drinkers of alcohol (Table ??). 21% of drinkers (18% of all over 16s) are estimated to be increasing risk drinkers, and 6.8% of drinkers (5.9% of all over 16s) are estimated to be higher risk drinkers. This equates to 30,714 higher risk drinkers and 94,124 increasing risk drinkers.

**Table 18: Numbers of abstainers/drinkers aged 16 and over, Cambridgeshire, 2014**

Local Authority	Abstainers		Drinkers		Lower risk drinkers*		Increasing risk drinkers*		Higher risk drinkers*	
	Prevalence	Number	Prevalence	Number	Percentage of drinkers	Number	Percentage of drinkers	Number	Percentage of drinkers	Number
Cambridge	16.7	18,183	83.3	90,736	70.6	64,085	21.5	19,470	7.9	7,181
East Cambridgeshire	13.3	9,266	86.7	60,293	71.9	43,367	21.2	12,802	6.8	4,124
Fenland	15.1	12,204	84.9	68,389	73.9	50,510	19.6	13,408	6.5	4,472
Huntingdonshire	13.4	18,858	86.6	122,105	72.4	88,363	21.0	25,596	6.7	8,146
South Cambridgeshire	12.8	15,760	87.2	107,166	72.3	77,526	21.3	22,848	6.3	6,791
Cambridgeshire	14.2	74,271	85.8	448,689	72.2	323,851	21.0	94,124	6.8	30,714
NN - Oxfordshire	17.6	96,517	82.4	450,445	70.9	319,537	20.8	93,660	8.3	37,248
England	16.5	7,275,582	83.5	36,737,480	73.3	26,911,755	20.0	7,347,070	6.7	2,478,655

\* See glossary

NN - CIPFA nearest neighbour for Cambridgeshire

Numbers estimated by applying the point estimate of prevalence to population estimates

Note that prevalence estimates have wide confidence intervals and so the precision of the estimated numbers is low

Source: Mid-2009 synthetic estimates of prevalence taken from the Local Alcohol Profiles for England 2014 and applied to mid-2014 ONS population estimates

<sup>102</sup> <https://www.gov.uk/government/consultations/health-risks-from-alcohol-new-guidelines>

## What the data tell us: Hospital Admissions due to Alcohol

**Headlines:** In 2013/14 Hospital admission rates were generally similar or below England and Oxfordshire. However rates in Cambridge and Fenland were generally poorer than the rest of the county. Although rates have generally remained the same since 2008/09 there has been an increase in the number of people admitted, reflecting population increases and this puts additional pressures on services.

- In 2013/14 1,890 people in Cambridgeshire were admitted to hospital with conditions wholly attributable (specific) to alcohol misuse.
- 64% of admissions were men.
- Alcohol-specific admission rates were significantly lower than the England average and similar to Oxfordshire. However the county falls in the top 25% of local authorities.
- The rates have increased slightly but remained statistically significantly lower than England and similar to Oxfordshire.
- 28% of all hospital specific admissions were Cambridge residents, the rate is statistically significantly higher in both sexes than England rates.
- In 2013/14 around 6,600 Cambridgeshire adults were admitted to hospital due to alcohol-related conditions, with around 12,200 separate admission episodes (takes into account that a person may experience multiple hospital admissions).
- The alcohol related admission rate was statistically significantly lower than the England average but the county falls in the top 25% of local authorities.
- However the rate alcohol related admissions was statistically significantly similar to national rates in Cambridge and Fenland.
- 65% of alcohol related admissions were in men.
- The admission episode rate in the county was statistically significantly lower than the national rate but statistically significantly higher in Fenland and Cambridge.
- Rates of alcohol related hospital episodes are significantly statistically lower than the national figure but falls within the top 25% of local authorities. However rates statistically significantly higher in Fenland and Cambridge.
- Although rates of alcohol related admission and episodes have remained stable since 2008/09, due to population increases, the numbers of alcohol related admissions and admission episodes have increased, putting increased pressure on services.

## Data in Detail

### Alcohol-specific admissions

In 2013/14, 1,890 people in Cambridgeshire were admitted to hospital with conditions wholly attributable to alcohol use; 64% were in men (Table ??). Age-standardised rates of alcohol-specific hospital admissions in Cambridgeshire as a whole are significantly lower than the England average in men and women (Figure ??). While rates are fairly similar in Cambridgeshire to Oxfordshire, among all of Cambridgeshire's statistical neighbours, however, the county's rate of alcohol-specific hospital admissions falls in the top 25% of local authorities.<sup>103</sup>

Rates of admissions vary by district, with statistically significantly higher than national average rates in Cambridge in both sexes (Figure ??). 28% of all alcohol-specific admissions in the county are in Cambridge residents.

**Table 19: Alcohol-specific hospital admissions by sex, Cambridgeshire, 2013/14**

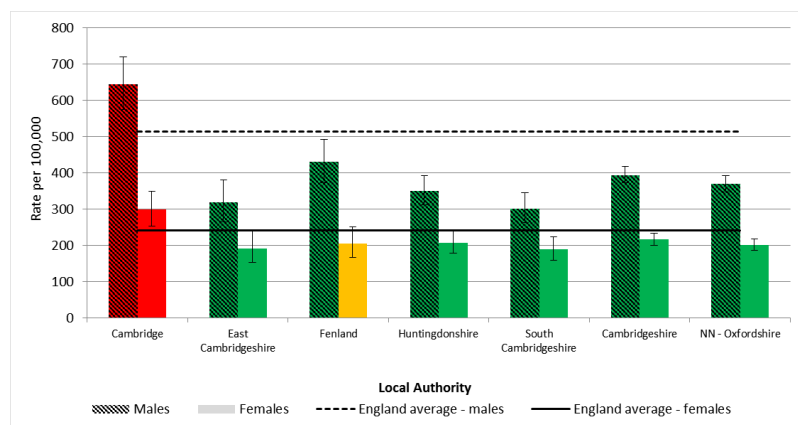
Local Authority	Males				Females			
	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI
Cambridge	360	644	575	720	175	300	254	351
East Cambridgeshire	125	320	266	382	80	193	153	240
Fenland	205	430	374	494	100	206	167	251
Huntingdonshire	300	351	312	393	180	208	178	240
South Cambridgeshire	215	303	263	346	145	190	160	224
Cambridgeshire	1,210	395	373	418	680	217	201	234
NN - Oxfordshire	1,165	370	349	392	670	203	187	219
England	130,590	515	512	518	64,655	241	239	243

DASR - Directly age-standardised rate, CI – Confidence Interval, NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

<sup>103</sup> Public Health England. Alcohol data: JSNA support pack – Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17: Cambridgeshire



**Figure 37: Alcohol-specific hospital admissions by sex (directly age-standardised rates per 100,000 population), Cambridgeshire, 2013/14**

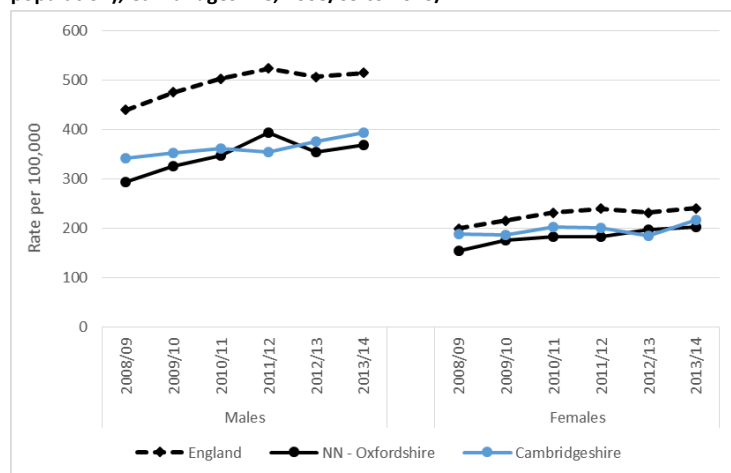


■ Statistically significantly higher than the England average  
■ Statistically similar to the England average  
■ Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire  
 Error bars represent 95% confidence intervals  
 Source: Local Alcohol Profiles for England, Public Health England

Rates of alcohol-specific hospital admissions for the county as a whole have increased slightly in both sexes since 2008/09, in line with national trends, but have remained statistically significantly lower than the England averages and similar to Oxfordshire (Figure ?? and Data Supplement).

**Figure 38: Alcohol-specific hospital admissions by sex (directly age-standardised rates per 100,000 population), Cambridgeshire, 2008/09 to 2013/14**



NN - CIPFA nearest neighbour for Cambridgeshire  
 Source: Local Alcohol Profiles for England, Public Health England

### Alcohol-related admissions

Data on alcohol-related hospital admissions include a bigger range of conditions where alcohol is implicated. Broad definitions of these indicators give better indications of impacts of alcohol on the community and on services.

In 2013/14, approximately 6,652 people were admitted due to conditions relating to alcohol use; 65% were in men (Table ??). Age-standardised rates of alcohol-related hospital admissions in Cambridgeshire as a whole are statistically significantly lower than the England average (Figure ??). There is some variation by district, however, with statistically similar to national average rates in Cambridge and Fenland in both sexes.

Among the county's statistical neighbours, the rate of alcohol-related admissions in Cambridgeshire falls in the top 25% of local authorities.<sup>104</sup> Compared to the county's nearest neighbour, rates are statistically significantly higher in men but similar in women.

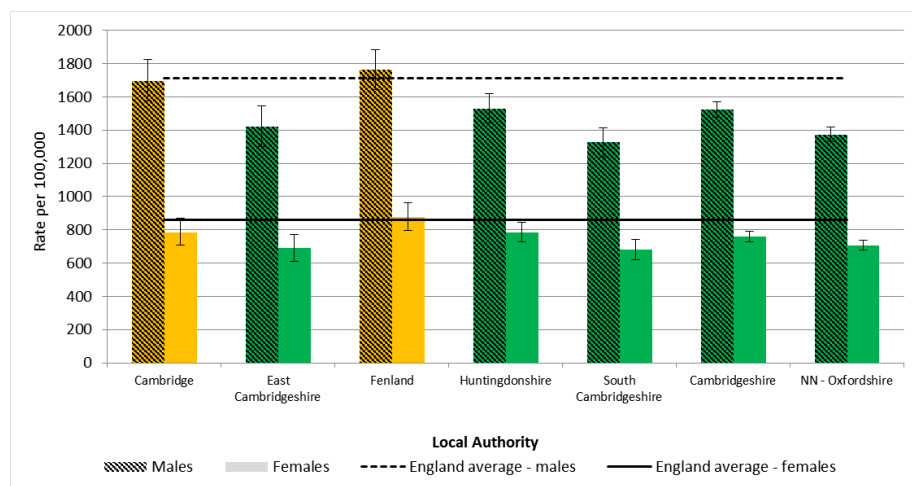
**Table 20: Alcohol-related hospital admissions (broad definition) by sex, Cambridgeshire, 2013/14**

Local Authority	Males				Females			
	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI
Cambridge	799	1,696	1,573	1,826	415	785	707	869
East Cambridgeshire	544	1,419	1,300	1,546	298	689	612	773
Fenland	846	1,762	1,644	1,886	447	878	798	964
Huntingdonshire	1,198	1,531	1,443	1,622	679	785	727	847
South Cambridgeshire	908	1,326	1,240	1,416	518	679	622	741
Cambridgeshire	4,295	1,524	1,478	1,571	2,357	760	730	792
NN - Oxfordshire	3,997	1,374	1,331	1,418	2,288	707	678	737
England	405,337	1,715	1,709	1,720	226,890	859	855	862

DASR - Directly age-standardised rate, CI – Confidence Interval, NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

<sup>104</sup> Public Health England. Alcohol data: JSNA support pack – Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17: Cambridgeshire

**Figure 39: Alcohol-related hospital admissions (broad definition) by sex (directly age-standardised rates per 100,000 population), Cambridgeshire, 2013/14**



Statistically significantly higher than the England average  
 Statistically similar to the England average  
 Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire

Error bars represent 95% confidence intervals

Source: Local Alcohol Profiles for England, Public Health England

Admission *episode* measures take into account that an individual may experience multiple hospital admissions. In 2013/14, there were approximately 12,183 hospital admission episodes among Cambridgeshire residents due to alcohol-related conditions (Table ??). Age-standardised rates of alcohol-related hospital admission episodes in Cambridgeshire as a whole are statistically significantly lower than the England averages (Figure ??). There is some variation by district, however, with statistically significantly higher than national average rates in Cambridge and Fenland men.

Among the county's statistical neighbours, the rate of alcohol-related admission episodes in Cambridgeshire falls in the top 25% of local authorities.<sup>105</sup> Rates are statistically significantly higher in Cambridgeshire men and women compared to the county's nearest neighbour Oxfordshire.

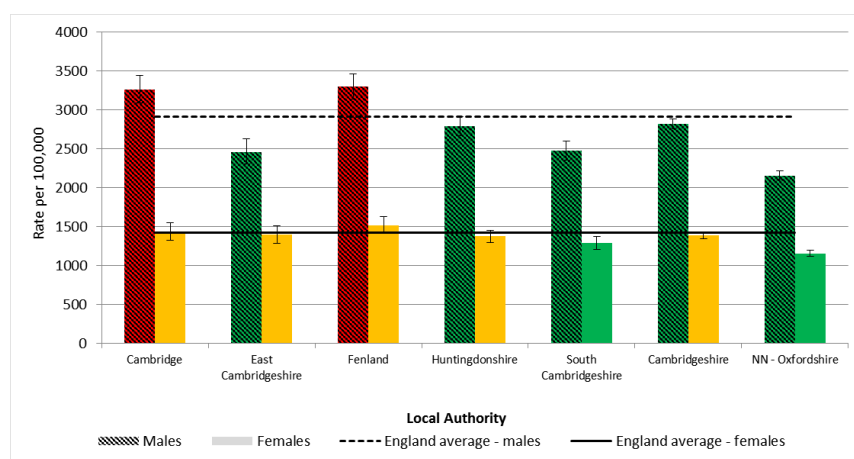
<sup>105</sup> Public Health England. Alcohol data: JSNA support pack – Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17: Cambridgeshire

**Table 21: Admission episodes for alcohol-related conditions (broad definition) by sex, Cambridgeshire, 2013/14**

Local Authority	Males				Females			
	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI
Cambridge	1,505	3,260	3,088	3,438	727	1,437	1,330	1,551
East Cambridgeshire	943	2,460	2,303	2,625	608	1,400	1,290	1,516
Fenland	1,587	3,297	3,135	3,465	775	1,521	1,415	1,633
Huntingdonshire	2,164	2,790	2,671	2,912	1,187	1,375	1,298	1,456
South Cambridgeshire	1,700	2,474	2,357	2,596	987	1,288	1,209	1,372
Cambridgeshire	7,899	2,821	2,759	2,885	4,284	1,392	1,350	1,434
NN - Oxfordshire	6,222	2,159	2,105	2,214	3,723	1,156	1,119	1,194
England	653,748	2,823	2,816	2,830	374,854	1,426	1,421	1,431

DASR - Directly age-standardised rate, CI – Confidence Interval, NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

**Figure 40: Admission episodes for alcohol-related conditions (broad definition) by sex and district (directly age-standardised rates per 100,000 population), Cambridgeshire, 2013/14**



■ Statistically significantly higher than the England average  
■ Statistically similar to the England average  
■ Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire

Error bars represent 95% confidence intervals

Source: Local Alcohol Profiles for England, Public Health England

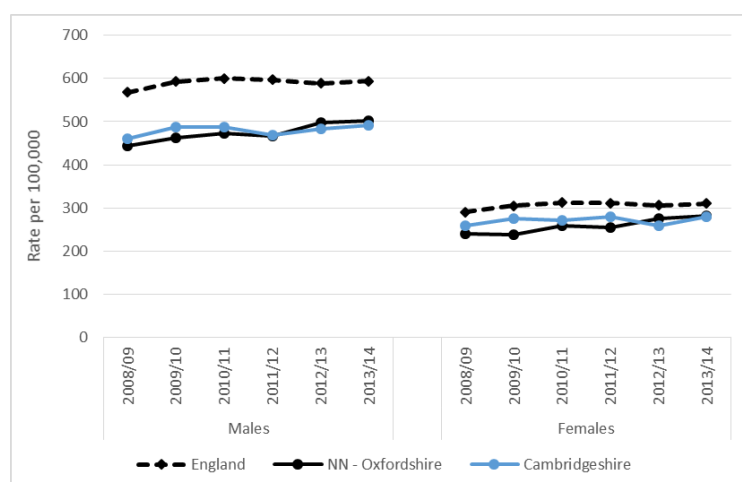
Narrow definitions of alcohol-related conditions are useful for comparing trends over time as they are less subject to changes in coding practice.

Rates of alcohol-related hospital admissions and admission episodes for the county as a whole have remained relatively stable since 2008/09, in line with national trends (Figures ?? and ??, Data

Supplement). Having said that, numbers of people admitted and numbers of admission episodes have increased<sup>106</sup> in line with known population increases, placing additional demand on services.

Population admission rates have been consistently statistically significantly lower than the England average in both sexes (Figure ??, Data Supplement) and similar to Oxfordshire.

**Figure 41: Alcohol-related hospital admissions (narrow definition) by sex, (directly age-standardised rates per 100,000 population), Cambridgeshire, 2008/09 to 2013/14**

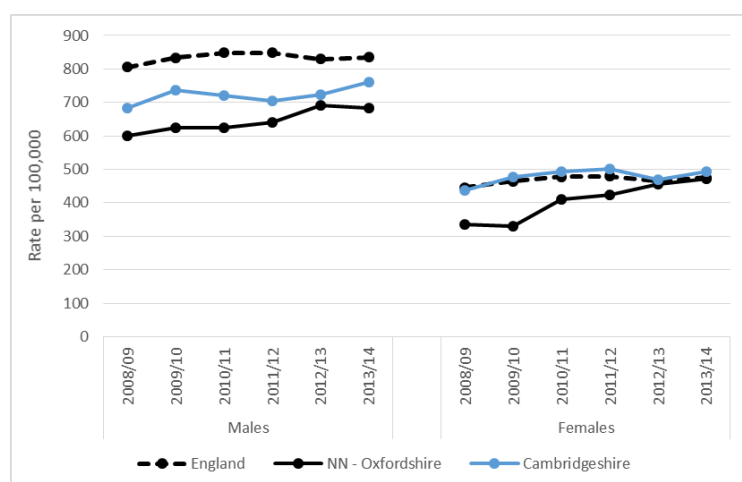


NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

Admission episode rates in women, however, are similar to the national average (Figure ??, Data Supplement). Compared to Oxfordshire, rates in men are higher in Cambridgeshire. Until recently rates were also higher in Cambridgeshire women but rates in Oxfordshire have increased to similar levels to Cambridgeshire.

<sup>106</sup> See Indicators 8 and 10 in the Local Alcohol Profiles for England (LAPE) for full data <http://fingertips.Public Health England.org.uk/profile/local-alcohol-profiles/data>

**Figure 42: Alcohol-related hospital admission episodes (narrow definition) by sex, (directly age-standardised rates per 100,000 population), Cambridgeshire, 2008/09 to 2013/14**



NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

In 2014/15, there were 2,125 hospital admissions episodes due to alcohol-related mental and behavioural disorders in Cambridgeshire; 69% were in men (Table ?). Age-standardised rates of these admissions in Cambridgeshire as a whole are statistically significantly lower than the England average in men and similar in women (Figure ?). Rates are statistically significantly higher, however, than in Oxfordshire. There is variation by district within the county, with statistically significantly higher than national average rates in Cambridge in both sexes.

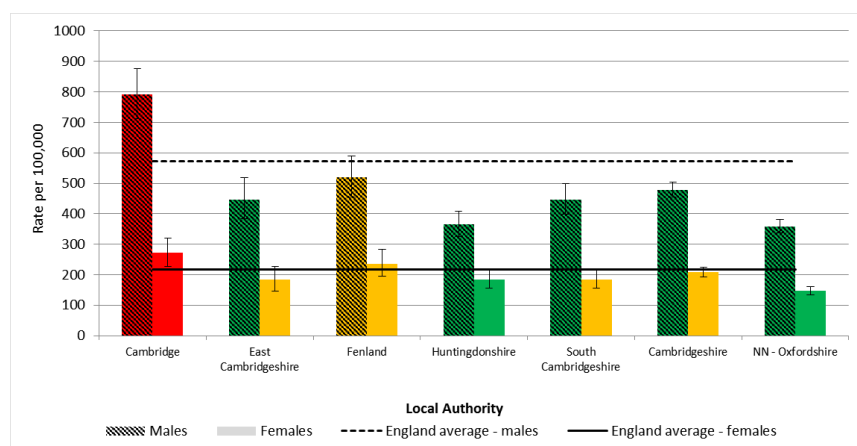
**Table 22: Hospital admission episodes for alcohol-related mental and behavioural disorders (broad definition) by sex, Cambridgeshire, 2014/15**

Local Authority	Males				Females			
	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI
Cambridge	415	792	713	877	155	271	228	320
East Cambridgeshire	180	447	384	518	80	184	146	228
Fenland	245	519	456	589	115	236	195	284
Huntingdonshire	310	365	325	408	160	185	157	216
South Cambridgeshire	315	445	397	498	145	184	155	217
Cambridgeshire	1,470	478	454	503	655	209	193	226
NN - Oxfordshire	1,125	359	338	380	485	146	134	160
England	145,670	573	570	576	58,030	217	215	219

DASR - Directly age-standardised rate, CI – Confidence Interval, NN - CIPFA nearest neighbour for Cambridgeshire

Source: Local Alcohol Profiles for England, Public Health England

**Figure 43: Hospital admission episodes for alcohol-related mental and behavioural disorders (broad definition) by sex (directly age-standardised rates per 100,000 population), Cambridgeshire, 2014/15**



■ Statistically significantly higher than the England average  
■ Statistically similar to the England average  
■ Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire

Error bars represent 95% confidence intervals

Source: Local Alcohol Profiles for England, Public Health England

Rates of hospital admissions due to alcohol-related mental and behavioural disorders have remained generally statistically significantly lower than the England average but appear to be increasing in men and consistently slightly higher than in Oxfordshire (Figure ?, Data Supplement)

## What the data tell us: Alcohol and Mortality

**Headlines:** Generally mortality rates have been similar or below England and Oxfordshire rates. However alcohol misuse is associated with a reduction in life expectancy, which has been more marked in Fenland.

- In 2014 there were 211 deaths in Cambridgeshire due to alcohol-related causes with 65% of them being male. The rate was similar to the Oxfordshire pattern.
- Age-standardised mortality rates from alcohol-related causes were significantly lower in Cambridgeshire for men compared to the England average but similar in women.
- Rates of alcohol related mortality have been relatively stable since 2008 and similar to England and Oxfordshire.
- In 2014 rates of alcohol-specific mortality were statistically significantly higher in the 20% most deprived wards in Cambridgeshire compared with the county average. This probably reflects the impact also of other local factors that affect health outcomes.
- In 2012-14 Average life expectancy was reduced by 8.6 months for men and 4.4 months for women due to alcohol related causes, lower than the England average.
- Average life expectancy was reduced by a higher amount in Fenland due to alcohol related conditions compared with the other districts.
- On average between 2006 to 2012-14 there were around 46 deaths per year due to liver disease with 58% of them being male.
- There was a general stable trend for liver disease rates since 2008 with lower rates than the England average.
- In 2012-14 alcohol related liver disease death rates for women have increased to a level similar to the English average but remain lower than Oxfordshire.

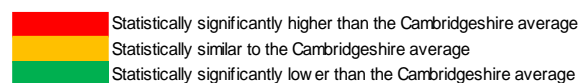
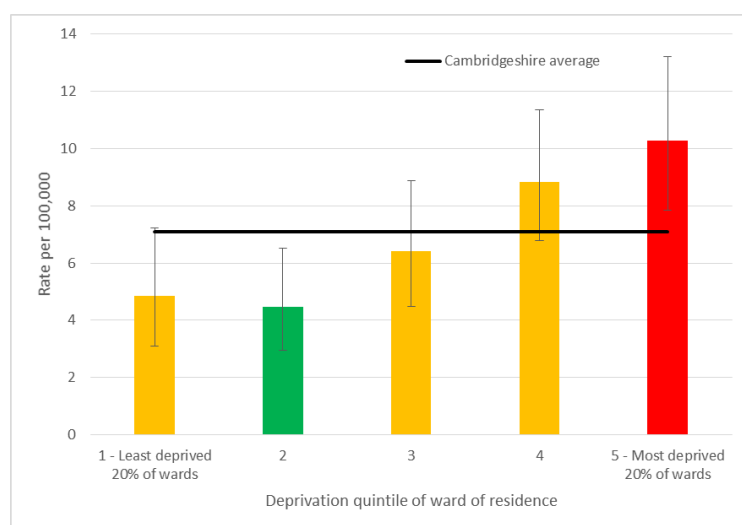


## Data in Detail

### *Alcohol-specific mortality*

Rates of alcohol-specific mortality generally increase with levels of deprivation in the county (Figure ??). The rate in the most deprived 20% of wards in Cambridgeshire is statistically significantly higher than the county average rate. This likely reflects other issues affecting people in deprived areas rather than increased consumption of alcohol.<sup>107</sup>

**Figure 44: Alcohol-specific mortality by deprivation quintile of ward of residence (directly age-standardised rates), Cambridgeshire, 2011-15**



Error bars represent 95% confidence intervals

Source: Health and Social Care Information Centre Primary Care Mortality Database, Office for National Statistics mid-year population estimates, Communities and Local Government Index of Multiple Deprivation 2010

<sup>107</sup> Public Health England. Health matters: harmful drinking and alcohol dependence. 21 January 2016. Available at: <https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence#health-inequalities-and-alcohol-dependence>

### Alcohol-related mortality

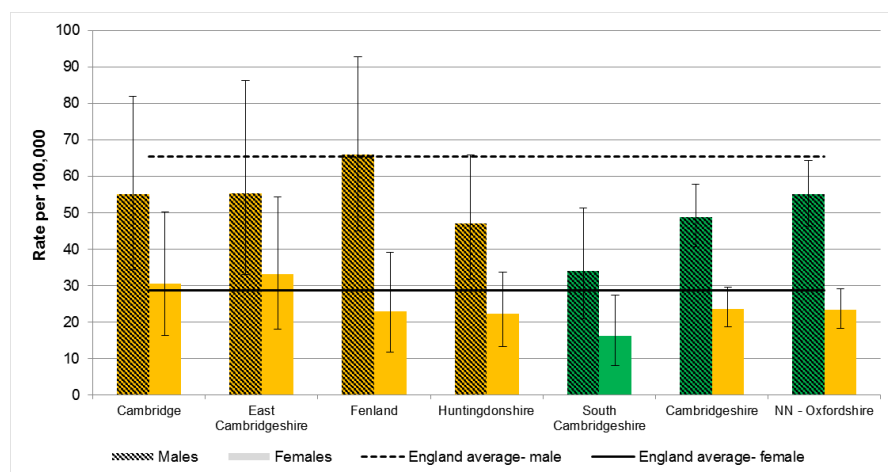
In 2014, there were 211 deaths in Cambridgeshire due to alcohol-related causes (Table ??). 65% of deaths are in men and death rates are higher in men than in women across all areas of the county. Age-standardised rates of alcohol-related deaths for Cambridgeshire as a whole are significantly lower than the England average in men but similar to the average in women (Table ??, Figure ??). Rates are significantly lower than the England average in both sexes in South Cambridgeshire. Rates of alcohol-related mortality show very similar patterns in Cambridgeshire to Oxfordshire, the county's nearest statistical neighbour.

**Table 23: Alcohol-related mortality by sex, Cambridgeshire, 2014**

Local Authority	Males				Females			
	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI	Number	DASR per 100,000	Lower 95% CI	Upper 95% CI
Cambridge	25	55.1	34.3	81.8	15	30.6	16.3	50.3
East Cambridgeshire	20	55.3	33.0	86.3	15	33.1	18.2	54.2
Fenland	33	66.0	45.0	92.8	13	23.0	11.9	39.1
Huntingdonshire	34	47.0	31.9	65.9	20	22.3	13.2	33.6
South Cambridgeshire	22	34.0	20.8	51.3	13	16.3	8.2	27.3
Cambridgeshire	134	48.8	40.6	57.9	77	23.7	18.6	29.7
NN - Oxfordshire	154	55.0	46.4	64.4	80	23.4	18.4	29.1
England	15,066	65.4	64.3	66.4	7,901	28.8	28.1	29.4

DASR - Directly age-standardised rate, CI - Confidence interval, NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

**Figure 45: Alcohol-related mortality by sex (directly age-standardised rates), Cambridgeshire, 2014**



Statistically significantly higher than the England average  
 Statistically similar to the England average  
 Statistically significantly lower than the England average

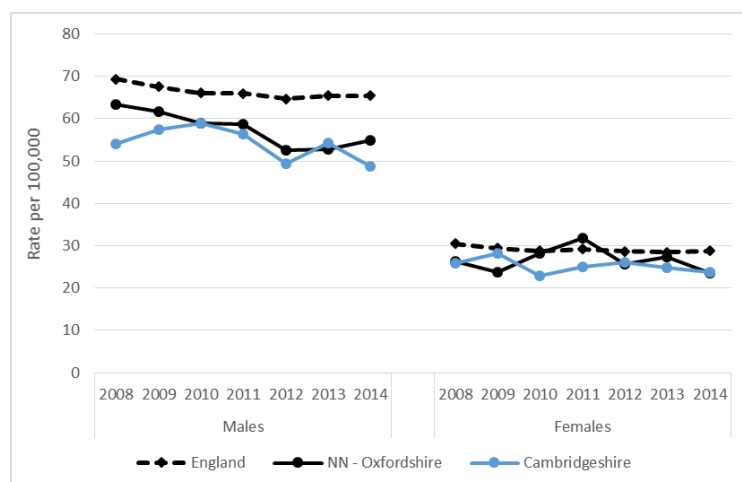
NN - CIPFA nearest neighbour for Cambridgeshire

Error bars represent 95% confidence intervals

Source: Local Alcohol Profiles for England, Public Health England

Rates of alcohol-related mortality have been relatively stable in Cambridgeshire since 2008, statistically similar to the national average in women, and generally statistically lower than the national average in men (Figure ?? and Data Supplement). Rates in Cambridgeshire are similar to those seen for the county's nearest statistical neighbour.

**Figure 46: Alcohol-related mortality by sex, (directly age-standardised rates per 100,000 population), Cambridgeshire, 2008 to 2014**



NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

#### *Life expectancy - Months of life lost*

Average life expectancy in men in Cambridgeshire is reduced by 8.6 months due to premature mortality from alcohol-related conditions (Table ??). Average female life expectancy is reduced by 4.4 months. Whilst Cambridgeshire compares favourably to the national average and is similar to Oxfordshire, life expectancy is reduced by a higher amount due to alcohol in Fenland.

**Table 24: Months of life lost due to alcohol by sex, Cambridgeshire, 2012-14**

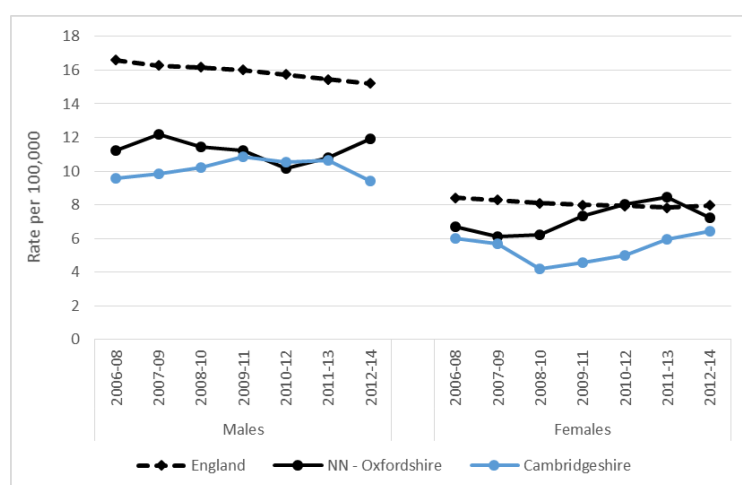
Local Authority	Males	Females
Cambridge	10.1	4.1
East Cambridgeshire	9.6	4.2
Fenland	11.9	5.7
Huntingdonshire	8.4	4.5
South Cambridgeshire	5.8	3.8
Cambridgeshire	8.6	4.4
NN - Oxfordshire	8.8	4.7
England	12.0	5.6

NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

### Chronic liver disease mortality

There are around 46 deaths due to chronic liver disease in Cambridgeshire per year, 58% of which are in men. Rates of mortality due to chronic liver disease are higher in men than in women (Figure??). In men in Cambridgeshire, rates have remained statistically significantly lower than the England average. The rate in women in the county has generally remained statistically significantly lower than the national average but has increased to a rate similar to England in 2012-2014. The rate in Cambridgeshire women, however, is lower in comparison to Oxfordshire.

**Figure 47: Mortality from chronic liver disease by sex, (directly age-standardised rates per 100,000 population), Cambridgeshire, 2006-08 to 2012-14**



NN - CIPFA nearest neighbour for Cambridgeshire  
Source: Local Alcohol Profiles for England, Public Health England

## What the data tell us: Alcohol Treatment Services

There are two alcohol providers in Cambridgeshire. The services provided by the Inclusion Service (North Staffordshire NHS Trust) are countywide and commissioned by Cambridgeshire County Council. In Huntingdonshire alcohol treatment services are provided by the Gainsborough Foundation that is commissioned by local GPs. The data for Inclusion unless otherwise stated is from the National Drug Treatment Monitoring System (NDTMS). This is the national mandatory reporting system. Where possible additional data are included for the Gainsborough Foundation, but these data are not strictly comparable due to differences in treatment thresholds and service models.

**Headlines:** There was an increase in the numbers in treatment between 2-13/14 and 2014/15. Over 75% were self-referred which could indicate that those misusing alcohol are not being identified by organisations and opportunities for making an early intervention could be missed. The numbers in treatment who were also receiving care from mental health services was considerably lower than England and Oxfordshire which could indicate non-disclosure or a high level of people who have not been diagnosed or are being seen in primary care.

### Inclusion (2014/15)

- 841 adults where alcohol was their only substance misuse problem received structured alcohol treatment services.
- The number in treatment increased from 571 in 2013/14.
- 78% of those in treatment were self-referred compared to 45% nationally and 60% in Oxfordshire. A lower % are referred from GP practices (9%) compared to the England average and Oxfordshire, both 20%.
- The total number in treatment (with or without other substance misuse) represented 3.8% of the estimated number of high risk drinkers. This is higher than Oxfordshire but lower than England (6.1%). This does, however, exclude patients treated by the Gainsborough Foundation.
- 59% in treatment were men.
- 79% were aged between 30 and 59 years, a similar pattern to England.
- Of the 674 clients who started treatment in 2014/15 51 patients (6%) were also receiving care from mental health services for reasons other than substance misuse, lower than England (20%) and Oxfordshire (15%).
- 93% of clients waited less than 3 weeks to start treatment, similar to the England figure of 95% but below the percentage for Oxfordshire.
- Of clients with known employment status: 36% were unemployed or economically inactive at the start of treatment compared England (43%) and Oxfordshire (18%)
- 5% of patients had a known housing problem compared to England (11%) and Oxfordshire (18%).
- 29% (336) of those in treatment for alcohol misuse (841) were also being treated for adjunctive drug use. This compares with 41% in England and 21% in Oxfordshire.

#### Gainsborough Foundation (February 2015 to January 2016)

- Of 199 referrals, 178 clients received some form of alcohol recovery support.
- Age and sex profile similar to Inclusion clients.

## Data in Detail

### *Clients in Treatment*

[Sources unless otherwise stated: Public Health England. Alcohol data: JSNA support pack – Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17: Cambridgeshire, Drug and Alcohol JSNA supporting data, and Local Alcohol Profiles for England. For detailed data tables, see the Data Supplement]

841 adults in Cambridgeshire received treatment from structured alcohol treatment services in 2014/15 (Table ??), 496 (59%) were men. Most of those in treatment (79%) were aged between 30 and 59 years, a similar pattern to the England average. The number in treatment has increased from 571 in 2013/14.<sup>108</sup>

**Table 25: Numbers in alcohol treatment by age group, Cambridgeshire, 2014/15**

Age group (years)	Cambridgeshire		England	
	Number	Percentage	Number	Percentage
18-29	78	9.3	9,088	10.2
30-39	193	22.9	19,461	21.8
40-49	273	32.5	29,163	32.7
50-59	195	23.2	21,679	24.3
60+	102	12.1	9,716	10.9
Total	841	100.0	89,107	100.0

Data for Oxfordshire not available

From February 2015 to January 2016, 199 referrals were made to the Gainsborough Foundation, 178 of which went forward with some form of alcohol recovery support. The age and sex distribution of these clients was very similar to those reported to NDTMS.

<sup>108</sup> Public Health England. Co-existing substance misuse and mental health issues Fingertips Data Tool using data from the National Drug Treatment Monitoring System

The total number currently in treatment for alcohol (with or without other substance misuse) represents 3.8% of the estimated number of higher risk drinkers in Cambridgeshire (Table ??). This is slightly higher than the county's statistical neighbour, Oxfordshire, but lower than the England average of 6.1%. It does, however, exclude clients in treatment with the Gainsborough Foundation.

**Table 26: Estimated percentage of higher risk drinkers in alcohol treatment, Cambridgeshire, 2014/15**

Local authority	Higher risk drinkers <sup>1</sup>	Number in treatment <sup>2</sup>	Percentage in treatment
Cambridgeshire	30,714	1,177	3.8
NN - Oxfordshire	37,248	1,270	3.4
England	2,478,655	150,640	6.1

NN - CIPFA nearest neighbour for Cambridgeshire

<sup>1</sup> Numbers of higher risk drinkers estimated by applying mid-2009 synthetic estimates of prevalence to local population estimates (Local Alcohol Profiles for England 2014, Office for National Statistics mid-year population estimates)

<sup>2</sup> Numbers in treatment citing alcohol misuse with or without other substance misuse (National Drug Treatment Monitoring System, 2014/15)

674 (80%) of all clients started treatment during 2014/15. 51 clients (6%) were also receiving care from mental health services for reasons other than substance misuse, lower than the England average of 20% and the value for Oxfordshire of 15%.

93% of clients waited less than three weeks to start treatment, similar to the national average of 95% but below the percentage for Oxfordshire (99.6%).

No clients seen by the Gainsborough Foundation (2015) were delayed beyond 3 weeks due to service provider issues, 83% were seen within seven days.

Sources of referral into treatment vary compared to national figures and figures for Oxfordshire (Table ??). 78% are self-referred in Cambridgeshire compared to 45% nationally and 60% in Oxfordshire. A lower percentage are referred from GPs in Cambridgeshire (9%) compared to the England average and Oxfordshire (both 20%).

**Table 27: Numbers in alcohol treatment by source of referral, Cambridgeshire, 2014/15**

Source	Cambridgeshire		NN - Oxfordshire		England	
	Number	Percentage	Number	Percentage	Number	Percentage
Self-referral	524	77.7	165	60.4	27,335	44.9
Criminal Justice System	31	4.6	8	2.9	4,619	7.6
GP	62	9.2	55	20.1	11,950	19.6
Hospital/A&E/Social Services	6	0.9	12	4.4	5,796	9.5
Other	51	7.6	33	12.1	11,223	18.4
Total*	674	100.0	273	100.0	60,923	100.0

NN - CIPFA nearest neighbour for Cambridgeshire

\* Where source of referral known

Among clients with known employment status, 36% in Cambridgeshire were known to be unemployed or economically inactive at the start of treatment, lower than the average for England (43%) and Oxfordshire (52%). 5% of clients in the county had a known housing problem, again lower than the average for England (11%) and Oxfordshire (18%).

157 clients received pharmacological interventions, 653 clients received psychosocial interventions and 151 clients received recovery support (clients may receive more than one intervention).

In addition to the 841 clients in treatment for alcohol misuse only, 336 clients were in treatment in Cambridgeshire for alcohol with adjunctive drug use (Table ??). This represents 29% of all clients in treatment with alcohol misuse problems, lower than the England average of 41% and value for Oxfordshire of 66%. 72 (21%) of these clients cited crack use, 76 (23%) cited cocaine use and 150 (45%) cited cannabis use. The percentage citing crack use is noticeably lower in Cambridgeshire than Oxfordshire (21% v. 52%); the England average is 28%.

**Table 28: Drugs use cited by clients in alcohol treatment with adjunctive drug use, Cambridgeshire, 2014/15**

Adjunctive drug use	Cambridgeshire		NN - Oxfordshire		England	
	Number	Percentage	Number	Percentage	Number	Percentage
Yes	336	28.5	837	65.9	61,533	40.8
No	841	71.5	433	34.1	89,107	59.2
Total	1177	100.0	1270	100.0	150,640	100.0

NN - CIPFA nearest neighbour for Cambridgeshire

## What the data tell us: Alcohol Treatment Outcomes

**Headlines:** There were substantial proportion of Inclusion clients who represented after discharge at six months. Also many clients were in treatment for longer than six months, which is the current desirable period for treatment and the data reporting requirement for NDTMS, suggesting that many require support for longer periods

### Inclusion Treatment Service (2014/15)

- 58% of clients spent between one and six months in treatment.
- 36% successfully completed alcohol treatment and did not represent within 6 months, statistically similar to the England average of 38% and value for Oxfordshire (39%).

### Gainsborough Foundation (February 2015 to January 2016)

- Of the 162 clients seen at least once by Gainsborough Foundation, 78% were considered 'dry' at one month and 62% at two months.



## Data in Detail

### Time in treatment

NICE Clinical Guidance CG115<sup>109</sup> suggests that harmful drinkers and those with mild alcohol dependence might benefit from a package of care lasting three months while those with moderate dependence might need a six month package and those with severe dependence or those with complex needs may need a package of care lasting up to a year. Retaining clients for their full course of treatment is important in order to increase the levels of successful treatment completion and reduce rates of early treatment drop out. Conversely, having a high proportion of clients in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system. Nationally, the typical treatment time is about three to more than six months, representing 30% of all exits. However it is difficult to compare figures across areas as length of time in treatment will be influenced by level of dependency.

In Cambridgeshire the majority of alcohol clients in treatment (58%) spent between one and less than six months in treatment (Table ??)

**Table 29: Length of time in treatment at exit, Cambridgeshire, 2014/15**

Length of time	Cambridgeshire		NN - Oxfordshire		England	
	Number	Percentage	Number	Percentage	Number	Percentage
<1 month	41	7.7	35	11.2	7,143	12.4
1 to <3 months	148	27.9	71	22.7	14,800	25.6
3 to <6 months	158	29.8	111	35.5	17,199	29.8
6 to <9 months	78	14.7	41	13.1	8,384	14.5
9 to <12 months	45	8.5	26	8.3	4,224	7.3
>12 months	61	11.5	29	9.3	5,999	10.4
Total	531	100.0	313	100.0	57,749	100.0

NN - CIPFA nearest neighbour for Cambridgeshire

### Re-presentations

Successful completion of treatment is used as the key proxy measure of recovery, because an individual is only recorded as having completed treatment successfully if they are assessed by the clinician treating them as free from dependence. The measure includes a non-representation element meaning that individuals don't get counted if they come back into treatment within six months. Clients who drop out of treatment or have their treatment withdrawn constitute a group who often have additional needs and who might benefit from receiving extended periods of treatment.<sup>110</sup>

Based on clients seen in 2014, 36% successfully completed alcohol treatment and did not re-present within six months, statistically similar to the England average of 38% and value for Oxfordshire (39%) (Table ??).

<sup>109</sup> NICE Clinical Guidance (CG115) Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (2011)

<sup>110</sup> Towards successful treatment completion – a good practice guide. NHS. National Treatment Agency for Substance Misuse

**Table 30: Clients successfully leaving alcohol treatment and not representing within 6 months, Cambridgeshire and Peterborough, 2014**

Completing treatment	Cambridgeshire		NN - Oxfordshire		England	
	Number	Percentage	Number	Percentage	Number	Percentage
Yes	282	35.8	188	39.2	34,342	38
No	505	64.2	292	60.8	56,032	62
Total	787	100.0	480	100.0	90,374	100

NN - CIPFA nearest neighbour for Cambridgeshire

Of the 162 clients seen at least once by Gainsborough Foundation, 78% were considered 'dry' at one month and 62% at two months.

#### *Non-Structured treatment Outcomes (Inclusion Service Data)*

There were 269 patients in 2014-15 who received two to four sessions of short term extended brief interventions two to four sessions and either went onto structured treatment or were discharged (data supplied to Cambridgeshire County Council from Inclusion).

#### *Residential rehabilitation*

Clients with complex health and social issues with complex problem are able to access residential care. It is funded by Cambridgeshire County Council Adult Social Care. Demand is managed within a set budget. Social care packages are also available but the numbers funded are very small.

**Table 31: Tier 4 residential rehab placements, Cambridgeshire, 2013/14 to 2015/16**

	2013/14	2014/15	2015/16
Number of rehab applications referred to panel	21	18	22
Number of placements agreed for funding	20	18	19
Number starting placement	19	18	17
Number completing placement	14	15	13

Source: Cambridgeshire County Council Drug and Alcohol Team

## What the data tell us: Prevalence of Illegal Drug Misuse

This sections address illegal drug misuse. The use of Novel Psychoactive Substances and Prescribing Drugs will be addressed in the New Patterns of Drug Misuse Section.

**Headlines:** Rates of illegal drug misuse are similar or below England and Oxfordshire. However there is still an estimated 8.6% of the population who misuse illegal drugs.

- In 2014 it was estimated that there were around 32,190 people, aged 16-59 years, who used illicit drugs. That is 8.6% of the population (based on national estimates).
- Nearly half, 47% (14,603) were aged between 16 and 24.
- There was an estimated 8235 frequent drug users of which 2,839 were young adults.
- Estimates for 2011/12 indicate that there were 1,779 users aged between 15 and 64 years using opiate and crack cocaine use (OCU) estimates –Rates of OCU were statistically significantly lower than rates for England and Oxfordshire.
- Rates of injecting drug users were statistically significant similar to the national average.

## Data in Detail

### Illicit drugs

Based on national prevalence estimates, there are 32,190 people in Cambridgeshire aged 16-59 who have used illicit drugs in the last year (8.6% of the population) (Table 14). Nearly half (47%, 14,603) are young adults aged 16-24 (19.4% of the population). There are 8,235 frequent drug users, of which 3,839 are in young adults.

**Table 32: Estimated numbers using illicit drugs\*, Cambridgeshire, 2014**

Local Authority	Used in the last year		Using more than once a month	
	16-24 year olds	16-59 year olds	16-24 year olds	16-59 year olds
Cambridgeshire	14,603	32,190	3,839	8,235
NN – Oxfordshire	16,174	34,091	4,252	8,721

\* As defined by the Misuse of Drugs Act

NN - CIPFA nearest neighbour for Cambridgeshire

Numbers estimated based on prevalence estimates for England and Wales 2014/15 applied to the mid-2014 population:

Using in the last year 16-24 year olds: 19.4%

16-59 year olds: 8.6%

Frequent drug use 16-24 year olds: 5.1%

16-59 year olds: 2.2%

Sources: Crime Survey for England 2014/15, Office for National Statistics mid-year population estimates

### Opiate and/or crack cocaine use (OCU)

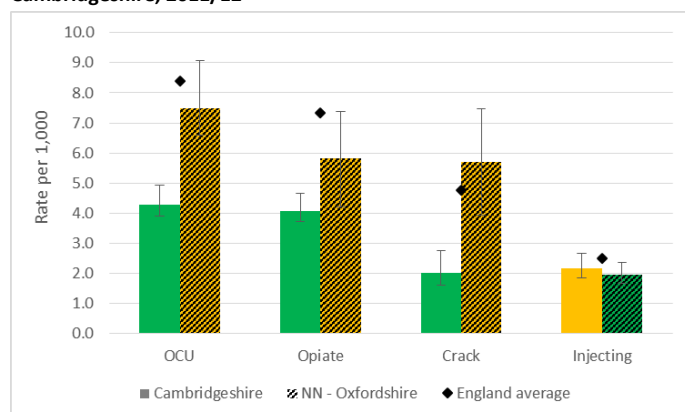
Latest estimates from 2011/12 indicated that there were 1,779 opiate and/or crack cocaine users (OCU) aged between 15 and 64 years in Cambridgeshire (Table ?). The rates of OCU, opiate and crack users in the population were statistically significantly lower than the England average and notably lower than the rates for Oxfordshire (Table ?, Figure?). Rates of injecting drug users in the county were statistically significantly similar to the national average.

**Table 33: Estimated numbers of opiate and/or crack users (OCU) aged 15-64 years, Cambridgeshire, 2011/12**

Drug group	Cambridgeshire				NN - Oxfordshire				England			
	Number of users	Rate per 1,000	Lower 95% CI	Upper 95% CI	Number of users	Rate per 1,000	Lower 95% CI	Upper 95% CI	Number of users	Rate per 1,000	Lower 95% CI	Upper 95% CI
OCU	1,779	4.3	3.9	4.9	3,258	7.5	6.6	9.1	293,879	8.4	8.3	8.6
Opiate	1,687	4.1	3.7	4.7	2,532	5.8	4.2	7.4	256,163	7.3	7.3	7.5
Crack	835	2.0	1.6	2.8	2,485	5.7	3.9	7.5	166,640	4.8	4.6	5.0
Injecting	903	2.2	1.9	2.7	854	2.0	1.7	2.4	87,302	2.5	2.4	2.6

NN - CIPFA nearest neighbour for Cambridgeshire, OCU - Opiate and/or crack cocaine, CI - confidence interval  
Source: Liverpool John Moores University

**Figure 48: Estimated numbers of opiate and/or crack users (OCU) aged 15-64 years, Cambridgeshire, 2011/12**



Statistically significantly higher than the England average  
Statistically similar to the England average  
Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire, OCU - Opiate and/or crack cocaine.  
Source: Liverpool John Moores University

## What the data tell us: Hospital Admissions due to Drug Misuse

**Headlines:** There are substantial numbers of people admitted to hospital with drug related mental health and behavioural disorders compared to numbers for drug use alone, suggesting that the needs of those with dual diagnosis are more complex and associated with a higher risk of hospital admissions.

- In 2013/14 there were 143 hospital admissions with a primary diagnosis of illicit drug poisoning (not necessarily the number of people as multiple admissions are counted for the same individual)
- 53% in women.
- Rates of admissions are lower in men and similar in women compared to the England averages.
- 2014/15 data indicates that 66% of hospital admissions occur in people aged 16 to 44 years.
- In 2013/14 there were 732 hospital admissions episodes with primary or secondary diagnosis of drug-related mental health and behavioural disorders, 71% were in men. These rates are lower than England but higher than Oxfordshire.
- 2014/15 data indicates that 75% of these admissions occur in people aged 16 to 44 years.

### Data in Detail

In Cambridgeshire in 2013/14, there were 143 hospital admission episodes where there was a primary diagnosis of illicit drug poisoning, 53% were in women (Table ??). This may not necessarily reflect the number of people affected as multiple admissions are counted from the same individual. The rates of admissions in Cambridgeshire are lower in men and similar in women in comparison to the England averages (Table ??, Figure ??); the opposite pattern by sex is seen in Oxfordshire.

2014/15 data for England indicate that 66% of these admissions occur in people aged 16 to 44 years.<sup>111</sup>

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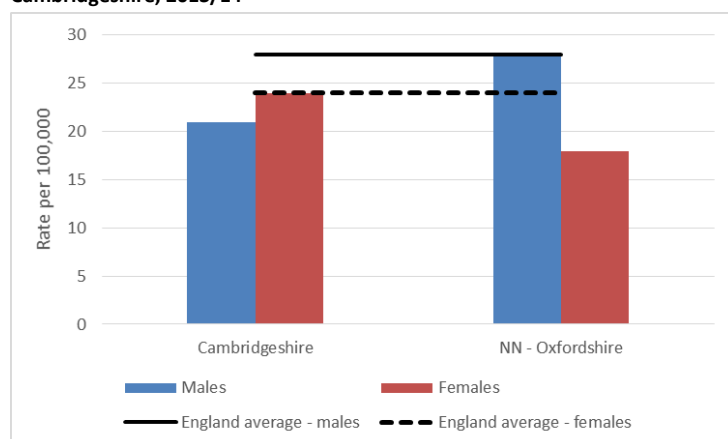
<sup>111</sup> Health and Social Care Information Centre. Statistics on Drug Misuse 2004/05 to 2014/15

**Table 34: NHS hospital admission episodes with a primary diagnosis of poisoning by illicit drugs, Cambridgeshire, 2013/14**

Local authority	Males		Females	
	Number	Rate per 100,000	Number	Rate per 100,000
Cambridgeshire	67	21	76	24
NN - Oxfordshire	91	28	61	18
England	7,303	28	6,614	24

NN - CIPFA nearest neighbour for Cambridgeshire. Based on ICD-10 codes T400 to T403, T405 to T409, T436  
Source: Health and Social Care Information Centre based on Hospital Episode Statistics

**Figure 49: NHS hospital admission episodes with a primary diagnosis of poisoning by illicit drugs, Cambridgeshire, 2013/14**



NN - CIPFA nearest neighbour for Cambridgeshire. Based on ICD-10 codes T400 to T403, T405 to T409, T436  
Source: Health and Social Care Information Centre based on Hospital Episode Statistics

In Cambridgeshire in 2013/14, there were 732 hospital admission episodes where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders, 71% were in men (Table ??). The rates of admissions are lower in men and women in comparison to the England averages but higher than rates seen in Oxfordshire (Table ??, Figure ??).

2014/15 data for England indicate that 75% of admissions occur in people aged 16 to 44 years.<sup>112</sup>

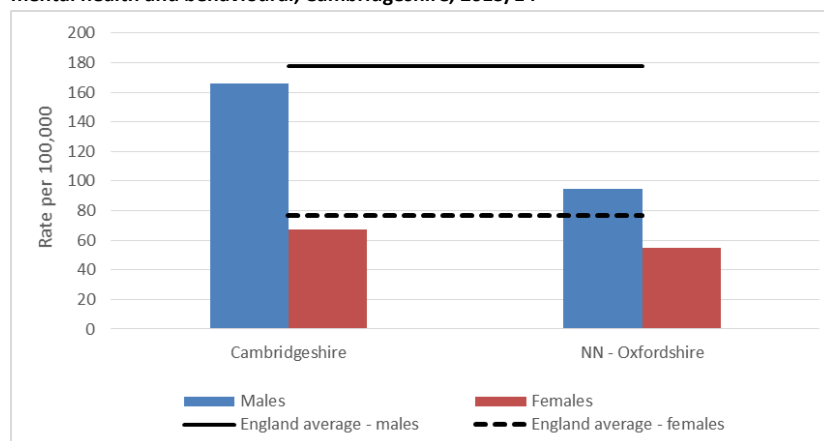
<sup>112</sup> Health and Social Care Information Centre. Statistics on Drug Misuse 2004/05 to 2014/15

**Table 35: NHS hospital admission episodes with a primary or secondary diagnosis of drug-related mental health and behavioural disorders, Cambridgeshire, 2013/14**

Local authority	Males		Females	
	Number	Rate per 100,000	Number	Rate per 100,000
Cambridgeshire	520	166	212	67
NN - Oxfordshire	311	95	183	55
England	46954	178	20968	77

NN - CIPFA nearest neighbour for Cambridgeshire. Based on ICD-10 codes F11-F16, F18, F19  
Source: Health and Social Care Information Centre based on Hospital Episode Statistics

**Figure 50: NHS hospital admission episodes with a primary or secondary diagnosis of drug-related mental health and behavioural, Cambridgeshire, 2013/14**



NN - CIPFA nearest neighbour for Cambridgeshire. Based on ICD-10 codes F11-F16, F18, F19  
Source: Health and Social Care Information Centre based on Hospital Episode Statistics

## What the data tell us: Drug-related Mortality

**Headlines:** Drug related death rates have been stable over the past ten years and has not seen the large increase in the England figures. A drug related death audit is being undertaken in 2016 in response to local concerns of under or misreporting.

- In 2014 there were 29 drug related deaths in Cambridgeshire in 2014 in 2015 there were 27 deaths.
- The annual number and crude rate of drug related deaths has been stable over the past ten years.
- Between 2011-15 the rate of drug related deaths varied with deprivation, it is statistically significantly higher in the 20% most deprived wards in Cambridgeshire compared with the county average.
- Crude rates are similar to England in all districts except South Cambridgeshire, where rates are significantly lower (not age-standardised so differences may be related to differences in age structures of the population).

## Data in Detail

### Mortality

In 2014, there were 29 drug-related deaths in Cambridgeshire and 27 deaths (Table ??). The annual number and crude rate of drug-related deaths has stayed relatively stable over the past ten years.

**Table 36: Drug-related mortality - annual numbers and crude rates, Cambridgeshire, 2006-2015**

Year	Cambridgeshire			
	Number of deaths	Rate per 100,000	Lower 95% CI	Upper 95% CI
2006	30	5.1	3.4	7.3
2007	23	3.9	2.5	5.8
2008	33	5.5	3.8	7.7
2009	21	3.5	2.1	5.3
2010	22	3.6	2.2	5.4
2011	24	3.9	2.5	5.7
2012	20	3.2	1.9	4.9
2013	26	4.1	2.7	6.0
2014	29	4.5	3.0	6.5
2015*	27	4.2	2.8	6.1

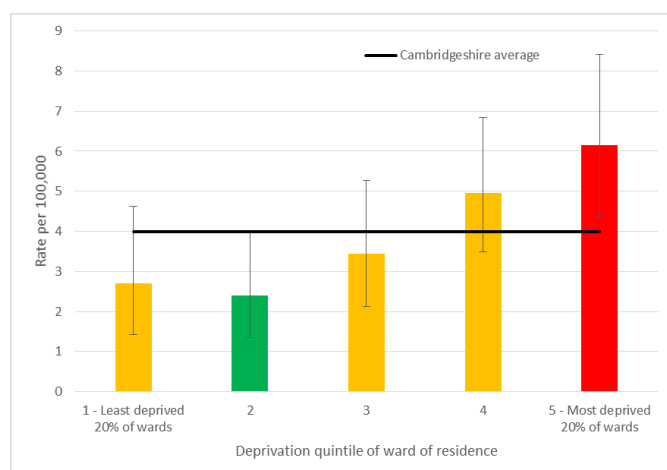
Rates for 2015 use mid-2014 population estimates

Source: Health and Social Care Information Centre Primary Care Mortality Database, Office for National Statistics mid-year population estimates



The age-standardised rate of drug-related deaths in Cambridgeshire varies with deprivation, with statistically significantly higher than county average rates in the most deprived 20% of wards (Figure ??).

**Figure 51: Drug-related mortality by deprivation quintile of ward of residence (directly age-standardised rates), Cambridgeshire, 2011-15**



Error bars represent 95% confidence intervals

Source: Health and Social Care Information Centre Primary Care Mortality Database, Office for National Statistics mid-year population estimates, Communities and Local Government Index of Multiple Deprivation 2010

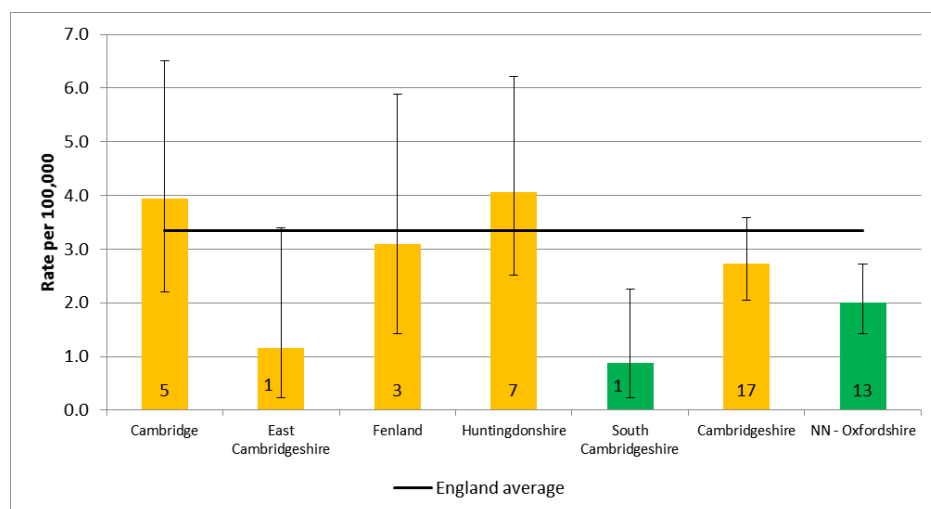
Crude rates of mortality due to drug misuse are similar to national average rates in all districts except South Cambridgeshire where rates are statistically significantly lower (Table ??, Figure ??). Rates in Cambridgeshire's statistical nearest neighbour Oxfordshire were also statistically significantly below the England average. It should be noted, however, that these rates are not age-standardised and so differences may be related to differences in the age structures of populations (drug misuse is more common in younger people so younger populations may have higher crude death rates).

**Table 37: Deaths related to drug misuse, Cambridgeshire, 2012-14**

Local Authority	Number of deaths	Rate per 100,000 population	Lower 95% CI	Upper 95% CI
Cambridge	15	3.9	2.2	6.5
East Cambridgeshire	3	1.2	0.2	3.4
Fenland	9	3.1	1.4	5.9
Huntingdonshire	21	4.1	2.5	6.2
South Cambridgeshire	4	0.9	0.2	2.3
Cambridgeshire	52	2.7	2.0	3.6
NN - Oxfordshire	40	2.0	1.4	2.7
England	5,424	3.4	3.3	3.4

NN - CIPFA nearest neighbour for Cambridgeshire, CI – confidence interval  
Source: Office for National Statistics - Deaths related to drug poisoning in England and Wales, 2006–2014

**Figure 52: Deaths related to drug misuse, Cambridgeshire, 2012-14**



■ Statistically significantly higher than the England average  
■ Statistically similar to the England average  
■ Statistically significantly lower than the England average

NN - CIPFA nearest neighbour for Cambridgeshire, Average number of deaths per year stated at the base of each bar.  
Error bars represent 95% confidence intervals  
Source: Office for National Statistics - Deaths related to drug poisoning in England and Wales, 2006–2014

## What the data tell us: Drug Treatment Services

**Headlines:** In 2014/15 overall Cambridgeshire treatment services for illegal drug misuse tended to compare favourably with England and Oxfordshire. Although there were differences between opiate and/or crack misuse and injecting drug use. There were a high number of self-referrals suggesting that as with alcohol misuse, drug misuse is often not identified by organisations and opportunities for early intervention are lost. Also of note were the numbers in treatment for longer than two years, which was most marked for those using opiates. Similar to alcohol this undermines the goal of abstinence after six months of treatment. The complexity of clients in Cambridgeshire was greater than England and Oxfordshire in terms of mental health, employment and housing issues which also offer challenges to the treatment six month target.

### Inclusion

- In 2014/15 1,564 adults in Cambridgeshire received treatment for drug misuse.
- 74.3% were opiate users.
- The percentage in treatment for non-opiate use was higher than in Oxfordshire (16% versus 5%).
- Engagement in treatment (more than three months) was higher for client using opiates (96%) compared to non-opiate use. Similar to England and Oxfordshire.
- 65% of clients are self-referrals compared to 47% nationally.
- Treatment penetration was higher than England and Oxfordshire for opiate and/or crack use but not injecting drug use.
- 87% of clients waited less than three weeks to start treatment, lower than the average for England of 97% and figure for Oxfordshire (99%).
- 46% of all clients had been in treatment for two or more years, slightly higher than the percentage for England (40%).
- Among clients using opiates, 60% of clients had been in treatment for more than two years, higher than the England average of 52% and value for Oxfordshire (54%).
- Among clients with known employment status, 63% were known to be unemployed or economically inactive at the start of treatment, higher than the average for England (54%) and Oxfordshire (56%).
- 29% of clients had a known housing problem, above the England figure (23%) but lower than Oxfordshire (35%).

## Data in Detail

[Sources unless otherwise stated: Public Health England. Drug data: JSNA support pack – Key data to support planning for effective drugs prevention, treatment and recovery in 2016-17: Cambridgeshire

1,564 adults in Cambridgeshire received treatment for drug use in 2014/15 (Table ??). 74.3% of clients were opiate users. The percentage in treatment for non-opiate use was higher in Cambridgeshire compared to Oxfordshire (16% v. 5%). Level of engagement (in treatment for 3 months or more) was higher for clients receiving treatment for opiate use (96%) compared to those receiving treatment for non-opiate use (Table ??), a similar pattern to Oxfordshire and England (data not shown).

216 clients were in treatment for prescription-only-medicine (POM) or over-the-counter (OTC) medicine misuse (see relevant section), 84% of which also used illicit drugs. 23 clients in treatment cited ecstasy use and 12 cited mePublic Health England drone use.

**Table 38: Numbers in drug treatment by drug type and level of engagement, Cambridgeshire and Peterborough, 2014/15**

Drug type	Cambridgeshire				NN - Oxfordshire			
	Number	Percentage of all clients	Of which engaged*		Number	Percentage of all clients	Of which engaged*	
Opiate	1,162	74.3	1,116	96.0	1,511	83.3	1,441	95.4
Non-opiate	248	15.9	200	80.6	85	4.7	62	72.9
Non-opiate and alcohol	154	9.8	112	72.7	219	12.1	165	75.3
All	1,564	100.0	1,428	91.3	1,815	100.0	1,668	91.9

NN - CIPFA nearest neighbour for Cambridgeshire

\* In treatment for three months or more

Treatment penetration within the total estimated drug using population is higher in Cambridgeshire compared to Oxfordshire and the England averages for OCU, opiate, and crack use but not for injecting drug use (Table ??).

**Table 39: Treatment penetration percentage by drug type, Cambridgeshire, 2014/15**

Drug type	Cambridgeshire	NN - Oxfordshire	England
OCU	71	51	55
Opiate	73	64	61
Crack	48	43	40
Injecting	55	67	56

NN - CIPFA nearest neighbour for Cambridgeshire

555 (35%) of all clients started treatment in 2014/15. 46% of all clients had been in treatment for 2 or more years, slightly higher than the percentage for England (40%). Among clients using opiates, 60% of clients had been in treatment for more than 2 years, higher than the England average of 52% and value for Oxfordshire (54%). Only 87% of clients waited less than 3 weeks to start treatment, lower than the average for England of 97% and figure for Oxfordshire (99%).

Sources of referral vary compared to national figures (Table ??), with 65% self-referred in Cambridgeshire compared to 47% nationally.

**Table 40: Numbers in drug treatment by source of referral, Cambridgeshire, 2014/15**

Source	Cambridgeshire		NN - Oxfordshire		England	
	Number	Percentage	Number	Percentage	Number	Percentage
Self-referral	358	64.6	376	60.1	37285	47.0
Criminal Justice System	92	16.6	70	11.2	19070	24.0
GP	29	5.2	28	4.5	6329	8.0
Hospital/A&E/Social Services	12	2.2	17	2.7	2370	3.0
Other	63	11.4	135	21.6	14329	18.1
Total*	554	100.0	626	100.0	79383	100.0

NN - CIPFA nearest neighbour for Cambridgeshire

\* Where source of referral known

1,154 clients received pharmacological interventions, 1,505 clients received psychosocial interventions and 809 clients received recovery support (clients may receive more than one intervention).

## What the data tell us: Drug Treatment Outcomes

**Headlines:** Although the percentage of those completing treatment is similar to England and Oxfordshire, 7% is a low proportion and suggests that treatment may be prolonged and complex. The low number of clients that achieve abstinence again suggest that treatment and abstinence can be challenging.

- In 2014/15 7% of opiate clients completed treatment and did not re-present within six months, statistically significantly similar to England and Oxfordshire.
- 34% of non-opiate clients completed treatment and did not re-present within six months, lower but statistically significantly similar to England and Oxfordshire.
- Between 2010 and 2014 rates of abstinence following six months of treatment are lower compared with national abstinence rates for both opiate and non-opiate users.

## Data in Detail

7% of opiate clients in Cambridgeshire in 2014 successfully completed treatment and did not re-present within six months (Table 25), statistically similar to the England average and level for Oxfordshire.<sup>113</sup> Among non-opiate clients, successful completion is higher at 34.4%, lower than but statistically similar to England and Oxfordshire. Cambridgeshire appears to be performing in line with national averages but it was not in the highest quartile compared with comparator local authorities (2013/14 data).<sup>114</sup>

**Table 41: Clients successfully leaving drug treatment and not representing within 6 months, Cambridgeshire, 2014**

Drug type	Cambridgeshire		NN - Oxfordshire		England	
	Number	Percentage	Number	Percentage	Number	Percentage
Opiate	81	7.0	95	6.2	11,293	7.4
Non-opiate	133	34.4	89	29.9	21,701	39.2

NN - CIPFA nearest neighbour for Cambridgeshire

\* Not representing within 6 months

Source: Public Health England Public Health Outcomes Framework Indicator 2.15

Table ?? shows six month outcome for people in drug treatment. In Cambridgeshire, rates of abstinence following six months of treatment are lower compared with national abstinence rates for most types of drug.

**Table 42: Abstinence rates in Cambridgeshire following 6 months drug abuse treatment in 2014 compared with Public Health England expected abstinence rates**

Drug	Abstinence rates		Expected range (%) for Cambridgeshire clients
	Number	Percentage	
Opiate	48	33.8	33.5 to 49.7
Crack	21	42.0	36.8 to 64.5
Cocaine	23	63.9	40.3 to 72.7
No longer injecting	33	50.0	54.0 to 76.9

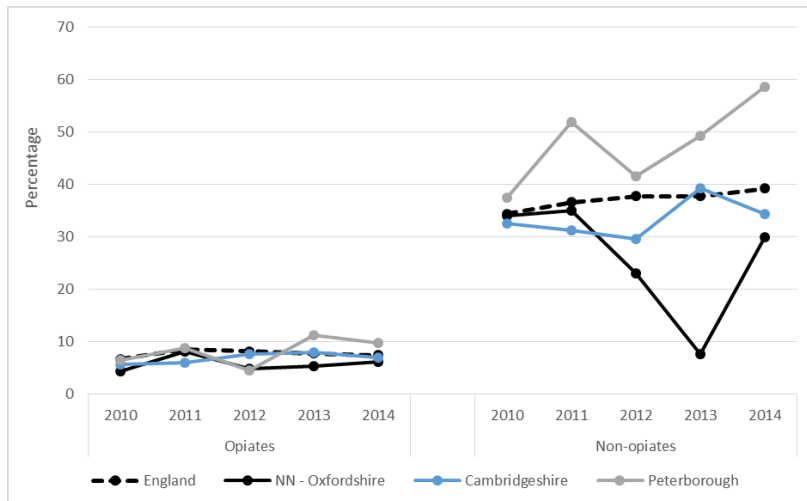
Source: Public Health England. Diagnostics outcomes monitoring executive summary. Quarter 2, 2014/15

The percentage of clients in the county successfully completing treatment and not representing has generally been slightly lower but statistically similar to the England average between 2010 and 2014, for both opiate and non-opiate users (Figure ??, Data Supplement).

<sup>113</sup> Public Health England Public Health Outcomes Framework Indicator 2.15

<sup>114</sup> Public Health England. Diagnostics outcomes monitoring executive summary. Quarter 2, 2014/15.

**Figure 53: Percentage of clients successfully completing drug treatment and not re-presenting within 6 months, Cambridgeshire and Peterborough, 2010-14**



NN - CIPFA nearest neighbour for Cambridgeshire

Source: Public Health Outcomes Framework indicator 2.15, Public Health England

## What the data tells us: Harm Reduction Interventions – Vaccination for blood-borne viruses and needle exchange schemes

**Headlines:** Cambridgeshire compares unfavourably with England and Oxfordshire in terms of its vaccination and testing for blood borne viruses. In addition there is limited access to pharmacies across the county providing needle exchange schemes.

### Blood borne viruses

In 2014/15 23% of eligible adults new to treatment accepted a course of Hepatitis B vaccination below England (40%) and Oxfordshire (28%).

Only 11% of those accepting vaccination completed the course below England (22%) and Oxfordshire (34%).

56% of previous or current injectors received a Hepatitis test below England (81%) and Oxfordshire (71%).

### Needle exchange

41% of Cambridgeshire community pharmacies offer a needle exchange scheme, the biggest number being Fenland.

### Supervised consumption

At any one time there is around 5% of those in treatment for opiate drug misuse who part of the supervised consumption scheme.



## Data in detail

Harm reduction services include vaccination for Hepatitis B and needle exchange schemes. A needle exchange programme aims to reduce the incidence and prevalence of blood borne diseases. Clients are given harm-reduction advice and access to drug services.

23% of eligible adults new to treatment accepted a course of Hepatitis B vaccination, below the national average of 40% and value for Oxfordshire of 28%. Only 11% of those accepting a course in Cambridgeshire completed the course, below the England average (22%) and Oxfordshire (34%). The percentage of previous or current injectors receiving a Hepatitis C test in Cambridgeshire is also below the England average and value for Oxfordshire, at 56% compared to 81% and 71% respectively.

41% of Cambridgeshire community pharmacies offer a needle exchange scheme, the biggest number being Fenland. No other information is available.

**Table 43: Pharmacies delivering needle exchange, 2015/16 Q4**

Area	Number of pharmacies	Number delivering needle exchange	Percentage
Cambridge	33	11	33.3
Huntingdonshire (including St Neots and St Ives)	23	7	30.4
Wisbech (including March and Chatteris)	15	10	66.7
East Cambridgeshire	8	4	50.0
Total	79	32	40.5

Source: Inclusion Drug Treatment Services

## Supervised consumption

Supervised consumption involves drugs being used are for maintenance treatment for opioid dependence and their introduction is associated with a reduction in drug related deaths. Currently there are 68 pharmacies providing supervised consumption and 61 (5.1% of those in treatment for opiate use) opiate users of the services. This % has remained constant over the past five years.

Pharmacies are distributed across the County, the highest proportion in Cambridge City however which is approximately 20% of the total. There is requirement that there should be no more than 10 miles to travel to a pharmacy for any client engaged in the service.

## Adult Services in Cambridgeshire

### Prevention in Cambridgeshire

In terms of universal or primary prevention there are regular campaigns promoting drug and alcohol issues, though in recent years this has been targeted at alcohol. High risk groups are targeted in some campaigns.

In terms of targeted or selective interventions Identification, Brief/Extended interventions and motivational interviewing for alcohol misuse is now offered to a range of health social care staff. It is part of the NHS Health Checks programme offered to 40-74 year olds and a countywide Workplace Programme.

The Cambridgeshire County Council Drug and Alcohol team offer Identification and Brief Advice Training for staff across a wide range of organisations. During 2015/16 210 individuals were trained from organisations which included housing, social care, primary and secondary care, criminal justice, and the voluntary sector. In localities where there is known issue these have been targeted at staff working in these areas.

Some projects have been launched as part of community safety initiatives such as the Wisbech Alcohol Project that has a focus upon migrant workers at high risk of alcohol misuse. (see Community Safety section)

### Adult Drug and Alcohol Treatment Services in Cambridgeshire

This section describes the Cambridgeshire drug and alcohol treatment services in adults; current pathways and provision In Cambridgeshire there were two distinct countywide services but in 2015/16 the services have started to integrate although it is not working to an integrated service specification. There is an additional Alcohol Treatment Service commissioned for the Huntingdon area by local GPs.

The countywide services are delivered in a variety of locations to cover the Cambridgeshire area and operate Monday-Friday (excluding bank holidays) and Saturday mornings in selected locations. The aim is to also provide out-of-hours provision at least once a week per client. Partnership working to increase the integration of care packages that clients receive is promoted with a range of other services, including mental health, sexual health/communicable diseases and young people's services, accident and emergency, homeless hostels and prisons.

The following key approaches underpin both the drug and alcohol pathways.

- A tiered or stepped care approach to the service is offered so people with all levels of need requiring the specialist services can be helped effectively. Within this approach the level of treatment is matched to the need of the individual, followed by increasingly intensive interventions for those not responding to the less intensive interventions.

- Abstinence will be the preferred goal for many but for some it is recognised that a reduction may confer benefits and may offer a stepping-stone to abstinence in the future.<sup>115</sup>
- Different pathways should be integrated or coordinated throughout the whole period of care including aftercare.
- An Access Point for all those requiring the treatment service is provided which works in an outreach capacity to those homeless individuals, migrants or others who are unable to access office bases.

In general both drug and alcohol services provide the following core interventions that can be included in a care pathway.

- Self-referral and professional referral
- Assessment
- Brief or extended interventions with motivational interviewing for non-dependent users
- Range of structured interventions that enables appropriate care plans to be developed dependent on substance used and need
- Detoxification
- Relapse prevention and recovery interventions
- Volunteering system that involves recovery support workers
- Harm reduction – needle exchange, blood borne virus vaccination

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<sup>115</sup> Models of care for alcohol misusers MoCAM Department of Health, 2006

## Adult Alcohol Treatment Services

In Cambridgeshire there are two providers of core Alcohol Treatment services. Cambridgeshire County Council currently commissions Inclusion (part of the South Staffordshire and Shropshire NHST Trust) to provide a countywide alcohol (and drug) treatment service. The Gainsborough Foundation provides services in Huntingdonshire and is commissioned by the local GPs.

**Table 44: Alcohol Treatment Services in Cambridgeshire Key Interventions**

Inclusion – countywide	Gainsborough Foundation – Huntingdonshire
<ul style="list-style-type: none"> <li>• Central Booking Telephone Number Self or Professional referral</li> <li>• Information and advice</li> <li>• Assessment</li> <li>• Extended Brief Interventions for non-dependent users.</li> <li>• Structured interventions –psychosocial and structured day programmes, relapse prevention and recovery planning</li> <li>• Community Detoxification accessed through a 24-hour help line</li> <li>• GP liaison and support</li> <li>• Peer support/volunteer programme/ recovery champions provide ongoing support through treatment and recovery</li> <li>• Practical advice and support regarding housing, employment etc., along with information and referrals to appropriate agencies. Includes liaison with other agencies.</li> <li>• Hospital Liaison Service in Cambridge University Hospitals Foundation Trust (CUHFT) and informally at Hinchingbrooke Hospital.</li> </ul>	<ul style="list-style-type: none"> <li>• Central Booking Telephone Number Self or Professional referral</li> <li>• Information and advice</li> <li>• Assessment</li> <li>• “ACR” programme for non-dependent users</li> <li>• Structured interventions – ANSWERS programme</li> <li>• Community Detoxification accessed through a 24-hour help line</li> <li>• GP liaison and support</li> <li>• Peer support/volunteer programme/ recovery champions provide ongoing support through treatment and recovery</li> <li>• Practical advice and support regarding housing, employment etc., along with information and referrals to appropriate agencies. Includes liaison with other agencies.</li> <li>• Hospital Liaison, informally with Hinchingbrooke Hospital</li> </ul>

### Overview description

Both services provide the key interventions recommended by NICE for the provision of treatment services. However the differences reflect the specific interventions that have been developed by the Gainsborough Service. Although Inclusion has a wider remit that includes prevention activities, brief interventions, hospital liaison. Gainsborough has a very experienced GP clinical lead who oversees the programme and approves treatment. However treatment, including detoxification, is not undertaken by trained nurses unlike the Inclusion service.

The Inclusion pathway (see figure?) includes the use of the AUDIT screening tool to assess the level of dependence and the score will determine the treatment pathway.

Brief/extended interventions are offered for non-dependent drinkers which includes a number of sessions which can result in patients being discharged or progressing to other treatments.

Gainsborough has developed its own psycho-social approach and tools. It uses a structured prevention and intervention “ACR” tool/resource to assess dependency and to prove to patients that they can drink within a set timetable only and exert control. Some patients have a number of sessions.

The Gainsborough ANSWERS programme is for use with dependent alcohol users and post detoxification. It is -

“ a unique structured programme of education that focuses upon understanding of illness, genetics, nature of dependence, rebuilding lives, repairing relationships, case histories and learning how to live without alcohol in a society that drinks, empathy and experience. It empowers patients with knowledge and understanding of how to take control of their lives again”.

As indicated above it is difficult to compare the outcomes of the two services. The community consultation for this JSNA demonstrated strong support for both services. Some service users (or ex – service users) in each service had used the other service previously but their preference always favoured the service currently being accessed.

The Gainsborough treatment model embodies the key psycho-social elements of the NICE treatment pathway that is used by Inclusion but also focuses upon factors like genetics. However Gainsborough patients appear to receive a more intensive service without any clear end date for completion of treatment.

The psycho-social interventions in both services reflect those recommended by NICE and include behavioural, cognitive, psychodynamic, motivational, social and where appropriate couples based interventions

Both services offer structured day programmes involves intensive community-based support for education, training and employment, parenting/family support etc.

### ***Hospital Liaison Services***

There is a dedicated Hospital Liaison Service provided by Inclusion at Cambridge University Hospitals NHS Foundation Trust (CUHFT). Their function is to make contact with patients identified by the hospital and link them to community based treatment and other appropriate services.

The Cambridgeshire and Peterborough Mental Health Trust is commissioned by CUHFT to also provide support to identified patients and link with community services.

There is no similar service at Hinchingsbrooke Hospital in Huntingdon but this was considered by 2015/16 by staff from the hospital, Inclusion, Gainsborough Foundation, the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridgeshire County Council commissioners

and Public Health. This has not been fully developed but informal support is provided by both the Inclusion and Gainsborough services.

#### ***Inpatient detoxification beds***

Three detoxification beds in Fulbourn Hospital are commissioned by Cambridgeshire County Council from the Cambridgeshire and Peterborough Foundation Trust (CPFT) for the use of alcohol and drug clients. These beds are more fully described in the appropriate section below. They are currently not accessed by clients accessing services from the Gainsborough Foundation.

#### ***Alcohol community detoxification***

Both the Gainsborough Foundation and Inclusion undertake community detoxification. Inclusion report that they undertake a significant number of assessments for community detoxes, however not all patients can be treated in the community for clinical and safety reasons.

#### ***GP provided community alcohol detoxification***

Cambridgeshire County Council commissions GP practices to provide community detoxes supported by Inclusion. At the time of writing 28 GP practices have contracted to provide this service for 2016/17. In 2015/16 the figure was 23. Robust data for the number of detoxifications is currently not available.

#### ***Inclusion Prescribing Services***

The alcohol Inclusion contract was originally commissioned as a non-prescribing contract with the vision that GP's would undertake all community detoxifications. However numbers of GPs undertaking community detoxifications remain low.

With regards to the drug contract it is a prescribing contract and Inclusion has sessional doctors and prescribing nurses within their team and it covers all associated FP10 costings. With regards to GPs they only undertake substitute prescribing under a shared care arrangement with Inclusion (Inclusion hold contracts directly with GPs) to limit any potential double prescribing issues occurring. All GP's are informed when inclusion prescribes for one of their patients. Inclusion staff only prescribe certain formulary medications such as methadone or buprenorphine.

#### ***Gainsborough Foundation Prescribing Services***

Prescribing is undertaken by the lead GP.

### **Other Commissioned Services**

#### ***Access GP Practice***

This GP practice in Cambridge City provides health services for homeless people which includes drug and alcohol interventions.

## Project Work

### *Abstinence Project Cambridge City*

Since February 2015 a three bed abstinence house is operating for hostel clients (Jimmy's) to reside in post detoxification to mitigate against the risk of relapse. (See Housing Section)

### *Outreach Work Cambridge City*

Inclusion is funded by Cambridge City Council to deliver outreach work in Cambridge to help people who have alcohol problems and are homeless. Its activities include finding accommodation solutions for homeless individuals, and providing specialist alcohol harm reduction advice and access to community detoxification. In quarter 1 of 2015-16, the service engaged with a total of 49 different homeless clients as well as 15 clients not fully engaged in the service but receiving advice and information. The average amount clients reduced their drinking was 10 units per day.<sup>116</sup>

### *Blue Light Project – Harm Reduction*

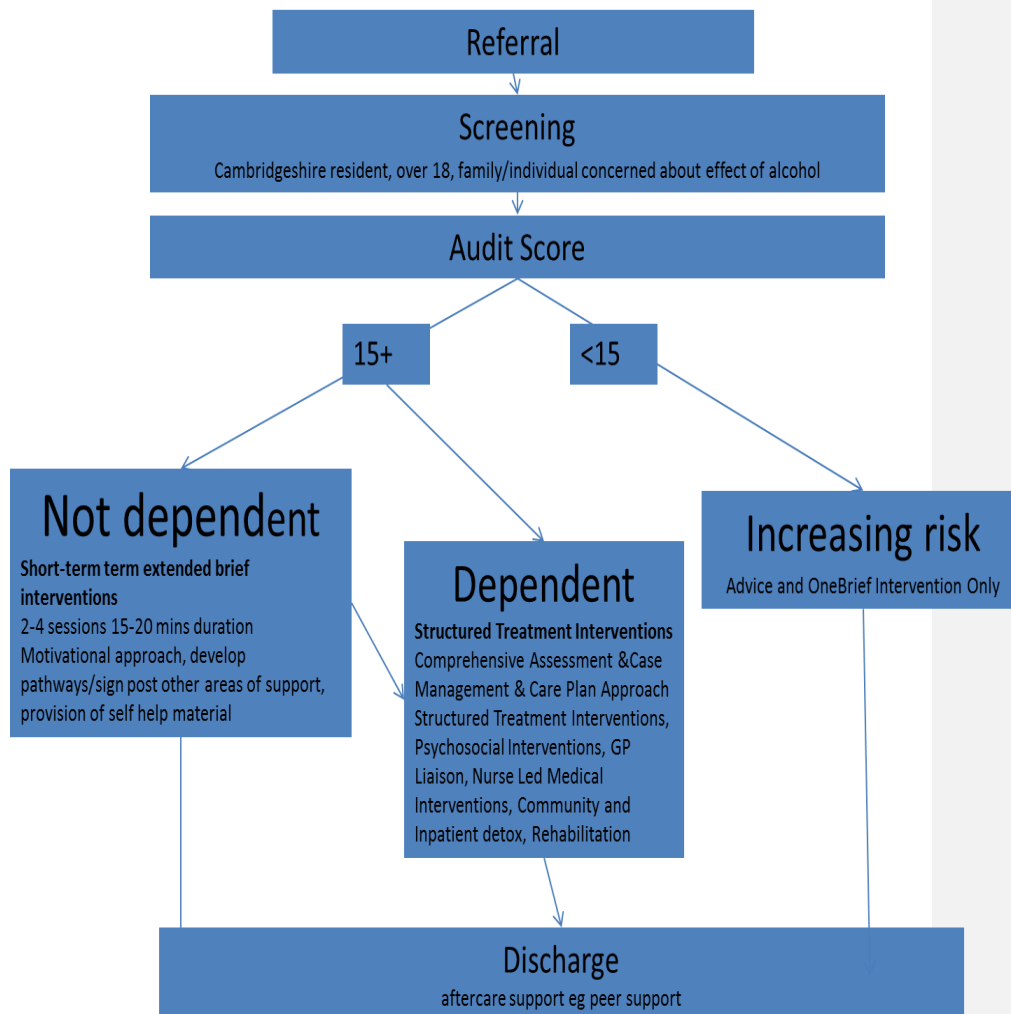
The Blue Light Project has been set-up to target some of the most risky, vulnerable individuals, focussing on those dependent drinkers who are not engaged with treatment services, are resistant to change and frequently use the emergency services. Harm reduction is practised such as dietary advice and vitamin supplementation to prevent nutritional deficiencies; reducing suicide risk and promoting eating while drinking. Outreach, befriending/peer mentoring approaches are used to improve engagement. As part of this work, Cambridgeshire County Council is developing guidance aimed at front-line workers to ensure different harm reduction approaches are explored with people who are treatment-resistant drinkers. The underlying principle is that this work does not demand additional resources in itself but the focus is on partners working together to embed harm reduction measures into their practice.

This model has been used in other parts of the country and has recently been evaluated by Sandwell Borough Council (July 2016) which has developed more formal arrangement with partners. Their headline evaluation results are at the moment only for 16 individuals. However of the 16 involved in the Project, 25 % have gone onto to successfully complete a course of treatment with the alcohol treatment services and a further 15% are currently accessing community support services; all other individuals are participating in on-going harm reduction and engagement approaches. There is positive feedback from the overseeing multi-agency group that this work has led to significant progress with integration and data sharing. An economic evaluation in terms of the impact on the emergency services is at the time of this report being developed.

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<sup>116</sup> Cambridge City Council Housing Advice Service. Grant monitoring form

Figure 54: Inclusion Alcohol Treatment Pathway





## Adult Drug Treatment Services

The Inclusion Service also provides the countywide drug treatment service. The current service specification includes the following services.

Countywide Services
Central telephone booking also offers information and advice
Assessment
Brief/extended interventions
Structured interventions - clinical, psychosocial, structured day programmes, cognitive behavioural therapy, individual and group counselling, 12 step/abstinence counselling, family approaches, relapse prevention and recovery planning
Community detoxification
Drug interventions programme (DIP) for those involved in the criminal justice system
Peer support/volunteer programme/ recovery champions provide ongoing support
Needle Exchange – Harm Reduction
Blood Bourne Virus vaccination – Harm Reduction
Specialist prescribing
GP Shared care

### ***Overview description***

The adult drug service provides a single point of contact for people requiring an assessment and further induction and/or referral into the service. People can self-refer, be referred by a professional (GPs etc.) or be referred via criminal justice pathways. People are booked into a triage assessment within five days of referral. Following triage, clients may be treated with a variety of interventions (see list above), depending on their type and severity of addiction, and personal characteristics and situation.

Structured psychological interventions are currently specified to include individual/group Cognitive Behavioural Therapy (CBT), relapse prevention therapy, individual and group counselling, motivational interviewing, 12 step/abstinence counselling, family approaches, peer support/mutual aid and brief interventions. The service is also specified to offer structured day programmes which provide, intensive community-based support for education, training and employment, parenting/family support etc.

The Drug Interventions Programme (DIP) manages referrals for adults with a primary, Class 'A', drug misuse issue and who are involved within the Criminal Justice system. The service aims to take active, targeted approaches to identify problem drug users, provides triage assessment and subsequent interventions and referrals. (See Criminal Justice System)

### ***Shared Care***

There is shared care contract for GPs to provide care to drug misusers in the community supported by Inclusion. There are currently four practices which are part of a drugs agreement with Inclusion (Nuffield Road, Lensfield Road, Trinity and Charles Hicks).

### ***Harm Reduction***

In their broadest sense, harm reduction policies, programmes, services and actions work to reduce the health, social and economic harms to individuals, communities and society that are associated with the use of drugs.<sup>117</sup>

A harm reduction approach recognises that a valid aim of drug interventions is to reduce the relative risks associated with drug misuse. This is by a range of measures such as reducing the sharing of injecting equipment, providing support for stopping injecting, and providing substitution opioid drugs for heroin misusers with support for abstinence from illegal drugs.

### ***Supervised Consumption***

Inclusion is also commissioned to oversee a supervised consumption scheme that is provided by community pharmacists. Pharmacies receive payment for observing patients and associated communication with the Inclusion service. The drugs used are for maintenance treatment for opioid dependence and their introduction is associated with a reduction in drug related deaths.

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<sup>117</sup> National Treatment Agency for Substance Misuse Harm Reduction Strategy 2009/10

Currently there are 68 pharmacies providing supervised consumption and 61 (5.1% of those in treatment for opiate use) opiate users of the services. This percentage has remained constant over the past five years.

Pharmacies are distributed across the County, the highest proportion in Cambridge City however which is approximately 20% of the total. There is requirement that there should be no more than 10 miles to travel to a pharmacy for any client engaged in the service.

There have been clear Guidelines for the use of supervised consumption through the use of methadone or buprenorphine for opiate dependency since 2007 based on a number of evidence reviews that provided strong evidence for the reduction of drug related deaths. A recent consultation by Public Health England concluded that these Guidelines should be reviewed to reflect more recent evidence.

### ***Needle Exchange***

Harm reduction services include a needle exchange programme which aims to reduce the incidence and prevalence of blood borne diseases. Clients are given harm-reduction advice and access to drug services. The service is only available to adults and young people are referred to Cambridgeshire Adolescent Substance Use Service. The Blood Borne Virus (BBV) service provides screening, risk assessment and interventions related to the treatment of blood borne viruses.

In 2014/15 the majority of interventions were conducted in the community. Almost all adult clients appear to receive pharmacological and psychosocial interventions and recovery support. In 2014/15 93% of clients received pharmacological intervention and almost all receive psychosocial support (97%). No data was presented to indicate which types of interventions are used.

### ***Blood Borne Virus (BBV) Testing and Vaccination***

The use of injecting drug increases the risk of blood borne viruses and contact with treatment services provides an opportunity to test for Hepatitis C and vaccinate against Hepatitis. There has been concern about the low level of vaccination for Hepatitis B and commissioners and the Treatment Service have been working with Public Health England to implement its Guidance and identify local solutions to increasing uptake.

The Treatment Service screen for vaccination at the earliest opportunity by recovery workers at each site, normally at the assessment once client consent has been gained. All frontline recovery workers are now trained to screen and vaccinate. Vaccinations are aligned to the clients' clinical appointments and are performed by dedicated BBV nurses. The nurses will also both screen and vaccinate as an outreach function where mobility or transport are issues for a client.

### ***Naloxone***

Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (such as methadone and morphine). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing. Naloxone blocks this effect and reverses the breathing difficulties. On

1 October 2015, new regulations came into force, which allowed for widening of the availability of Naloxone.

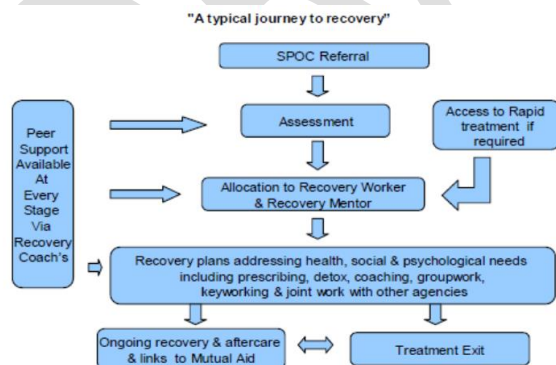
A range of drug treatment services can order Naloxone from a wholesaler so that people engaged or employed in their services can, as part of their role, make a supply of the Naloxone available to others without a prescription. This is so that the Naloxone supplied to others can be used in the case of a suspected heroin (or other opiate) overdose to try and save a life.

People employed or engaged in the provision of drug treatment services in the course of their drugs work can supply Naloxone that has been obtained by their service to others, as long as it is supplied to others for the purpose of being available to save life in emergency. A prescription is not needed for the Naloxone to be supplied in this way.

For example, a worker in a recognised drug treatment service could supply naloxone for use in an emergency, without the need for a prescription, to a family member or friend of a person using heroin, or to an outreach worker for a homelessness service whose clients include people who use heroin. However current clinical guidance recommends that such naloxone supply should be accompanied by provision of suitable training and advice for those who are supplied the naloxone.

In Cambridgeshire all frontline staff in Inclusion have been trained in the use of Naloxone and every client who accesses the service for opiate use treatment is risk assessed, particularly those who inject heroin, and are actively encouraged to carry a take home Naloxone kit. The changes in the legislation has led Inclusion to support training for other agencies to hold and dispense Naloxone which includes hostels and other accommodation providers.

**Figure 55: Inclusion Drug Treatment pathway**



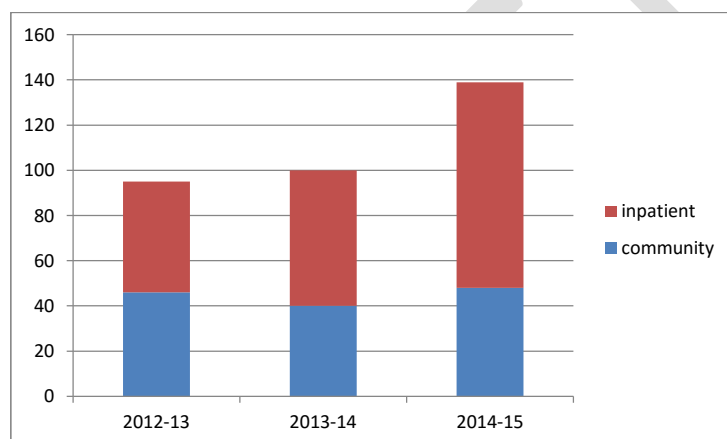
## Drug and Alcohol Services – Shared Treatment Interventions

### *Drug and Alcohol Detoxification Treatment*<sup>118</sup>

The clinical decision on the use of inpatient versus community location for detoxification is based on clinical safety criteria as well as whether prescribing in the community can be arranged for the patient.

Community detoxification is described above. Three in-patient beds for alcohol and drug detoxification are commissioned from Cambridgeshire and Peterborough Foundation Trust by Cambridgeshire County Council and are provided at Fulbourn Hospital. Detoxification usually takes 14 days; but in 2014 a seven day detoxification was introduced for less chaotic alcohol clients. This reduces the cost of the detoxification and increases the number of people receiving treatment.

**Figure 56: Numbers of community versus in-patient alcohol detoxification, 2012-13 to 2014-15.**



Source: Cambridgeshire Drug and Alcohol team

Between 2012/13 and 2014/15 the number of community alcohol detoxifications remained stable, but the number of inpatient detoxifications increased, particularly in 2014-15. The main factor for the increase in admissions was the introduction of seven day alcohol detoxes (as opposed to 14 day detoxes).

Inclusion staff report that there are patients who would have been assessed as suitable for community detoxification but were unable to receive it because they did not belong to a prescribing practice. While the number of these cases is limited it represents an inequity in provision.

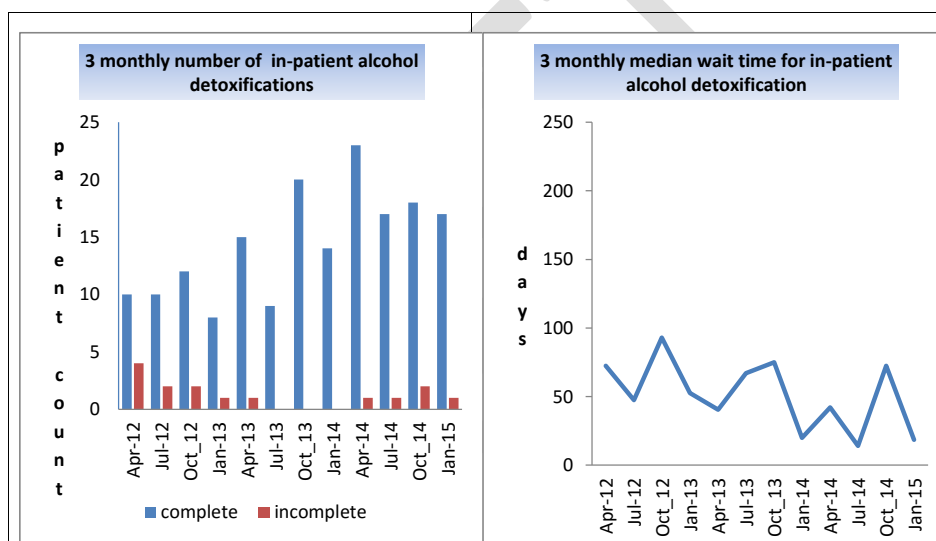
Comparison of in-patient versus community detoxification is complicated by more complicated cases being treated in hospital. At the time of writing the waiting time for community detoxification was

<sup>118</sup> Cambridge and Peterborough Foundation Trust and Inclusion provide quarterly data to Cambridge County Council

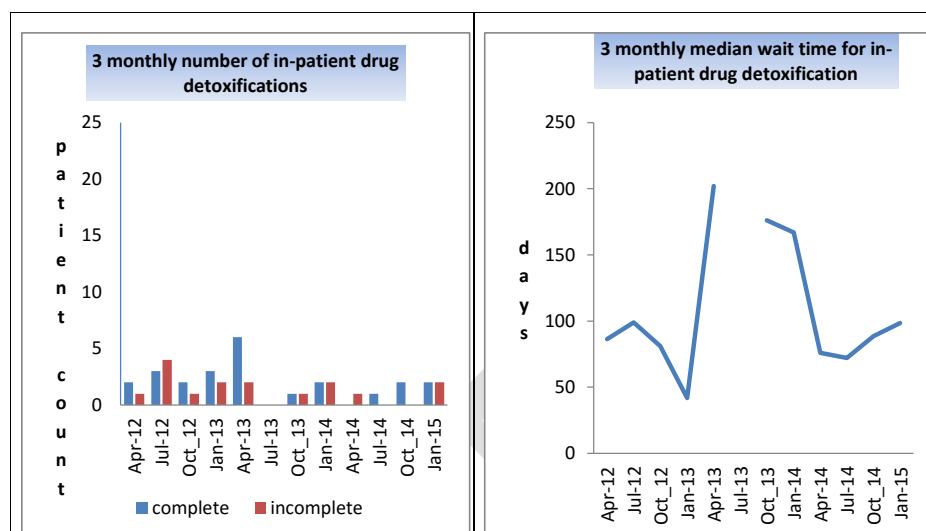
not an issue although it does take a few weeks from initial assessment to actually undertaking the detoxification, so that all the necessary assessment and checks can be put in place. Inclusion reports that all patients completed treatment over the period 2013-14 and 2014-15.

For inpatient treatment, waiting times are dependent on a variety of factors such as risk and need. Some patients are more 'elective' in nature and their admission requires longer planning (mostly opiate detoxification patients) whilst other patients require a more urgent response due to deterioration in physical/psychiatric co-morbidities. There are more alcohol detoxifications than drug detoxification. While the number of incomplete alcohol detoxifications has not increased from April 2012, the number of complete alcohol detoxifications has increased, without any increase in the waiting time.

**Figure 57: Numbers of complete and incomplete detoxification in admitted patients along with median wait time per quarter for alcohol detoxification**



**Figure 58: Numbers of complete and incomplete detoxification in admitted patients along with median wait time per quarter for drug detoxification 2012 - 2015**



Source: Cambridgeshire Drug and Alcohol team

### Recovery Services

The 2010 UK Drug Strategy<sup>119</sup> definition of recovery is

“Involves three overarching principles – wellbeing, citizenship, and freedom from dependence. It is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people.”

The Advisory Council on the Misuse of Drugs has<sup>120</sup> identified from high quality evidence key elements for recovery that include a range of interventions that focus on building individual residence and fostering learning and socio-economic opportunities to support recovery and prevent relapse.

The Gainsborough Foundation “ANSWER” Programme includes relapse prevention approaches and includes preparation for discharge through practical problem solving support for debt, finance, social services and other professional liaison. They have former clients who volunteer to act as champions, providing support to prevent relapse and ongoing recovery. There is telephone support and advice, website information and support.

<sup>119</sup> HM Government. UK DRUG STRATEGY 2010 Reducing Demand, Restricting Supply, Building Recovery : Supporting People to Live a Drug Free Life

<sup>120</sup> Advisory Council on the Misuse of Drugs Recovery from drug and alcohol dependence: an overview of the evidence 2012

Similarly Inclusion encourages each client to engage in meaningful activities which may be related to securing employment, training or volunteering. Inclusion has developed a detailed directory which is available for patients and they are supported to explore the opportunities which are available.

To maintain abstinence Inclusion offer a wide range of relapse prevention groups in different areas of the county, clients are also encouraged to access mutual aid groups like Alcoholics Anonymous (AA) and Narcotics Anonymous. In November 2016 the DAAT will be working with AA and Inclusion to highlight and celebrate the role AA can make to assist and sustain recovery.

Like Gainsborough Inclusion has also created a structured programme for past users to become Recovery Champions who will act as peer mentors and now these are integrated into all aspects of the Inclusion delivery model. Some of these individuals have gone on to be successfully recruited as paid members of staff.

The recovery champions from Inclusion and Gainsborough were highly praised and valued by those who took part in the consultation for this JSNA. They provide support and linking clients with other services.

Historically recovery champions were volunteers but now Cambridgeshire County Council has an 'independent service user' contract which is currently provided by SUN Network. The service is countywide and basically employs a 30-hour engagement worker to cover the county which links with other recovery workers from the Inclusion Service. It is a flexible service ultimately providing service user voice for the services and also for those who do not access services. The service provides advocacy support and helps aid communication with hard to reach groups.

Cambridgeshire County Council Drug and Alcohol commissioners and local partners continue to work to develop the capacity of the Recovery Community. As part of this a Recovery Hub, funded by Public Health England is currently under construction on Mill Road in Cambridge. This flagship project will be a base for recovery orientated groups and projects serving to further embed and develop a self-sustaining approach to recovery Cambridge.

The most commonly and strongly held view that emerged in the consultation from current and ex-service users was the need for a 24 hour crisis telephone support line. It was consistently stated that recovery is challenging and certain everyday events can precipitate relapse that could be averted by having the opportunity to talk to someone. Examples used by mental health services were cited as examples of good practice.

### ***The Drug and Alcohol Service Model and Integrated Services***

Individuals with drug and alcohol problems often have a range of complex health and social issues which makes their care packages multi-faceted and involves working with a wide range of services. Integration refers to many aspects of the care pathway and can include working with GPs, mental health services, criminal justice systems, housing services, employment services along with other social services from both voluntary and statutory sectors.



In Cambridgeshire there has been a drive towards greater integration. Historically the drug and alcohol services have been commissioned separately in Cambridgeshire. However in 2015/16 assisted by having Inclusion as the provider for both drug and alcohol services steps were taken to start integrating the services, although they are not commissioned under an integrated service specification.

In Cambridgeshire, there has been a push towards an integrated service between the treatment services and GPs, but this integration has proved challenging. There is a formal contractual shared care scheme with GPs for alcohol detoxification but only a minority of practices have entered into a contract to provide this service. (23 in 2015/16 and 28 in 2016/17). It has also proved challenging to secure robust data to access the impact of the service. Similarly there is a shared care service for drug treatment but only four practices are contracted to provide the service

Similar challenges have been noted in other UK areas where alternative commissioning arrangements are being implemented to improve integration between the provider and GP services. Alternative prescribing arrangements such as nurse-prescribing are used in some UK areas, including independent and supplementary prescribing.<sup>121</sup>

In terms of more informal arrangements there are many between criminal justice, mental health and housing services that are detailed in these sections. In addition there are working arrangements with employment services and voluntary agencies.

## What the evidence says

### Evidence for Primary Prevention for Adults

#### Adults, Families and Communities – Universal Interventions

The evidence for universal prevention for adults is based on multi-component models where different initiatives in the community bring people together to address substance misuse. An approach recommended in NICE's 2010 Guidance.<sup>122</sup>

For example promoting community partnerships have been established in different settings that undertake a range of interventions. Evaluations undertaken of different community projects have been positive. Across the country the Community Alcohol Partnerships have evaluated well, which includes the St Neots initiative. They are associated with improvements in alcohol and drug misuse and community safety issues.<sup>123</sup> Other initiatives like the Troubled Family Programme<sup>124</sup> which had an exceptional evaluation, also provide evidence of the protective effect on children and adults. However there has been criticism of the evaluation of the Troubled Families Programme which

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<sup>121</sup> National treatment agency for substance misuse. Nurse prescribing in substance misuse 2005. NHS

<sup>122</sup> NICE PH Guidance (PH24) Alcohol use disorders – preventing harmful drinking (2010)

<sup>123</sup> <http://www.communityalcoholpartnerships.co.uk/>

<sup>124</sup> [www.gov.uk/government/policies/helping-troubles-families-turn-their-lives-around](http://www.gov.uk/government/policies/helping-troubles-families-turn-their-lives-around)

secured an almost 100% success rate,<sup>125</sup> which experts would be difficult to achieve given the challenging issues being addressed.

Workplace programmes are another example of multi-component intervention which includes policies and prevention elements along with referral to treatment. There is extensive guidance from NICE recommending workplace programmes that offer support for healthy behaviours.

Local media campaigns like Change4Life have the ability to be visible and reach a large number of people. However the campaigns are required to meet some evidence based standards which includes identified target group, based on a solid theoretical basis, linked to the programmes, target parents and aim to change cultural norms.<sup>126</sup>

Specific prevention interventions for children and young people and older people are picked up in the relevant sections.

### **Motivational Interviewing and Brief/Extended Interventions.**

There is considerable evidence in support of opportunistic screening, brief advice and extended interventions for alcohol and drug misuse amongst adults who are not yet accessing any treatment services<sup>127 128</sup> and not dependent users (see definitions). Brief interventions are endorsed by NICE as there is strong evidence to suggest that they reduce alcohol consumption among a substantial minority of problem drinkers.<sup>129</sup> Problem drinkers have been shown to reduce their consumption by as much as 20% after a brief intervention.

NICE recommends that interventions focusing upon alcohol should be undertaken by health and social care as an integral part of their practice.<sup>130</sup> However the strongest evidence for them is when they are used in specific settings<sup>131</sup> namely Emergency Departments in general hospitals and Primary Care. NICE updated evidence review in 2014 identified a systematic review that again supported the use of hospital and primary care settings for identification and brief advice.<sup>132</sup>

However many individual and systematic review studies<sup>133 134 135 136</sup> that found evidence in support of these interventions recommend further research to establish length of effect and more high quality studies.

<sup>125</sup> Crossley S, The Troubled Families Programme: the perfect social policy.

<https://www.crimeandjustice.org.uk/sites/crimeandjustice.org.uk/files/>

<sup>126</sup> NICE Guidance (PH6) Behaviour Change : general approaches (2006)

<sup>127</sup> National Collaborating Centre for Mental Health. DRUG MISUSE Psychosocial interventions (2008)

<sup>128</sup> University of Sheffield, School of Health and Related Research. Screening and Brief Interventions for Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People (2010)

<sup>129</sup> Raistrick 2006, Miller 2004 and Hester 1995.

<sup>130</sup> NICE Guidelines 24 Alcohol-use disorders: prevention (2010)

<sup>131</sup> University of Sheffield, School of Health and Related Research. Screening and Brief Interventions for Prevention and Early Identification of Alcohol Use Disorders in Adults and Young People (2010)

<sup>132</sup> NICE Alcohol-use disorders: preventing harmful drinking. Evidence update 2014

<sup>133</sup> Watson, JM, Fayter D, Mdege N, Stirk L, Sowden AJ, Godfrey C. Interventions for alcohol and drug problems in outpatient settings: A systematic review. *Drug and A*, 32(4) 356-367 (2010)

<sup>134</sup> Woolard R, Baird J, Longabaugh R, Nirenberg T, Lee CS, Mello MJ, Becker B. Project reduce: reducing alcohol and marijuana misuse: effects of brief intervention in the emergency department *Addictive Behaviours* Vol 38, 3 1732-9

<sup>135</sup> Saitz R, Palfai TP, Cheng DM, Alford DP, Bernstein JA, Lloyd Travalgini CA, Melli SM, Chaisson CE, Samet JH. Screening and Brief Interventions for drug use in primary care: the ASPIRE randomised clinical trial. *JAMA* Vol 312, 5 502-13 (2014)

<sup>136</sup> Newton A, Dong K, Mabood N, Ata N, Ali S, Gokiert R, Vandermeer B, Tjosvold L, Hartling L, Wild TC. Brief Emergency department interventions for youth who misuse alcohol and other drugs. A systematic review. *Paediatric Emergency care* 29(5) 673-684 (2013)

There is less evidence for the effectiveness of the interventions for drug misuse. Trials of interventions with non-cannabis and mixed substance misuse have examined the effectiveness of brief psychosocial interventions to reduce drug misuse. These trials took place in primary care, sexual health and emergency care departments. The results consistently showed that any effect was small and not long lasting and the conclusion drawn was that it appears unlikely that brief interventions effective for treating mixed drug misuse in non-treatment seeking people. It is unclear whether brief interventions would be effective for mixed drug use in treatment-seeking individuals.

There is some evidence however from trials for interventions with cannabis users. Trial participants were recruited through media advertising and were therefore pre-dominantly treatment seeking. Trials showed a positive effect of brief interventions for reducing cannabis use at post-treatment. At 6-12 month follow-up the positive effect neared, but did not reach, significance. Trials used delayed/no treatment as the control group and this may have introduced bias. However, in all studies, control groups reduced their cannabis use from pre to post-treatment and study findings may have represented real effects. It appears likely that brief interventions are effective for treatment of cannabis misuse in treatment-seeking people but it is unclear whether effects are maintained into the longer-term.

### **Psychosocial interventions – Alcohol misuse**

Psychological interventions for people experiencing alcohol misuse or dependence have traditionally made use of the interaction between the service user and a therapist. In addition, more recently, there has been some growth and expansion in the use of self-help-based interventions involving DVDs, books, computer programmes or self-help manuals.

Psychological interventions include a range of different approaches such as behavioural, cognitive, psychodynamic, motivational and social. The emphasis of each therapy is different, depending on the theoretical underpinning of the approach. Behavioural approaches, for example, are based on the premise that excessive drinking is a learned habit and the individual can be taught a different behavioural pattern by creating negative experiences/events in the presence of alcohol and positive experiences/events in alcohol's absence.

Cognitive approaches, on the other hand, emphasise the role of thinking and cognition either prior to engaging in drinking behaviour or to prevent or relapse.

Motivational enhancement therapy is based on the methods of motivational interviewing; helping people to recognize problems related to their drinking and to resolve ambivalence towards behavior and belief in the ability to change, adopting a supportive rather than a confrontational position.

Social approaches focus the work on the social environment, families or wider social networks. Social behaviour and network therapy comprises a range of cognitive and behavioural strategies to help clients build social networks supportive of change which involve the patient and members of the patient's networks (for example, friends and family) with the aim of helping the patient to build 'positive social support for a change in drinking'.

Couples-based interventions involve a range of approaches involving the spouse or partner in the intervention. A behavioural approach assumes that family members can reward abstinence.

Behavioural couples therapy assumes that substance use impairs relationship functioning, and severe relationship distress combined with attempts by partners to control substance use may prompt craving, reinforce substance use, or trigger relapse. To break this vicious circle and transform the relationship into a positive force, the therapy aims to build support for abstinence and to improve relationship functioning. It features a 'recovery contract' which involves the couple in a daily ritual to reward abstinence, together with techniques for increasing positive activities and improving communication.

In some instances, a combination of approaches is used and described under the term of 'multimodal' treatment, guided by the rationale that a combination of approaches is more powerful than each individual component.

## NICE Recommendations

NICE recommendations<sup>137 138</sup> include

- **Motivational intervention:** For all people who misuse alcohol: a motivational intervention forms part of the initial assessment.
- **Psychological interventions:** For harmful drinkers and people with alcohol dependence: psychological interventions such as cognitive behavioural therapies, behavioural therapies or social network and environment-based therapies) focused specifically on alcohol-related cognitions, behaviour, problems and social network and for those who have a regular partner, behavioural couples therapy. Behavioural couples therapy should be focused on alcohol-related problems and their impact on relationships.

The NICE recommendations were based on a review of the evidence for efficacy of a range of psychological interventions in harmful drinkers or those mildly dependent on alcohol. This showed some advantage for couples therapy over treatment as usual and other active interventions. There was evidence that cognitive behavioural therapy, social behaviour and network therapy, and behavioural therapies were better than treatment as usual or control.

## Psychological Interventions for Drug Misuse

A review of the evidence indicated that motivational interviewing<sup>139 140 141 142</sup> alone for mixed drug addictions was not shown to be effective and other strategies, such as Cognitive Behavioural Therapy (CBT) and relapse prevention may be more effective in addition to, or instead of,

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<sup>137</sup> NICE CG115

<sup>138</sup> NICE quality standard QS11

<sup>139</sup> Woodruff SI, Clapp JD, Eisenberg K, et al. Randomized clinical trial of the effects of screening and brief intervention for illicit drug use: the life shift/shift gears study. *Addiction Science & Clinical Practice* 2014; 9:8.

<sup>140</sup> Stotts AL, Schmitz JM, Rhoades HM, and Grabowski J. Motivational Interviewing With Cocaine-Dependent Patients: A Pilot Study. *Journal of Consulting and Clinical Psychology* 2001; 69(5):858-862.

<sup>141</sup> StePublic Health Englandns RS, Roffman RA, Curtin L. Comparison of Extended Versus Brief Treatments for Marijuana Use. *Journal of Consulting and Clinical Psychology* 2000; 68(5):898-908.

<sup>142</sup> Stein MD, Herman DS, Anderson BJ. A motivational intervention trial to reduce cocaine use. *Journal of Substance Abuse Treatment* 2009; 36:118-125.

motivational interviewing. The long-term effectiveness of CBT interventions alone was clearer, with moderate significant effects at six to twelve months follow-up.<sup>143</sup>

For psychological interventions in patients with cannabis misuse or dependence there was a significant treatment effect. However there were issues with the robustness of the trials with concerns about lack of control groups. In three of the cannabis intervention trials, full CBT intervention was compared with a brief psychological intervention (a reliable control group) and these trials showed a small positive treatment effect confirming that CBT is likely to be an effective treatment for cannabis abuse or dependence.<sup>144</sup>

Powers et al evaluated the effectiveness of behavioural couples therapy for alcohol and drug use disorders in a meta-analysis including 12 randomised-controlled trials and concluded that behavioural couples therapy reported better outcomes than individual-based treatment for married or cohabiting individuals who sought help for alcohol dependence or drug dependence problems.<sup>145</sup>

Only one trial of family therapy in adults was identified.<sup>146</sup> Patients undergoing out-patient drug and alcohol treatment (CBT) received additional family therapy, where they attended counselling sessions with a family member. Compared with those not undergoing family therapy, family therapy patients had higher rates of abstinence from all substances that approach significance but findings were not maintained into the longer-term (6 month follow-up)

### **NICE Recommendations<sup>147</sup>**

**Self-help:** People who misuse drugs should be provided information about self-help groups. These groups should normally be based on 12-step principles; for example, Narcotics Anonymous and Cocaine Anonymous.

**Contingency management:** Drug services should introduce contingency management programmes – to reduce illicit drug use and/or promote engagement with services for people receiving methadone maintenance treatment.

**Behavioural couples therapy** Behavioural couples therapy should be considered for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse. The intervention should: focus on the service user's drug misuse; consist of at least 12 weekly sessions.

**Cognitive behavioural therapy and psychodynamic therapy:** Cognitive behavioural therapy and psychodynamic therapy focused on the treatment of drug misuse should not be offered routinely to people presenting for treatment of cannabis or stimulant misuse or those receiving opioid

<sup>143</sup> Watkins KE, Hunter SB, Hepner KA, et al. An effectiveness trial of group cognitive behavioral therapy for patients with persistent depressive symptoms in substance abuse treatment. Arch Gen Psychiatry. 2011; 68(6):577–584.

<sup>144</sup> The Marijuana Treatment Project Research Group. Brief Treatments for Cannabis Dependence: Findings from a Randomized Multisite Trial. Journal of Consulting and Clinical Psychology 2004; 72(3):455–466.

<sup>145</sup> Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews [Internet]. Behavioral couples therapy (BCT) for alcohol and drug use disorders: a meta-analysis. MB Powers, E Vedel, and PM Emmelkamp. Review published: 2008.  
<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0026430/>

<sup>146</sup> Liddle HA, Dakof GA, Parker K, et al. Multidimensional family therapy for adolescent drug abuse: results of a randomised clinical trial. Am J Drug Alcohol Abuse 2001; 27(4):651–688.

<sup>147</sup> NICE CG51: <https://www.nice.org.uk/guidance/cg51>

maintenance treatment. Evidence-based psychological treatments (in particular, cognitive behavioural therapy) should be considered for the treatment of comorbid depression and anxiety disorders in line with existing NICE guidance for people who misuse cannabis or stimulants, and for those who have achieved abstinence or are stabilised on opioid maintenance treatment.

## Drug and Alcohol Interventions

### Detoxification

#### *Where should detoxification take place?*

The organization of care was addressed in Models of Care for Alcohol Misusers (MoCAM) developed by the National Treatment Agency and the Department of Health and the Review of the Effectiveness of Treatment for Alcohol Problems.<sup>148</sup> Alcohol service commissioning and provision across England is variable which has been attributed to some lack of clarity in the most appropriate setting and organisation of care.

Current practice in the management of assisted withdrawal, and the general provision of alcohol treatment services, tends to follow MoCAM guidance that suggested community settings were preferred for the treatment of the majority of people who misuse alcohol, as they are seen as more cost effective and more likely to promote change in their drinking behaviour in a normal social environment. However, it was noted that some people would require treatment in hospital or in supported residential accommodation, including those who are severely dependent, have a history of withdrawal complicated by seizures or DTs, are in poor physical or psychological health, are at risk of suicide, or misuse drugs. Homeless people, those who lack social support or stability, or those who have had previous unsuccessful attempts at withdrawal in the community may also require inpatient treatment.

#### *Clinical effectiveness*

A randomised trial<sup>149</sup> conducted in a US Department of Veterans Affairs medical centre compared the effectiveness and safety of inpatient (n=77) and outpatient (n=87) assisted withdrawal. Patients with serious medical or psychiatric symptoms predicted delirium tremens and a very recent history of seizures were excluded from this study. The authors reported that more inpatients than outpatients completed assisted withdrawal. However inpatient treatment was significantly longer and more costly than outpatient treatment. Additionally, both groups had similar reductions in problems post-treatment when assessed at one and six month follow-up. Although abstinence was statistically significantly higher for the inpatient group at one month follow-up, these differences were not observed at 6-month follow-up. The authors concluded that outpatient assisted withdrawal should be considered for people with mild-to-moderate symptoms of alcohol withdrawal.

<sup>148</sup> Review of the effectiveness of treatment for alcohol problems Duncan Raistrick, Nick Heather and Christine Godfrey. National Treatment agency for substance misuse. 2006

<sup>149</sup> N Engl J Med. 1989 Feb 9;320(6):358-65. Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome., Volpicelli JR, Raphaelson AH, Hall CP.

### *Cost effectiveness*

NICE performed a cost analysis comparison of inpatient, outpatient and home-based assisted withdrawal finding that, provided that the different assisted withdrawal settings have similar effectiveness, then outpatient and home-based assisted withdrawal are probably less costly (and thus potentially more cost effective) than inpatient assisted withdrawal, resulting in an estimated cost saving of approximately £3,400 to £5,600 per person treated.

### *What is the effect of delay of detoxification on outcomes?*

It is accepted that change in addictive behaviour is dependent on the psychological stage of the patient. Timing is therefore likely to be important for treatment success.<sup>150</sup> Delay in treatment of psychiatric disorders were discussed by Wang et al;<sup>151</sup> delay referred to delay in talking to a professional about a disorder. It was noted that delay in treatment can be associated with social problems such as unstable employment but also that not all studies show a relationship between duration of lack of treatment and outcomes.

## **Recovery Interventions**

The evidence underpinning recovery and relapse prevention includes the treatment therapies such as CBT but also a range of interventions that contribute to the development of personal resilience. This has been termed “recovery capital”. Commentators define recovery capital as the “breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery” from substance misuse (dependency)<sup>152</sup> This initial concept was revisited<sup>153</sup> and proposed that there are four components to recovery capital:

- Social capital is defined as the sum of resources that each person has as a result of their relationships, and includes both support from and obligations to groups to which they belong; thus, family membership provides supports but will also entail commitments and obligations to the other family members.
- Physical capital is defined in terms of tangible assets such as property and money that may increase recovery options (e.g. being able to move away from existing friends/networks or to fund an expensive detox service).
- Human capital includes skills, positive health, aspirations and hopes, and personal resources that will enable the individual to prosper. Traditionally, high educational attainment and high intelligence have been regarded as key aspects of human capital, and will help with some of the problem-solving that is required on a recovery journey.

<sup>150</sup> Blissmer B, Prochaska JO, Velicer WF, et al. Common Factors Predicting Long-term Changes in Multiple Health Behaviors. *Journal of health psychology*. 2010;15(2):205-214. doi:10.1177/1359105309345555

<sup>151</sup> Wang PS, Berglund P, Olsson M, Pincus HA, Wells KB, Kessler RC. Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):603-613.

<sup>152</sup> Cloud, W. & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions*, 1(1), 83-104.

<sup>153</sup> Cloud W, Granfield R, Conceptualizing recovery capital: expansion of a theoretical construct *Subst Use Misuse*. 2008;43(12-13):1971-86. doi: 10.1080/10826080802289762.

- Cultural capital includes the values, beliefs and attitudes that link to social conformity and the ability to fit into dominant social behaviours.

The strongest evidence identified by the<sup>154</sup> Advisory Council on the Misuse of Drugs for building recovery capital is for the following interventions to accompany treatment.

- Carers and family support
- Education, employment and volunteering
- Improvements in physical health
- Access to housing and socio-economic security
- Access to social care if required
- Involvement in community groups
- Involvement in recovery communities
- Reduction in media stigmatization of substance misuse

### Computer based programmes

There is some evidence that computer based programmes that include web or individual feedback is effective in stimulating behaviour change in relation to alcohol and drugs. However there is evidence which is under developed and many lack rigour. Currently the findings are strongest for short and limited medium term effects.

For example three trials examined the effectiveness of internet-delivered interventions for substance misuse. Two trials tested interventions for cannabis misuse<sup>155 156</sup> and one for cocaine use.<sup>157</sup> They all used internet advertising to recruit participants with regular drug use. For cannabis intervention, there was a small positive effect of intervention at three month follow-up but no longer-term data. For the cocaine intervention there was no significant effect at six months following intervention (SMD -0.09, CI -0.37 to 0.19). Internet interventions may be helpful for reducing cannabis use but it is unclear whether these effects are sustained in the long-term.

### Hospital Liaison Services

Hospital liaison services were initially introduced as part of mental health services. They aim to liaise between acute services and mental health services along with other services as necessary. They were adopted primarily for use with alcohol related admissions but there are services across the country where they are used for both drug and alcohol admissions.

The context for their development was a concern nationally with cohort of patients who frequently attend the emergency department and have high levels of repeated hospital admissions. This group have complex physical health, psychiatric and social needs, but the most common factor is high

<sup>154</sup> Advisory Council on the Misuse of Drugs Recovery from drug and alcohol dependence: an overview of the evidence 2012

<sup>155</sup> Marsch LA, Guarino H, Acosta M, et al. Web-based Behavioral Treatment for Substance Use Disorders as a Partial Replacement of Standard Methadone Maintenance Treatment. *J Subst Abuse Treat* 2014; 46(1).

<sup>156</sup> Rooke S, Copeland J, Norberg M, Hine D and McCambridge J. Effectiveness of a Self-Guided Web-Based Cannabis Treatment Program: Randomized Controlled Trial. *J Med Internet Res*. 2013; 15(2):e26.

<sup>157</sup> Schaub M, Sullivan R, Haug S, and Stark L. Web-Based Cognitive Behavioral Self-Help Intervention to Reduce Cocaine Consumption in Problematic Cocaine Users: Randomized Controlled Trial. *J Med Internet Res* 2012; 14(6):e166.



levels of alcohol use. Within this group, there are a high proportion of 'dual diagnosis' patients: those with both mental health and alcohol problems. The multi-disciplinary Hospital Liaison teams work therefore were developed to work with people who have these complex needs. They have been shown to be effective in patients with high levels of inpatient bed use.

An evaluation of a team in Salford found that out of the total number of admissions in three months fell from 151 prior to the intervention period, to 50 following the intervention. Emergency department attendances also fell from 360 in three months to 146 following the intervention period.

Other evaluations have been positive and NICE on its shared learning database describes the experience of Tameside Hospital NHS Foundation Trust.<sup>158</sup> In 2010/11, the alcohol-attributable admission episodes rate in Tameside was 25.63% higher than the North West. The number of alcohol-related Hospital attendances to the Emergency Department in 2012/13 was reported at 2,149 demonstrating a 52.1% increase in activity over five years. This period preceded the appointment of the Hospital Alcohol Liaison Service (HALS). Within the first 16 months of the service being operational, 1600 patients were screened and assessed by the HALS team, 879 (54.9%) of which were admitted as a direct result of their alcohol misuse.

## Harm Reduction

Harm reduction is both a policy approach and used to describe a specific set of interventions to reduce the harms associated with drug use; it shifts the focus from abstinence as the immediate treatment goal. Most of the literature focused on harm reduction is in relation to drug misuse and provides evidence for needle and syringe exchange and outreach programmes.<sup>159</sup>

### *Needle and Syringe Exchange Programmes*

Needle and syringe exchange programmes aim to reduce risk among injection drug users. That is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment, such as HIV, hepatitis B and C. In turn, this will reduce the prevalence of blood-borne viruses and bacterial infections. The programmes provide sterile needles and syringes in exchange for used equipment and often provide free human immunodeficiency virus (HIV) and Hepatitis C virus (HCV) testing with counselling and referral where necessary. From these exchange programmes, people may be enrolled into drug treatment services and access to other health and welfare services.

Interventions have aimed to increase rates of uptake of drug treatment from needle and syringe exchange programmes. In one trial<sup>160</sup> participants in an exchange programme were randomised to motivational enhancement or no intervention. There was no difference between the motivational enhancement group and control group in the proportion of people entering treatment services,

<sup>158</sup> NICE Learning Database Tameside Hospital NHS Foundation Trust 2015 <https://www.nice.org.uk/sharedlearning/improving-safety-through-the-establishment-of-a-hospital-alcohol-liaison-service-hals-alongside-the-launch-of-a-therapeutic-chlordiazepoxide-prescribing-detoxification-regime>

<sup>159</sup> Ritter A, Cameron J A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs Drug Alcohol Review 2006 Nov ; 25 (6): 611-24

<sup>160</sup> Michael Kidorf, Van L. King, Karin Neufeld, Jessica Peirce, Ken Kolodner & Robert K. Brooner. Improving substance abuse treatment enrollment in community syringe exchangers. Addiction. 2009; 104: 786–795.

there was no difference in drug use (heroin, cocaine or all injection use) and no difference in rates of syringe sharing.

In another trial,<sup>161</sup> drug users seeking treatment after referral from a syringe exchange programme were randomised to case management (Case Managers assist clients in transportation, child care, social services referrals to health services etc) or no intervention. Case management increased the proportion of participants registering with treatment services.

NICE in 2009<sup>162</sup> recommended the use of needle and syringe exchange schemes. These Guidelines have been superseded by NICE's 2014 <sup>163</sup>Guidelines that were updated to reflect recent evidence. The more recent guidelines provide review evidence that the schemes can be effective but acknowledge that there are many caveats that demand more research. These in the main reflect the need to consider the heterogeneity of drug users and the lack of understanding of how different groups perceive and use needle and syringe schemes along with evidence for their use with children and young people. The evidence highlighted the key factors affecting their success as the immediate availability and accessibility of the schemes.

The analyses for the original guidance estimated that needle and syringe programmes used as a channel for treating injecting drug users for chronic Hepatitis C were cost effective. The modelling showed that if only health costs and benefits are counted, then a needle and syringe programme that increased coverage by 25% in a city with a high incidence of Hepatitis C virus was cost effective (estimated ICER £11,400). However, an increase in coverage by 12.5% was not cost effective (estimated ICER £31,600). For a low-incidence city, the estimated ICER for an increase in coverage of 25% was £11,800, whereas for an increase of 12.5% the ICER was estimated as £26,100.

If the costs to the criminal justice system are included, the modelling showed that a 12.5% increase in coverage for a high-incidence city was not cost effective (estimated ICER £38,700). But if coverage increased to 25%, the estimated ICER fell to £19,900. For a low-incidence city, for a 12.5% increase in coverage the ICER was £29,300, and for a 25% increase in coverage the ICER was £12,300.

Needle and syringe programmes can also help reduce the number of people who are injecting drug users by acting as a 'gateway' to opiate substitution therapy. So these programmes may help reduce the costs of drug-related crime. When these indirect ('gateway') effects were modelled, it showed that a 13.5% increase in the rate of referral to opiate substitution therapy resulted in ICERs of between £11,000 and £17,000, depending on prevalence.

### *Supervised consumption schemes*

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<sup>161</sup>Steffanie A. Strathdee, Erin P. Ricketts, Steven Huettnner et al. Facilitating entry into drug treatment among injection drug users referred from a needle exchange program: Results from a community-based behavioral intervention trial. *Drug Alcohol Depend.* 2006; 83(3): 225–232.

<sup>162</sup> NICE Public Health Guidelines 18 Needle and Syringe Schemes

<sup>163</sup> NICE Public Health Guidelines 52 Needle Exchange Schemes <https://www.nice.org.uk/guidance/ph52/evidence>

Since 2006 other evidence has emerged that support other harm reduction approaches which includes supervised consumption schemes and the use of naloxone by ambulance crews and other frontline staff. A recent review of the evidence found that reductions in alcohol use resulted in major benefit to physical health including reducing alcohol assisted injuries, cardiac conditions were improved, weight reduction and improvements in liver function. The literature reviewed also demonstrated considerable socio-economic benefits a reduction in alcohol intake.<sup>164</sup>

There is also increasing evidence for the use of drugs to support harm reduction approaches especially amongst long term drug and alcohol users.<sup>165</sup>

Supervised consumption refers to treatment with the drugs methadone or buprenorphine as part of a support programme to help the person manage their opioid dependence. It should only be given after a review of the risks with individual people and an assessment of which drug would be most appropriate. Any use should be closely supervised initially and reviewed regularly.

NICE recommends its use and this is underpinned by extensive reviews of the evidence. There is evidence that supervised consumption is associated with a reduction in mortality, greater retention in treatment programmes and a decreased use of opioids. The economic evidence is less well developed and the different studies are not comparable. However NICE modelling found that incremental cost effective ratio for the use of Methadone compared with no treatment resulted in an ICER of £13,700 per additional QALY gained. The analysis of buprenorphine compared with no treatment resulted in an ICER of £26,400 per additional QALY gained.

### *Naloxone*

Naloxone blocks or reverses the effects of opioid medication, including extreme drowsiness, slowed breathing, or loss of consciousness. Naloxone is used to treat a narcotic overdose in an emergency situation.

UK law around naloxone changed on 1 October 2015, the main change is that now any worker in a commissioned drug service can now distribute Naloxone without prescription.

### **Integration of care using case management approaches.**

Case management is defined as the bringing together of the assessment, planning, coordination and monitoring of care under one umbrella. In a number of cases all four of these activities will be undertaken by one individual, but in other cases some of the above functions will be undertaken by other team members or health professionals and coordinated by one individual.

NICE reviewed the evidence for the clinical efficacy of case management as an intervention to promote abstinence and reduce alcohol consumption, as well as improving client engagement, treatment adherence and use of aftercare services. Evidence from randomised trials and

<sup>164</sup> Charlet K, Heinz A Harm Reduction – a systematic review on the effects of alcohol reduction on physical and mental symptoms. *Addiction Biology* doi 10.1111/adb.12414 2016

<sup>165</sup> Collin SE et al Extended-release naltrexone and harm reduction counselling for chronically homeless people with alcohol dependence. *Substance Abuse* 2015 36(1): 21-33 doi : 10/1080/08897077

observational studies indicates that when case management is compared with standard treatment, case management had significant benefit over treatment as usual for certain drinking-related outcomes (for example, lapse and frequency/quantity of alcohol use), and outcomes evaluating engagement and completion of treatment and aftercare. It must be noted, however, that the overall quality of the evidence base was limited. Case coordination was recommended for the delivery of care coordination for those with harmful alcohol misuse and mild dependence. This recommendation balanced the concern of the considerable number of agencies involved in the delivery of alcohol misuse services versus this relatively intensive intervention for people who misuse alcohol.

A meta-analysis of case management that included drug and alcohol services found it effective across all targeted outcomes when compared with standard of care which included staying in treatment and personal functioning.<sup>166</sup>

### Models of care: integrated services

The integration of drug and alcohol services appears logical due to the high numbers of patients with concurrent alcohol and drug dependence. Treatment within the same service may bring efficiencies and improve rates of treatment of secondary addictions/dependence. However, when considering the introduction of an integrated service, the mode of recruitment is likely to be an important consideration. Stigmatisation may affect the recruitment of patients with primarily alcohol dependence to a substance misuse service.

The difficulty of combining alcohol and drug services due to differences in the perceptions of these types of clients has been highlighted in studies. Alcohol and drugs hold different values in society and it is questioned whether clients are willing to enter the same treatment service and whether they can be treated with the same strategies. No research evidence was found to answer this question. In Cambridgeshire, for both alcohol and drug treatment services, currently, the majority of clients self-refer (78% and 65% for alcohol and drug respectively). If patients with predominantly problems of alcohol misuse are dissuaded from referral to a joint 'substance misuse' because of stigmatisation, some difficulty may be anticipated with maintaining service recruitment.

In addition, the effectiveness of interventions for secondary addiction/dependence is unclear. No evidence was found to show that patients undergoing treatment for drug abuse could be successfully treated for alcohol addiction. A number of studies of brief interventions, and one of a more intensive cognitive behaviour intervention in patients with concurrent alcohol and drug dependence,<sup>167</sup> all showed no positive effect on alcohol use. For patients with a primary alcohol addiction, no evidence was found relating to the effectiveness of treatments for secondary drug dependence.<sup>168</sup>

<sup>166</sup> Rapp RC, Noortgate W The Efficacy of Case Management With Persons Who Have Substance Abuse Problems: A Three-Level Meta-Analysis of Outcomes Journal of Consulting and Clinical Psychology © 2014 American Psychological Association 2014, Vol. 82, No. 4, 605–61

<sup>167</sup> Carroll KM, Nich C, Ball SA, McCance E and BJ Rounsaville. Treatment of cocaine and alcohol dependence with psychotherapy and disulfiram. *Addiction* 1998; 93 (5): 713–728.

<sup>168</sup> Gossop M, Stewart D and Marsden J. Effectiveness of drug and alcohol counselling during methadone treatment: content, frequency, and duration of counselling and association with substance use outcomes. *Addiction*. 2006; 101:404–412.

## *Drug and Alcohol Misuse and Sexual Health*

There is a link between substance misuse and sexual risk behaviours. In studies adolescents, alcohol misuse was associated with behaviours such as unprotected sex and increased sexual partners.<sup>169</sup> Compared to young people not in treatment, young people in treatment for substance misuse were more likely to engage in unprotected sex (50% vs 11%) and have a higher lifetime number of sexual partners (6 vs. 1). In adults, of patients seeking treatment for Hepatitis C, 53% had a lifetime diagnosis of an alcohol use disorder and 67% had a lifetime diagnosis of a drug use disorder. In another study of men attending sexual health clinics, sex under the influence of drugs was more likely to involve anal intercourse, sex with a casual partner, and less condom use.<sup>170</sup>

There is evidence that models of an integrated sexual health and substance misuse service. Two trials, one of a group discussion intervention in men who have sex with men,<sup>171</sup> and one of a counselling intervention in HIV-positive patients,<sup>172</sup> showed a tendency to overall positive effect on substance use/dependence at post-treatment and the incidence of unprotected sex at follow up. These findings were only significant in the study of HIV positive patients. However, the study in men who have sex with men showed a positive intervention effect (reduction) in the frequency of sex under the influence of drugs or alcohol.

Due to recognition of the poor sexual health in patients treated for drug addiction, a London Local Authority<sup>173</sup> has implemented the provision of a sexual health clinic within the existing drug and alcohol service. Sexual health clinics were advertised to patients through their keyworkers from the substance abuse clinic. To avoid stigma, patients could refer to clinics as 'men's' and 'women's' clinics (advertised as such on posters) in order to be registered for an appointment. Formal evaluation has not been conducted but positive uptake is reported.

## **A Long Term Condition Model of Care**

The current model of a successful six month treatment intervention is defined as abstinence being achieved at six months. This is at variance with clinical experience and studies. These confirm that although some individuals can be successfully treated within an acute care framework, many patients need multiple episodes of treatment over several years to achieve and sustain recovery.<sup>174</sup> The progress of many patients is marked by cycles of recovery, relapse, and repeated treatments, often spanning many years before eventuating in stable recovery, permanent disability, or death. A

<sup>169</sup> Thurstone C, Salomonsen-Sautel S, Mikulich-Gilbertson SK et al. Prevalence and predictors of injection drug use and risky sexual behaviors among adolescents in substance treatment: Prevalence and predictors of IDU and risky sex. *Am J Addict.* 2013 ; 22(6): 558–565. doi:10.1111/j.1521-0391.2013.12064.x.

<sup>170</sup> Sims OT, Pollio DE, Hong BA. An assessment of concurrent drug and alcohol use among patients seeking treatment for hepatitis C. *Annals of Clinical Psychiatry* 2016;28(1):31-36.

<sup>171</sup> Kurtz SP, Stall RD, Buttram ME, Surratt HL and Chen M. A Randomized Trial of a Behavioral Intervention for High Risk Substance-Using MSM. *AIDS Behav.* 2013 November ; 17(9): . doi:10.1007/s10461-013-0531-z.

<sup>172</sup> Gilbert P, Ciccarone D, Gansky SA et al. Interactive "Video Doctor" Counseling Reduces Drug and Sexual Risk Behaviors among HIV-Positive Patients in Diverse Outpatient Settings. *Plos ONE* 2008; 3(4): e1988.

<sup>173</sup> Vanthuyne A, Mundt-Leach R, Boyd A, Broughton S, Pittrof R. Sexual and reproductive healthcare provided onsite in an inner-city community drug and alcohol service. *J Fam Plann Reprod Health Care* 2016;42:152–154. doi:10.1136/jfprhc-2014-101126.

<sup>174</sup> *Addict Sci Clin Pract.* 2007 Dec; 4(1): 45–55. Managing Addiction as a Chronic Condition Michael Dennis, Ph.D.<sup>1</sup> and Christy K Scott, Ph.D

model of long-term, active care management for drug and alcohol misuse, is comparable to the way treatments for other chronic conditions are managed in medicine.<sup>175</sup>

Studies indicate that the progress of different patients is variable. Patients with higher substance use severity and environmental obstacles to recovery such as substance use in the home or family problems have been found less likely to transition from drug and alcohol misuse to recovery or treatment. Patients were more likely to transition from use to recovery when they believed their problems could be solved, desired help with their problems, reported high self-efficacy to resist substance use, and received addiction treatment during the quarter. The age at first substance use and the duration of use before starting treatment are related to the length of time it takes people to reach at least one year of alcohol and drug abstinence. The median time of use has been found to be significantly longer for people who start at a young age and patients who begin treatment within the early years of their drug use have been found to achieve a year or more of abstinence before those that entered treatment later.

Five-year abstinence and recovery as a treatment outcome measure has been suggested from a US source. Currently as captured in this JSNA one of the public health outcomes framework indicators include the number of users of opiates and non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within six months as a percentage of the total number of opiate/non-opiate users in treatment.<sup>176</sup> This measurement puts an emphasis on recovery and is routinely collected, allowing comparison across areas. The measurement is lower for opiates compared to non-opiates (7.4% versus 39.2% in England for 2014).

## What is this telling us?

### Alcohol

- Overall Cambridgeshire compares well to national and comparator areas for alcohol misuse and hospital admissions. However across some indicators Cambridgeshire falls into the top 25% of its statistical neighbours and would benefit from further consideration.
- There is variation between the districts in Cambridgeshire with Cambridge City and Fenland having higher rates of alcohol misuse, admission rates along with poorer outcomes that relate to deprivation.
- There is a difference in the rates of alcohol specific mortality with them generally higher in the 20% most deprived wards.
- Numbers of adults in treatment for alcohol misuse rose from 571 in 2013/14 to 841 in 2-14/15, however only 3.8% of the estimated high risk drinkers in treatment.

<sup>175</sup> Creating a New Standard for Addiction Treatment Outcomes A Report from the Institute for Behavior and Health, Inc. Robert L. DuPont, MD, President Institute for Behavior and Health, Inc. Aug 2014

<sup>176</sup> <http://www.phoutcomes.info/public-health-outcomes-GO-framework#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/90245/age/234/sex/4>

- Socio-economic factors are prevalent amongst those in treatment. Although only 5% in treatment having known housing problems which is considerably lower than national or comparator figures and contrasts with feedback from services and service users.

## Drugs

- Overall, Cambridgeshire is comparable to national and comparator areas but there are some differences.
- Recruitment rates (penetration) of the Cambridgeshire drugs service was better than national averages for other types of drug use, recruitment of injection-using clients was not, which merits further investigation.
- Rates of abstinence at six months are generally worse for Cambridgeshire compared with national rates and rates of comparative local authorities. When the overall proportion of patients' successfully completing treatment (and not re-presenting) is compared, Cambridge has similar rates to national rates and it may be that a six month assessment window gives a poor representation of the overall efficacy of the Cambridgeshire service.
- The time taken to treatment completion also tended to be longer in Cambridgeshire compared with national times (a higher proportion of clients were in treatment for less than two years). This may reflect the level of dependency of Cambridgeshire patients the fact that many clients have been long term users.
- Cambridgeshire compares unfavourably to national and comparator areas for Hepatitis B vaccination uptake and completion and lower rates of Hepatitis C testing compared with national rates. Research evidence was not found to indicate types of interventions that may increase uptake but this may be an area for further development. Initial work has started in Cambridgeshire working with Public Health England to address this issue.
- As is true nationally, treatment efficacy tends to be lower for clients with problems of opiate drug use, whereas higher post-treatment rates of abstinence are seen for clients with problems of crack or cocaine abuse. Cambridgeshire is at the lower end, but within the expected range, of abstinence rates predicted by Public Health England for this local authority. However, the poor rate of abstinence for patients treated for Cannabis abuse may be surprising. There is no Public Health England 'recommended range' but rates are substantially worse compared to national rates and a reasonable number of clients are treated for this type of addiction.

## Models of Care

- Historically, addiction treatment systems and research have been organized to provide and improve the outcomes of acute episodes of care. The conceptual model has been that an addicted person seeks treatment, completes an assessment, receives treatment, and is discharged, all in a period of weeks or months. However the changing patterns of drug use indicates that other more flexible models of service delivery could be developed where abstinence is not the key objective but the focus is on harm reduction and robust management approaches.
- GP engagement in either alcohol or drug treatment remains challenging. The adoption of long term condition approach to care includes GPs having a more active role. The development of GP

Federations where there will be wider range of skills could facilitate this approach along with greater use nurse prescribers would support greater GP practice involvement.

- The Cambridge University Hospital Foundation Trust (CUHFT) Hospital Liaison Service is provided by Inclusion and is highly regarded by local stakeholders as a means to manage frequent hospital admissions and to provide an opportunity to start treatment or provide closer management if necessary for those already in treatment. Evidence shows that it is an effective service. Currently there is only a service at CUHFT and not at Hinchbrook Hospital, which has been criticised by stakeholders. Cambridgeshire County Council has discussed this issue with the Hospital, Cambridgeshire and Peterborough Clinical Commissioning Group, Inclusion and the Gainsborough Foundation. These discussions are ongoing and relate to the perceived barriers of low numbers of substance misuse patients to warrant the investment. Currently attempts are being made to secure hospital data to try and establish the size of the issue.

### **Integrated Care Models**

There is general move to greater integration of services and there are different models that reflect differing levels of formal through to informal integration. In terms of substance misuse services there is a range of possible advantages.

- Clients who use substance misuse services have a range of needs that include not only treatment but also many have mental health and range of socio economic challenges that can undermine successful treatment of management of their condition.
- Many clients use both drugs and alcohol, although there is mixed evidence for treating them concurrently in terms of outcomes. However there are obvious advantages to the clients in terms of accessibility of services and a consistent approach to interventions to address wider needs.
- There are obvious cost efficiencies from integrating services and also develops a wider range of staff skills.
- Integration however may also be informal and be effected through closer collaborative working with clear pathways to the wide range of services that clients require. This could include co-location, joint commissioning and shared protocols. However for a system wide integrated approach to be effective a shared vision that can be translated into joint commissioning strategies and robust responsive services is more likely to embed genuine integrated services than just joint working. The evidence base however is underdeveloped for fully integrated services and any moves need to reflect experiences to date elsewhere and involve careful evaluation.



## CHAPTER 6: Misuse of drugs and alcohol in older people

Please note that in all Chapters the local comparator area cited is Oxfordshire

What the data tells us.

**Headlines:** There is an increasing quantity of information which suggests that the misuse of drugs and alcohol is an issue for older age groups. This includes those who are long term misusers of drugs and alcohol but also those who start misusing later in life, which is associated with life changes especially isolation and loneliness.

### National

- In 2007 the English Psychiatric Morbidity Survey indicated that the prevalence of drug misuse in those over aged 60 years is lower than in any other age groups. (2007).
- There are some indications that drug use in older age groups may be increasing (1993-2007).
- In 2010/11 estimates in England found there were 143,778 heroin, other opiates and crack cocaine users in the 35-64 year old age group, the oldest age group for which estimates are available; and there was been an increase in the number of users in this age group.
- Despite drinking comparatively little, older drinkers consume alcohol far more often than other age groups and the cumulative effect of this regular or frequent drinking may be problematic.
- Despite lower levels of alcohol consumption, more older people are admitted to hospital with an alcohol-related condition than younger age groups.
- Alcohol related death rates are highest among those aged 55-74 years of age.

### Cambridgeshire

- In 2014/15 to 2015/16 the Tier 3 treatment services there were around 270 clients aged 50 years or over. The majority of these were heroin users.

***Please note that this section refers to illegal drug misuse, the misuse of prescription drugs will be addressed in the relevant chapter***

## Data in detail

### The National Picture

#### *What do we know about drug and alcohol misuse in older people*

Older people (generally used in this report to describe people aged 65 years and over) form an increasing segment of the population in Cambridgeshire.<sup>177</sup>

As described in the recent JSNA chapter on primary prevention of ill health,<sup>178</sup> there are many positive health behaviours demonstrated within the population of older adults.<sup>179</sup> Nonetheless there are patterns of problematic use, and there are risk factors for substance misuse, such as major life circumstances that may be particularly pertinent for older people. Older adults are not a homogenous group, and appropriate responses require recognition of the vast range of cultural differences, preferences and perspectives on what healthy ageing means to individuals and their communities.

Data from the 2007 English Psychiatric Morbidity Survey indicates the prevalence of drug misuse in those over aged 60 years is lower than in any other age groups.<sup>180</sup> Further analysis of this study showed that, amongst those people aged 60 and over who had misused drugs in the last 12 months, drugs used were cannabis (43%), tranquilisers (40%), magic mushrooms (27%), amyl nitrate/poppers (7%) and anabolic steroids (7%).

While the use of these substances may not all be problematic, physiological changes associated with ageing mean that older people have a reduced ability to metabolise and excrete drugs, which can result in enhanced or prolonged drug effects.

And there are some indications that drug use in older age groups may be increasing; figure XY shows trend data in cannabis use:

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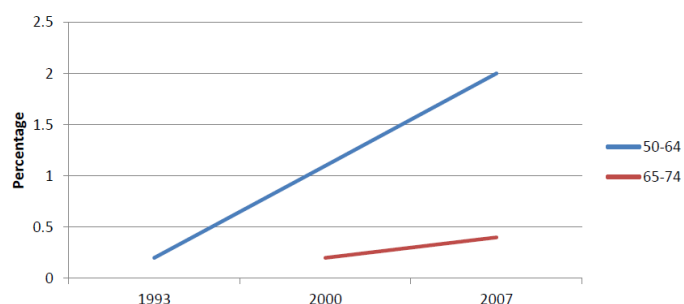
<sup>177</sup> Demographic information including population estimates and forecasts are available on Cambridgeshire Insight website at: <http://www.cambridgeshireinsight.org.uk/populationanddemographics>

<sup>178</sup> Cambridgeshire JSNA 2014 Primary Prevention of Ill Health in Older People. Available at: <http://www.cambridgeshireinsight.org.uk/primary-prevention-ill-health-older-people2014>

<sup>179</sup> GfK NOP Social Research for Public Health England (2013) Lifecourse Tracker - Wave 2 report: <https://www.gov.uk/government/publications/lifecourse-tracker-wave-2-report-final>

<sup>180</sup> English Psychiatric Morbidity Survey (2007)

**Figure 59: Trends in cannabis use in people aged 50 and over in England**



Source: Fahmy, Hatch, Hotopf and Stewart, 2012

There are no national data on the number of older people (over 65) using the most harmful illicit drugs. Estimates suggest that in England in 2010/11, there were 143,778 heroin, other opiates and crack cocaine users in the 35-64 year old age group, the oldest age group for which estimates are available; and there has been an increase in the number of users in this age group.

As described in the section on the misuse of prescription and over-the-counter medicines, chronic pain and polypharmacy are important cross-cutting themes, and particularly pertinent for older people who have more long term conditions and painful conditions which may result in the use of pain-relief medication and multiple other medications.

#### *The Cambridgeshire picture -Cambridgeshire drug treatment service*

Service data from Inclusion (local service provider) in Table? has highlighted the ageing opiate client population locally. In its Tier 3 services there were around 270 clients aged 50 years or over. The majority of these were heroin users. It should be noted that this cohort will include a proportion of long-term users who may have been involved in the Treatment Service for many years.

**Table 45: Primary substance misuse for Tier 2 and 3 drug clients aged 50 years and over, Cambridgeshire (Inclusion), 2014/15-2015/16**

Substance	2014/15		2015/16	
	Number	Percentage	Number	Percentage
Cannabis	12	4.3	11	4.1
Cocaine / crack	8	2.9	10	3.7
Heroin	210	75.5	196	73.1
Methadone	28	10.1	27	10.1
Other non-opiates	9	3.2	12	4.5
Other opiates	11	4.0	12	4.5
Total	278	100.0	268	100.0

Source: Inclusion Drug and Alcohol Treatment Service

There is a proportion of these clients aged over 50 that have dual diagnosis.

**Table 46: Tier 2 and 3 drug clients aged 50+ with a dual diagnosis, Cambridgeshire (Inclusion), 2014/15-2015/16**

Age group	2014/15			2015/16		
	All clients	Dual diagnosis		All clients	Dual diagnosis	
		Number	Percentage		Number	Percentage
50-54	177	26	14.7	172	28	16.3
55+	101	14	13.9	96	15	15.6
Total	278	40	14.4	268	43	16.0

Source: Inclusion Drug Alcohol Treatment Service

There are also people with chronic dependence staying in the service for many years, including over 15 years. The proportion in treatment for 6 or more years is 34.1%, compared with a national average of 31.3%.

The providers have also reported that some older clients don't want to access the drug and alcohol services, and may be solely managed by GPs.

### Prevention of drug and alcohol misuse in older people - considerations

At a generalised level, there is a trend that alcohol consumption declines with age. However this statement masks important details on consumption, hospital admissions, and mortality:

1. Despite drinking comparatively little, older drinkers consume alcohol far more often than other age groups and the cumulative effect of this regular or frequent drinking may be problematic.<sup>181</sup>
2. Despite lower levels of alcohol consumption, more older people are admitted to hospital with an alcohol-related condition than younger age groups.<sup>182</sup>
3. Alcohol related death rates are highest among those aged 55-74 years of age.<sup>183</sup>

Older people experience high and increasing levels of alcohol-related harm; in light of an ageing population this has an important bearing on the need for health and social care services.

One of the key explanatory factors is that due to physiological changes in later life, smaller levels of alcohol and drugs may produce greater intoxication effects in older people.<sup>184</sup>

Therefore, many researchers and commentators believe that the current description of 'misuse' is not sufficiently sensitive for the older population: "One could define alcohol misuse in the elderly as

<sup>181</sup> Demographic information including population estimates and forecasts are available on Cambridgeshire Insight website at: <http://www.cambridgeshireinsight.org.uk/populationanddemographics>

<sup>182</sup> Demographic information including population estimates and forecasts are available on Cambridgeshire Insight website at: <http://www.cambridgeshireinsight.org.uk/populationanddemographics>

<sup>183</sup> Cambridgeshire JSNA 2014 Primary Prevention of Ill Health in Older People. Available at: <http://www.cambridgeshireinsight.org.uk/primary-prevention-ill-health-older-people2014>

<sup>184</sup> Holdsworth C, Mendonca M, Frisher M, Shelton N, Pikhart H, Oliveira C De. Alcohol Consumption, Life Course Transitions and Health in Later Life. 2014;(c):1-8.

[http://www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2014/alcoholconsumption\\_laterlifepaper\\_keelee-ucl-2014.pdf](http://www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2014/alcoholconsumption_laterlifepaper_keelee-ucl-2014.pdf).

any alcohol use, not necessarily heavy use or meeting criteria for alcohol abuse or dependence, that leads to either subjective distress, discrete adverse events, or functional decline” Trevisan, 2014.<sup>185</sup>

Researchers<sup>186</sup> have described three different trajectories of problematic alcohol consumption in older people:

- Early-onset drinkers (Survivors): those who have a continuing problem with alcohol which developed in earlier life.
- Late-onset drinkers (Reactors): they begin problematic drinking later in life, often in response to traumatic life events such as the death of a loved one, loneliness, pain, insomnia, retirement, etc.
- Intermittent (Binge drinkers): they use alcohol occasionally and sometimes drink to excess which may cause them problems.

The patterns of alcohol consumption within the older population are complex with variation by gender, marital status, ethnicity, socioeconomic group.<sup>187</sup> As per the general population, there is the ‘alcohol harm paradox’ that although more affluent groups consume more alcohol, less affluent groups are more susceptible to the harms associated with alcohol consumption.

There has been little research into older people who misuse illegal drugs, the focus has been upon prescription drug, which is addressed in a later chapter. However, the pressures that older people may confront suggest that it is a complex picture again reflecting gender, marital status, partners and a range of contextual socio-economic factors. The misuse found in older people who are long term users was described in an earlier chapter and will be addressed again in the Emerging Issues chapter.

Overall there is limited published evidence on preventative measures for drug and alcohol misuse in older adults. A recent pan-European study of grey literature on initiatives to prevent the harmful effects of alcohol for older people found a lack of information on initiatives, and indications that alcohol use in older people is not perceived as a major issue for prevention.<sup>188</sup>

### **Risk factors for Substance Misuse in older people**

There are a range of life experiences that are described as risk factors for drug and alcohol misuse across the population; notably many of these circumstances may be particularly experienced in later life – such as retirement and bereavement. Researcher Sarah Wadd from the Substance Misuse and Ageing Research Team, University of Bedfordshire has described the following circumstances as potentially leading to increased use or misuse:

- Bereavement

<sup>185</sup> Quoted in ‘Problematic Substance Use in Older People’ Presentation by Sarah Wadd, University of Bedfordshire, June 2015. Available at: <http://www.beds.ac.uk/research-ref/iasr/mrc/archive/26-june-2015>

<sup>186</sup> Institute of Alcohol Studies. *Older People and Alcohol*. London; 2013.

<sup>187</sup> Holdsworth C, Mendonca M, Frisher M, Shelton N, Pikhart H, Oliveira C De. Alcohol Consumption, Life Course Transitions and Health in Later Life. 2014;(c):1-8.

[http://www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2014/alcoholconsumption\\_laterlifepaper\\_keelee-uci-2014.pdf](http://www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2014/alcoholconsumption_laterlifepaper_keelee-uci-2014.pdf).

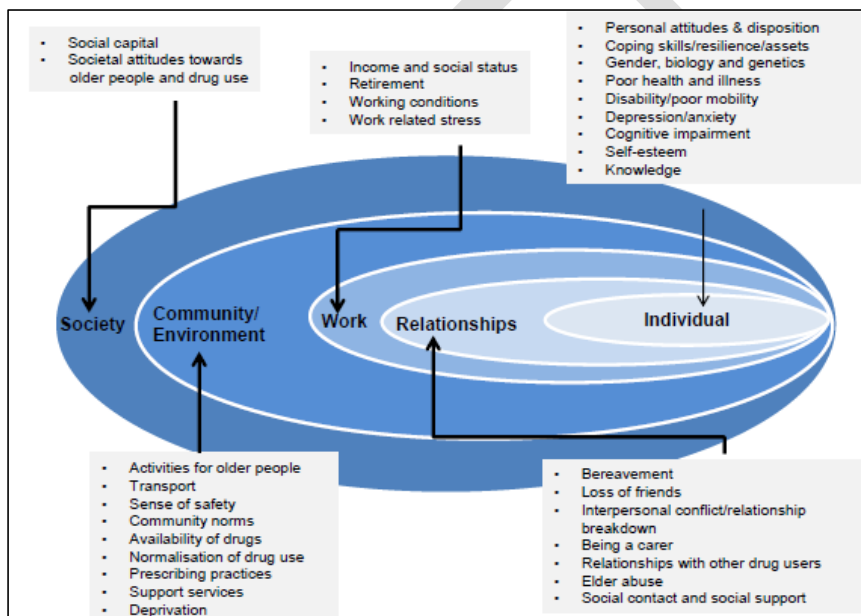
<sup>188</sup> Palacio-Vieira J, Segura L, Gual A, et al. Good practices for the prevention of alcohol harmful use amongst the elderly in Europe, the VINTAGE project. *Ann Ist Super Sanità*. 2012;48(3):248-255.

- More time and opportunity to drink
- Loneliness and boredom
- Loss of friends and social status
- Being a carer
- Chronic pain

Sociocultural issues may also have a bearing on risk, for example ethnicity or sexual orientation.<sup>189</sup>

Effective prevention strategies may need to recognise the social determinants of health and wellbeing in older people, for example the detrimental impacts of isolation and loneliness on health. These protective factors are identified in the figure below.

**Figure 60: Potential risk and protective factors for drug use in older people. Source - The Forgotten People**



<sup>189</sup> Wadd S, Galvani S. *The Forgotten People : Drug Problems in Later Life.*; 2014.

## Universal/population prevention approaches

### Education and Information

There may be gaps in knowledge about the risks of substance misuse in older people among both the general public, and health and care staff. For example, a large-scale (16,710 respondents) survey within a Big Lottery Fund study on the relationship between older adults and alcohol, found 74% respondents were unable to correctly identify the recommended drink limits. The report noted:

*“there are many stages where individuals or organisations can identify alcohol-related harm in older adults. However, we have found that these stages often lack an appreciation of the role age can have on alcohol-related harm. Government strategies and public health initiatives often focus on younger people; networks of family members, colleagues and friends who often identify problem drinking in older adults can decline in later life; both primary and acute care services often do not appreciate the relationship between alcohol-related harm and age; and treatment and service provision are often not designed with the needs of older adults in mind”.*

### Guidelines

There is a wider national question on whether guidelines on alcohol consumption for the population should be separately described for older people, an approach championed in other countries. While there are not general recommendations of lower levels in the UK, the recent CMO review of guidelines does highlight older people as a group in their advice on short term effects of alcohol: ‘some groups of people are likely to be affected more by alcohol and should be more careful of their drinking on any one occasion’.

## Selective (targeted interventions) prevention interventions

### Identification of drug and alcohol misuse in older people

There are many factors that may hinder timely and appropriate recognition of substance misuse in older people.<sup>190</sup> These can be grouped into two main groups:

1. Characteristics of the population group (older people) – often very ashamed; tend to drink at home alone; may experience problems even at low levels of alcohol use; memory can be an issue.
2. Characteristics of professionals – find it difficult to conceive that older people have alcohol/drug problems; may be reluctant to ask ‘embarrassing’ questions of older people.

One important factor is that warning signs for harmful use of alcohol and drugs may be wrongly attributed to the ageing process. Warning signs of substance misuse may include:

- Self-neglect, malnutrition, incontinence
- Recurrent accidents, injuries or falls

<sup>190</sup> Problematic Substance Use in Older People’ Presentation by Sarah Wadd, University of Bedfordshire, June 2015. Available at: <http://www.beds.ac.uk/research-ref/iasr/mrc/archive/26-june-2015>

- Cognitive decline, confusion, memory problems
- Unexpected delirium during hospitalisation
- Unstable or poorly controlled blood pressure
- Gastrointestinal problems
- Liver function abnormalities
- Tremor, poor motor coordination, shuffling gait

It is notable that some of these signs may be present in other ageing related decline. It is appropriate therefore to consider alcohol and other substance misuse in patients who repeatedly present with unexplained falls and fluctuations in physical or psychological stage.

### Screening and Diagnosis

Where potential misuse has been recognised, detailing this further can be difficult with existing screening tools or diagnostic approaches not tailored appropriately for older people. Due to limitations in the instruments for screening for alcohol problems, the use of a combination of screening methods is advised.<sup>191</sup>

The Substance Misuse working group Royal College of Psychiatrists<sup>9</sup> has highlighted difficulties in applying diagnostic criteria for substance dependence in older adults. The table below details these difficulties and draws from the criteria in the DSM-IV system which is primarily used in the US; notably there are considerable overlaps with the ICD system used in the UK and Europe.

**Table 47: Applying diagnostic criteria for substance dependence to older adults**

Criteria	Special considerations for older adults
Tolerance	Even low intake might cause problems owing to physiological changes
Withdrawal	May not develop physiological dependence
Taking larger amounts or over a longer period than was intended	Cognitive impairment can interfere with self-monitoring
Unsuccessful efforts to cut down or control use	Reduced social pressures to decrease harmful use
Increased time spent obtaining substances or recovering from effects	Negative effects can occur with relatively low use
Giving up activities because of use	Decreased activities because of comorbid psychiatric and physical disorder Social isolation and disability making detection more difficult
Continued used despite physical or psychological consequences	May not know or understand that problems are related to use, even after medical advice Failure of clinician to attribute problems to alcohol or drug misuse

<sup>191</sup> Crome I, Brown a, Dar K, Harris L, Janikiewicz S. Our Invisible Addicts: First Report of the Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists. *London R Coll Psychiatr*. 2011. <http://www.rcpsych.ac.uk/files/pdversion/CR165.pdf>.



Therefore it is acknowledged that comprehensive assessment and specialist clinical judgement are essential to effective diagnosis; guidance notes on this are provided in the Royal College of Psychiatrists information guide.<sup>192</sup>

## Treatment of drug and alcohol misuse in older people

### Alcohol

As indicated above researchers have described three different trajectories of problematic alcohol consumption in older people<sup>193</sup>:

- Early-onset drinkers (Survivors): those who have a continuing problem with alcohol which developed in earlier life.
- Late-onset drinkers (Reactors): they begin problematic drinking later in life, often in response to traumatic life events such as the death of a loved one, loneliness, pain, insomnia, retirement, etc.
- Intermittent (Binge drinkers): they use alcohol occasionally and sometimes drink to excess which may cause them problems.

There is some evidence to indicate that older people are more adherent to alcohol treatment than younger adults,<sup>194</sup> and are just as likely to benefit from it.<sup>195</sup>

Late-onset drinkers may be particularly receptive to treatment.<sup>196</sup> Even a one-time brief encounter of 15 minutes or less can reduce non-dependent problem drinking by more than 20% (US Department of Health and Human Services 1998).

However, early-onset drinkers with many years of alcohol misuse and previous experience of treatment services are not necessarily treated successfully in later life. Research by Dr Wadd at the University of Bedfordshire, has detailed the differences in early-onset and late-onset drinkers (see figure below) again highlighting a poorer treatment prognosis for early-onset i.e. chronic alcohol misuse.

<sup>192</sup> Rao RT, Crome I, Crome P, Iliffe S, Ramakrishnan A. *Substance Misuse in Older People : An Information Guide*. London; 2015.

<sup>193</sup> Institute of Alcohol Studies. *Older People and Alcohol*. London; 2013.

<sup>194</sup> Oslin DW, Pettinati H, Volpicelli JR. Alcoholism Treatment Adherence: Older Age Predicts Better Adherence and Drinking Outcomes. *Am J Geriatr Psychiatry*. 2002;10(6):740-747. doi:10.1097/00019442-200211000-00013.

<sup>195</sup> Lemke S, Moos RH. Treatment and outcomes of older patients with alcohol use disorders in community residential programs. *J Stud Alcohol*. 2003;64(2):219-226. doi:10.15288/jsa.2003.64.219.

<sup>196</sup> Menninger JA. Assessment and treatment of alcoholism and substance-related disorders in the elderly. *Bull Menninger Clin*. 2002;66(2):166-183. doi:10.1521/bumc.66.2.166.23364.

**Figure 61: Difference between late-onset and early-onset drinking in the over 50s<sup>197</sup>**

Characteristic	Early Onset	Late Onset
Alcohol consumption	Higher	Lower
Alcohol-related problems	More	Fewer and less severe
Alcohol dependence	More likely	Less likely
Binge drinking	More likely	Less likely
Social resources	Fewer	More
Psychiatric comorbidity	More likely	Less likely
Family history of alcohol problems	More likely	Less likely
Life satisfaction	Poorer	Greater
Treatment prognosis	Poorer	Better

Some researchers and practitioners contend that persisting alcohol misuse and alcoholism should be viewed as a long term health condition or chronic disease, with more sustainable models for continuing care and support over an extended period of time.<sup>198 199</sup> The proportion of early-onset drinkers, and those with chronic abuse of alcohol, are likely to need more intensive support than brief interventions.

#### *Evidence on treatment approaches*

Two questions have been identified by local stakeholders:

1. Whether there is evidence for specialist or alternative treatment services or models for the misuse of alcohol in older people?
2. Whether eligibility criteria for treatment of older people in mainstream services should be amended?

A brief scan of the literature revealed significant limitations in the evidence; it is therefore not possible to provide a comprehensive response to these questions. The findings of a review by the Substance Misuse in Older People research team at the University of Bedfordshire are described in the sections below. The review comprised a literature review and qualitative work through interviews and focus groups with both practitioners and older people service users, summarised as follows.<sup>200</sup>

<sup>197</sup> Holley-moore G, Beach B. Drink Wise, Age Well : Alcohol Use and the Over 50s in the UK. 2016. <http://drinkwiseagewell.org.uk/get-support/resources/>.

<sup>198</sup> McKay JR, Hiller-Sturmhofel S. Treating Alcoholism As a Chronic Disease. *Alcohol Res Heal*. 2011;33(4):356-370. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3625994/> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3625994/pdf/arh-33-4-356.pdf>.

<sup>199</sup> Dennis M, Scott CK. Managing addiction as a chronic condition. *Addict Sci Clin Pract*. 2007;4(1):45-55. doi:10.1151/ascp074145.

<sup>200</sup> Wadd S, Lapworth K, Sullivan M, Forrester D, Galvani S. *Working with Older Drinkers.*; 2011. [http://alcoholresearchuk.org/downloads/finalReports/FinalReport\\_0085](http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0085).

### *Provision through specialist treatment services*

Accumulating evidence suggests that these older peoples' services may be linked to better treatment outcomes and adherence than mixed-age services (Kofoed, Tolson et al. 1987; Kashner, Rodell et al. 1992; Atkinson 1995; Blow, Walton et al. 2000; Slaymaker and Owen 2008). However, in the United Kingdom, we have only been able to identify five substance misuse agencies which have an older peoples' service. Based on 2004 data on the number of alcohol services operating in England (Drummond, Oyefeso et al. 2005), this suggests that less than 1% of alcohol services in England provide a service specifically for older people.

The four specialist older peoples' alcohol services that we visited during this study were tailored to meet the needs of older people including smaller caseloads, a lengthy and comprehensive assessment process, a slower pace and extended period of treatment, the option of home visits, a high level of multi-agency working and case management, family and peer involvement and a focus on age-specific issues.

There have been no formal evaluation studies in the UK therefore it is not clear whether or not treatment outcomes for older people attending these services are better than those for mixed-age services. Some older people that we interviewed stated that the treatment that they had received in the older peoples' service was superior to treatment they had received previously in mixed-age services.

### *Provision through general treatment services*

Empirical data on what interventions work best with older people are limited but it is generally acknowledged that empirically supported treatments in adults can be successfully applied to the treatment of older people (Kalapatapu 2010).

Modifications such as slowing the pace of therapy, placing follow-up outreach calls and providing written information may improve the effectiveness of some therapies (American Psychiatric Association 2000) and interventions should focus on age-specific issues such as loss and isolation. Interventions that have been successfully used to treat alcohol problems in older people include brief interventions, family interventions, motivational counselling, cognitive behavioural approaches and group support work.

**Figure 62: Examples of interventions that have been successfully used to treat older people with alcohol problems**

Treatment	Example	Evidence of Effectiveness
Brief interventions	Project GOAL, a brief intervention consisting of two 10-15 minute counselling sessions with a doctor in a primary care setting and two follow-up scripted phone calls by clinic staff who provided advice and education (Fleming, Barry et al. 1997).	At 12-month follow-up, Project GOAL was found to yield a significant reduction in weekly alcohol use, episodes of binge drinking and frequency of excessive drinking in comparison with that of control group.
Family work	In a social work case study, Perkins and Tice (1999) describe an 80-year old widow who was an early onset drinker. The social worker worked with the family to gain insight into her drinking, why she relapsed and why she refused their help. Through a process of dialogue and collaboration, the social worker and family influenced her state of readiness to change.  In another case study, Haley, (1999) described how a multidisciplinary team consisting of a doctor, psychologist, social worker and nutritionist worked with the daughter of a 72-year-old man during his treatment for alcohol misuse and dementia. She was educated on the medical consequences of alcohol misuse, supervised his medication and dietary regimens and limited his access to alcohol.	Not evaluated.
Motivational counselling	Combined medication and motivational counselling delivered by nurse-practitioner over a 3-month period. Included a biopsychosocial evaluation, direct advice to the patient on coping with risky situations and assessment of outcomes and needs over time (Oslin, Pettinati et al. 2002).	Older people had greater medication adherence and attended more therapy sessions resulting in less relapse.
Cognitive behavioural approaches	Gerontology Alcohol Project (GAP) (Dupree and et al. 1984), a day-treatment programme for older drinkers in which both self-management techniques and cognitive behavioural therapy are used. The treatment approach emphasizes self-management, skills acquisition and social support.	At 12 month follow-up, 75% of participants in GAP maintained their drinking reduction goals and increased the size of their social support network.
Group support work.	The GET SMART programme (Schonfeld, Dupree et al. 2000), an outpatient programme for older people with substance misuse problems consisting of 16 weekly group sessions using cognitive behavioural and self-management approaches. Group sessions initially analyse substance use behavior to determine high-risk situations for substance use, followed by a series of modules teaching skills for coping with social pressure, isolation, uncomfortable feelings (such as depression, anxiety, anger and frustration), cues for substance use, urges and slips or relapses.	Of the 49 patients who completed the programme, 55% remained abstinent six months after the programme while an additional 27% were abstinent at the time of follow-up but had experienced at least one 'slip' after completing the programme. Those who completed treatment were significantly more likely to be abstinent than those who did not complete the programme.

### *Referral Criteria for Older people*

The NICE Guideline for assessment and management of harmful drinking states the need for referral criteria to be adjusted in older people:

*1.2.1.5 When assessing the severity of alcohol dependence and determining the need for assisted withdrawal, adjust the criteria for ... older people... who may have problems with the metabolism of alcohol.*

*1.3.4.6 Consider a lower threshold for inpatient or residential assisted withdrawal in vulnerable groups, for example, homeless and older people.*

### *Broader issues in providing care for older people*

As described in the section on prevention of substance misuse in older people, older people may particularly face life circumstances that increase their risk of substance misuse. A holistic approach to treatment may need to factor these circumstances. Qualitative work has been used to describe principles that allow treatment services to be more effectively tailored to older adults<sup>201</sup> such as:

- Establishing case-finding and referral system for isolated older people.

<sup>201</sup> National Institute for Health and Care Excellence. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE Clinical Guideline CG115. *Natl Collab Cent Ment Heal.* 2011.

- Focussing on age-specific issues such as grief, loneliness, boredom, retirement, and rebuilding client's social support network.
- Providing diversionary activities and social activities.
- Offering a choice of venue, including home visits, for ease of access and to offer some form of anonymity for those who fear the stigma of having a drug or alcohol problem.
- Providing longer and more frequent sessions where there are complex needs or an extensive history of drug or alcohol use.
- Providing nutritional, healthy living and safety advice (e.g. falls prevention).
- Supporting families and carers.
- Having greater linkage across health and social care systems.
- Engaging older people in planning and delivery of the service.
- An emphasis on building trust and confidence.

### Other approaches – harm reduction and brief advice

In recognition that older people may not respond to campaigns and promotional materials with the same reaction as working age adults, work for an alcohol campaign (alcohol effects) in older people identified that drinking behaviour reconsideration among over 55s might be most impacted by the idea of alcohol exacerbating any existing health conditions, with a focus particularly on stroke, localised cancer and heart disease.<sup>202</sup> This learning can be applied to Identification and Brief Advice (IBA) interventions with older people.

#### National Guidelines and policy

Key national guidelines and information on treatment of alcohol misuse has been published on behalf of the Older Persons' Substance Misuse Working Group at the Royal College of Psychiatrists including their 2015 information guide. Further standards and guidelines pertaining to older people may be found in NICE guidelines for adults. Several policy papers have been produced by organisations such as Alcohol Concern and Drugscope which highlight particular issues in regards to treatment of older people.

#### Shared care

There are no specific substance misuse services for older people locally; older adults will be included under community detox arrangements.

A national review (Healthcare Commission 2009<sup>203</sup>) identified barriers for older people in accessing general substance misuse services:

*“Even when they were theoretically available, they were either not offered in an age-appropriate way or were not available when staff attempted to refer to them. Many were geared towards younger people, usually males, and were felt not to be appropriate for older people, who could feel vulnerable in the atmosphere”.*

<sup>202</sup> Identification and Brief Advice: A recommended approach for older people. Presentation by George Ames, Forsters/DH. March 2010. Available at: <http://www.alcohollearningcentre.org.uk/Topics/Latest/Resource/?cid=5995>

<sup>203</sup> Healthcare Commission. (2009). *Equality in later life: A national study of older people's mental health services*. London.

## Drugs

There is little in the literature about treatment for older people that are not chronically dependent. Those with chronic dependence stay in the service for many years, including over 15 years. In Cambridgeshire the proportion in treatment for six or more years is 34.1%, compared with a national average of 31.3%.

For new clients local providers report that some older clients don't want to access the drug and alcohol services, and would prefer to be managed by GPs.

### Considerations for treatment

A national review (Healthcare Commission 2009<sup>204</sup>) identified barriers for older people in accessing general substance misuse services: *"Even when they were theoretically available, they were either not offered in an age-appropriate way or were not available when staff attempted to refer to them. Many were geared towards younger people, usually males, and were felt not to be appropriate for older people, who could feel vulnerable in the atmosphere."*

There is therefore a question about the definitions of success applied in management of chronic and long-term opiate dependence that applies to all age groups and discussed in an earlier chapter. Harm reduction may be particularly important for older people with a lifelong history of illicit drug misuse for whom abstinence may be an unrealistic goal (Wadd 2011<sup>205</sup>). Models may need to be adapted appropriately, for example some older people may benefit from outreach needle/syringe exchange and supervised methadone consumption in their own homes (Wadd 2011).

The ageing population of drug users has implications for social care services, with an associated requirement for home and residential care services, including for service users with complex needs, displaying challenging behaviour, and cognitive decline associated with their substance use (Wadd 2011).

This issue is addressed again in the section on Emerging and Complex Issues.

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<sup>204</sup> Healthcare Commission. (2009). *Equality in later life: A national study of older people's mental health services*. London.

<sup>205</sup> Wadd, S., & Galvani, S. (2014). *The Forgotten People : Drug Problems in Later Life*.

### What is this telling us?

- There are indications of increasing numbers of older people who misuse alcohol and drugs in Cambridgeshire, these may reflect patterns of both longer life expectancy for individuals with chronic drug and alcohol use, and changes in drinking patterns in later life.
- There is a need for a holistic approach to prevention of substance misuse in older people with join-up within and around Older Peoples' services (both statutory and third sector).
- Therefore awareness raising and education of health and care professionals may be considered as a key part of prevention approaches.
- There may be particular value in developing local strategies among clinicians in terms of identification and diagnosis for older people with substance misuse to ensure clarity in reference to national guidelines.
- While there are several possible service models for provision, evidence suggests that the heterogeneity of this client group means that treatment must be tailored to individual needs and linked to their wider social context.
- Current service models locally do not necessarily reflect a proactive approach to treatment for older people and there may be opportunities to extend awareness of alcohol misuse and treatment among wider health and care professionals to improve the identification and management of older people dependent on alcohol.
- That there is a cohort of long term drug users over the age of 50 who require ongoing support which raises the issue with the adoption of harm reduction approach. Given that older people who are late misusers may have a wide range of complex needs suggests that this group may also require a more extended period of treatment

## CHAPTER 7: Changing Patterns of Drug Misuse

In recent years there have been new patterns of drug use which illegal and illegal usage along with changing age patterns linked to harm reduction and recovery approaches.

### New Psychoactive Substances (NPS)

What is the data telling us?

**Headlines:** National concern with the increasing use of NPS has led to a change in the legislation. There have been numerous local reports of NPS misuse requiring hospital admission.

- In 2014 it was estimated that around 3,400 people aged 16-24 misused NPS in Cambridgeshire.

Based on national prevalence estimates, 3,369 people in Cambridgeshire aged 16-59 are using NPS (2.8% of the population) (Table ??). The majority of these users are aged 16-24 (63%, 2,100). 83% of NPS users had used an illicit drug in the last year.

**Table 48: Estimated numbers misusing new psychoactive substances\*, Cambridgeshire, 2014**

Local Authority	Used in the last year	
	16-24 year olds	16-59 year olds
Cambridgeshire	2,108	3,369
NN - Oxfordshire	2,334	3,568

NN - CIPFA nearest neighbour for Cambridgeshire

\* Newly available drugs that mimic the effect of drugs such as cannabis, ecstasy and powder cocaine, which may or may not be illegal to buy

Numbers estimated based on prevalence estimates for England and Wales 2014/15 applied to the mid-2014 population:

Prevalence  
16-24 year olds: 2.8%  
16-59 year olds: 0.9%

Sources: Crime Survey for England 2014/15, Office for National Statistics mid-year population estimates



## What are New Psychoactive Substances?

NPS refers to newly available drugs that mimic the effect of drugs such as cannabis, ecstasy and powder cocaine, and which may or may not be illegal to buy, but are sometimes referred to as 'legal highs'.<sup>206</sup> Those commonly in use include the following.

**Spice** - Replicates the doping effect of cannabis and comes as a smoking mix and has been known to cause paranoia, delirious ranting and hallucinations. Similar drugs go by the names black mamba and annihilation.

**Laughing gas** - Otherwise known as nitrous oxide, laughing gas comes in canisters and is used recreationally after being inhaled, often out of balloons. It gives users a light-headed, euphoric feeling that lasts for several seconds, but, due to it depriving the body of oxygen, can be fatal when taken in excess.

**Salvia** - Unlike other synthetic legal highs, salvia comes from a plant. It can still be sold but only on the proviso that it is not marketed for human consumption. When smoked or chewed, it can create a hallucinogenic experience.

**Methodrone** - The drug which also goes by the name "mcat" and "meow meow" mimics the effects of many amphetamines such as speed and ecstasy (3,4-methylenedioxy-methamphetamine (MDMA)), providing similar feelings of elation, but with a potentially deadly impact on the heart and central nervous system. It was outlawed within months and is currently a class B drug.

Concern about the number of deaths associated with the use of NPS has led to a change in the legislation. The UK Psychoactive Substances Act came into effect on the 26 May 2016 banning NPS. This legislation makes it an offence to produce, supply, offer to supply, possess with intent to supply, import or export (including over the internet) any psychoactive substances. Possession of a psychoactive substance is not an offence, except in a 'custodial institution' such as a prison or young offenders' institution. Supplying NPS to someone else, or buying them from internet sites based abroad to be delivered here, can earn a prison sentence and/or a fine. The maximum custodial sentence available in a solemn prosecution under the Psychoactive Substances Act 2016 is seven years.

Based on national prevalence estimates, 3,369 people in Cambridgeshire aged 16-59 are using NPS (2.8% of the population) (Table ?). The majority of these users are aged 16-24 (63%, 2,100). 83% of NPS users had used an illicit drug in last year.

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<sup>206</sup> Crime Survey for England 2014/15

## The misuse of prescription drugs and over the counter medication

This section will primarily focus on those who become inadvertently dependent on prescription or over-the-counter medicines, whether by self-medicating or prescribed usage all ages in the population. This is causing concern nationally and locally amongst stakeholders. There are a range of drugs and pharmaceutical agents that may be considered as ‘medicine’:

- Prescription-only medicines (POMs) are pharmaceutical treatments that must be prescribed by a suitably qualified healthcare professional and are not available for sale to the general public.
- Over-the-counter medicines (OTCs) or ‘general sales medicines’ are available for sale directly to consumers.
- ‘Pharmacy only medicines’ are available for purchase in the UK under the supervision of a pharmacist.

(NB Independent prescribers include doctors, dentists, nurse prescribers, pharmacists and optometrists. Some other healthcare staff may be supplementary prescribers within their competence, working within a clinical management plan agreed with the independent prescribers.)

The broadest definition of misuse in this context is the use of medications for other purposes or ways than prescribed or intended. This includes taking someone else’s prescription medications, increasing the dose of prescribed medications without a doctor’s consent, and the use of medications as an alternative to illegal drugs.

The National Treatment Agency (now part of Public Health England) identified and described three distinct but overlapping populations who experience problems with medicines<sup>1</sup>:

- *Those who overuse medicines to cope with genuine or perceived physical or psychological symptoms.*
- *Those for whom the prescribed use of a medicine inadvertently led to dependence, sometimes called involuntary or iatrogenic addiction.*
- *Those who use medicines as a supplement or alternative to illicit drugs or as a commodity to sell.*

**Figure 63: Alternative descriptions of sub-populations who experience problems with medicines**

People who entirely inadvertently became dependent on prescribed medicines	Damaged people who were always liable to become dependent on something as a way of coping with their problems	People who prefer illicit drugs but will top-up/substitute with medicines when they have to
	People who self-medicate but get into problems	People who start on prescription or OTC drugs because they’re available/legal

Source: presentation by Steve Taylor, May 2014, Public Health England.

## What the data tells us.

**Headlines:** There is limited intelligence about the misuse of medicines that reflects the scale of the problem, different and changing prescribing practices, misuse may not be recorded in patient records and the information excludes GP data. However there are indications at national and local level that a substantial number of people are involved on misusing medicines.

### National picture

- In 2012 national reports found
  - An increase in opioid prescribing.
  - Around 12% of patients in drug and alcohol services reporting misuse of OTCs and POMs.
  - Around 2% of adults in drug and alcohol treatment services specifically for the misuse of medicines.
  - Around 12% of adults in drug and alcohol treatment services reporting misuse of OTCs and POMs.
- In 2016 a cross sectional study in the UK reported a life time prevalence of OTC drug misuse to be around 19% and of abuse 4.1%, lifetime dependence prevalence was 2%, around 1% currently dependent and 1.3% dependent in the past.

### Cambridgeshire picture

- In 2014 based on national prevalence estimates 20, 212 people aged 16-59 misused prescription only painkillers, 5.4% of the population.
- 27% were aged 16-24.

## National position

There are important limitations in the available intelligence to describe the population dependency on POMs and OTCs nationally or locally. Pertinent challenges in estimating the scale of the problem include:

- The long list of medicines that can be problematic, and the scale of work required to consider these – initial analysis to explore whether local hospital admissions data would be informative for this JSNA identified at least 28 different ICD-10 codes that align with the commonly misused medicines in the Public Health England commissioning guide, and it would not be possible to distinguish if the admission were related to the medication.

- Even a specific focus on opioids, benzodiazepines and z-drugs recognises that these are broad groups of medicines, indicated for a wide range of conditions.
- Both the prevalence and the treatment approaches for associated illnesses and disorders are not static within the population; distinguishing changes in prescribing practice alone is insufficient to designate an increase in problematic use.
- The impacts of any dependence on medications, may not result in increased health service usage, or be reflected in medical records.

In 2011 the Department of Health commissioned two reports<sup>207 208</sup> to understand the extent of the problem in the population. They reviewed available evidence and described the limitations in the data, noting that:-

Prescribing data shows:

- An increase in the number of opioid prescriptions in England (more than doubled 2004-2012).
- A slight decrease in the number of prescriptions for hypnotics and anxiolytics.

Treatment data (NDTMS<sup>209</sup>) shows:

- About 12% of adults in drug treatment services reporting misuse of OTCs and POMs.
  - Only about 2% of adults in treatment services are specifically for misuse of OTCs and POMs
- These reports may underestimate the scale of the problem and the access to support that is available for people with misuse of POMs and OTCs. This is partially due to the limitations of the data sources, for example GP data does not contribute to the estimates.

More recently a report authored by the Substance Misuse team at the University of Bedfordshire cited a range of international primary studies that would indicate a sizeable scale of misuse of prescription medication particularly among older people including:

- A UK-based study finding 40% of primary care patients (60+) who had been on low dose opioid analgesics for a year, fulfilled World Health Organisation criteria for dependence.
- A study of 'chronic users' of benzodiazepines or z-drugs aged 65 and over in France found that 35% showed signs of dependence.
- A study of 50-59 year olds in the United States found that 20% had started using prescription drugs non-medically after the age of 40; another study estimated that 11% of women aged 60 years and over misuse prescription medicines each year.<sup>210</sup>

<sup>207</sup> Reed K, Bond A, Witton J, Hickman M, Strang J. *The Changing Use of Prescribed Benzodiazepines and Z-Drugs and of over-the-Counter Codeine-Containing Products in England*; 2011. [www.appgita.com/wp/...Report-1-NAC-benz-and-drug-addiction.pdf](http://www.appgita.com/wp/...Report-1-NAC-benz-and-drug-addiction.pdf).

<sup>208</sup> NHS National Treatment Agency for Substance Misuse. *Addiction to Medicine*. Vol 0. London; 2011. <http://www.nta.nhs.uk/uploads/addictiontomedicinesmay2011a.pdf>.

<sup>209</sup> National Drug Treatment Monitoring System

<sup>210</sup> Wadd S, Galvani S. *The Forgotten People : Drug Problems in Later Life*; 2014.

A small scale (n= 411) cross-sectional survey in the UK on non-prescription medicines (OTCs) found a life-time prevalence of misuse at 19.3% and of abuse at 4.1%. In terms of dependence, lifetime prevalence was 2% with 0.8% currently dependent and 1.3% dependent in the past. Dependence was reported with analgesics (with and without codeine), sleep aids and nicotine products.<sup>211</sup>

(Definitions applied in the study: 'Misuse' - use for a legitimate medical purpose, but in an incorrect manner, e.g. in terms of dosage or duration of use; 'Abuse' - use for a non-medical purpose, e.g. to achieve mind-altering effects or weight loss; 'Dependence' - repeated use in which the person has a need or desire to use the non-prescription medicine and has difficulty in voluntarily stopping or altering their use.)

National (and international) evidence is therefore indicative of a POM and OTC medicine.

## The Cambridgeshire picture

Based on national prevalence estimates, 20,212 people in Cambridgeshire aged 16-59 are misusing prescription only painkillers (5.4% of the population) (Table ?). 27% were young adults aged 16-24 (7.2% of the population). 25% of those misusing prescription only painkillers reported using an illicit drug in the last year.

**Table 49: Estimated numbers misusing prescription only painkillers\*, Cambridgeshire, 2014**

Local Authority	Used in the last year	
	16-24 year olds	16-59 year olds
Cambridgeshire	5,420	20,212
NN - Oxfordshire	6,003	21,406

NN - ClIFFA nearest neighbour for Cambridgeshire

\* The survey question on painkillers asked respondents whether they had taken prescription-only painkillers not prescribed to them, which they took only for the feeling or experience it gave them.

Numbers estimated based on prevalence estimates for England and Wales 2014/15 applied to the mid-2014 population:

Prevalence  
16-24 year olds: 7.2%  
25-59 year olds: 5.4%

Sources: Crime Survey for England 2014/15, Office for National Statistics mid-year population estimates

Applying the local NDTMS data from adults in treatment services,<sup>212</sup> indicates local levels of those citing POM/OTC use for Cambridgeshire that are very slightly lower in proportion than the current national metrics:

The percentage of clients in treatment citing POM-OTC use in Cambridgeshire is slightly lower than the average for England (14% v. 16%) (Table ??).

<sup>211</sup> Fingleton NA, Watson MC, Duncan EM, Matheson C. Non-prescription medicine misuse, abuse and dependence: a cross-sectional survey of the UK general population. J Public Health (Bangkok). 2016;1-9. doi:10.1093/pubmed/fdv204.

<sup>212</sup> Public Health England. Drug data: JSNA support pack. Key data to support planning for effective drugs prevention, treatment and recovery in 2016-17, Cambridgeshire. 2016.

**Table 50: Numbers in drug treatment for prescription-only medicines (POM) and over-the-counter medicine (OTC) misuse, Cambridgeshire, 2014/15**

With illicit drug use	Cambridgeshire		England	
	Number	Percentage of those in treatment	Number	Percentage of those in treatment
Yes	181	12	26,266	13
No	35	2	6,173	3
Total	216	14	32,439	16

Source: Public Health England. Drug data: JSNA support pack. Key data to support planning for effective drugs prevention, treatment and recovery in 2016-17, Cambridgeshire. 2016.

In Cambridgeshire local prescribing data is monitored by the Medicines Management Team at Cambridgeshire and Peterborough Clinical Commissioning Group.

The rate of prescribing (overall volume) is tracked, and allows comparison of volumes of prescribed medicine between local practices and with other areas and national figures across time. However it is not possible to determine to individual patient level, nor adjust for local disease patterns.

Similarly to the national picture, there is a lack of clarity on the scale of the problem locally, and much of the evidence is anecdotal and qualitative in nature, but indicative of the presence of dependence on prescribed medicines within the local population.

## Which Drugs

The medicines that are most commonly misused leading to some form of dependence in the UK are:<sup>213</sup>

- Opioids used to treat pain.
- Sedatives (or hypnotics) and anti-anxiety medications (including benzodiazepines and Z-drugs).
- Stimulants such as methylphenidate used to treat attention deficit hyperactivity disorder (ADHD) and sleep disorders.
- Anticonvulsants and mood stabilising drugs.

A more comprehensive list of is available in the PUBLIC HEALTH ENGLAND guide on commissioning treatment for dependence on prescription and over-the-counter medicines.<sup>214</sup>

<sup>213</sup> Public Health England 2013 Commissioning treatment for dependence on prescription and over the counter medicines: a guide for NHS and local authority commissioners.

<sup>214</sup> Royal College of General Practitioners 2013 RCGP Substance Misuse and Associated Health prescription and over the counter medicines misuse

## Risk factors

A number of factors are associated with an increased risk of problematic use of prescription and over-the-counter medicines:

- Personal or family history of substance abuse.
- Age 16-45 years.
- Older people with complex physical and psychological needs complicated by pain.
- History of pre-adolescent sexual abuse.
- Certain psychological diseases (ADHD, obsessive-compulsive disorder, bipolar disorder, schizophrenia, depression).
- Exposure to peer pressure or a social environment where there is drug abuse.
- Easier access to prescription drugs, such as working in a healthcare setting.
- Lack of knowledge or understanding about POMs or OTC drugs by the prescriber.

The vast breadth of the risk factors for problematic use listed above is indicative of several different patterns of misuse among population groups – as described above there are a variety of sub-populations who misuse POM or OTC medicines.

The 2014/15 Crime Survey for England and Wales explored the misuse of prescription-only painkiller misuse.<sup>215</sup> Of note the survey only sampled adults aged 16-59 years; the question asked respondents whether they had taken prescription-only painkillers not prescribed to them finding:

- While the misuse of prescription-only painkillers declined overall with age, higher levels of use of prescription-only painkillers relative to illicit drugs were seen in some older age groups; for example 4.5% of 45-54 year olds reported having misused prescription-only painkillers in the last year, compared with 3.2% who reported having used illicit drugs.
- People with a long-standing illness or disability were more likely to have misused prescription-only painkillers (8.5% compared to 4.8% without an illness) and to have used an illicit drug in the last year (11.9% compared with 8.1% without an illness). Cannabis use was a large contributor to these proportions.
- Data on personal and household factors suggests that the misuse of prescription painkillers is distributed more evenly across the general population than the use of illicit drugs.

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<sup>215</sup> Home Office. Drug misuse: findings from the 2014/15 Crime Survey for England and Wales. 2015.

## Cross cutting themes

The use of POM and OTC medicines is associated with important population health issues:

### *1. Self-harm – poisoning or overdosing*

Prescription drugs and OTC medication may be used in poisoning and overdosing incidents, particularly in the home environment.

Analysis of recent hospital admissions data on children and young people in Cambridgeshire and Peterborough, 2015, found:

- Self-poisoning by, and exposure to, nonopioid analgesics, antipyretics and antirheumatics are the main reason for hospital admissions for self-harm in children and young people.
- The majority of self-harm incidents occur at home.

### *2. Chronic pain*

Chronic pain was identified as a key characteristic of increased risk of poor health outcomes for those living with Long Term Conditions in recent JSNA work<sup>216</sup>. Estimates for the prevalence of chronic pain in the whole population typically range between 10% and 30%<sup>9</sup> and there are several important demographic patterns.<sup>217</sup>

1. Chronic pain increases with age.
2. Chronic pain is reported more prevalent in women.
3. Chronic pain is more commonly reported by those from socially or financially disadvantaged groups.
4. Chronic pain is most prevalent in patients with other chronic diseases.
5. Chronic pain can be considered as a very common and costly chronic disease in its own right.

Many of the opioid-related agents used in managing chronic pain, are those found to be commonly misused. Further guidance on pain management is available, for example a consensus statement from the British Pain Society on the use of opioids for persistent pain highlights adverse effects and offers important cautions and prescribing notes.<sup>218</sup>

<sup>216</sup> Cambridgeshire JSNA (2015) Long Term Conditions across the Lifecourse. Available at:

<http://www.cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecycle-2015>

<sup>217</sup> Reid KJ, Harker J, Bala MM, et al. Epidemiology of chronic non-cancer pain in Europe: narrative review of prevalence, pain treatments and pain impact. *Curr Med Res Opin.* 2011;27(2):449-462. doi:10.1185/03007995.2010.545813.

<sup>218</sup> Stannard C. Opioids for persistent pain: Good practice. 2010;(June):1-36.



### 3. Polypharmacy and medicines optimisation

Polypharmacy is the use of multiple medicines; data from the Health and Social Care Information Centre shows that the average number of prescription items per year for any one person in England increased from 13 (in 2003) to 19 (in 2013). Important drivers for polypharmacy include the number of people living with multiple conditions, and the number of older people in the population, with an upward trend nationally and locally due to increasing life expectancy.



A 2013 report by the King's Fund<sup>219</sup> uses the following definitions:

**Appropriate polypharmacy** is prescribing for an individual for complex conditions or for multiple conditions in circumstances where medicines use has been optimised and the medicines are prescribed according to best evidence.

**Problematic polypharmacy** is where multiple medications are prescribed inappropriately, or where the intended benefit of the medication is not realised. The reasons why prescribing may be problematic may be that the treatments are not evidence-based, or the risk of harm from treatments is likely to outweigh benefit, or where one or more of the following apply:

- The drug combination is hazardous because of interactions.
- The overall demands of medicine-taking, or 'pill burden', are unacceptable to the patient.
- These demands make it difficult to achieve clinically useful medication adherence (reducing the 'pill burden' to the most essential medicines is likely to be more beneficial).
- Medicines are being prescribed to treat the side effects of other medicines where alternative solutions are available. This reduces the number of medicines prescribed.

Medicines optimisation is a priority in addressing polypharmacy, and may be defined as 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines'. Further resources and publications such as from the Royal Pharmaceutical Society, and NHS England, are available with more detailed guidance to support clinicians and prescribers in their role in optimising medicines.

<sup>219</sup>Reed K, Bond A, Witton J, et al. Polypharmacy and medicines optimisation Making it safe and sound. Kings Fund. 2013;3(June):372-387. doi:10.1136/bmjopen-2013-002913.

## Evidence for interventions to address the misuse of medicines

### Prevention and prescribing and approaches

It is recognised that there is significant variation in prescribing practice for many potentially problematic medicines. A qualitative systematic review of eight studies to explore clinicians' experiences and perceptions of primary care benzodiazepine prescribing identified a range of factors to support the author's conclusion that 'benzodiazepine prescribing decisions in primary care are complex, demanding and uncomfortable'.<sup>220</sup>

Another qualitative systematic review of 21 studies<sup>221</sup> on prescriber practices in relation to minimising potentially inappropriate medications identified broad enablers and barriers within four analytical themes: problem awareness; inertia; self-efficacy in regard to personal ability to alter prescribing; and feasibility of altering prescribing in routine care environments given external constraints.

The difficulties in addressing the misuse of medicines are not limited to primary care, with pharmacists also implicated in tackling drug-seeking behaviour. A recent Delphi-type study with a panel of pharmacists and health care professionals in Australia<sup>222</sup> identified the following strategies as effective and most likely to have an impact on the misuse of non-prescription combination analgesics containing codeine in a community pharmacy setting:

- Utilisation of a national real-time database to monitor product sales to aid identification of at-risk people.
- Development of a referral pathway for management of people whom pharmacists have identified as at-risk.
- training to improve pharmacist communication with people

Other findings from similar studies with pharmacists in regards to OTC misuse have identified practical strategies such as removing products from sight, claiming products were not in stock, alerting or counselling customers to the abuse potential of products, refusing sales, suggesting customers contact their doctor, and supplying only limited amounts. Raising awareness was recognised as being necessary amongst both the public and health care professionals such as doctors.<sup>223</sup>

<sup>220</sup> Sirdifield C, Anthierens S, Creupelandt H, Chipchase SY, Christiaens T, Siriwardena AN. General practitioners' experiences and perceptions of benzodiazepine prescribing: systematic review and meta-synthesis. *BMC Fam Pract.* 2013;14(191). doi:10.1186/1471-2296-14-191.

<sup>221</sup> Anderson K, Stowasser D, Freeman C, Scott I. Prescriber barriers and enablers to minimising potentially inappropriate medications in adults: a systematic review and thematic synthesis. *BMJ Open.* 2014;4(12):e006544. doi:10.1136/bmjopen-2014-006544.

<sup>222</sup> Gibbins AK, Wood PJ, Spark MJ. Managing inappropriate use of non-prescription combination analgesics containing codeine: A modified Delphi study. *Res Soc Adm Pharm.* May 2016. doi:10.1016/j.sapharm.2016.02.015

<sup>223</sup> Cooper RJ. Over-the-counter medicine abuse - a review of the literature. *J Subst Use.* 2013;18(2):82-107. doi:10.3109/14659891.2011.615002.

## Clinical management approaches

A literature search for service models or pathways for the management of dependence on POM/OTCs yielded few returns. Overall, the primary research evidence is focussed more narrowly on specific drugs or drug groups, and particular target populations; it has not proved possible to identify approaches that could clearly apply across the full range of POM/OTCs misuse in the population. As there is more detailed evidence available on the treatment of harmful use of benzodiazepines, this is presented to exemplify effective approaches for medicines misuse.

### *Managing withdrawal from benzodiazepines in primary care*

The 2013 CMO report<sup>224</sup> notes that a stepped-care approach to benzodiazepine discontinuation in primary care is recommended, with hospital-based discontinuation as a last resort, and cites evidence showing that:

- Three major intervention approaches are effective – education, audit and feedback.
- Tapering over weeks or even months should be instituted.
- Similar regimens are effective in the elderly.
- Minimal interventions are often surprisingly cheap and effective

In addressing needs in severely dependent patients, the report highlights the ‘exemplary comprehensive advice to GPs on prescribing and withdrawing benzodiazepines and Z-drugs’ in Northern Ireland. It notes the strong preference by patients’ advocacy groups for a national tranquilliser treatment agency separate to existing addiction treatment centres.

### *Psychosocial interventions for harmful use of benzodiazepines*

A Cochrane review<sup>225</sup> updated in 2015 considered research trial evidence on psychosocial interventions for benzodiazepine harmful use, abuse or dependence. 25 studies (randomised-controlled trials) including 1666 people were analysed. The main findings on the interventions to reduce benzodiazepine use were that:

- Cognitive behavioural therapy plus taper is effective over three months in reducing use, though this is not sustained to six months and beyond.
- There is insufficient evidence to support motivational interviewing.
- Emerging evidence suggests that a tailored GP letter, a standardised interview, and relaxation approaches could be more effective than generic or ‘treatment as usual’ approaches.

## Drug and alcohol treatment service approaches

Data from the local treatment services shows treatment of OTC and POM misuse has a higher rate of success when the misuse did not involve the use of illegal drugs. This requires further analysis in terms of treatment options.

<sup>224</sup> Davies S. Annual Report of the Chief Medical Officer 2013. 2013.

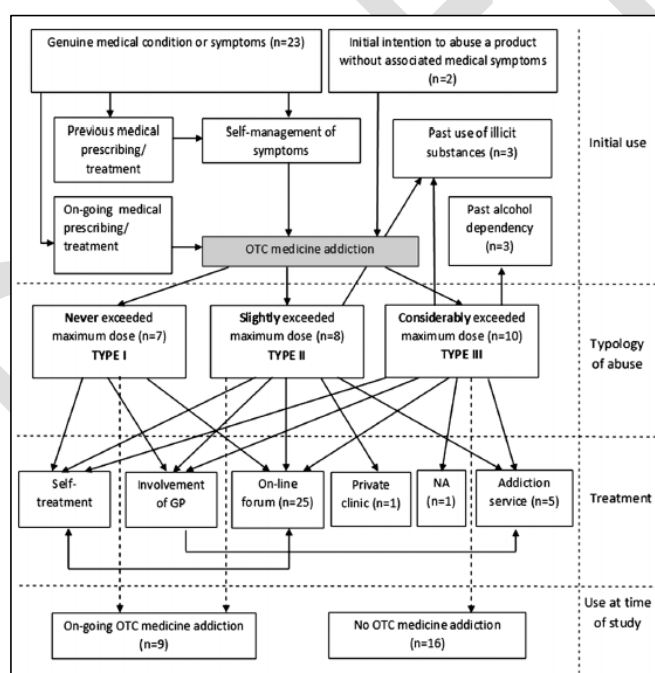
<sup>225</sup> Darker CD, Sweeney BP, Barry JM, Farrell MF, Donnelly-Swift E. Psychosocial interventions for benzodiazepine harmful use, abuse or dependence. Cochrane Database Syst Rev. 2012;(2). doi:10.1002/14651858.CD009652

- There is a higher success rate for those who reported problems with POM/OTC medicines (49.7% successfully completing treatment), compared with the wider treatment population (38.5% successfully completing treatment).
- There are poorer outcomes for those who report problems in relation to both POM/OTC medicines and illegal drugs (29.4% successful completion), which is likely to reflect the increased complexity of needs.

### Further Treatment approaches (OTCs)

A qualitative study<sup>226</sup> of people dependent on OTC medicines (majority codeine, some decongestant and sedative antihistamine abuse) found three distinct groupings of participants associated with the quantities of medicines taken (see figure XY). A range of treatment approaches were implicated, perhaps most notably that all participants (with varying levels of participation) had accessed at least one of the online support groups – Overcount and Codeinefree - particularly in attempts to self-treat.

**Figure 64: Initial use, typology and treatment of OTC dependence in a qualitative study of 25 patients<sup>16</sup>**



<sup>226</sup> Cooper RJ. Over-the-counter medicine abuse - a review of the literature. J Subst Use. 2013;18(2):82-107. doi:10.3109/14659891.2011.615002.

## National policy and guidelines

### *Guidance for practitioners*

The Substance Misuse and Associated Health unit at the Royal College of General Practitioners (RCGP)<sup>227</sup> has issued a series of factsheets on prescription and over-the-counter medicines misuse and dependence, targeted at primary and community care practitioners. The content is briefly summarised below.

#### *Prevention*

- The following preventative steps are described:
  - Education for prescribers and dispensers, including on risk factors and identifying signs of misuse.
  - Appropriate prescribing – as part of a management plan, and following guidelines where available.
  - Monitoring of treatment, including regular medication reviews.
  - Discussions with patients on goals and expectations for their pharmacotherapy.

#### *Identification*

- There are a range of non-specific signs and specific signs that a patient may be misusing their medication.
- Early interventions are important so that misuse is addressed before more serious problems develop; template phrasing is provided to initiate difficult conversations.
- One of the key challenges is distinguishing drug misuse from inadequate symptom control, particularly in individuals taking analgesics – careful review is required by generalists, and referral to specialists where clinically indicated.<sup>228</sup>

#### *Treatment*

- Patients with problem use of POMs or OTCs can be safely and effectively managed by their GP, perhaps in conjunction with specialist services using a shared-care approach.
- Patients who misuse medicines often prefer to be managed in primary care.
- A shared-care approach involves the GP working closely with a knowledgeable worker in substance misuse, with the patient fully involved in the care plan.
- A full multidisciplinary team approach is warranted if the patient has significant physical health, mental health and/or social needs and a number of agencies are involved.
- The treatment approach will vary according to the drugs the patient is misusing.
- Further information is provided on treating patients who misuse POM/OTC opioids, or POM benzodiazepines, or POM stimulants.

<sup>227</sup> Factsheets 1-4. Endorsed by royal pharmaceutical society, PUBLIC HEALTH ENGLAND and SMMGP <sup>2,2,2</sup>

<sup>228</sup> A newly published resource 'Opioids Aware' [Public Health England and the Faculty of Pain Management] <http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware> introduces a ceiling dose for morphine (and equivalence of morphine) of 120mg total daily dose, and insists doses should not be increased without specialist input

### *Guidance for Commissioners*

Public Health England has published guidance for Commissioners, summarised here:

#### **Commissioning treatment for dependence on prescription and over-the-counter medicines: a guide for NHS and local authority commissioners.**

Primary care will be the first line setting for responding to local need, noting that:

- Primary care practices can be expected to respond to dependence problems as part of regular routine care.
- Patients and their GPs may be unaware of a problem with prescription or OTC medicine.
- Addiction to Medicines (ATM) outreach services can help to identify problems and link patients to appropriate treatment.
- Specialist responses can support and advise GPs.

Specialist responses will usually be commissioned as part of the local drug and alcohol misuse treatment system, from one or more of the alternatives:

- Primary care as an enhanced service.
- A provider of integrated treatment services.
- A specific ATM provider.

Voluntary sector responses may form part of the local response ranging from informal support groups to full service organisations; contracts with the VCO sector should honour 'the compact'.

Overall, providing coordinated and integrated responses to patients will require strong partnership work between pain management, mental health, and drug and alcohol treatment services.

### *Government policy*

The Select Committee report on psychoactive substances and prescription drugs,<sup>229</sup> identified the following key recommendations:

- We recommend that the Royal College of General Practitioners produce guidance for GPs who are treating addiction to prescription drugs stating that all cases ought to be recorded on the National Drug Treatment Monitoring System (NDTMS) in order to further clarify the prevalence of prescription drug misuse.
- We recommend that medical practices start an anonymous data collection of those patients who have been proven to be, or a medical professional has reasonable suspicion of being, addicted to prescription drugs and how they are being supplied.

<sup>229</sup> House of Commons Home Affairs Committee. Drugs : new psychoactive substances and prescription drugs. Twelfth Report of Session 2013-14. 2013;HC819 (December).

A Command Paper response from central government<sup>230</sup> did not accept all the recommendations, particularly in regards to the recording and collation of data, but highlighted the steps that are being taken to address the misuse of prescription drugs including:

- The Medicines and Healthcare Products Regulatory Agency published a learning module on benzodiazepines in April 2013.
- Public Health England published a commissioning guide for addiction to medicine services in June 2013.
- The Centre for Pharmacy Postgraduate Education published a learning module for pharmacists and others in August 2013.
- The National Institute for Health and Care Excellence includes among its Clinical Knowledge Summaries advice on benzodiazepine and z-drug withdrawal.
- The Royal College of General Practitioners and Substance Misuse Management in general practice continues to run training for GPs on addiction to medicine and how to support patients to withdraw from long-term use.

### Cambridgeshire picture: Local services

#### *Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Medicines Management Team*

The Medicines Management Team works to ensure that the CCG optimises medicines usage, to improve patient outcomes, and demonstrate value for money from prescribing in all the services the CCG provides or commissions on behalf of patients. The objectives of the service are to:

- Ensure a strong clinical focus to medicines management and ensure evidence based prescribing is used to improve patient outcomes.
- Ensure meaningful engagement with prescribers, patients, carers and their communities.
- Promote cost effective and value for money prescribing.
- Deliver clinical and financial governance around medicines as well as supporting the CCG in meeting its statutory and regulatory responsibilities relating to medicines.
- Collaborate with other CCGs, local authorities and NHS England on medicines management.
- Work in accordance with an agreed service level agreement with the NHS England Controlled Drugs Accountable Officer for Midlands and East and attendance at Local Intelligence Network for Controlled Drugs.
- Provide local and strategic leadership and management supporting the delivery of safe, evidence based and cost-effective prescribing.

The Medicines Management Team produce and disseminate regular newsletters to prescribers and community pharmacists to raise awareness of key issues and concerns, and draw attention to the sources of evidence, resources and support available. Much of the prescribing analysis is dependent

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<sup>230</sup> Government. Drugs : New Psychoactive Substances and Prescription Drugs : New Psychoactive Substances and Prescription. The Government Response to the Twelfth Report from the Home Affairs Committee Session 2013-14 HC 819.; 2014

on the data and tools available and is at an overview level in identifying local and regional variation. It is notable that many of the medicines implicated in POM and OTC misuse are in routine use for multiple indications. However, audits may be conducted for specific medicines of interest where feasible and capacity allows, and high volume usage or non-standardised quantities prescribed are highlighted to individual practices or prescribers. Three recent areas of analytic work are highlighted here:

#### 1. Pregabalin and Gabapentin

Medicines Management have proactively highlighted to prescribers concerns about abuse of pregabalin and gabapentin, as well as opioid medication thorough newsletters which are distributed to general practice, community pharmacy and acute trusts pharmacy department. There has been a recent recommendation to reclassify pregabalin and gabapentin to Schedule 3 controlled drugs by the Advisory Committee on the Misuse of Drugs.<sup>231</sup>

#### 2. Fentanyl

Practices with higher than average costs related to immediate use fentanyl products were audited to determine if prescribing practice was outside of guidelines. This identified that approximately 50% of the total expenditure on fentanyl immediate release preparations across the CCG related to five patients. While treatment in those patients had, in the main, been provided initially for clear clinical reasons, this was not always in line with licensed indications, doses had subsequently escalated, and ongoing treatment now required review. However, due to the complex nature of the underlying conditions GPs reported concerns about how to make changes.

#### 3. Benzodiazepines

Within one Local Commissioning Group area, where prescribing of benzodiazepines is higher than average, work has been undertaken directly by a member of the medicines management team to support patients to reduce doses and/or stop treatment. To date (April 2016) 121 patient records have been reviewed following a standard operating procedure (SOP) from a practice list size of 11,884. The SOP excluded interventions to patients currently receiving treatment from mental health services or substance misuse services (24 patients).

The SOP identifies patients who have benzodiazepines and/or z-drugs on repeat, enabling the patient to order supply. Of those 121 records, no appropriate prescribing was noted (i.e. short course maximum four weeks). 27 patients were prescribed and ordering more than one benzodiazepine/z-drug. Recommendations were made to the GP to approve standard dose reduction (letter and proposed reduction schedule, leaflet regarding withdrawal, good sleep guide and/or good relaxation guide) for 67 patients. 46 prescriptions have been dose reduced or stopped. Patients started on long term prescriptions recently, including since November 2015 when work began; and prescribers content that patients have consented to the risks of long term treatment when review of notes suggests potential addiction, are causes for concern and suggest ongoing need for prescriber education.

<sup>231</sup> See [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/491854/ACMD\\_Advice\\_-\\_Pregabalin\\_and\\_gabapentin.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491854/ACMD_Advice_-_Pregabalin_and_gabapentin.pdf); [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/385791/PUBLIC\\_HEALTH\\_ENGLAND-NHS\\_England\\_pregabalin\\_and\\_gabapentin\\_advice\\_Dec\\_2014.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PUBLIC_HEALTH_ENGLAND-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf)



### *Identification and Management*

There is an opportunistic rather than systematic approach to identification of dependence on POMs and OTCs across Cambridgeshire. It is not clear how far primary care clinicians are proactive in identifying issues to misuse and dependence, there is no specialist service to support primary care in management of the misuse locally.

Anecdotal reports suggest that community pharmacists may log requests and concerns in regards to dependence on medicine, and may contact the patient's GP, with a range of responses and actions. The local provider of drug and alcohol treatment services for Cambridgeshire has a remit for support to primary care though not specifically around addiction to medicines.

### *Training and awareness*

There are some national training resources available for prescribers and dispensers including a Centre for Pharmacy Postgraduate Education (CPPE) e-learning module for community pharmacists and The Royal College of General Practitioners' (RCGP) training for prescribers.<sup>232</sup> The Local Pharmaceutical Committee promotes these and other opportunities in ensuring a skilled pharmacy workforce; RCGP tools are highlighted to prescribers by the Medicines Management Team. Specific pieces of work by the Medicines Management Team may increase awareness of prescribing patterns among primary care. Medication use reviews remain a key area of focus in managing patients with long term conditions.

## **What is this telling us?**

- The scale of the problem of misuse or dependence on medicines in Cambridgeshire is unknown, although estimated to be in line with national trends, there are indications that it is a concern.
- Problematic use of medicines is likely to be dispersed across the population, although there are important links with the management of chronic pain and polypharmacy, where targeted approaches may be appropriate.
- There is evidence for a range of interventions including approaches in primary care and pharmacies. National guidelines and resources exist for both practitioners and commissioners, and there may be advantages in raising awareness of these and other related resources.
- There is currently no structured pathway or care approach locally for identifying and managing POM/OTC misuse in identification and management. There may be opportunities therefore to strengthen the support available for prescribers and dispensers.

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<sup>232</sup> RCGP training for prescribers available at: <https://www.cppe.ac.uk/programmes/l/addict-e-01/>.

## What is this telling us? Changing patterns of drug misuse

The changes in drug use present challenges for prevention and treatment services.

- The changes that are occurring with drug misuse reflect the availability of NPS and prescription drugs. In terms of prevention this is calling for more information about these drugs and their potential harms, especially with high risk groups. However, professionals working in front-line services require information about the risks of these drugs and where help can be obtained.
- The age profile of clients using drug treatment services is important as they are more at risk of physical ill health as part of the aging process. Also there is substantial proportion of clients who are older who are long term users of drug treatment services and who have complex drug use patterns. They have not achieved a full recovery and their drug use is in effect a long term condition that involves complex drug use, social, mental and physical health needs.
- The implication for treatment of these long term patients is that the approach is managed through the adoption of harm reduction approaches to mitigate the impact of the complexities of their drug use and wider aspects of their lives. Also currently the mandatory data reporting system for drug and alcohol services (NDTMS) does not differentiate this cohort and this reflects on various indicators routinely reported.
- These figures are not dramatically different from national ones and the comparator area but the numbers indicate that there is a substantial cohort of patients who require more information and a different treatment approach.

## CHAPTER 8: Emerging Issues

### Complex patients

There has been concern expressed locally and nationally about the increasing complexity of clients being treated for drug misuse.

**Headlines:** There is a substantial number of people receiving drug treatment who have complex treatment needs and this is associated with poorer treatment outcomes

#### Cambridgeshire

- In 2015/16 there were 30.3% high complexity clients in drug treatment, similar to England (29.5%) but lower than Oxfordshire.
- 20.2% were low complexity patients higher than England (14.9%) and Oxfordshire (9.4%).
- 82% of high complexity patients had been in treatment previously compared to 25.5% of low complexity patients.
- Of those clients who had been in treatment previously they were much more likely to have all the indicators of complexity than those new to treatment. These were similar to the figures for England.
- 11.4% of clients in Cambridgeshire with previous treatments had three or more unplanned exits, lower than the English figure of 16.3%.
- 32.9% of low complexity patients completed treatment compared to 2.7% of very high complexity cases.

### Public Health England Analysis of Client Complexity

A recent report by Public Health England (PHE) looked at the level of complexity in drug users accessing services which was prompted by the increase nationally in drug related deaths.

It analysed data relating to opiate, non-opiate and non-opiate and alcohol clients and assigned complexity to clients based on a scoring system according to the presence of complexity indicators. No complexity index is available for alcohol clients.

Analysis of Cambridgeshire adult patients (2015/16) in treatment found 522 (30.3%) are very high complexity clients (Table ??), slightly higher than the England average of 29.5%, but lower than the 35.8% of clients seen in the county's nearest neighbour, Oxfordshire. The percentage of adults in treatment of very low complexity is higher in Cambridgeshire compared with the national average and Oxfordshire (20.2% v. 14.9% and 9.4% respectively).

**Table 51: Adult drug treatment population by complexity group, Cambridgeshire, 2015/16**

Complexity group	Cambridgeshire		Oxfordshire		England
	Number	Percentage	Number	Percentage	Percentage
Very low	347	20.2	175	9.4	14.9
Low	272	15.8	261	14.0	18.0
Medium	249	14.5	268	14.4	16.0
High	331	19.2	489	26.3	21.6
Very High	522	30.3	666	35.8	29.5
Total	1721	100.0	1859	100.0	100.0

Source: Public Health England Recovery Diagnostic Toolkit

In terms of those high complexity clients who have had previous treatment episodes, 82% of have been on a previous treatment journey compared to just 26.5% of very low complexity clients (Table ??).

**Table 52: Percentage of the adult drug treatment population previously treated, by complexity group, Cambridgeshire, 2015/16**

Complexity group	Cambridgeshire		Oxfordshire	
	Number	Percentage	Number	Percentage
Very low	92	26.5	50	28.6
Low	210	77.2	190	72.8
Medium	165	66.3	142	53.0
High	250	75.5	336	68.7
Very High	428	82.0	534	80.2

Source: Public Health England Recovery Diagnostic Toolkit

The ratio of complexity between previous and new clients indicates that on all indicators complexity is greater in previous patients (Tables ?? and ??). Clients with a previous treatment journey are much more likely to have complexity indicators than those new to treatment.

In Cambridgeshire, clients with a previous treatment journey are

- 2.4 times as likely to be a daily injector (5% v. 2.1%).
- 2.1 times as likely to be a daily opiate user (12.9% v 6.1%).
- 2 times as likely to use crack for between 1 and 6 days (12.6% v 6.4%).
- 1.5 times more likely to be a heroin user (69.7% v 46.2%).
- 1.5 times more likely to be a benzodiazepine user (10.5% v. 10%).

These patterns are fairly similar to those seen for the England averages. 11.4% of clients in Cambridgeshire with previous treatment had three or more unplanned exits, lower than the England average of 16.3%.

**Table 53: Complexity indicators for clients with a previous treatment journey, Cambridgeshire, 2015/16**

Complexity indicator	Cambridgeshire		Oxfordshire		England
	Number	Percentage	Number	Percentage	Percentage
Heroin user	798	69.7	1059.0	84.6	73.7
Methadone user	168	14.7	41.0	3.3	11.1
Other opiate user	88	7.7	413.0	33.0	8.5
Uses Opiate between 1-27 days	363	31.7	393.0	31.4	26.8
Daily opiate use	148	12.9	227.0	18.1	17.0
Daily injector	57	5.0	85.0	6.8	5.4
Uses Crack between 1 - 6 days	144	12.6	180.0	14.4	10.7
Uses amphetamines 7 days or more	15	1.3	11.0	0.9	1.7
Uses alcohol 9 days or more	274	23.9	295.0	23.6	21.4
Benzodiazepine user	108	9.4	88.0	7.0	10.5
One or two previous unplanned exit	436	38.1	552.0	44.1	39.2
Three or more previous unplanned exit	130	11.4	284.0	22.7	16.3

Source: Public Health England Recovery Diagnostic Toolkit

**Table 54: Complexity indicators for new clients, Cambridgeshire, 2015/16**

Complexity indicator	Cambridgeshire		Oxfordshire		England
	Number	Percentage	Number	Percentage	Percentage
Heroin user	266	46.2	427	70.3	52.4
Methadone user	65	11.3	30	4.9	13.1
Other opiate user	34	5.9	297	48.9	9.7
Uses Opiate between 1-27 days	128	22.2	156	25.7	17.4
Daily opiate use	35	6.1	61	10.0	7.8
Daily injector	12	2.1	11	1.8	1.8
Uses Crack between 1 - 6 days	37	6.4	68	11.2	5.8
Uses amphetamines 7 days or more	6	1.0	8	1.3	2.0
Uses alcohol 9 days or more	106	18.4	144	23.7	21.4
Benzodiazepine user	37	6.4	39	6.4	10.0

Source: Public Health England Recovery Diagnostic Toolkit

Completion of treatment is also a factor when looking at complexity of cases. Treatment completion declines as complexity of clients increases. 32.9% of very low complexity clients in Cambridgeshire completed treatment in 2015/16 compared to just 2.7% of very high complexity clients (Table ??).

**Table 55: Adult drug treatment completion by complexity group, Cambridgeshire, 2015/16**

Complexity group	Cambridgeshire		Oxfordshire		England
	Number	Percentage	Number	Percentage	Percentage
Very low	114	32.9	48	27.4	43.9
Low	36	13.2	34	13.0	21.4
Medium	30	12.0	22	8.2	13.6
High	24	7.3	28	5.7	7.3
Very High	14	2.7	17	2.6	3.4

Source: Public Health England Recovery Diagnostic Toolkit

### What is this telling us?

- The data suggest that nearly a third of patients in drug treatment services have complex treatment needs. This is linked with treatment history with over 80% of those with complex needs having had previous treatment episodes compared to just over 25% for those with lower complexity. Again analysis of the ratio between previous and new patients for individual complexity indicators demonstrates the differences between these groups.
- The chapter on older people in this document provides data that indicates a cohort of service users that fall into an older age group and are long-term service users. It is likely that this cohort, as with any aging population, will have potentially greater needs in terms of complexity of drug misuse along with health and social care.
- These complexities will put additional demands on treatment services and potentially it calls for different approaches to the models of care.

## Alcohol-related brain damage (ARBD)

ARBD is an umbrella term for the alcohol-related conditions that affect brain function. They include Wernicke-Korsakoff syndrome, alcohol-related dementia, and other forms of alcohol-related cognitive impairment.<sup>233</sup> It may also be known as 'alcohol-related brain injury' or 'alcohol-related brain impairment' (ARBI) or described as 'alcohol-induced' rather than 'alcohol-related' as the terminology is not consistent; some commentators (and local practitioners) would contend that 'brain damage' is not the most appropriate term, however, as it appears increasingly used in the literature, it will be used in this section.

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<sup>233</sup> Ridley NJ, Draper B, Withall A. Alcohol-related dementia: an update of the evidence. *Alzheimers Res Ther.* 2013;5(1):3. doi:10.1186/alzrt157

## What the data tell us

**Headlines:** There is limited information on the prevalence and incidence of ARBD due to diagnosis issues. Evidence from other parts of the country and Cambridgeshire services suggest that there are between 2 and 3 new cases per month.

### National picture

- In 2015 a report found that in Western Scotland the prevalence of Wernicke-Korsakoff Syndrome as the highest in Western Europe (7.34 per 10,000).
- The number of people admitted to hospital with amnesic syndrome associated with alcohol misuse syndrome has risen by 140% during the past ten compared with a 10% increase in those aged 15-29 years.
- Between 50-80% of clients presenting to alcohol treatment services may show signs of cognitive impairment.
- Post-mortem studies indicate that between 0.5% and 1.5% of the population have changes to their brain as a result of alcohol misuse and of the alcohol dependent population an estimated 35% will exhibit evidence of ARBD (Wernicke-Korsakoff Syndrome and cerebellar atrophy).
- There is an established specialist service in The Wirral serving a population of 300,000 in an area of known high alcohol misuse that reports approximately three cases per month.

### Cambridgeshire picture

- There is only anecdotal evidence from service providers and health care professionals who report between two and three cases presenting each month.



## Data in detail

### National estimates

There is limited information on the prevalence and incidence of alcohol-related brain damage in the population due to several important factors:

- The varied diagnosis criteria and definitions.
- There is no standardised and sensitive diagnosis instrument.
- ARBD may not be the presenting condition in health services.
- The presence of ARBD may not be recorded on admission or discharge records.

Indicative estimates on prevalence in the population for specific alcohol disorders are available from Scotland and Australia. Western Scotland is known for the highest prevalence of Wernicke-Korsakoff Syndrome in Western Europe (7.34 per 10,000 in Lanarkshire).<sup>234</sup>

In line with population trends of increasing life expectancy and higher alcohol consumption in older age groups, a few important findings indicate that ARBD is an area of public health concern:

- *The number of people aged 60 years and older admitted to hospitals in England with amnesic syndrome associated with alcohol misuse syndrome has risen by more than 140% during the past 10 years, compared with a less than 10% increase in those aged 15–59 years.*<sup>235</sup>
- *As many as 50-80% of patients presenting to alcohol treatment services may show signs of cognitive impairment, which includes subtle or transient cognitive disruptions, as well as clinically severe impairments.*<sup>236</sup>

Indicative data has also been drawn from historic large-scale post-mortem studies,<sup>237</sup> with findings that:

- Between 0.5% and 1.5% of the general adult population have changes to their brain as a result of alcohol misuse.
- Of the population of alcohol-dependent people, an estimated 35% will exhibit evidence of ARBD (Wernicke-Korsakoff Syndrome or cerebellar atrophy)

The main issue with deriving estimates from post-mortem brain damage, is that not all of the people will have exhibited a clinical presentation of the illness during their life. The established specialist service in the Wirral, serving a population of 300,000, in an area of known high alcohol misuse rates, report approximately three cases a month referred from hospital care.

<sup>234</sup> Royal College of Psychiatrists :Older persons Substance Misuse Working Group 2015 Cross Faculty Report Substance Misuse in Older People: an information guide FR/OA/AP/01

<sup>235</sup> Rao R, Draper B. Alcohol-related brain damage in older people. *The Lancet Psychiatry*. 2015;2(8):674-675. doi:10.1016/S2215-0366(15)00215-1.

<sup>236</sup> Royal College of Psychiatrists :Older persons Substance Misuse Working Group 2015 Cross Faculty Report Substance Misuse in Older People: an information guide FR/OA/AP/01

<sup>237</sup> Royal College of Psychiatrists :Older Persons Substance Misuse Working Group 2015 Cross Faculty Report Substance Misuse in Older People: an information guide FR/OA/AP/01

### *The Cambridgeshire picture*

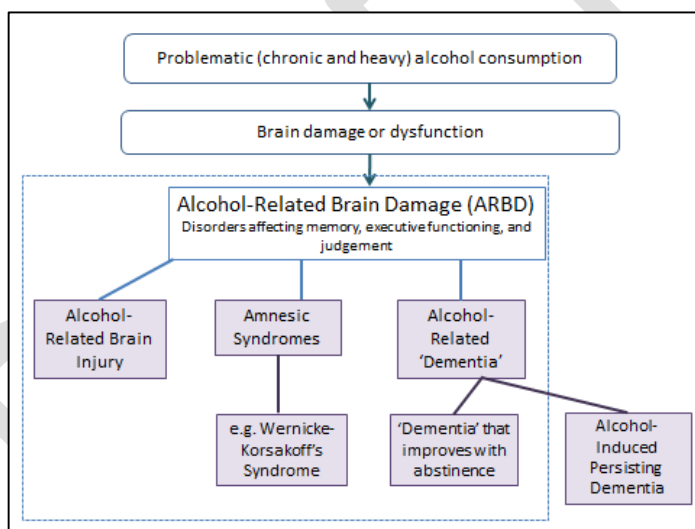
There is also indication that alcohol-related brain damage is a concern locally, with anecdotal intelligence from service providers and health care professionals of 2-3 cases presenting each month.

As highlighted above, due a lack of awareness and under-diagnosis, as well as the complexity of needs, these patients may be receiving sub-optimal care. There is no established care pathway and a key issue is the social care gaps.

### **What is ARBD?**

As indicated above there are a number of conditions that fall under ARBD

**Figure 65: Types of conditions that are considered as forms of ARBD**



Although there is no specific clinical diagnosis of ARBD, there are important shared characteristics and epidemiology for the conditions

As a syndrome, ARBD is characterised by:

- A prolonged cognitive impairment.
- A causative link to excessive alcohol ingestion and thiamine deficiency.

The symptoms that patients may show are primarily impairments in memory, executive functioning, and judgement.<sup>238</sup>

### Wernicke-Korsakoff Syndrome

Korsakoff's syndrome is a brain disorder usually associated with heavy alcohol consumption over a long period.<sup>239</sup> The syndrome is part of a wider condition called Wernicke-Korsakoff syndrome; Korsakoff's is typically preceded by Wernicke's encephalopathy. The syndrome is caused by a lack of thiamine (vitamin B1). There are several reasons why people who drink excessive amounts of alcohol are susceptible:

- Many heavy drinkers have poor eating habits and their diet does not contain essential vitamins.
- Alcohol can interfere with the conversion of thiamine into the active form of the vitamin (thiamine pyrophosphate).
- Alcohol can inflame the stomach lining, cause frequent vomiting, and make it difficult for the body to absorb the key vitamins it receives.
- Alcohol also makes it harder for the liver to store vitamins.

The main symptom of Wernicke-Korsakoff syndrome is memory loss, particularly of events that occur after the onset of the condition. Wernicke-Korsakoff syndrome is the most common amnesic disorder.

### Alcohol-related dementia

Alcohol-related dementia (or alcohol-induced dementia) is caused by direct and indirect effects of alcohol on the brain. These include the impacts of widespread damage to nerve cells and blood vessels, head injuries, and poor diet.<sup>240</sup>

Symptoms include problems with:

- memory
- attention
- learning new tasks
- reasoning and problem-solving

There is a debate on the extent to which alcohol-related dementia is a direct result of the neurotoxicity of the alcohol, and how far it represents other underlying pathologies such as thiamine deficiency, affecting cognition and function.<sup>241</sup> The relationship between alcohol and dementia is complex. There are examples of patients presenting with cognitive impairment abusing alcohol as a

<sup>238</sup> Rao R, Draper B. Alcohol-related brain damage in older people. *The Lancet Psychiatry*. 2015;2(8):674-675. doi:10.1016/S2215-0366(15)00215-1.

<sup>239</sup> Alzheimer's Society. Factsheet: What is Korsakoff's syndrome? *What is Korsakoff's Syndr*. 2012:1-9.

<sup>240</sup> Alzheimer's Society. Factsheet: What is Korsakoff's syndrome? *What is Korsakoff's Syndr*. 2012:1-9.

Barrett E, Burns A. *Dementia Revealed: What Primary Care Needs to Know*. Vol 81.; 2014. <http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf>

<sup>241</sup> Ridley NJ, Draper B, Withall A. Alcohol-related dementia: an update of the evidence. *Alzheimers Res Ther*. 2013;5(1):3. doi:10.1186/alzrt157

means to cope with stress, or itself as a potential cause of their impairment. Alcohol may be a cause, an effect, or a complication of dementia.<sup>242</sup>

There is also a distinction for presentations of 'dementia' where improvement is seen on withdrawal from alcohol and an improved diet. Some commentators argue that the use of term 'dementia' within this field is unhelpful because this differs from other forms of dementia which are progressive and unremitting diseases.<sup>243</sup> Alcohol-induced persisting dementia' is listed in the DSM-IV<sup>244</sup> classification system for a diagnosis which specifies the persistence of cognitive and functional decline following cessation of alcohol consumption.

This section will focus on the grouping of ARBD as described by the Royal College of Psychiatrists<sup>245</sup> and displayed in the schematic above, where there is a potential for recovery in some symptoms.

## Diagnosis of alcohol-related brain damage

### Risk factors

In addition to problematic alcohol consumption, there are groups at higher risk:

- Patients are likely to be aged 40-60 years.
- Females present a decade (or more) younger than males; women also tend to have a shorter alcohol-use history than men.
- Patients may have concomitant brain damage from head trauma.
- There are associations with socioeconomic deprivation including homelessness and social isolation.

### Identification

There are several junctures where ARBD can be identified in patients:

- Admission to hospital.
- The main barrier to assessment and interventions in hospital is the emphasis on high-level turnover and rapid discharge; simple cognitive screening instruments by ward staff or liaison teams may be recommended.

Presenting to alcohol treatment services:

- The NICE guideline 2010 (CG100) on alcohol-use disorders stipulates routine cognitive screening of people presenting to alcohol treatment services.

<sup>242</sup> Barrett E, Burns A. *Dementia Revealed: What Primary Care Needs to Know*. Vol 81.; 2014. <http://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf>

<sup>243</sup> Wilson K, Halsey A, MacPublic Health Englandrson H, et al. The psycho-social rehabilitation of patients with alcohol-related brain damage in the community. *Alcohol Alcohol*. 2012;47(3):304-311. doi:10.1093/alcalc/agr167

<sup>244</sup> Diagnostic and Statistical Manual of mental Disorders 4<sup>th</sup> edition

<sup>245</sup> Royal College of Psychiatrists :Older persons Substance Misuse Working Group 2015 Cross Faculty Report Substance Misuse in Older People: an information guide FR/OA/AP/01

- There are estimates that 50-80% of patients presenting to services may show signs of cognitive impairment.

#### Attendance at memory clinics

- Initial research on the routine alcohol screening of people accessing memory services suggests that it is feasible and acceptable.<sup>246</sup>

There is no standardised screening or diagnostic tool; differing scales will be required to measure alcohol consumption, cognition and functional capability. The CAGE assessment is one example of a brief evaluation of drinking behaviour in older adults.<sup>247</sup>

Though the number of patients affected by ARBD may be small, they may be high cost users of services. A study by Popoola and colleagues cited in the Royal College report found that over a six month period, in 44 patients with ARBD admitted to acute hospital care, the average length of stay was 84.0 (+/-72.3) days, with mean lost bed days of 15.9 (+/-36.6).

#### Considerations in identification and assessment

- As described in the section on alcohol in older people, it is widely recognised that health professionals may be unaware or reluctant to raise issues around alcohol consumption with older patients.
- Cognitive impairment can complicate the identification of alcohol problems and vice versa.
- It may be difficult to distinguish between prolonged or permanent effects of excess alcohol and shorter terms states of intoxication, withdrawal, and physical illness.
- As there are a range of conditions within the ARBD grouping, there is a range of presentations of disorders. In particular, the majority of patients may exhibit more subtle, less specific cognitive damage, and more gradual onset than classical Korsakoff's syndrome which is a relatively rare form.
- Depression and anxiety often co-exist with ARBD and a dual diagnosis approach may be relevant.
- People with ARBD are often socially isolated and may lack family or friends who can support them in explaining their history to clinicians.
- These are often complex patients requiring support from multiple services; adherence to treatment and support may be poor, particularly due to cognitive decline, and it is felt that often because of their poor adherence these patients are neglected.

<sup>246</sup> Randall-James J, Wadd S, Edwards K, Thake A. Alcohol screening in people with cognitive impairment: an exploratory study. *J Dual Diagn.* 2015;11(1):65-74. doi:10.1080/15504263.2014.992095.

<sup>247</sup> Boyle P, Boffetta P, Lowenfels AB, et al. *Alcohol: Science, Policy and Public Health.* OUP Oxford; 2013. <https://books.google.co.uk/books?id=ebyqDnEYczEC>.

## Prognosis

There is evidence of fairly swift recovery of some symptoms with abstinence for patients with ARBD, as measured both scientifically and functionally:

- Alcoholics evaluated before and after a period of abstinence show some recovery of tissue volume in the brain.
- The majority of ARBD patients presenting to alcohol treatment services will significantly improve in cognitive performance within three months of abstinence.
- Longer-term cognitive, functional, and behavioural problems may take two to three years to resolve.
- The most detailed evidence on longer-term results suggests that in terms of an outcome of 'satisfactory placement in appropriate social settings' for patients with ARBD:
  - o 25% make a full recovery
  - o 25% make a partial recovery
  - o 25% make a minor recovery
  - o 25% show no improvement at all

Notably while ARBD is associated with significant and relapse rates, there are good opportunities for recovery and life in the community; the majority of patients benefit from follow-up support, including appropriate nutrition and psychosocial care planning.

## Evidence for effective treatment

### Treatment of Wernicke-Korsakoff Syndrome

A Cochrane Review on the evidence for the efficacy, form, dose and duration of thiamine in preventing and/or treating Wernicke-Korsakoff syndrome found that there was insufficient evidence from quality trials to guide clinicians on its use.<sup>248</sup>

### Pharmaceutical management

Notes on the treatment and management for 'alcohol use disorders' via detoxification and rehabilitation have been published drawing from clinical expertise where evidence is limited.<sup>249</sup>

### Neuropsychological rehabilitation

The authors of a systematic review of 16 studies on neuropsychological rehabilitation for ARBD have tentatively identified a number of memory rehabilitation strategies and options for practice where the evidence suggests there may be benefits, such as an associate verbal learning procedure.

<sup>248</sup> Day E, Bentham PW, Callaghan R, Kuruvilla T, George S. Thiamine for prevention and treatment of Wernicke-Korsakoff Syndrome in people who abuse alcohol. *Cochrane Database Syst Rev.* 2013;(7):CD004033. doi:10.1002/14651858.CD004033.pub3.

<sup>249</sup> Caputo F, Vignoli T, Leggio L, Addolorato G, Zoli G, Bernardi M. Alcohol use disorders in the elderly: a brief overview from epidemiology to treatment options. *Exp Gerontol.* 2012;47(6):411-416. doi:10.1016/j.exger.2012.03.019.

## National guidance on treatment services

There is limited national guidance in the provision of services for people with ARBD: the Department of Health publications on Models of Care, 2006 and Guidance for Developing alcohol treatment pathways, 2009 fail to provide detail beyond the need for 'comprehensive assessment' and NICE guidelines on treatment are confined to the acute treatment of Wernicke's encephalopathy.

Research groups and policy organisations have published reports seeking to raise awareness of the issues including Alcohol Research UK, Alcohol Concern, The Substance Misuse and Ageing Research at the University of Bedfordshire, and the Mental Welfare Commission in Scotland.

## Related guidance

The Mental Capacity Act 2005 provides a legal framework to facilitate an ability to make an assessment of an individual's capacity to make decisions; mental capacity may be impaired temporarily or more chronically in patients with ARBD.

## Commissioning principles

The College Report on alcohol and brain damage<sup>250</sup> states: *the main thrust of commissioning should be to augment existing service provision, so as to provide an integrated and coordinated response to diagnosis, assessment and rehabilitation.* They identify three main configurations of services towards these ends:

- Single-service model.
- ARBD services within mental health trusts.
- Specialist services in generic teams.

They also describe key principles for service commissioning:

1. The development of a single point of referral.
2. The building of expertise in diagnosis and management and development of a care pathway.
3. Integrated social and psychiatric care.
4. Assertive follow-up and management.
5. The adoption of patient-centred approach to rehabilitation.
6. Ready access for specialist services to wider mental health expertise.
7. Provision of in-patient access and access to longer-stay institutions.

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<sup>250</sup> Royal College of Psychiatrists :Older Persons Substance Misuse Working Group 2015 Cross Faculty Report Substance Misuse in Older People: an information guide FR/OA/AP/01

## **Evaluated Service models**

Service models in areas with high numbers of patients may provide intelligence and key principles for management of ARBD patients.

### **Lanarkshire scoping study**

A scoping study was completed to inform service design in Lanarkshire. Six services (UK and Australia) which targeted individuals with ARBD were reviewed; the authors found four common key service themes:

#### *Client engagement*

- Support to an increasingly younger client group, many of whom were homeless.
- Clients were offered the opportunity to self-refer to the services.
- Recognised the prevalence of dual disability amongst the client group, many of whom displayed presenting conditions other than ARBD.

#### *Service delivery*

- Multi-agency intervention and multi-agency delivery of services, combining health, social care and third sector providers.
- Each model had a clear service pathway and access to care.
- A recognition of three types of ARBD clients:
  - Slow to recover – diagnosed brain damage and needing specialist support and accommodation with 24 hour care.
  - Stopped drinking and will accept intervention but may relapse. These clients were considered to benefit from:
    - Recreation, social support & employment opportunities.
    - Own tenancy or support accommodation.
    - Community mental health team/primary care support.
  - Continues drinking and is resistant to intervention. The clients tended to present at crisis point and often required:
    - Outreach contact to encourage a breakthrough.
    - Adults with Incapacity Act intervention if their brain damage was causing a risk.
- The service offering reflected the continuum of ARBD conditions. In each case, there was a movement from short to long term care interventions, with an increasing focus on maximising client independence irrespective of length of care package and a clear recovery ethos.

#### *Service infrastructure*

- Whilst the models had a multi-agency approach, each agency had clear responsibilities in service planning and delivery with one lead agency.
- Each model used a single shared assessment approach.
- Each model had a highly effective, system for sharing information amongst agencies.



### Workforce planning and development

- The service models included developing frontline staff skills to address a lack of understanding of ARBD.

### The Wirral Service Model

The delivery of a community service for ARBD in the Wirral described by Wilson and colleagues emphasises the role of person-centred care planning, close follow-up, and collaborative work with a variety of community agencies.<sup>251</sup> The service is embedded within a specialist team for patients with early on-set dementia and follows a pattern of five therapeutic phases of rehabilitation:

Phase	Characterisation	Duration
<b>1. Stabilisation</b>	Acute withdrawal, management of encephalopathy, thiamine supplementation, physical stabilisation.	Variable; dependent on physical health
<b>2. Psychosocial assessment</b>	Evidence of fairly rapid improvement in cognitive and behavioural profile. Period of on-going assessment in therapeutic environment. Introduction of early routine, structure and support.	May last up to three months. Duration may be increased when complicated by other organic and psychiatric conditions
<b>3. Therapeutic rehabilitation</b>	Period of more gradual improvement in cognitive and behavioural skills Progressive, active, personalised rehabilitation Skill acquisition, planning, problem solving	May last up to three years. Can be complicated by co-morbid physical and mental illnesses.
<b>4. Adaptive rehabilitation</b>	Rate of cognitive and behavioural improvement has slowed or ceased; Social and physical environment is adapted to optimise independence	Duration will vary on personal circumstances and access to facilities.
<b>5. Social integration and relapse prevention</b>	Building new social relationships, structure routines and alcohol relapse prevention	Long-term follow up required

At the point of review (end December 2010), 69 patients had been referred; the service outcomes for the 41 patients accepted into the service were:

- 4 deaths
- 4 relapsed to uncontrolled drinking:
- 1 lost to follow up
- 32 non-relapsed surviving patients (78% intake), of whom:
  - 32 on care plans (some of which are joint health and social care)
  - 18 living in community institutions
  - 14 supported in their homes

<sup>251</sup> Wilson K, Halsey A, MacPublic Health Englandrson H, et al. The psycho-social rehabilitation of patients with alcohol-related brain damage in the community. *Alcohol Alcohol*. 2012;47(3):304-311. doi:10.1093/alcalc/agr167.

## Local services

Cambridgeshire does not currently seem to have a clear service pathway for individuals with alcohol-related brain damage. They are not explicitly covered within local dementia pathways as detailed in the JSNA in Older People's Mental Health; there are exclusion criteria on alcohol consumption for CPFT early-onset dementia services.<sup>252</sup> So while older adults may be able to access mental health and other services for Older People, there is a particular gap for those younger than 65 years.

In addition, there are pertinent challenges in meeting care needs. The case example below highlights the key issue that there are unclear pathways for people leaving hospital with ARBD conditions, particularly as they are much younger than the onset of dementia or other neurological/mental health conditions.

**Case example:** A 52 year old female who had an ongoing history of alcohol misuse but had no contact with alcohol treatment services was admitted to Addenbrooke's. During her stay Korsakoff's syndrome was diagnosed, and it was not appropriate for her to return home. Due to the age of the patient, and a lack of clarity in funding arrangements, it was challenging accessing on-going care. This led to a 26 day delay from the time the patient was ready to leave hospital for them securing a bed and moving into a suitable care home.

There is evidence that needs of this patient group, from diagnosis through to provision, are currently addressed in an ad hoc and individualised manner locally by health and social care. A local service manager highlighted the particular pressures on family, friends and carers in these situations, particularly if trying to limit or deny alcohol.

In addition to statutory health and care services, the guidance notes the importance of third sector provision, in particular advocating routine referrals for patients with ARBD to their local Headway for carer support groups and comprehensive assessment or other relevant organisations. Headway Cambridgeshire provides specialist services and support to people with an acquired brain injury, their family and carers.

Where information was available, the scale of local provision is detailed below.

### Headway

The following is information is from Cambridgeshire Headway organisation and indicates its experience of working with ARBD

- Relatively few clients are seen at Headway Cambridgeshire with Korsakoffs syndrome and Wernickes Encephalopathy.
- In their experience they consider that possibly the greater social and health impact, are found in the numbers of clients
  - where alcohol has played a part in how they have acquired their brain injury and/or;
  - who develop alcohol dependency issues as a coping mechanism as a result of:



<sup>252</sup> Cambridgeshire JSNA 2014 Older People's Mental Health. See page 56 of the report. Available at: <http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/older-peoples-mental-health-2014>. S

- the physical and psychological effects of their injury e.g self-esteem, depression, poor body image, personality and emotional change
- the detrimental impact the injury has had on their life e.g family breakdown, loss of employment, loss of role in society, loss of hobbies and meaningful activity
- lack of support/specialist services.

#### *Findings from service data<sup>253</sup>*

A total of 31 Headway Cambridgeshire clients were identified with alcohol related injuries. Of these 22% were because of falls and 65% were due to an assault.

A further 23 clients were identified by staff as now being dependent on alcohol post-injury.

Overall, it is conservatively estimated that in approximately 10% of clients' alcohol has adversely impacted on their health and wellbeing or was a causative factor in their injury.

#### *Limitations of the data*

It is extremely difficult to get a totally clear picture for the following reasons:

- It is suspected that many clients (reflecting the general population) regularly drink at above low-risk levels however would not classify themselves as alcohol dependent;
- Some clients may have had secondary changes/deterioration in their brain functioning as a result of their post-injury alcohol use that have not been diagnosed or attributed to alcohol due to their pre-existing injury;
- Whilst the cause of the initial injury is important for treatment purposes, the rehabilitation model is geared towards dealing with the effects on the individual in question and their families, therefore it is not always possible to differentiate between clients who acquired their injury as a consequence of alcohol and other contributory factors unless this is clinically relevant;
- It is anticipated that for many of the total 57 clients who were the victim of assaults, the perpetrator of the assault may have been under the influence of alcohol however this information would not always be known/recorded.

#### *Service Approach*

Headway Cambridgeshire offer day service and community support across Cambridgeshire and Peterborough. Its social rehabilitation methods focus on the cause as well as the effects of the injury and are aimed at supporting those who are often socially isolated, working with each individual to achieve the best possible levels of recovery for them.

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<sup>253</sup> Among a database of 564 active clients on the Headway Cambridgeshire database, searched April 2016

Delivery is through a range of hub based and community based services includes:

- Specialist strategies targeted at learning new ways to compensate for abilities that have permanently changed due to brain injury.
- A rehabilitation pathway where every client is supported to develop an individual plan of care with their key worker.
- An alcohol free environment, with alcohol not allowed on the premises.
- Tailored daily timetables to accommodate clients on an alcohol management plan, recognising that not all clients can attend a full days' programme without using alcohol.
- Daily living assessments are undertaken and support strategies and assessments are developed around all aspects of living cooking, budgeting, travel etc.
- Community based activities are offered and community engagement is promoted that is away from the pub which includes café socials, bowling, horticulture, bushcraft and outdoor activities.
- It works closely with alcohol dependency services such as Inclusion and Addaction as well as Mental Health and Older People's/Dementia services and GPs to promote a holistic approach to treatment and support.
- Staff offer personal support attending medical and lifestyle appointments such as Benefits/ Doctors and assist with form filling.

A healthy diet is promoted through cooking programmes and the nutritional requirements of alcohol dependency, especially thiamine intake, are addressed.

- Educational workshops promoting healthy responses to stress and anxiety, brain injury and lifestyle, cognitive strategies and benefits are offered.
- In the organisation's experience, strengthening support networks and promoting family understanding and support is key to the continued success of taught strategies. Much of its work is around offering emotional and practical support to family members as well as brain injury information and advice, to include issues around alcohol use and brain injury.

#### *Alzheimer's Society*

- The Alzheimer's Society in Cambridgeshire offers support to people living with dementia in Cambridgeshire and their family and carers. They estimate that problematic alcohol use has been a characteristic for 19 people that they have supported over the last five years. The support they provide includes 1:1 support and information, using person-centred approaches in addressing behavioural issues, and support with linking to other services, for example around accommodation and housing, to help service users remain independent, and living with a high quality of life. Eligibility for support by the Alzheimer's Society is

precluded to those with a diagnosis of dementia (or seeking a diagnosis); they are unable to support those with other forms of alcohol-related brain damage.

#### *The Stroke Association*

The Stroke Association in Cambridgeshire provide support including to those who have had a stroke who have alcohol dependency, but do not receive referrals for people with alcohol-related brain damage.

#### **What is this telling us?**

- ARBD is a broad way of looking at brain damage related to alcohol, often affecting people much younger with dementia and other forms of cognitive impairment and who may benefit from tailored care.
- There are no precise estimates on numbers but indications of people with ARBD in Cambridgeshire, there are gaps in our knowledge about local provision, particularly on the extent of local screening approaches and proactive identification.
- There may be service gaps, both in terms of health service pathways and referrals, and in the eligibility criteria for third sector provision, to offer care and support to people with ARBD. However there may be opportunities to provide further support within existing services.

## CHAPTER 9: Dual Diagnosis

There are various definitions used to describe dual diagnosis, but generally the term is used to describe individuals who have co-existing substance misuse and mental illness. The severity of each of these conditions may vary greatly, and at what point, or threshold, a dual diagnosis is defined will vary. Locally, the Dual Diagnosis Strategy more specifically refers to those individuals who have *severe mental illness* and who also experience a *high severity of problematic substance misuse*.<sup>254</sup> Substance misuse in this case refers to prescribed or illicit drugs, and/or alcohol and substances such as solvents.<sup>255</sup> These individuals are very complex and are often very vulnerable with multiple needs.

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<sup>254</sup> Dual Diagnosis Steering Group (2014) Dual Diagnosis Strategy. <http://www.cambsdaat.org/wp-content/uploads/2015/06/Dual-Diagnosis-STRATEGY-2014.pdf>

<sup>255</sup> Dual Diagnosis Steering Group (2014) Dual Diagnosis Protocol <http://www.cambsdaat.org/wp-content/uploads/2015/06/Dual-Diagnosis-Joint-Protocol.pdf>

## What is the data telling us?

**Headlines:** Dual diagnosis is a national and local issue with a substantial proportion of people in drug and alcohol services and mental health services who have dual diagnosis.

### National

- In 2003 the COSMIC study of four UK inner city areas found that 75% of users of drug services and 85% of users of alcohol services were experiencing mental health problems. It also found that in community mental health teams there was a dual diagnosis rate of 44%.
- In 2005 a study in Bromley found that 93% of patients in alcohol services and 91% in drug services had dual diagnosis.

### Cambridgeshire

#### Children and young people

- In 2014/15 the Cambridgeshire Child and Adolescent Substance Use Service (CASUS) received 38 referrals from health and mental health services, this was 17-19% of referrals each quarter<sup>1</sup>. This would not include those that are not in touch with mental health services already so is likely to be an underestimate.
- The vulnerabilities notably more common among children and young people compared with the England average, include using two or more substances, identified mental health problems and involvement in self-harm.

#### Adults

- Of those in drug treatment in 2014/15 in Cambridgeshire, 23% of newly presenting clients (126 individuals) were also in contact with mental health services for reasons other than substance misuse. This is slightly higher than the England level (21%)
- Of those in alcohol treatment in 2014/15 in Cambridgeshire, 51 clients (6%) were also receiving care from mental health services for reasons other than substance misuse. This is below the England average (20%).
- In 2013/14 there were 732 hospital admission episodes where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders. Rates are lower in comparison to England and Oxfordshire.

## Data in detail

### National picture

Depression, anxiety and schizophrenia are most likely to be associated with substance misuse, although there can also be associations with other conditions such as eating disorders and post-traumatic stress disorder.<sup>256</sup> Alcohol use may particularly be found in those with bipolar disorders, schizophrenia and personality disorders. It is difficult to ascertain an accurate representation of the number, or proportion, of people in the general population with a dual diagnosis. Most studies are based on specific populations, for example those in contact with community mental health services or in prison. In addition, studies will only include diagnosed cases, so there is likely to be considerable underreporting.

The Department of Health funded COSMIC study of four UK inner city areas found that 75% of users of drug services, and 85% of users of alcohol services were experiencing mental health problems.<sup>257</sup> Figure ? illustrates the mental health problems that were identified among the substance misuse patients.<sup>258</sup> In the drug treatment population the prevalence was highest for depression and/or anxiety disorder, and this was also reflected in the alcohol treatment population.<sup>259</sup>

**Figure 66: COSMIC Study: Estimated prevalence of mental health problems among substance misuse patients.**

Condition	% of drug treatment population (95% confidence interval)	% of alcohol treatment population (95% confidence interval)
Psychiatric disorder	75% (68.2-80.2)	85% (74.2-93.1)
Non-substance-induced psychotic disorders	8% (4.7-12.3)	19% (10.4-31.4)
Personality disorder	37% (30.6-43.9)	53% (40.1-66.0)
Depression &/or anxiety disorder	68% (60.9-73.8)	81% (68.6-89.6)
Severe depression	27% (21.1-33.3)	34% (22.3-47.0)
Mild depression	40% (33.7-47.1)	47% (34.0-59.9)
Severe anxiety	19% (14.0-24.9)	32% (20.9-45.4)

Source: Table from NHS Brighton and Hove/Brighton and Hove City Council (2012). Dual Diagnosis Needs Assessment.

<sup>256</sup> Crome et al. (2006) The relationship between dual diagnosis: substance misuse and dealing with mental health issues. Social Care Institute for Excellence.

<sup>257</sup> Weaver, T., Charles, V., Madden, P., Renton, A. (2002) A Study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse and Mental Health Treatment Populations.

<sup>258</sup> Weaver T et al. (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry Sep 2003, 183 (4) 304-313.

<sup>259</sup> Weaver T, Charles V, Madden P, Renton A. Co-morbidity of substance misuse and mental illness collaborative study (COSMIC). Drug Misuse Research Initiative/Department of Health 2002.



Another study that was based on patients in Bromley found that when screened, 93% of patients in alcohol services and 91% in drug services had a dual diagnosis. The study further looked at how prevalence varied across settings:

- 62% in the forensic service.
- 55% in the in-patient mental health service.
- 37% in community mental health team.
- 24% in primary care sample.<sup>260</sup>

The COSMIC study also looked at the prevalence of dual diagnosis in community mental health team patients and found a fairly similar figure of 44%. Table ? shows the substances that these patients were using, most common were harmful alcohol use (26%, CI 20.5-31.0) and cannabis (25%, CI 20.2-30.7).

**Table 56: COSMIC Study: Use of substances by Community Mental Health Team patients**

Substance	Use in the past year by community mental health team patients (%)
Harmful alcohol or drug use	44% (38.1-49.9)
Any drug use	31% (25.5-36.6)
Harmful alcohol use (AUDIT ≥8)	26% (20.5-31.0)
Cannabis	25% (20.2-30.7)
Dependent cannabis use	12.8% (9.1-17.2)
Sedatives/tranquillisers	7% (4.7-11.2)
Crack cocaine	6% (3.3-9.1)
Heroin	4% (2.0-6.9)
Ecstasy	4% (2.0-6.9)
Amphetamines	3% (1.5-6.0%)
Cocaine	3% (1.2-5.5)
Opiate substitutes	1.4% (0.4-3.6)

Source: Table from NHS Brighton and Hove/Brighton and Hove City Council (2012). Dual Diagnosis Needs Assessment.

<sup>260</sup> Strathdee G et al. (2005) Dual Diagnosis in A Primary Care Group (PCG), (100,000 Population Locality): A Step-By-Step Epidemiological Needs Assessment and Design of a Training and Service Response Model.

## The local picture

### Children and Young People and dual diagnosis

The Cambridgeshire Child and Adolescent Substance Use Service (CASUS) cater for clients up to the age of 19 years. CASUS data records the number of referrals that the service receives from 'health and mental health services' collectively. In 2014/15 there were 38 referrals from health and mental health services, this was 17-19% of referrals each quarter.<sup>261</sup> This would not include those that are not in touch with mental health services already so is likely to be an underestimate.

The vulnerabilities amongst clients that were notably more common compared with the England average, include using two or more substances, identified mental health problems and involvement in self-harm.

**Table 57: Top ten vulnerabilities among young people in specialist substance misuse services, Cambridgeshire, 2014/15**

Vulnerability	Number	Percentage	NN - Oxfordshire percentage	England percentage
Began main problem substance under 15	131	99	88	93
Using two or more substances	97	73	71	61
Identified mental health problem	46	35	10	18
Involved in self-harm	37	28	13	17
Affected by domestic abuse	29	22	15	21
Affected by others' substance misuse	24	18	29	21
Involved in offending/antisocial behaviour	24	18	13	32
Not in education, employment or training	23	17	21	17
Looked after child	22	17	15	12
Child in need	16	12	*	6

NN - CIPFA nearest neighbour for Cambridgeshire

\* Value suppressed due to risk of deductive disclosure

The identification of mental health problems is more common in females than males (47% v. 29%), as was involvement in self-harm (44% v. 20%). These patterns by sex are similar to those seen for England.

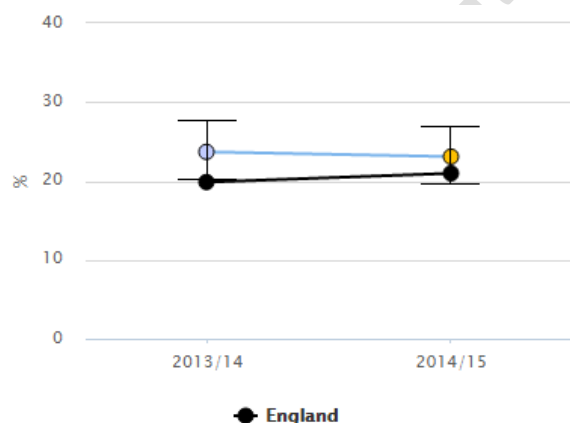
<sup>261</sup> Data provided by the DAAT via quarterly monitoring reports.

## Adult Dual Diagnosis

This information is also found in the chapter that addresses adult drug and alcohol misuse. However, here there must be caution in interpreting this data, as it does not include those not seeking treatment for their mental illness or substance misuse problem. Furthermore, it does require the client to disclose that they are in contact with mental health services. Stigma may prevent individuals disclosing this information.

Figure 7 indicates that of those in drug treatment in 2014/15 in Cambridgeshire, 23% of newly presenting clients (126 individuals) were also in contact with mental health services for reasons other than substance misuse. This is statistically similar to the England average (21%).

**Figure 67: Concurrent contact with mental health services and substance misuse services for drug misuse, Cambridgeshire, 2013/14 to 2014/15**

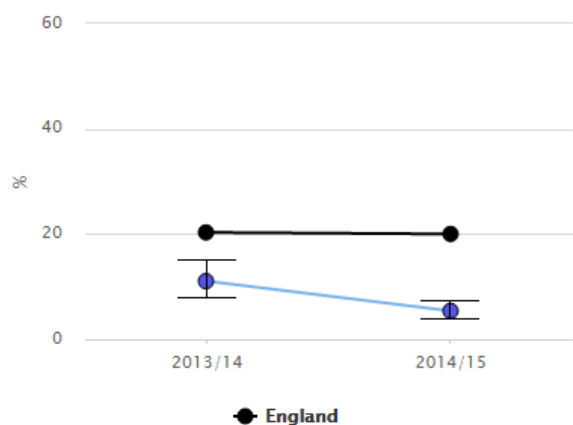


Statistical significance compared to the England average: ● Lower ● Similar ● Higher

Source: Public Health England Co-existing substance misuse and mental health issues Fingertips Data Tool (based on data from the National Drug Treatment Monitoring Service)

Figure ? indicates that of those in alcohol treatment in 2014/15 in Cambridgeshire, 36 clients (5.4%) were also receiving care from mental health services for reasons other than substance misuse. This is statistically significantly below the England average (20%).

**Figure 68: Concurrent contact with mental health services and substance misuse services for alcohol misuse, Cambridgeshire, 2013/14 to 2014/15**



Statistical significance compared to the England average:

● Lower ● Similar ● Higher

Source: Public Health England Co-existing substance misuse and mental health issues Fingertips Data Tool (based on data from the National Drug Treatment Monitoring Service)

### Hospital admissions

In Cambridgeshire in 2013/14, there were 732 hospital admission episodes where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders, 71% were in men (Table ?). The rates of admissions are lower in men and women in comparison to the England averages but higher than rates seen in Oxfordshire (Table? Figure ?).

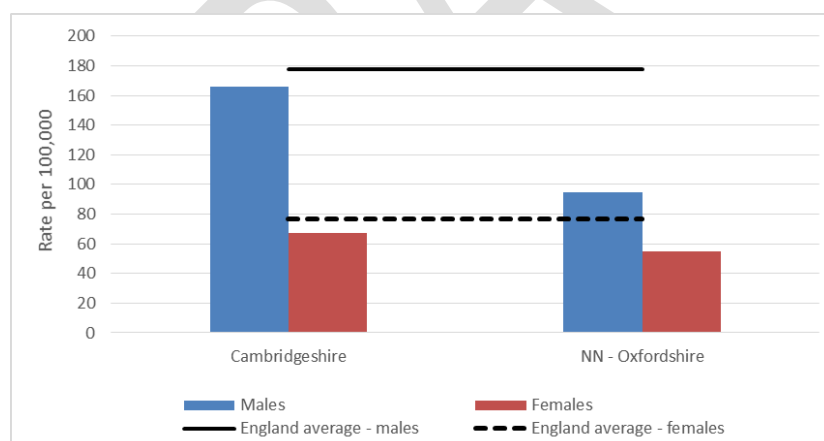
2014/15 data for England indicate that 75% of admissions occur in people aged 16 to 44 years.<sup>262</sup>

**Table 58: NHS hospital admission episodes with a primary or secondary diagnosis of drug-related mental health and behavioural disorders, Cambridgeshire, 2013/14**

Local authority	Males		Females	
	Number	Rate per 100,000	Number	Rate per 100,000
Cambridgeshire	520	166	212	67
NN - Oxfordshire	311	95	183	55
England	46954	178	20968	77

NN - CIPFA nearest neighbour for Cambridgeshire. Based on ICD-10 codes F11-F16, F18, F19  
Source: Health and Social Care Information Centre based on Hospital Episode Statistics

**Figure 69: NHS hospital admission episodes with a primary or secondary diagnosis of drug-related mental health and behavioural, Cambridgeshire, 2013/14**



NN - CIPFA nearest neighbour for Cambridgeshire. Based on ICD-10 codes F11-F16, F18, F19  
Source: Health and Social Care Information Centre based on Hospital Episode Statistics

<sup>262</sup> Health and Social Care Information Centre. Statistics on Drug Misuse 2004/05 to 2014/15

### ***Integrated Mental Health Team (IMHT)***

As part of pilot work within Cambridgeshire focusing on supporting those in mental health crisis, a small mental health team are now based within the police control room. They are able to support police officers in terms of providing advice and guidance, and are able to access the IT system that allows an individual's mental health record to be viewed, and thus allow a more informed response. The team have only been in operation since March 2016. Between 29.03.16 - 18.05.16 there were 556 unique referrals to the IMHT team and 752 referrals overall. A range of issues were identified, of the referrals there were 23 in relation to drugs and 56 alcohol related issues.

### **Suicide**

In a large national sample of suicides of 105 health trusts, of those who committed suicide within 12 months of being in contact with a mental health service, 9% had a primary diagnosis of alcohol dependence, and 4% drug dependence (n=2,145).<sup>263</sup> In terms of secondary clinical diagnosis, 9% were reported as having alcohol dependence and 8% drug dependence. Overall, 17% (16% to 19%) were misusing both alcohol and drugs.<sup>263</sup> Locally, the British Transport Police (BTP) reported that between 1/4/15-31/3/16 there were 11 individuals known to have alcohol and/or drug abuse problems that were recorded as suicidal or presuicidal/mental health incidents on BTP jurisdiction.<sup>264</sup> This figure will include the Peterborough area too. A local review of the suicide files in Cambridgeshire and Peterborough is underway, of the 50 files reviewed as of 21.06.16, 15 had either a current or past substance misuse problem (report currently unpublished).

### **Dual Diagnosis - considerations**

There are several theories as to the co-existence of substance misuse and mental illness. In some cases, the misuse of these substances may be an attempt to manage the symptoms of a mental illness or side-effects of medication; for example difficulties sleeping or low confidence.<sup>265 266</sup> In other cases, symptoms of a psychiatric illness may be exacerbated, or potentially triggered, by substance misuse. The inter-twinning of the conditions can make diagnoses particularly challenging with, for example, symptoms of drug withdrawal or use being quite similar to some of the symptoms that may be experienced in psychiatric illness. These challenges can make treatment even more complicated and historically individuals have become trapped between mental health and substance misuse services.

The mental health strategy for England, 'No Health without Mental Health', highlights the importance of addressing the physical health needs of those with mental illness, including substance misuse problems. The strategy calls for mental health services to be delivered in close co-ordination with drug and alcohol services to offer effective support to complex adults. Locally this coordination

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<sup>263</sup> Appleby et al. (1999) Suicide within 12 months of contact with mental health services: national clinical survey. *BMJ*, 318(7193): 1235–1239.

<sup>264</sup> Smith, P. (2016) Suicide Prevention & Mental Health Team: County Level Data Document – 2015/16. (requested access only)

<sup>265</sup> Solutions for Public Health (2014) Cambridgeshire JSNA: Autism, Personality Disorders and Dual Diagnosis.

<sup>266</sup> Royal College of Psychiatrists (2012) Mental Illness, Offending and Substance Misuse. Accessed 13.05.16

<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/mentalillness/offending.aspx>

is guided by the dual diagnosis protocol which has been shaped by the Dual Diagnosis Good Practice Guide.<sup>267</sup>

### ***Risk Factors***

The Bromley study, which screened 589 people, found that those who were identified as having a dual diagnosis (45% screened positive) were more likely to be young, male and unemployed.<sup>268</sup> The study also found that predictive factors for dual diagnosis included criminal involvement, risk behaviour and poorer quality of life. These findings are drawn from a relatively small sample from one locality so may not be reflective of the local Cambridgeshire population.

Mental illness or substance abuse are known to be more prevalent in certain populations. Offenders have a particularly high level of mental illness and substance misuse. A 2009 report into prison mental health in-reach services found that 71% of the prison population had a current SMI, substance misuse problem or both. Dual diagnosis was identified in 18% of the prison population.<sup>269</sup>

Those who are homeless are also at higher risk of mental illness and substance abuse. Estimates suggest approximately 70% of people accessing homelessness services have a mental health problem<sup>270</sup> and St Mungo's homelessness charity estimate 64% of their clients have drug and/or alcohol problems.<sup>271 272</sup> Dual diagnosis estimates in this population vary widely from 10-50%<sup>273 274</sup> and it would be very difficult to get an accurate picture as many individuals will be out of contact with services. Those who are homeless are estimated to be 40 times less likely to be registered with a GP than the general population.<sup>275</sup>

<sup>267</sup> Turning Point (2002). Dual Diagnosis Good Practice Handbook. <http://www.turning-point.co.uk/media/170796/dualdiagnosisgoodpracticehandbook.pdf>

<sup>268</sup> Stratthdee G et al. (2005) Dual Diagnosis in A Primary Care Group (PCG), (100,000 Population Locality): A Step-By-Step Epidemiological Needs Assessment and Design of a Training and Service Response Model.

<sup>269</sup> Shaw J et al. (2008) A national evaluation of prison mental health in-reach services.

<sup>270</sup> Homeless Link (2011) Homelessness, mental health and wellbeing guide.

<sup>271</sup> St Mungo's 2010 client survey: [www.mungos.org/homelessness/facts/homelessness\\_statistics](http://www.mungos.org/homelessness/facts/homelessness_statistics).

<sup>272</sup> Mental Health Network NHS Confederation (2009)

<sup>273</sup> St Mungo's (2009) Happiness matters: homeless people's views about breaking the link between homelessness and mental ill health.

<sup>274</sup> Rees S (2009) Mental ill health in the adult single homeless population: a review of the literature. Crisis.

<sup>275</sup> Crisis (2002) Critical condition: homeless people's access to GPs.

## Local services for children and young people

Cambridgeshire and Peterborough Foundation Trust (CPFT) provide drug and alcohol services for young people in Cambridgeshire up to the age of 18 years through the CASUS service.

Figure 70 illustrates the CASUS specialist treatment pathway which splits into three routes. Those young people who both misuse substances and require specific mental health support will follow the Integrated Care Pathway (ICP). The treatment model that CASUS use for working with these patients is 'Adolescent Metallization Based Integrative Treatment' (AMBIT). CASUS has been working with the Anna Freud Centre in the development of this model which is particularly relevant for hard to reach young people who have complex needs.

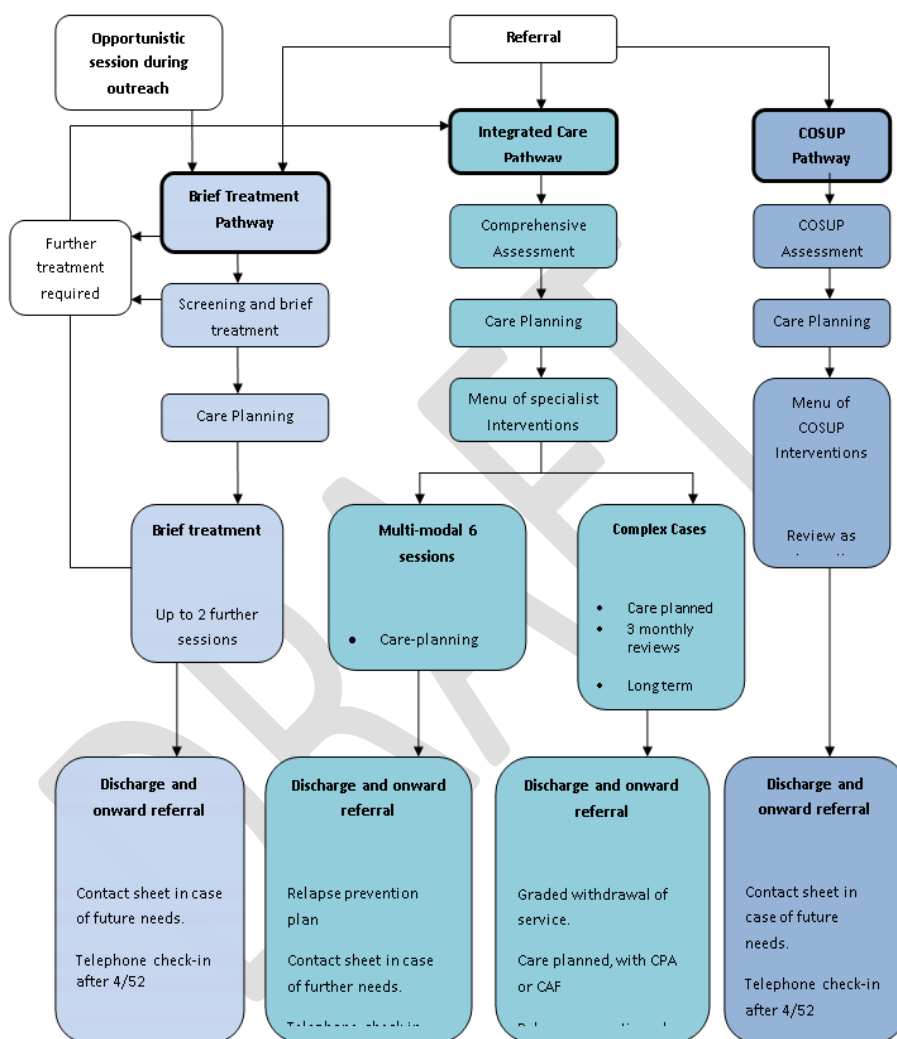
In terms of young dual diagnosis patients, the provider that delivers the treatments may differ depending on whether they are already under the care of mental health services. If the child is currently receiving care from the Child and Adolescent Mental Health Service (CAMHS), which is also provided by CPFT, then a CASUS assessment will be undertaken. A decision will be made as to whether the substance misuse service will take responsibility for the young person's mental health care also. There may also be an option to work jointly, or to see the young person together. The service is also able to offer home visits for those that have particular needs, for example those with general anxiety disorder.



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**Figure 70: CASUS Specialist Treatment Pathway Source: CPFT (2016) CASUS Operational Policy**

## CASUS Specialist Treatment Pathway



Delivered via a robust MANUALIZED treatment model based on review of effectiveness trials

### "Adolescent Mentalization Based Integrative Therapy"

Authors: Prof Peter Fonagy, Dr Mary Taget, Dr Eia Asen, Dr Peter Fuggle, Dr Dickon Bevington, Rabia Maliki,  
Neil Dawson

## Adult services: Anxiety and depression & Coexisting substance misuse

The Increasing Access to Psychological Therapies (IAPT) NHS service provides support for people with depression and anxiety disorders aged 17 and over. IAPT offers a range of brief supported self-help and talking therapy options based on cognitive behavioural therapy (CBT).<sup>276</sup> CBT is a form of psychotherapy that focuses mainly on current problems and aims to provide individuals with a greater ability to identify problems in life and develop strategies to resolve them. The local IAPT service has recently introduced a self-referral option, so there is no longer a need for professionals to refer individuals to the service.

Locally practitioners within the IAPT service will receive some drugs and alcohol training as part of mandatory, rather than core, training. Screening questions are included in the forms that clients complete about drugs and alcohol use and responses are followed up. Clients are not excluded on the basis of low-level usage that is not impacting on their functioning, but where drugs and alcohol are the main problem then specialist input would be required.

Nationally IAPT, together with DrugScope and the National Treatment Agency for Substance Misuse, have produced guidance for IAPT services on working with those who have substance misuse problems. The guidance highlights the importance of IAPT and drug and alcohol treatment services working together to address the needs of people with co-occurring problems. The guidance also states that IAPT services should offer an assessment to any drug using or drinking client referred, even if substances feature heavily in the referral.

The guidance states that IAPT should be considered suitable if:

- The client is able to attend sessions and has motivation to limit their drug or alcohol use.
- The client is stable, i.e. using medication as prescribed and not using additional non-prescribed medication or illicit drugs.
- The client has a history of drug or alcohol use but is now abstinent.

IAPT would not initially be suitable if:

- The client is dependent on illicit drugs or alcohol and not in contact with a treatment service.
- The client is in treatment with a drug or alcohol treatment service but unable to make changes in their substance use as a consequence of mental health issues.

Locally, further clarity is being given to the IAPT service's inclusion criteria in relation to drugs and alcohol. Those with moderate-to-severe alcohol or substance use would not be suitable for the IAPT service. To further discuss referrals into the IAPT service from substance misuse services, practitioners from Inclusion will be attending meetings with each of the IAPT teams (Cambridge, Peterborough, Fenland and Huntingdon).

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<sup>276</sup> CPFT Psychological Wellbeing Service (IAPT) <http://www.cpft.nhs.uk/help/iapt.htm> (accessed 4.4.16).

There remains a challenge, particularly for substance misuse services, in terms of clients that have moderate to severe substance misuse problems and anxiety or depression.

### **Adult services: severe mental illness & Coexisting substance misuse**

Building on national policy and guidance, the countywide dual diagnosis strategy endeavours to set out a plan to ensure that those with a dual diagnosis can readily access coordinated inter-agency assessment, treatment and support to address the complex mix of problems they present with<sup>254</sup>.

Representatives from mental health services and drug and alcohol services have also developed a local Dual Diagnosis Protocol.<sup>277</sup> This outlines how the Dual Diagnosis Care Pathway will be implemented and gives clarity on the roles of the services involved. North and south Locality Dual Diagnosis Groups have been established to implement and monitor the joint working protocol. The protocol applies to individuals with a dual diagnosis who require treatment and or support, and who are:

- 18 years and over
- Resident in Cambridgeshire and Peterborough
- Require specialist mental health services as a result of their symptoms
- Require specialist drug and alcohol services
- Require joint care and assessment.

Patients with coexisting mental illness and substance abuse may be referred via the Advice and Referral Centre (ARC) which is for accessing mental health services provided by Cambridgeshire and Peterborough Foundation Trust (CPFT). With GP agreement referrals to the ARC can be made by substance misuse services. Referrals are then triaged and an assessment takes place. Alternatively, referrals are made to the substance misuse service where they are also triaged.

Alternatively mental health services or substance misuse services will take a lead with support from other services as needed. If both substance misuse and mental health needs are assessed as being low, then primary care/GP will lead with advice from mental health/substance misuse services including Dual Diagnosis Link Workers (see below), as required.

The lead organisation for an individual's care will depend on their needs as illustrated in Figure ? If an individual is identified as having a high level of substance misuse need and a high severity of mental illness they will follow the dual diagnosis pathway.

Individuals who have a severe mental health problem and substance abuse will have a joint assessment between mental health and substance misuse services if possible. A single care plan will

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<sup>277</sup> Dual Diagnosis Steering Group (2014) Dual Diagnosis Protocol <http://www.cambsdaat.org/wp-content/uploads/2015/06/Dual-Diagnosis-Joint-Protocol.pdf>

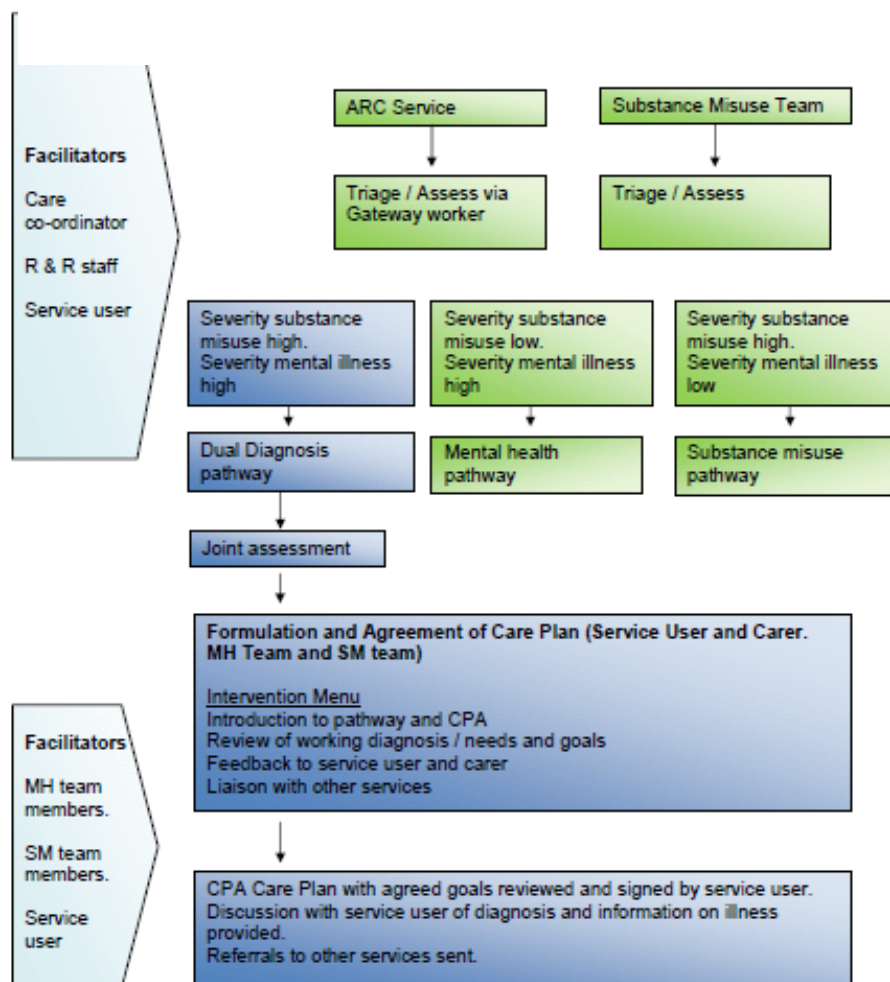
then be developed wherever possible. All individuals with severe mental health problems who also misuse substances will be subject to the Care Programme Approach (CPA).<sup>278</sup>

**Figure 71: The scope of substance use and mental health problems in people with dual diagnosis.**  
**Source: Department of Health Dual Diagnosis Good Practice Guide 2002/Dual Diagnosis Steering Group (2014) Dual Diagnosis Protocol**

<p><b>Severity substance misuse HIGH</b>  <b>Severity MI LOW</b>  e.g. dependent drinker who experiences increasing anxiety</p> <p>( substance misuse lead/coordinate care  Advice/support from MH teams )</p>	<p><b>Severity substance misuse HIGH</b>  <b>Severity MI HIGH</b>  e.g. individual with schizophrenia who misuses cannabis daily to compensate for social isolation</p> <p>( MH lead/coordinate care  advice/support from substance misuse teams )</p>
<p><b>Severity substance misuse LOW</b>  <b>Severity MI LOW</b>  e.g. recreational misuse of 'dance drugs' that have begun to struggle with low mood after weekend use.</p> <p>( Primary care lead/coordinate care  advice/support from MH/substance misuse teams )</p>	<p><b>Severity substance misuse LOW</b>  <b>Severity MI HIGH</b>  e.g. individual with bipolar disorder whose occasional binge drinking And use of other substances destabilises their mental health</p> <p>( MH lead/coordinate care advice  /support from substance misuse teams )</p>

<sup>278</sup> The Care Programme Approach is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. Source: <http://www.nhs.uk/conditions/social-care-and-support-guide/pages/care-programme-approach.aspx> (accessed 4.4.16).

Figure 72: Dual Diagnosis Care Pathway. Source: Dual Diagnosis Steering Group (2014) Dual Diagnosis Steering Group<sup>2</sup>



Dual Diagnosis Link Workers are identified individuals within mental health and substance misuse teams that support colleagues and promote joint working between services. To support implementation of the protocol a three tiered training programme has been developed:

- **Level 1– E-Learning Package** -Training in recognition and first line dual diagnosis interventions for individual teams in primary care settings, mental health services and substance misuse services.

- **Level 2 – Link Worker Training** -Psychosocial/longer term interventional, dual diagnosis training for identified Link Workers selected from each community and substance misuse teams.
- **Level 3 – Identified Experts** – Individuals in the field of dual diagnosis who have received the post registration training. These professionals may be within CPFT or non-statutory sector and will act as sources of expertise and advice for practitioners.

As of May 2016, 49 individuals have attended Level 1 training and roles have included Housing Support, GP, police, Jimmy's (emergency accommodation provider) and other voluntary sector organisations. 51 individuals have attended level 2 training including those from substance misuse services, community mental health teams and voluntary sector organisations.

### *Chronically Excluded Adults Service*

The Chronically Excluded Adults Service caters for particularly chaotic, high need individuals. Typically those accessing the service will have multiple problems, the complexity of which may not be well catered for in mainstream services. Most clients, as reported in a 2015 Project Development Strategy, had offending history (71%) were homeless and had a mental health diagnosis (57%). Analysis shows that of the 35 people that had accessed the service in a three year period, seven (20%) were consistently attending or had completed treatment for problematic alcohol and/or drug use.<sup>279</sup> Many of these individuals would therefore be expected to have co-existing substance misuse problems and mental illness.

Following entry to the project, the number of individuals consistently attending, or having completed treatment for, problematic alcohol and/or drug use rose from 7 (20%) to 19 (54%) individuals. This analysis was conducted for 35 individuals that accessed the service across 3 years. Further details on the savings and outcomes for the Chronically Excluded Adults Service is included in the Criminal Justice section of this report.

### **Potential service gaps**

A range of issues have been highlighted through discussions with providers of substance misuse and mental health services in Cambridgeshire, and through the broader engagement work with stakeholders for this Joint Strategic Needs Assessment as a whole. The findings are summarised below.

### **Data Sharing**

As highlighted earlier in this chapter, it is not possible at the present time to identify the number of people with dual diagnosis locally. In part, this will be because some people have not sought the help of services or have not been diagnosed so it will not be possible to ascertain this information. However, data from substance misuse and mental health service providers could be brought

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<sup>279</sup> James, S. (2015) Chronically Excluded Adults Service In Cambridgeshire Project Development Strategy 2015-2018.

together to get a clearer picture of the number of people with a dual diagnosis in treatment services. However, although services do have systems in place to record whether a patient has a dual diagnosis, whether this is recorded will depend on it being identified by the practitioner. It will rely on the practitioners identifying the issues, which may at first not be apparent in an individual, and will rely on everybody working to the same definitions and thresholds of recording.

There is currently nowhere that brings CPFT data and Inclusion data together, however, initial exploration through this report suggests that potentially this could be compiled using date of birth and initials as NHS Numbers were deemed to not be reliable enough. A new data sharing protocol would be required to undertake this work.

The sharing of data, and the join up of services, was the highest concern for people in terms of dual diagnosis at the initial JSNA stakeholder event held in June 2015.

### **Services for those with mild to moderate mental health problems and co-existing mental health problems**

As previously described, the IAPT service offers support to those with mild to moderate mental health problems. There is currently progress being made locally to ensure there is clear guidance for practitioners in terms of the referrals that can be accepted of individuals that misuse substances. The IAPT service is not suitable for patients with moderate to severe substance misuse problems, therefore there is a gap in service provision for those patients that have coexisting moderate to severe substance misuse need and anxiety or depression.

### **Personality Disorder Service Waiting List**

As previously discussed, there will be a number of patients with a personality disorder who also have coexisting substance misuse problems. Currently the Cambridgeshire Community Personality Disorder Service has 180 people on the assessment waiting list and 87 people on the treatment waiting list. There is currently a waiting time for an assessment of approximately six months, although this may vary. The service is actively addressing the waiting list for assessments and has set aside time purely for assessments which would hope to reduce the wait to within three months.

In terms of receiving treatment, the service takes clients on in cohorts of up to 40 individuals. Usually 2.5 cohorts are taken on a year if the service is fully staffed. Currently there are two staff vacancies which does have an impact.



This can cause problems in terms of developing and delivering joint care plans and treatment regimes, as illustrated by the case study below which was provided by Inclusion. It must be remembered that this is one particular case and will not be the experience of all clients. What the case study does highlight though, is the challenge of coordinating multiple services for individuals that require treatment input from a number of specialisms. In particular, this challenge is exacerbated by the varying capacities or waiting times of services, which can impact on an individual's care plan as a whole.

Case Study – Karen (name changed to protect the individual's identity)

Karen is a 40 years old woman who started using cannabis at the age of 12, she then went on to use heroin and benzodiazepines for a long period of time. Karen has stabilised on a methadone prescription for approximately 18 months and has had several attempts of a prescription reducing regimen for the benzodiazepine use (treatment regimen ceased in August 2015). However, Karen has since struggled with alcohol, heroin and illicit benzodiazepine use.

Karen was also referred to the Community Personality Disorder Service (CPDS) in October 2014 and was assessed in the following March as suitable to receive treatment. As part of Karen's treatment, a care plan was formed by the substance misuse service with the CPDS input as a key part of the support package in the benzodiazepine reduction regimen, leading up to the cessation of the prescription in August 2015.

Karen is yet to commence treatment with the CPDS which has meant that the support that formed part of the care plan was not received.

### **Implementing the dual diagnosis protocol**

Although the dual diagnosis protocol has been developed locally, there remain some challenges with implementing it. This arises, in part, because some practitioners are unaware of the protocol which could be a result of high staff turnover. In addition, the dual diagnosis training that has been developed is a means of implementing the strategy, and uptake to the training has not been as high as was hoped.

### **Asperger's and autism**

Substance misuse services have reported that some clients are using drugs to deal with the social anxiety of Asperger's and autism. This is a more specialist area of care and building better skills in this area may be of benefit to the substance misuse services.

## Challenges highlighted by adolescent substance misuse services

### Transition between services

The children's substance misuse service works with young people up to the age of 18 years, whereas Child and Adolescent Mental Health Services work with those aged under 17 years of age. This disparity can cause challenges when transitioning between services.

### Child and Adolescent Mental Health Services (CAMHS)

Locally the CAMH service has seen sizeable waiting times for appointments which meant that patients that required CAMH support were held within the substance misuse service for long periods of time. Increased investment into the CAMHS has reduced waiting lists which has had a positive impact on the CASUS service.

Further challenges can occur when a young person's substance misuse difficulties are under control but mental health issues are not. There is an apparent lack of interim services to discharge clients to for monitoring and support, for example support groups.

### Rural access

Some areas of Cambridgeshire are rural with poor transport connections. The CASUS service offers home visits, but the time required to undertake these visits impacts on capacity.

### Changes to the Education System

With the introduction of academies, schools have more autonomy and CASUS report a variation in the willingness of schools to engage with the services. This was similarly raised by the youth offending substance misuse service.

### Budget Challenges

The substance misuse service team size has reduced recently and it was highlighted by a clinical there is a critical size of the team that is required to enable delivery practically and safely across the county.

### Engagement of Young People

Services rely on voluntary engagement of individuals and there are inevitably some young people that do not seek support, or who do not proceed with treatment.

## Evidence for effective treatment

### Children and young people

It is difficult to identify research specifically focusing on dual diagnosis treatment in young people that met the criteria for inclusion. This would certainly be an area that would require additional research, and locally this should be a consideration when designing service evaluations.

Evidence was looked at for the approach used locally - AMBIT (Adolescent Mentalization-Based Integrative Treatment). AMBIT applies the principle of mentalization to relationships with clients, team relationships and working across agencies.<sup>280</sup> It is a developing approach that can be applied to complex individuals with multiple needs. Four relevant articles on AMBIT were found. Cambridgeshire and Peterborough Foundation Trust clinicians have been central to the development of this approach and have heavily inputted to the literature available and pilot work.

Authors recognise that this is a developing approach that requires further evaluation. As part of one study the local CASUS service is described, including their locally adapted outcome frameworks used as part of the AMBIT approach. The findings from the work with 44 clients (59% males) between 13-17 years was described. The presenting issues varied by gender, with males having typically chronic externalizing problems, in contrast to the females in this cohort. The process encourages shared ongoing reflective team learning. Before and after treatment there were significant positive improvements seen in self-reported mental wellbeing measures, physical wellbeing and overall wellbeing. These results aligned with the clinician reported improvements in substance use scores.

There is clearly a need to further study the effectiveness of the AMBIT approach, but the limited evidence does suggest that this may be a promising approach for working with complex individuals with multiple problems.

### Adults

The first part of this evidence review covers current substance misuse interventions for those who have both a mental illness and substance misuse problems. Definitions of dual diagnosis vary between studies therefore several of the studies focus on people with a mild to moderate depression and anxiety so would not fall within the local protocol definition. For completeness these studies have been included in the first section followed by studies that focus on participants with severe mental illness. The aim of this review is to look at the impact of interventions on substance misuse of dual diagnosis patients, therefore outcomes relating to changes in mental illness symptoms, although often included, are not the main focus of this review.

### Psychosocial interventions in patients with anxiety or depression

A 2009 meta-analysis<sup>281</sup> reviewed the impact of integrated psychological treatment for substance use (various substances) and co-morbid anxiety or depression compared to treatment for substance

<sup>280</sup> Fuggle, P. et al. (2015) The Adolescent Mentalization-based Integrative Treatment (AMBIT) approach to outcome evaluation and manualization: adopting a learning organization approach. *Clinical child psychology and psychiatry*, 20 (3), p. 419-435, 1461-7021 .

<sup>281</sup> Hesse, M. (2009) Integrated psychological treatment for substance use and co-morbid anxiety or depression vs. treatment for substance use alone. A systematic review of the published literature. *BMC Psychiatry* 9 (6).

misuse alone. The meta-analysis found there was promising evidence in terms of the impact of integrated psychological treatment on substance misuse outcomes for patients with depression symptoms. Compared to controls, interventions had an average of 13.75% more days abstinent from substance misuse than the controls when applied to the

### *Cognitive Behaviour Therapy*

A 2011 study<sup>282</sup> looked at the effect of CBT for depression (in addition to standard alcohol treatment), compared to a relaxation control in participants with alcohol dependence and elevated depressive symptoms (Beck Depression Inventory score  $\geq 15$ ). There was no significant difference between alcohol outcomes or decrease in depression scores at 12 months follow-up between treatment and control. In this study the control was eight individual sessions of training and practice in meditative and deep-breathing techniques, rather than standard care.

A study by Lydecker et al. (2010)<sup>283</sup> did, however, show a positive impact of CBT in veterans with co-morbid major depressive disorder. The study compared integrated CBT (I-CBT) plus pharmacotherapy with a group based 12-Step Facilitation Therapy (therapist-guided group intervention with principles used in a range of addiction treatments, adapted to include depression issues) plus pharmacotherapy, which acted as the control. The CBT was a combination of CBT for depression and CBT for addiction.

Greater reductions in frequency of alcohol/drug (cannabinol, and/or stimulant dependence) use were seen in the intervention group. This study was conducted with veterans and included largely male participants, so the transferability of the findings to other population groups is unclear.

### *Group based CBT*

A further study investigated the effectiveness of group based CBT for depression in a residential treatment setting for substance abuse.<sup>284</sup> The Building Recovery by Improving Goals, Habits and Thoughts (BRIGHT) programme is delivered in sixteen two-hour group sessions to patients with a Beck Depression Inventory-II (BDI-II) score of over 17. At baseline, the most common substances used were amphetamines (36.8%), followed by cocaine (20.4%), alcohol (15.4%), and heroin (12.4%).

Substance abuse outcomes were measured as percentage of days use out of days available (e.g. not in hospital) in the past 30 days. At six months after baseline, the percentage of days use for alcohol was 8% in the intervention group (vs. 18% in usual care) and 8% in the intervention group for substance misuse (vs. 20% in usual care). The groups did not differ at baseline.

<sup>282</sup> Brown et al. (2011) A Randomized Controlled Trial of Cognitive-Behavioral Treatment for Depression Versus Relaxation Training for Alcohol-Dependent Individuals With Elevated Depressive Symptoms. *J. Stud. Alcohol Drugs*, 72, 286-296.

<sup>283</sup> Lydecker et al. (2010) Clinical Outcomes of an Integrated Treatment for Depression and Substance Use Disorders. *Psychol Addict Behav.* 24(3): 453-465.

<sup>284</sup> Watkins et al. (2011) An effectiveness trial of group cognitive behavioral therapy for patients with persistent depressive symptoms in substance abuse treatment. *Arch Gen Psychiatry* 68(6), 577-584.

### Computer Based CBT

Kay-Lambkin et al. (2009)<sup>285</sup> studied the effect of nine sessions of motivational interviewing and CBT, which was delivered either face to face with a clinician or via computer, compared to a control (brief intervention [BI] only). Participants were recorded as having depression (>17 on Beck scale) and either problematic alcohol use or cannabis usage. Across interventions, improvements were made in depression, alcohol and cannabis outcomes.

### Psychosocial interventions In individuals with a severe mental illness

A recent Cochrane review looked at psychosocial interventions for those with substance misuse and severe mental illness.<sup>286</sup> This review included 32 RCTs and overall rated the quality of studies as low or very low. The review identified the following psychosocial interventions, some of which were combined (e.g. CBT and motivational interviewing):

#### Individual Approaches

- Cognitive Behavioural Approaches
- Motivational Interviewing (MI)
- Contingency Management (rewards, for example monetary, are offered in response to abstinence or reductions in substance misuse).<sup>287</sup>

#### Group Approaches

- Social Skills Training

Findings from the Cochrane review are outlined below for each of the approaches, together with findings from additional reviews that differed in their search methods or criteria to give a broader overview.

### Cognitive Behavioural Therapy

The Cochrane review only found two eligible studies comparing cognitive behaviour approaches to treatment as usual. There was no significant difference in use of cannabis in the previous four weeks at three or six months follow up. A review by Cleary et al. (2009) identified eight eligible studies, but the two of highest quality showed no improvements in mental state or substance misuse outcomes.<sup>288 289</sup> One of these studies also very specifically focused on young people (average age 20-21 years) with first episode psychosis. In addition the study lacked a 'treatment as usual' control.

<sup>285</sup> Kay-Lambkin et al. (2009) Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: a randomized controlled trial of clinical efficacy. *Addiction*, 104, 378–388.

<sup>286</sup> Hunt et al. (2013) Psychosocial interventions for people with both severe mental illness and substance misuse. The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

<sup>287</sup> Cleary et al. (2009) Psychosocial treatments for people with co-occurring severe mental illness and substance misuse: systematic review. *Journal of Advanced Nursing* 65(2), 238–258.

<sup>288</sup> Edwards et al. (2006) Randomized controlled trial of a cannabis-focused intervention for young people with first-episode psychosis. *Acta Psychiatrica Scandinavica* 114, 109–117.

<sup>289</sup> Naeem et al. (2005) Cognitive behaviour therapy for schizophrenia in patients with mild to moderate substance misuse problems. *Cognitive Behaviour Therapy* 34, 207–215.

### *Motivational interviewing*

Eight trials were identified in the Cochrane review, and overall alcohol dependence and abuse did not differ significantly between intervention and control groups. There was no significant difference in the likelihood of participants using amphetamine or cannabis or polydrug use at three or 13 months. One small study was identified that had favourable outcomes for the treatment group in terms of not abstaining from alcohol at six months.<sup>290</sup>

A review by Cleary et al. (2009), however, found that motivational interviewing had the best quality evidence for reducing substance abuse in the short-term. Some of the studies that this finding was based on did not have an experimental design; of the seven RCTs that were included, four showed a decrease in substance use. Effects were in some cases lost when a more comprehensive analysis was undertaken.

### *Contingency Management*

The Cochrane review identified two trials of contingency management that met criteria for Inclusion.<sup>291 292</sup> However none of them produced conclusive results and identified a lack of research in the area.

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<sup>290</sup> Graeber et al. (2003) {published data only} A pilot study comparing motivational interviewing and an educational intervention in patients with schizophrenia and alcohol use disorders. *Community Mental Health Journal* 39(3):189–202.

<sup>291</sup> McDonell et al. (2013) Randomized controlled trial of contingency management for stimulant use in community mental health patients with serious mental illness. *American Journal of Psychiatry*, 170(1):94–101.

<sup>292</sup> Tracy et al. (2007) Contingency management to reduce substance use in individuals who are homeless with co-occurring psychiatric disorders. *American Journal of Drug and Alcohol Abuse*, 33(2):253–8.

### *Cognitive Behavioural Therapy and Motivational Interviewing*

The Cochrane review by Hunt et al. (2013) identified seven studies that compared cognitive behavioural approaches plus MI to treatment as usual. Results were mixed. However, Cleary et al. (2009) found that some significant improvements in substance misuse outcomes were seen across 4 RCTs although there was considerable heterogeneity between studies and findings.

The study by Haddock et al. (2003) was an integrated psychosis and substance abuse intervention. The primary outcomes measure focused on global functioning and disease symptomology. Both saw improvements that lasted at the 18 month follow-up point. This study is now over 10 years old so the financial figures used will not be reflective of current costs.

The diversity of studies in terms of substance misuse or mental illness inclusion makes pooling findings more challenging. The studies included are also of varying quality, and not all have a full experimental design. There does appear to be some evidence of the effect of CBT for those with anxiety and depression and co-occurring substance misuse, but there are insufficient findings to draw any strong conclusions on recommended interventions beyond those that form part of mainstream substance misuse services.

### *First episode psychosis*

A systematic review was conducted by Wisdom et al. in 2011.<sup>293</sup> The review looked at patients with a first episode psychosis to answer two research questions:

- To what extent do these patients become abstinent from substance misuse after a first episode of psychosis without specialist substance misuse interventions?
- Is the addition of specialist substance abuse treatment effective?

The review includes findings from nine studies looking at psychiatric treatment only (usually includes some advice on avoidance of drugs and alcohol to avoid relapse) for these patients, and a further five that cover integrated treatment. The findings from each of the studies are summarised in Table ? showing the substance abuse and mental health outcomes.

Across the studies reviewed by Wisdom et al., cannabis and alcohol were the prominent substances that patients were using. In approximately half of cases across studies there was a reduction in substance misuse at follow-up, and this tended to be within the first six weeks and remained fairly stable. Fewer relapses (in terms of mental illness) and hospitalisations were consistently found to be associated with those that were abstinent compared to those who had persistent substance misuse.

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<sup>293</sup> Wisdom et al. (2011) Substance use disorder among people with first-episode psychosis: A systematic review of course and treatment. *Psychiatr Serv.* 62(9), 1007-1012.

**Table 59: Summary of findings table taken from systematic review conducted by Wisdom et al. 2011293**

Summary of findings from studies of first-episode psychosis treatment with or without specialized substance abuse treatment

Study	Substance use outcome	Mental health outcome	Functional outcome
Without specialized substance abuse treatment			
Archie et al., 2007 (11)	Improvement <sup>a</sup>	No change	No change
Baeza et al., 2009 (43)	Mixed findings	Improvement	Not assessed
Grech et al., 2005 (5)	Improvement	Mixed findings	Not assessed
Harrison et al., 2008 (44)	Improvement	Mixed findings	No change
Kovaszny et al., 1997 (7)	Observational only	No change	Observational only
Lambert et al., 2005 (24) and Hinton et al., 2007 (45)	Improvement	Improvement	Not assessed
Turkington et al., 2009 (46)	Improvement	Observational only	Observational only
Verdoux et al., 2001 (47)	Improvement	Not assessed	Not assessed
With specialized substance abuse treatment			
Addington et al., 2001 (48)	Improvement	No change	Mixed findings
Carr et al., 2009 (49)	Improvement	Not assessed	Not assessed
Edwards et al., 2006 (50)	No change	No change	No change
Gleeson et al., 2009 (51)	No change	Improvement	No change
Kavanagh et al., 2004 (52)	No change	Not assessed	Not assessed

<sup>a</sup>Improvement indicates the intervention group demonstrated a statistically significant increase in positive outcomes or a decrease in negative outcomes compared with the comparison or control group. "Mixed findings" indicates improvement on some measures of the outcome and no difference or negative findings on other measures of the outcome. [For additional information, see online appendix at [ps.psychiatryonline.org](http://ps.psychiatryonline.org).]

The review did not find consistent evidence that specialist substance misuse interventions for those who have experienced first episode psychosis had a significant effect on substance misuse. There were only a small number of studies included and they had relatively small sample sizes so results cannot be deemed conclusive. However, patterns of abstinence seen in patients (including controls) reflected the initial decreases seen in studies with patients not receiving specialist treatment. The results of this study might suggest that it could potentially be beneficial to initiate specialist substance misuse treatment after the first six months following first episode psychosis, so that those that have persistent substance misuse can be targeted.



## Service Models

### *Integrated treatment models*

Integrated treatment (IT) refers to an approach whereby clients are offered a combined treatment for both the mental health problem and substance misuse issue by the same professional or team at the same location and same time.<sup>294</sup> Multiple interventions are offered, for example motivational interviewing or CBT. These models unify services at the provider level rather than requiring clients to negotiate separate mental health and substance abuse treatment programmes. A study by Wüsthoff et al. (2014) investigated the impact of IT on treatment outcomes for patients that had co-existing mental health problems and substance misuse, but were not considered to have a SMI. Inclusion criteria were anxiety disorder and/or depression with or without a personality disorder together with a disorder of abuse or dependence on drugs or alcohol.

Results from the study show that both the intervention and control groups reduced alcohol and drug use across the 12 months of the trial, but the intervention group did not improve significantly more than the control group. There were no significant changes in psychiatric symptoms in either group across the 12 months.

A 2013 Cochrane review of psychosocial interventions for those with both severe mental illness and substance misuse also reviewed integrated treatment models. The review identified 4 RCTs<sup>295 296 297 298</sup> of integrated models of care compared to treatment as usual. Analysis found that there was low quality evidence of no difference in alcohol or substance use remission at 36 months between the two models. The study also found there was no significant difference in terms of the number of individuals lost to treatment or death by 36 months. Studies took place across a variety of settings, all with a community element although one also had a residential element and another had a prison element. One study did measure outcomes relating hospital days and arrests, but the results were not suitable for analysis. The four studies were based in America so it is difficult to know whether findings can be applied to local UK populations.

A further study, by Morrens et al.<sup>299</sup> compared integrated residential based treatment to usual residential psychiatric care. The intervention consisted of a specialised assessment, a range of interventions such as counselling and motivational interviewing, and post-discharge support from a case manager. The social network of the patient was also involved in the treatment.

At three month follow-up there were significant improvements seen in the intervention group in drug use that were not reflected in the usual care group. The effect appeared to be present at

<sup>294</sup> Wüsthoff et al. (2014) The effectiveness of integrated treatment in patients with substance use disorders co-occurring with anxiety and/or depression – a group randomized trial. *BMC Psychiatry* 2014, 14:67.

<sup>295</sup> Burnham et al. (1995) An experimental evaluation of residential and non-residential treatment for dually diagnosed homeless adults. *Journal of Addictive Diseases*, 14(4): 111–34.

<sup>296</sup> Chandler et al. (2006) Integrated treatment for jail recidivists with co-occurring psychiatric and substance use disorders. *Community Mental Health Journal*, 42(4): 405–25.

<sup>297</sup> Drake et al. (1998) Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: a clinical trial. *American Journal of Orthopsychiatry*, 68(2): 201–15.

<sup>298</sup> Essock et al. (2006). Comparison of ACT and Standard Case Management for Delivering Integrated Treatment for Co-occurring Disorders. *Psychiatric Services*, 57(2): 185–96.

<sup>299</sup> Morrens et al. (2007) Treatment Outcomes of an Integrated Residential Programme for Patients with Schizophrenia and Substance Use Disorder. *Eur Addict Res*, 17: 154–163.

12 month follow-up too, but attrition from both groups was high so this should be interpreted with caution. The attrition rate was lower in the intervention group, although still sizeable (42% completed the study from the intervention group vs. 20% in the usual care group).

### *UK Models*

As academic literature on this topic is limited, a more general internet search was conducted to identify integrated models of service delivery in the UK, the services identified are described below.

#### *Greater Manchester Dual Diagnosis Service*

There are dual diagnosis services that have been developed within the UK, for example in Greater Manchester there is a self-referral service. The service offers:

- A confidential and non-judgmental service.
- Advise on the treatment of service users who experience substance misuse and concurrent mental health problems.
- Provide advice to inpatient wards and community teams.
- Provide guidance to practitioners, service users and carers involved with a range of health and social care agencies.
- Work closely with specialist substance misuse services.
- Provide information about other help and services which are available in the local area such as recovery programmes, and back to education or work courses.

#### *Humber NHS Foundation Trust*

There are also a number of examples in the UK of dual diagnosis teams based within mental health service settings. The dual diagnosis liaison service, part of Humber NHS Foundation Trust, provides a range of clinical, training and liaison services for those identified as having substance misuse within the mental health services.<sup>300</sup> The team of specialist nurses offer a consultative/supervisory role to those nurses identified as having a lead responsibility within their service. The service works to a strategic plan that is supervised and supported by the consultant psychiatrist and clinical nurse specialist in addictions.

#### *Tees, Esks and Wear NHS Foundation Trust*

The model adopted in Tees, Esks and Wear NHS Foundation Trust includes specialist dual diagnosis practitioners working in the different areas throughout the Trust.<sup>301</sup> The practitioners give clinical support within their own localities, mainly supporting the dual diagnosis leads by providing specialised clinical support for staff and help for these complex clients. The practitioner's role may include undertaking assessments and recommending care as well as providing supervision and contributing to staff development.

<sup>300</sup> Humber NHS Foundation Trust. Dual Diagnosis Liaison Service <http://www.humber.nhs.uk/services/dual-diagnosis-liaison-service.htm> (accessed 26.05.16).

<sup>301</sup> Tees, Esks and Wear NHS Foundation Trust. Dual Diagnosis Service. [http://www.teew.nhs.uk/site/care-and-treatment/service/Dual%20diagnosis%20\(substance%20misuse\)%20service](http://www.teew.nhs.uk/site/care-and-treatment/service/Dual%20diagnosis%20(substance%20misuse)%20service) (accessed 26.05.16).

The team was established in response to demand within mental health services and in line with the Department of Health Mental Health Policy Implementation Guide. Working alongside the clinical staff in mental health care settings and using a practice development approach, the team helps facilitate and train professionals in the early recognition of, and interventions in, the problems associated with substance misuse.

### *Lewisham*

The model adopted in the London borough of Lewisham has two dual diagnosis practitioners based in assertive outreach (AO) teams as part of a wider dual diagnosis service.<sup>302</sup> The AO teams work closely with the community mental health teams. The practitioner roles focus on care coordination, supervision and training and joint assessment work. The service reports reduced admissions for care coordinated clients. In terms of challenges, the service identifies the competing demands of being based in a different team, and clarity of role with colleagues.

### *Birmingham and Solihull Mental Health NHS Foundation Trust*

The COMPASS (Combined Psychosis and Substance Use) Programme has been running within Birmingham and Solihull Mental Health NHS Foundation Trust since 1998.<sup>303</sup> The team supports people with co-existing psychosis and substance misuse problems, offering a consultation liaison service to those within adult services or substance misuse services. The model takes an integrated shared care approach, whereby there are six sessions across 12 weeks that involve the individual, substance misuse worker, and a COMPASS team member. The service will visit people's homes if needed for appointments, and the aim is to ensure that individuals are accessing the support they need.

The COMPASS team also has a training function, upskilling substance misuse services to deliver integrated care. The team also have a role in supporting the development of shared care agreements between services.

## **NICE Guidelines**

NICE Guidance specifically relating to the 'Severe mental illness and substance misuse (dual diagnosis) - community health and social care services' is currently in development and is due to be published in November 2016.<sup>304</sup> This will focus on identifying the services people with a severe mental illness who misuse substances receive, and the content, configuration and acceptability of these services to meet wider health and social care needs. In particular there will be a focus on those living in the community who may have multiple needs. The guidance will be for local authorities, NHS England, Health and Wellbeing Boards and Clinical Commissioning Groups.

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<sup>302</sup> Goodwin, P. and Sherrok, C. South London and Maudsley NHS Foundation Trust. The Dual Diagnosis Practitioner Role in an Assertive Outreach Team (powerpoint, accessed 26.05.16)

<sup>303</sup> Mental Health Network (2009) Seeing double: meeting the challenge of dual diagnosis.

<sup>304</sup> NICE. Guideline scope: Severe mental illness and substance misuse (dual diagnosis): community health and social care services. <https://www.nice.org.uk/guidance/gid-phg87/resources/severe-mental-illness-and-substance-misuse-dual-diagnosis-community-health-and-social-care-services-final-scope2> (accessed 9/12/15).

More specific NICE clinical guidance is available for Psychosis with Substance Misuse in over 14s: Assessment and Management (CG120),<sup>305</sup> this guidance includes:<sup>306</sup>

- Recognition, treatment and care of adults and young people with psychosis and coexisting substance misuse in primary care and across mental health and substance misuse services.
- Patient access to both age-appropriate mental healthcare and substance misuse services.
- Organisation of services including care coordination, joint working arrangements between specialist substance misuse services and CMHT, referral guidelines.
- Inpatient services.
- Involvement and communication of patients and the families.

The guidance recommends that healthcare professionals in all settings, including those in A& E, prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed drugs. The guidance also advises professionals to consider joint working arrangements with specialist substance misuse/mental health services in particular cases.

In terms of treatment, clinicians are guided to relevant specialist NICE Guidelines including:

- Bipolar disorder: assessment and management (CG185 [update of CG38 as referred to in guidance]).
- Psychosis and schizophrenia in adults: prevention and management (CG178 [update of CG82 as referred to in guidance]).
- Alcohol-use disorders: diagnosis and management of physical complications (CG100).
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115).
- Drug misuse in over 16s: psychosocial interventions (CG51).
- Drug misuse in over 16s: opioid detoxification (CG52).

Within these there is very limited information with regards to specific treatments or interventions for those with a dual diagnosis.

### *Dual Diagnosis Good Practice Guide*

The Dual Diagnosis Good Practice Guide, and supporting handbook, although published in 2002, remains a key source of guidance for those delivering services catering for the needs of those with co-existing substance misuse and mental health issues.

The components of good practice are outlined in the supporting handbook, which were drawn from the practical experience of professionals and service users as well as from research and policy guidance. The components identified, which summarise the Good Practice standards, include:

- **Working with service users, carers and families** - including having open dialogue, listening to service users, and providing information in appropriate language.
- **Planning and commissioning of services** - including having a co-ordinated approach to commissioning mental health and substance misuse services.

<sup>305</sup> NICE (2011). Psychosis with substance misuse in over 14s: assessment and management (CG120).

<sup>306</sup> Solutions for Public Health (2014) Cambridgeshire JSNA: Autism, Personality Disorders and Dual Diagnosis.

- **Service delivery** – including agreement of protocols between services, and mainstreaming services so that those with a SMI and co-existing substance misuse are treated largely within mainstream mental health services.
- **Locally agreed definition of dual diagnosis** – including referral mechanisms for those that fall outside of the definition.
- **Inter-agency working** – including a shared protocol and strategy with clarity on roles and responsibilities.
- **Assessment** – including screening across services and multi-agency/disciplinary assessments.
- **Treatment and co-ordination of care** – including the need to work long-term with clients that may disengage and re-engage with support.
- **Experience and skills** – including the need for a mechanisms for information exchange, sharing skills and inter-agency training.
- **Monitoring, evaluation and research** – ensuring there are methods for assessing and evaluating to shape improvements in service delivery.

## What is this telling us?

- Information sharing – it would be helpful to bring together the data held by substance misuse and mental health service providers. This would be useful in terms of estimating the number of people with a dual diagnosis in substance misuse services, although there will be a lot of people that aren't within services so there is no accurate way of defining the size of the issue.
- Data collection – Across services there is a need to ensure there is greater recording of dual diagnosis, as well as greater consistency in how this is recorded. It should be standard practice for all services, including those for young people, to collect data on the number of clients who have coexisting mental health and substance misuse problems. Further clarity on a consistent approach could perhaps be provided as part of the dual diagnosis strategy refresh which will take place in 2017.
- Collaboration between services – there is currently no strong evidence base for integration of services or a particular model that is favoured, but collaboration is clearly a strong theme. There is an ongoing need to build collaboration and overcome the organisational challenges between services. Service models that other areas are implementing have not been evaluated in terms of outcomes and cost-effectiveness, so it is not possible to say whether integration of services would improve patient experience and outcomes.
- NICE Guidance on 'Severe mental illness and substance misuse (dual diagnosis) - community health and social care services' is being published later in the year so it will be important to ensure that the recommendations are reflected upon and consideration is given to them in terms of implementation in a local context.
- The Cambridgeshire and Peterborough Suicide Audit will be published in autumn 2016 and it is clear that substance misuse will be highlighted as part of this work. It is important for the

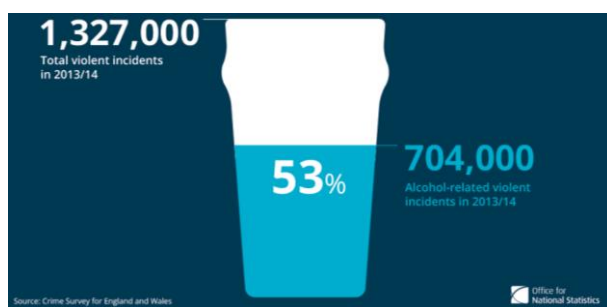
local suicide prevention work to recognise the role of substance misuse as a risk factor locally, and consider the local action plan in light of this.

- One of the key gaps identified is in terms of service provision for those with substance misuse problems and mild to moderate mental health problems. Currently there is not a statutory service that these individuals can access to address their mental health needs. The service pathway and options for addressing this gap need consideration. Furthermore, this group should be considered when reflecting upon improvements on data capture.
- There is a clear need for more research specific to dual diagnosis, particularly in adolescents. Currently it is difficult to say which interventions are better than mainstream treatment for those with multiple needs. This should be a consideration when looking at local services, ensuring that there is adequate evaluation in place, which may require consideration of data sharing agreements.
- It is important to recognise the importance of engaging the education system as initial signs from those working with schools suggest that attitudes are changing as schools change. It is important to consider this issue as a whole in terms of drugs and alcohol, not just those with a dual diagnosis or engaging with the criminal justice system. This will require engagement with schools to understand the best way to address this issue.
- In recognition of the dearth of evidence available in terms of service models, it is important to evaluate any new service models implemented to contribute to the evidence base. Currently there are several service models around the country, but there is not accessible literature on the impact on outcomes, patient experience or cost effectiveness.
- In terms of dual diagnosis training, it is important to ensure that new or changing services are accessing the training. Furthermore, it is important that the value of dual diagnosis training is recognised in existing services, particularly in terms of ensuring new staff are trained.

## CHAPTER 10: Drugs and alcohol in the criminal justice system

There is a significant relationship between substance misuse and the criminal justice system. Drug or alcohol addiction may fuel or exacerbate criminal activity, for example through theft to meet the cost of purchasing supplies.

**Figure 73: Infographic showing proportion of violent incidents in 2013/14 in England that were alcohol-related. Source: ONS, Crime Survey for England.**



The criminality associated with substance misuse can have a significant impact on the victims and surrounding community. There is also a resultant high proportion of offenders within the criminal justice as a whole with drug and alcohol misuse problems that require treatment services and interventions.

## What the data tells us.

**Headlines:** There is a strong link between drug and alcohol misuse and different types of criminal behaviour. The aim is to ensure that those involved are able to access treatment whilst in and on release from the criminal justice system, as this is associated with preventing further criminal activity.

### National

- The 2013/14 Crime Survey for England found that 53% of violent incidents were alcohol related.
- The 2013/14 Crime Survey found that 36% of domestic violence incidents the victims believed the offender to be under the influence of alcohol.
- In 2014 there were a total of 8,210 drink driving casualties in Great Britain, which was the lowest on record. 77% of those seriously killed or injured are male. The highest proportion of those drivers and riders killed and over the alcohol limit were between 25-39 years old, 25% of those killed were in this age group.
- In 2014/15 the HM Chief Inspectorate Annual Report surveyed samples from 49 adult prisons and found 41% of women and 28% of men had problems with drugs and 30% of women and 19% of men said they had a problem with alcohol.

### Cambridgeshire

- In 2012/13 the estimated levels of alcohol related crimes indicated that the levels of alcohol related crimes is highest in Fenland and Cambridge. (These figures are due to be updated).
- A study in Cambridge City between 2011/12 to 2012/13 found that over half of the 100 incidents in a sample from the extended city area were linked to alcohol.
- From 2011 there was an apparent decline in drug related offences.
- In 2015 there were 1,781 drug related offences (although there are caveats about the robustness of drug related crime with the National Statistics badge being removed from police statistics in 2014).
- Between 2011 and 2015 there were 310 drivers from Cambridgeshire and Peterborough reported as being impaired by alcohol at the time of having a collision. Locally, the peak age band for drivers reported as being impaired by alcohol at the time of having a collision is 20-24 years old but numbers remain high up to age 34.
- The Criminal Justice Monthly Reports caseload data for December 2015 recorded 143 clients with and 135 in structured treatment, mostly for opiate use. Over 50% accessed Service voluntarily. (clients in the criminal justice system who are in treatment).



## National estimates

Drug users are estimated to be responsible for between a third and a half of acquisitive crime.<sup>307 308</sup> In addition, their role in violent crimes is considerable. According to the 2013/14 Crime Survey for England, 53% of violent incidents were alcohol-related (**Error! Reference source not found.**). Reducing the amount of 'alcohol-fuelled violent crime' is one of the key outcomes of the most recent government Alcohol Strategy.<sup>309</sup> Research also typically finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault.<sup>310 311</sup>

Drug and alcohol misuse is known to be particularly prevalent amongst the prison population with a large scale survey of over 3,000 prisoners (on remand or sentenced), undertaken in 1997, showing that over half of the male prisoners recorded hazardous drinking levels in the year before going to prison (58% of male remand<sup>312</sup> and 63% sentenced male prisoners).<sup>313</sup> The prevalence amongst females in the year before entering prisons was over 30% (36% of female remand prisoners and 39% of sentenced male prisoners).<sup>313</sup> 54% of female and 51% of male remand prisoners reported a measure of drug dependence in the year before prison.<sup>313</sup> Particularly high levels of dependency prior to coming to prison were seen among men held for burglary and women on remand for theft, with over 70% reporting some drug dependence.<sup>313</sup>

The Psychiatric Morbidity Survey is now almost 20 years old, however, more recently HM Chief Inspectorate Annual Report for 2014-15 also surveyed samples from 49 adult prisons.<sup>314</sup> The report found that higher proportions of women than men said they had a problem with drugs (41% against 28%) or alcohol (30% against 19%) on arrival into prison, but mandatory drug testing and reports from staff and prisoners indicated that drug misuse was less common in women's prisons, with misuse of medication the main concern.

## Alcohol Related Crime

Alcohol related crime usually refers to alcohol-defined offences, such as driving with excess alcohol, and offences in which the consumption of alcohol is thought to have played a role, such as assault or criminal damage where the individual was thought to be under the influence of alcohol.<sup>315</sup> There is likely to be under-reporting of alcohol related crimes as individuals may not always be tested for alcohol consumption following a crime, and not all incidents will be reported. In particular, those crimes which are considered 'minor', such as driving whilst under the influence but where no injury has been inflicted, are not necessarily considered notifiable in the national data.

<sup>307</sup> MacDonald et al. (2005). Measuring the harm from illegal drugs using the Drug Harm Index. Home Office Online Report 24/05.

<sup>308</sup> National Offender Management Service. (2014) Supporting Community Order Treatment Requirements.

<sup>309</sup> HM Government (2012) The Government's Alcohol Strategy. [Produced under the coalition government.]

<sup>310</sup> Bennett, L & Bland, P. 'Substance Abuse and Intimate Partner Violence', National online recourse centre on violence against women.

<sup>311</sup> Institute of Alcohol Studies (2014) Alcohol, Domestic Abuse and Sexual Assault.

<sup>312</sup> 'Remand' refers to the decision by a court to ensure an individual spends time in prison (or secure centre for young people if under 18 years) until their hearing at a magistrates' court. Source: <https://www.gov.uk/charged-crime/remand> (accessed 20th May 2016).

<sup>313</sup> Office for National Statistics (1997) Psychiatric morbidity among prisoners: Summary report.

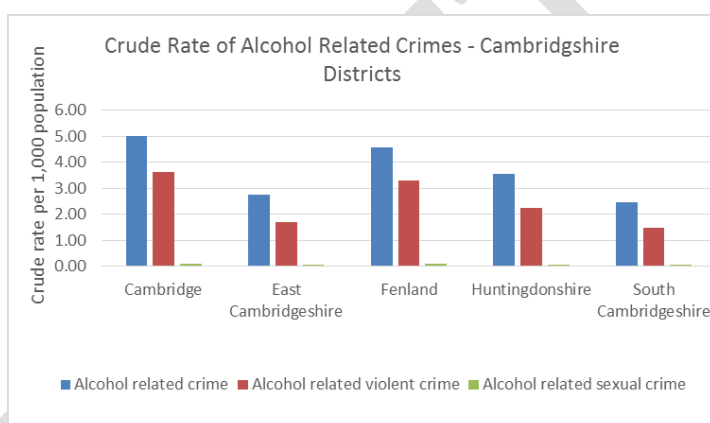
<sup>314</sup> HM Chief Inspector of Prisons for England and Wales (2015) Annual Report 2014-15.

<sup>315</sup> Institute of Alcohol Studies. UK Alcohol-Related Crime Statistics.

Alcohol related crime data has previously been reported as part of the nationally produced Local Alcohol Profiles, however, the data has not been updated since 2012/13 because the methodology for generating them is currently under review. New data is due to be published in summer 2016.

The 2012/13 for alcohol-related crime data found in Figure 74 are estimates produced by applying an 'attributable fraction' for the influence of alcohol, ascertained from a sample from 16 police stations collecting data for groups of crimes, which was then applied to police reported data.<sup>316</sup> This methodology only enables an estimate to be made and it may not truly reflect what is seen in reality. The estimates suggest that the level of alcohol related crimes and violent crimes is highest in Cambridge and Fenland. Alcohol related sexual crime rates are particularly low, but under-reporting of sexual crimes in general is known to be an issue.

**Figure 74: Crude Rate of Alcohol Related Crimes in Cambridgeshire Districts per 1,000 population 2012/13**



**Source: Local Alcohol Profiles**

Local analysis of police data was attempted by the Research Team at Cambridgeshire County Council. It was not possible to accurately identify the number of incidents of alcohol-related violent crime locally. Specific key word searches were used to pull out the relevant police data such as 'drunk', 'intox', 'drinking', 'alcohol' etc. but the data that this produced was not felt to be sufficiently reliable to include in this report. This may be because of the reporting and recording of alcohol as a factor in the crime. Furthermore, A&E and ambulance data was reviewed to establish whether it would be possible to identify violence related to alcohol. Unfortunately it was not possible to distinguish between specific types of incident, for example, those including a relationship with drugs or alcohol.

The Cambridgeshire Research & Performance Team did a detailed analysis of anti-social behaviour in the Cambridge City area across a two year period (2011/12-2012/13). The study found that over a

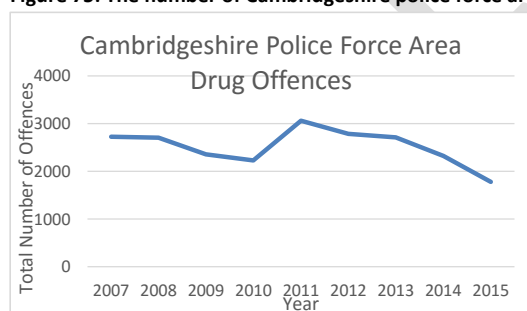
<sup>316</sup> Public Health England (2014). User Guide: Local Alcohol Profiles for England 2014.

half of the 100 incidents in the sample of the extended city area were linked to alcohol. In particular, issues of street drinking and the night time economy. It is important to highlight that this information is drawn from antisocial behaviour data that are not an accredited national statistic because of well-known problems with data quality. The data is not subject to the requisite level of data assurance, there are problems with multiple reporting of a single incident, and inconsistencies exist between constabularies regarding reporting.<sup>317</sup>

## Drug Related Crime

Figure ?**Error! Reference source not found.** shows the police reported drug offences for the Cambridgeshire Police Force since 2007. At the end of December 2015, there were 1,781 drug related offences recorded by the police. The data shows a peak in 2011 followed by a steady decline since then. This data, and in particular trends, should be interpreted with particular caution. The 'National Statistics' badge was removed from police reported data in 2014 because of concerns over data quality.<sup>318</sup> In addition, drug data is particularly affected by changes in police activity and priorities, therefore the data may not provide a true local picture of criminality.<sup>318</sup>

**Figure 75: The number of Cambridgeshire police force area drug offences by year.**



**Source: Office for National Statistics. Police Reported Crime Data (April 2016)**

## Drink Driving

In 2014 there were a total of 8,210 drink driving casualties in Great Britain, which was the lowest on record.<sup>319</sup> It is estimated that 220 of these were fatal. Across all road accidents 70% of those seriously killed or injured are male (based on 2014 data) and this rises to 77% for drink driving accidents. The highest proportion of those drivers and riders killed and over the alcohol limit are between 25-39 years old. 25% of those killed in 2014 were in this age group. Drink driving data is based on breath tests taken at the scene of an accident or toxicology reports from coroner's reports. Alcohol or drugs may also be recorded as a contributory factor by police officers following a collision.

<sup>317</sup> Cambridgeshire County Council Research and Performance Team (2013). Estimating the scale and nature of street based anti-social behaviour in Cambridge City.

<sup>318</sup> Office for National Statistics (2016) User Guide to Crime Statistics for England and Wales.

<sup>319</sup> Department for Transport (2016) Reported road casualties in Great Britain: Estimates for accidents involving illegal alcohol levels: 2014 (final) and 2015 (provisional).

In the five years 2011 to 2015 there were 310 drivers from Cambridgeshire and Peterborough reported as being impaired by alcohol at the time of having a collision.<sup>320</sup> 13 of these were involved in fatal collisions, 80 in serious collisions and 217 in slight collisions. Locally, the peak age band for drivers reported as being impaired by alcohol at the time of having a collision is 20-24 years old but numbers remain high up to age 34. Between 2011-2015 there were also 27 cyclists from Cambridgeshire and Peterborough reported as being impaired by alcohol at the time of having a collision.

### **Partner abuse and alcohol or illicit drugs**

Research typically finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault.<sup>321</sup> <sup>322</sup> The 2013/14 Crime Survey for England and Wales found that in 36% of domestic violence incidents victims believed the offender(s) to be under the influence of alcohol.<sup>323</sup> Whilst it is difficult to establish causation, there does appear to be an association. Victims of intimate partner violence may also be more at risk of substance misuse. This relationship may, in part, be mediated by the greater risk of mental illness that could be experienced following abuse. Alcohol or drugs could also be used as a means to cope with abuse or a mental illness.<sup>324</sup>

Locally the 'Cambridgeshire and Peterborough Domestic Abuse and Sexual Violence Partnership' is made up of key agencies that have a role in preventing, and providing services and support to survivors of domestic abuse and sexual violence.

<sup>320</sup> Cambridgeshire County Council Road Safety Education Team (2016).

<sup>321</sup> Bennett, L & Bland, P. 'Substance Abuse and Intimate Partner Violence', National online recourse centre on violence against women.

<sup>322</sup> Institute of Alcohol Studies (2014) Alcohol, Domestic Abuse and Sexual Assault.

<sup>323</sup> Office for National Statistics (2015) Findings from the 2013/14 Crime Survey for England and Wales and police recorded crime over the same period on violent crime and sexual offences. Chapter 5- Violent Crime and Sexual Offences - Alcohol-Related Violence.

<sup>324</sup> Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P. J., Kaewken, O. (2015). An applied research paper on the relationship between intimate partner violence and substance use. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health.

### Cambridgeshire adult treatment services

Service data is submitted to the National Drug Treatment Monitoring System (NDTMS) and compiled in the Criminal Justice Monthly Reports. Based on data from December 2015, 143 clients were on the caseload and 135 of these were in structured treatment. There were 16 new referrals to structured treatment. Of the caseload, 91% were of White British ethnicity and 78% were males. From the start of September through to end of December there were an average of 19 new referrals to structured treatment a month (range = 15 to 22). The average time on the caseload was 265 days.

Table? shows the number of clients accessing the Criminal Justice Intervention Team (CJIT) by substance used – the majority of clients were opiate users (123 in December 2015) and 95% (117 clients) of these were in structured treatment.

**Table 60: Substance use of clients accessing Criminal Justice Intervention Team (December 2015).**

Substance use of clients	Number of clients on caseload in month	Number of clients on caseload in month also in structured treatment
Opiates	123	117 (95%)
Non-opiates, alcohol, alcohol and non-opiate, no main drug	20	18 (90%)
Alcohol	6	6 (100%)

**Source: NDTMS.**

The majority of clients access the service on a voluntary basis with 52% of the caseload (75 clients) accessing following release from prison, and almost 95% if these were in structured treatment (Table ?). A further 36 clients accessed the service via other voluntary routes with small numbers being required to participate in the service.

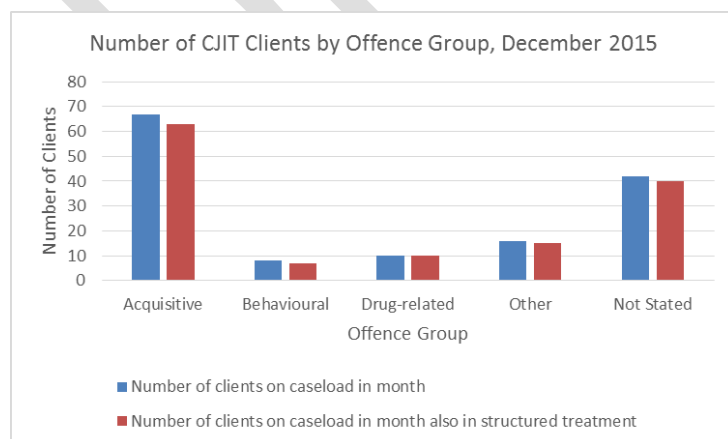
**Table 61: Number of clients by referral route, numbers smaller than five have been suppressed (December 2015)**

	Number of clients on caseload in month	Number of clients on caseload in month also in structured treatment
Voluntary following release from prison	75	71
Voluntary Other	36	32
Required by PPO scheme	8	8
Required assessment imposed after positive test	<5	<5
Restriction on bail	<5	<5
Conditional Caution	<5	<5
Pre-sentence Report	<5	<5
Voluntary following cell sweep	<5	<5
Referred by treatment provider (post-treatment)	<5	<5
Required by Offender Manager	<5	<5
Other	8	8
Not stated	<5	<5

Source: NDTMS

Figure 76: Figure ? shows the offences associated with the clients, the majority of whom fell within the acquisitive crime group (e.g. burglary and theft) (67 clients), 94% of which were accessing structured treatment.

**Figure 76: Number of clients accessing CJIT by offence group (December 2015).**



Source: NDTMS

## Prevention of criminal activity

[Source: Public Health England. Drug data: PCC support pack Cambridgeshire PFA. Summary of area data for Police and Crime Commissioners in 2013-14]

Data from the Department of Health endorsed Local Value for Money tool suggests nearly 65,000 crimes were prevented in Cambridgeshire during 2012/13 from people being in effective drug treatment (Table ??).

**Figure 77: In-year estimated crimes prevented from people being in effective drug treatment, Cambridgeshire PFA, 2012/13**

Crime	Number of crimes prevented
Buying/selling stolen goods	20,999
Drug dealing	16,630
Shoplifting	14,398
Prostitution	4,622
Begging	2,380
Other stealing	1,721
Cheque/credit card fraud	793
Theft from a vehicle	725
Business burglary	657
Robbery	455
Bag snatch	326
Theft of a vehicle	256
House burglary	223
Total	64,185

Data from September 2013 indicate that 30% of clients in treatment in Cambridgeshire had a prior conviction, the same as the England average.

In 2013/14, 269 people were released from prison and transferred to community treatment in Cambridgeshire. Of these, 43% were successfully engaged in treatment, higher than the national average of 29%.

## Prisons

Although prison settings are beyond the scope of this JSNA, for completeness, data relating to substance misuse in prisons has been included in this section. The prevalence and details of substance misuse within prisons is also relevant to those that will be accessing community services following release from prison.

Prisons are inspected at least once every five years and assessed on the basis of expectations that fall within four tests of a 'healthy establishment'. Within this assessment they survey a proportionate sample of the prison population and include questions on drugs and alcohol use prior to entering the prison. The data from the most recent inspection reports for Cambridgeshire and Peterborough prisons is presented in Table 62.<sup>325 326 327 328</sup> On interpretation, it must be considered that this data is self-reported and based on recall. Responses from a representative samples of prisoners within each establishment responding to: 'Did you have a problem with [drugs/alcohol] when you came into this prison?'

**Table 62: Cambridgeshire and Peterborough inspection reports**

Prison	Drugs		Alcohol		Date of Inspection
	Yes	No	Yes	No	
HMP and YOI Peterborough (women)	44% (65)	56% (83)	27% (39)	73% (108)	July 2014
HMP Peterborough (men)	28% (44)	72% (113)	17% (27)	83% (129)	February 2015
HMP Littlehey	13% (27)	87% (183)	12% (25)	88% (185)	March 2015
HMP Whitemoor	10% (14)	90% (127)	10% (14)	90% (125)	January 2014

The annual report of HM Chief Inspectorate also highlights the impact of novel psychoactive substances (NPS), particularly in male prisons. A reported increase in violence in male prisons has been attributed, in part, to NPS either directly as a result of prisoners being under the influence of these drugs or in increased bullying due to drug debts.

## Mental Health

The Psychiatric Morbidity Survey, undertaken in 1997, found that of the over 3,000 prisoners (on remand and sentenced) over 90% had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence).<sup>313</sup> Personality disorder was particularly prevalent with 78% male remand prisoners and 50% of female prisoners having a personality disorder. Co-occurrence of mental disorders (substance misuse was included within this definition) was also high, and in particular those with drug dependence of all kinds were far more likely to be assessed as having personality disorder than those without dependence.<sup>313</sup>

<sup>325</sup> HM Chief Inspector of Prisons (2015) Report on an unannounced inspection of HMP Littlehey.

<sup>326</sup> HM Chief Inspector of Prisons (2014) Report on an unannounced inspection of HMP Whitemoor.

<sup>327</sup> HM Chief Inspector of Prisons (2015) Report on an unannounced inspection of HMP Peterborough (men).

<sup>328</sup> HM Chief Inspector of Prisons (2015) Report on an unannounced inspection of HMP & YOI Peterborough (women)



## Local Services

### Children and Young People

#### Youth Offending Service (YOS)

The Cambridgeshire County Council Youth Offending Service provide drug and alcohol misuse interventions to young people (10-18 years) in the Criminal Justice System on 'out-of-court disposals' and 'court disposals'. An out-of-court disposal is a way of dealing with a crime or offence that does not require a prosecution in court e.g. Youth Cautions and Youth Conditional Cautions. The Substance Misuse Team deliver Tier 3 interventions and advise YOS Officers on their delivery of Tier 1 and 2 interventions. Individuals that require higher level Tier 3 interventions and complex cases are referred to the Cambridgeshire Child and Adolescent Substance Use Service (CASUS), which is provided by CPFT. The pathway for referrals is illustrated in **Error! Reference source not found.**

Young people access the service via community out of court disposals or the court system. Those that attend following a community resolution or youth caution will be voluntarily engaging with the service, however, non-compliance has implications for future disposals in the case of a youth caution. Engagement can be enforced as part of a youth conditional caution.

Individuals that proceed through the court system and receive a Youth Rehabilitation Order will be screened (using Asset Plus tool) by a YOS Case Manager and if suitable referred to the substance misuse team. Similarly, following a "Referral Order", a Youth Offending Panel may refer an individual to a YOS Case Manager for screening. If the individual is already engaged with the CASUS service, then a joint decision will be made as to which service the individual accesses. Those with particularly high needs or very short orders will also be referred to CASUS.

The Asset Plus assessment tool is being rolled out across the country, and was introduced locally in February 2016. The tool enables a broad assessment that encompasses health issues and identifies those who abuse substances. YOS Case Holders are trained to provide universal educational work with targeted and specialist interventions being delivered by the substance abuse team.

The support provided by the substance abuse team will cover a range of aspects of substance misuse; legal aspects, physical and mental health effects and what the individual knows about substances. They also offer therapeutic work such as motivational interviewing, solution focused and person centred interventions. A psychologist is based within the YOS, so can also provide additional support as required.

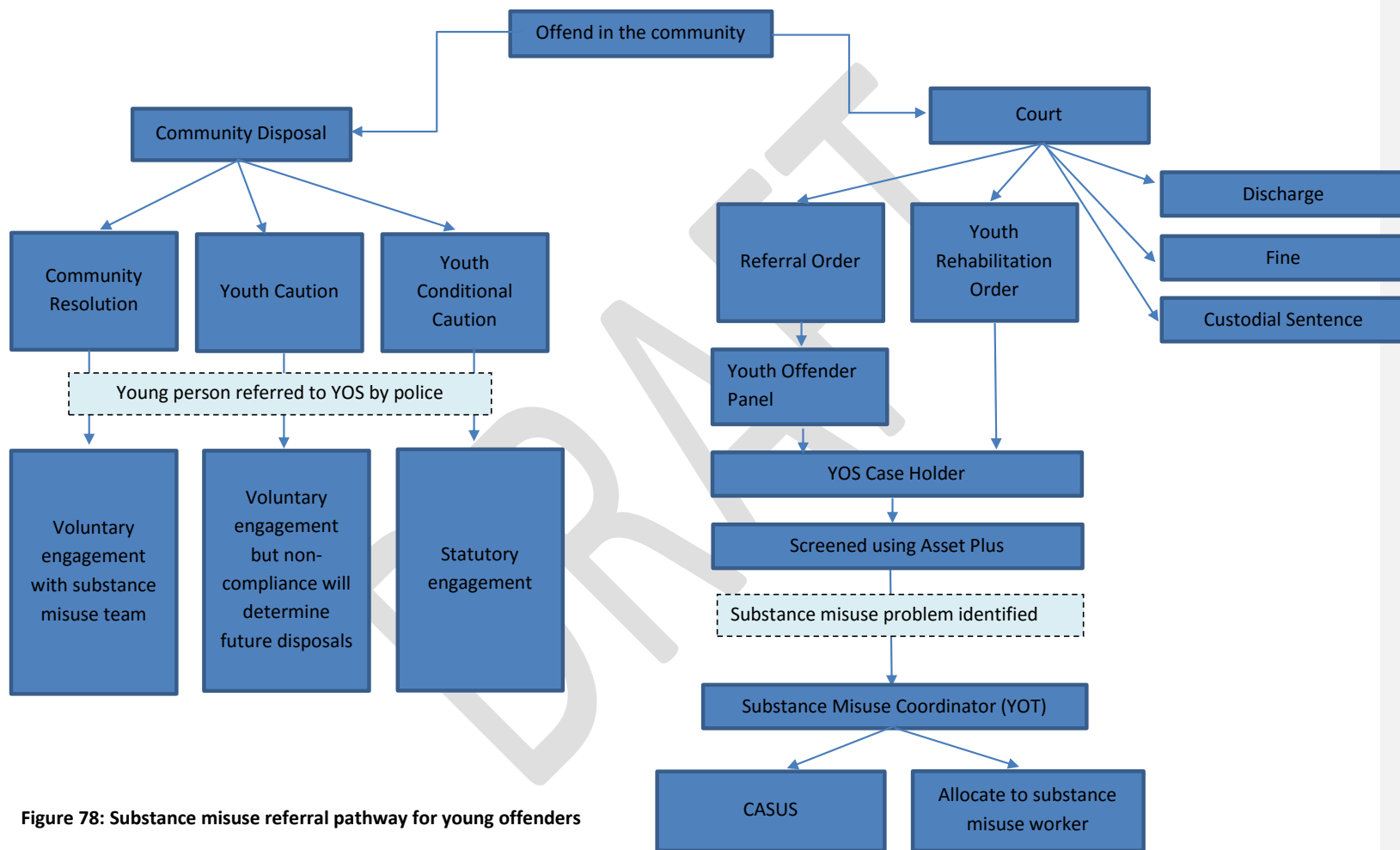
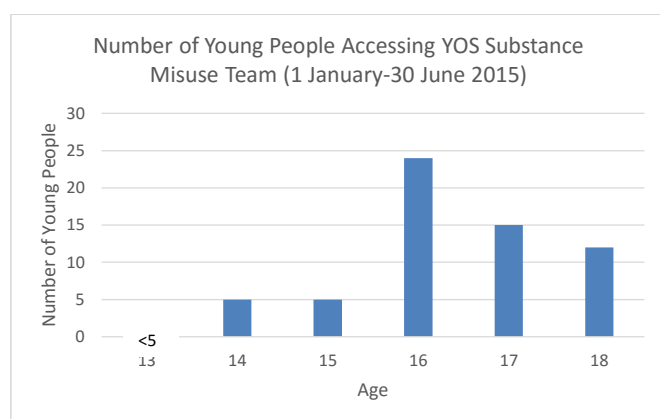


Figure 78: Substance misuse referral pathway for young offenders

The age profile of those accessing the YOT substance misuse team is shown in Figure 79, the average age was 16 years and 95% were males, anecdotally this is reflective of the young people accessing the YOS as a whole. 72% of young people were 'White British', and 10% were of 'Any Other White Background'. Of the referrals to the service, 55% were court disposals (vs. 45% out of court disposals) and the majority of these were referral orders (65%). The majority of out of court disposals were community resolution programmes (46%) or youth cautions and conditions (32%).

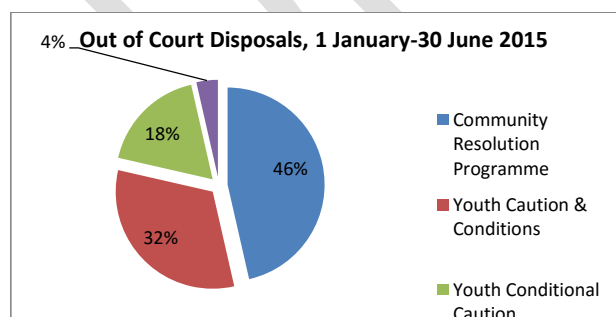
**Figure 79: Age profile of young people accessing the YOS Substance Misuse Team between 1 January - 30 June 2015.**

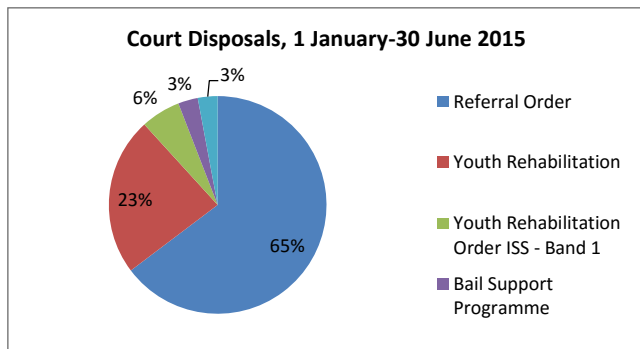


Source: Magilton, S. (2016) Review of the Provision of Specialist Substance Misuse Treatment in Cambridgeshire Youth Offending Service and CASUS.

#### *Types of referrals to YOS*

**Figure 80: Breakdown of referrals to the YOS by type of Disposal, 1 January-30 June 2015.**





Source: Magilton, S. (2016) Review of the Provision of Specialist Substance Misuse Treatment in Cambridgeshire Youth Offending Service and CASUS.

In some cases, a young person who is referred to the YOS will access substance misuse support via CASUS, this may occur if the young person is already accessing treatment with CASUS, they have a very short order or they have a particularly high level of need. Between 1 January - 30 June 2015 those referred because of their high level of need were most often for mental health issues that were escalating in risk, for example, a young person presenting with psychosis. During this period, approximately six cases were referred to CASUS from YOS for high end needs. Between 5-10 individuals remained with CASUS throughout the disposal, with CASUS and the YOS working jointly. Less than five young people were referred to CASUS for continued support post disposal.

- Cannabis (50)
- Alcohol (7)
- Cannabis and Alcohol (<5)
- Cocaine (<5)
- MDMA (<5)
- Ketamine (<5)
- Cannabis (<5)
- Cocaine (<5)

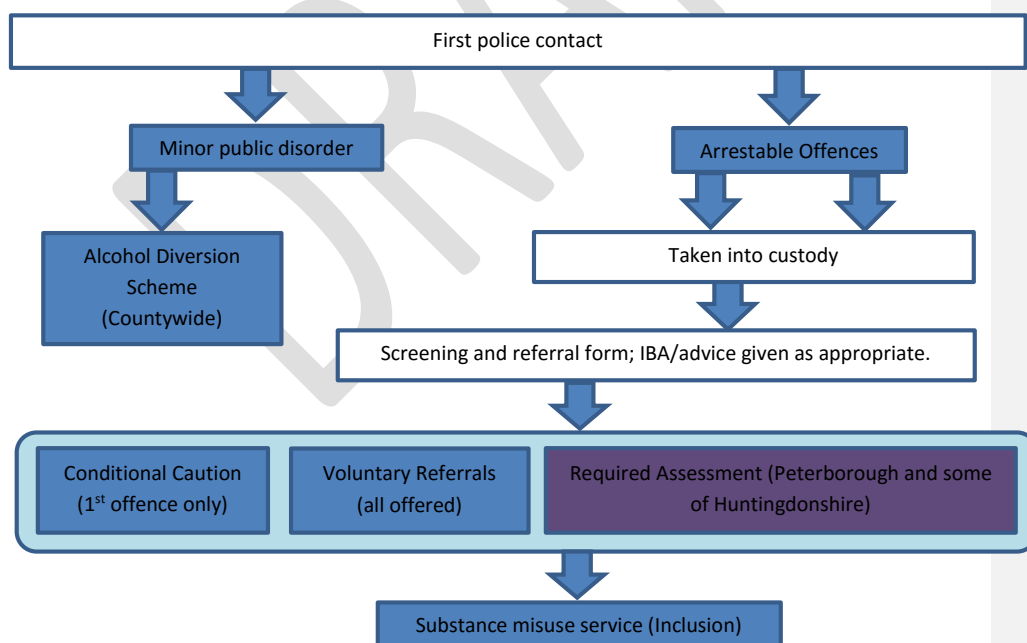
## Adult services

Drug and alcohol misuse services within prisons are commissioned by NHS England and delivered by prison in-reach teams. Individuals may enter the service via a variety of routes as illustrated in Figure?

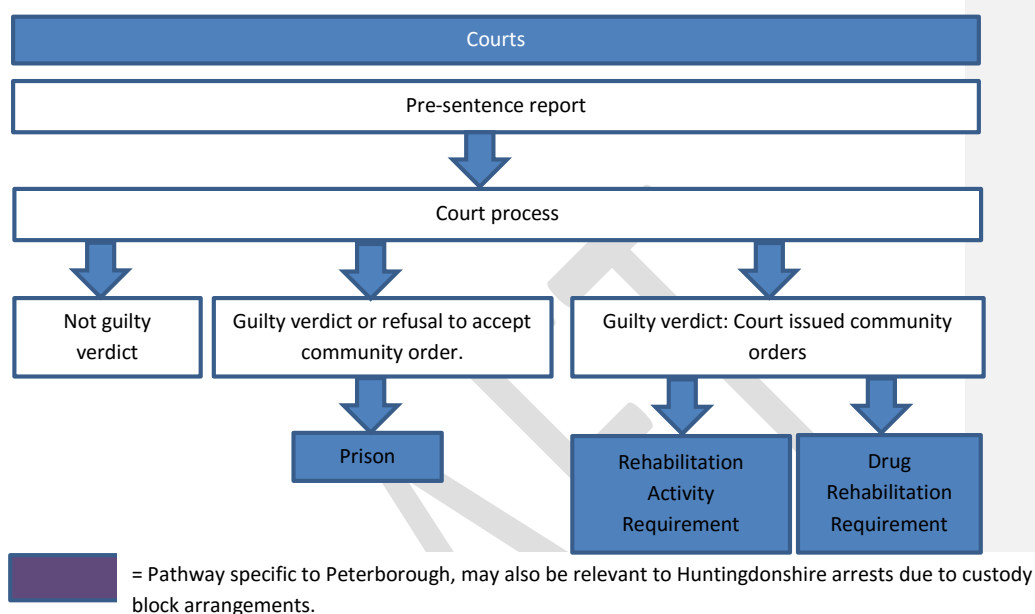
At the first contact with the police, an offender may be offered the chance to avoid arrest, and thus a criminal record, via the Alcohol Diversion Scheme which is commissioned by the police. The service is offered countywide, allowing participants to attend an awareness session (covering effects of behaviours etc.) instead of being arrested. Alternatively the individual may not wish to take up this offer, or may have committed an arrestable offence, and therefore be taken into custody.

Those who are taken into custody are screened for substance misuse, and brief advice given as appropriate. A referral may be made to the substance misuse service on a voluntary basis. In some cases an offender may receive a conditional caution (first offence only) which is a police custody based caution with the added requirement for an offender to attend the substance misuse service. This is voluntary and forms part of the national Drug Interventions Programme (DIP) initiative. In parts of Huntingdonshire individuals may also be tested for drugs on arrest (required assessment) and have mandatory referral to drug treatment, however, it is not mandatory to engage with the service.

**Figure 81: Substance misuse pathway for adults entering the criminal justice system in Cambridgeshire.**



**Figure 82: Cambridgeshire substance misuse pathway for those entering the court setting.**



Those offenders that reach the court process will have a Pre-Sentence Report compiled which takes into account previous offences, including trigger behaviours such as substance misuse (Figure ?). If drugs and alcohol are identified, then the report writer (Probation Officer) should approach the treatment service for a recommendation which might, for example, include whether a community-based intervention is suitable.

If the individual is given a custodial sentence they will access the healthcare provided within a prison. However, if the individual receives a guilty verdict and is issued with a community order they may be subject to treatment requirement. Twelve possible requirements can be made as a condition of a community order or suspended sentence including:<sup>329</sup>

- The Drug Rehabilitation Requirement (DRR)
- The Alcohol Treatment Requirement (ATR)

<sup>329</sup> National Offender Management Service (2015) Healthcare for Offenders. <https://www.gov.uk/guidance/healthcare-for-offenders> (accessed 7.4.16)

DRRs comprise structured treatment and regular drug testing. The amount and intensity of drug treatment delivered under the DRR can be tailored to individual needs regardless of the seriousness of the offence.

## **Prisons**

An individual will receive a full assessment to identify any drug and alcohol issues when entering prison. There are three within the Cambridgeshire and Peterborough area (Peterborough prison [category B], Littlehey Prison [category C], Whitemoor Prison [category A]). Within Peterborough Prison, this is undertaken by a screening nurse within 24 hours of entering the prison. Individuals will then be offered treatment from services commissioned via NHS England and delivered in the prisons.

Locally, the Substance Treatment Action and Recovery Team (START) which is part of the Inclusion Community Drug and Alcohol Treatment Service, accept the majority of referrals from local and resettlement prisons. The team includes a prison-link worker who engages with prospective service users in the prisons to aid transition to the community upon release. Individuals will still then need to present to the community based service once released to access treatment. This service also relies on the prisons notifying the service of substance users, and these will largely be the prescribed opiate clients who would like to actively engage with substance misuse services.

## **Integrated Offender Management**

As part of Integrated Offender Management (IOM), the most persistent and problematic offenders are identified and managed jointly by partner agencies working together. They aim to contribute to effective release planning for prisoners, liaising as appropriate with a range of services such as mental health in-reach teams or local mental health services in the community in which the prisoner is being transferred to. The Integrated Offender Management Teams will screen referrals and signpost. They will also provide and deliver appropriate psycho-social support for service users aged 18 or over with mild to moderate psychological needs.<sup>330</sup>

An agreed cohort of offenders will be managed jointly by named police staff and case management staff using enforcement and rehabilitative techniques.<sup>331</sup> Cambridgeshire Drugs and Alcohol Action Team is a part of the county IOM scheme and is responsible for supporting the delivery of drug & alcohol treatment services to offenders within the cohort.<sup>331</sup>

## **Chronically Excluded Adults**

The Chronically Excluded Adults Service caters for particularly chaotic, high need individuals. Typically those accessing the service will have multiple problems, the complexity of which may not be well catered for in mainstream services. Working with these individuals may also require patience, with their often chaotic lifestyles making engagement more challenging. The service began in 2011/12 and now consists of one Project Manager and three Case Workers. The majority of clients that the service works with will be well known to services, but have a history of poor engagement or

<sup>330</sup> CPFT. Integrated Offender Management. <http://www.cpft.nhs.uk/services/integrated-offender-management.htm> (Accessed 14.06.16).

<sup>331</sup> Criminal Justice. Cambridgeshire DAAT. <http://www.cambsdaat.org/help-support/adult-treatment/criminal-justice/> (accessed 14.06.16).

unsuccessful interventions. Most clients, as reported in a 2015 Project Development Strategy,<sup>279</sup> had offending history (71%), were homeless, and had a mental health diagnosis (57%).

Analysis shows that of the 35 people that had accessed the service in a three year period, eight (20%) were consistently attending, or had completed treatment for, problematic alcohol and/or drug use.<sup>332</sup> Post-project intervention, this figure had risen to 19 individuals (54%). Arrests and contact with criminal justice system (including anti-social behaviour) also fell from 97% prior to engagement with the service, to 71% post intervention. Furthermore, in the 12 months prior to starting the project, 43% of individuals had been in prison and the figure after entry to the project fell to 14%.

A cost effectiveness analysis was undertaken to assess whether the investment in working intensively with this client group was countered by the savings to services. As Table ? shows, the intervention was deemed cost-effective by Year 2. The reduction in crime costs accounts for 90% of the costs saved by the project.<sup>279</sup>

**Table 63: Average annual cost of service use per client (Year 1 client group) and average per person reduction in service use in Year 2 compared to baseline**

	Baseline	Year 1	Year 2	Savings compared to baseline
Crime	£25,236	£18,012	£14,772	£10,464
Drug and alcohol	£1,644	£2,268	£1,740	-£96
Health	£2,016	£1,836	£1,968	£48
Mental Health	£7,368	£12,708	£6,228	£1,140
Housing	£7,248	£5,256	£7,320	-£72
Total	£43,512	£40,080	£32,028	£11,484

## Liaison and Diversion Service

The 2009 Bradley Report, a review of people with mental health problems or learning disabilities in the criminal justice system, recommended that ‘all police custody suites should have access to Liaison and Diversion services.<sup>333</sup> In Liaison and Diversion services, mental health nurses and other support staff are placed in police stations and courts with the aim of identifying people coming into the criminal justice system with mental health conditions, learning disabilities and other vulnerabilities. The aim is to promptly refer them into services to get the treatment or support they need. They also provide police and courts with up-to-date information to inform decisions around

<sup>332</sup> James, S. (2015) Chronically Excluded Adults Service In Cambridgeshire Project Development Strategy 2015-2018.

<sup>333</sup> Lord Bradley (2009) The Bradley Report.



sentencing and to ensure the right support is provided at the court stage. The service carries out a number of roles including:

- Identifying current vulnerabilities in adults and potential vulnerabilities in young people
- Enhanced screening
- Referral to other agencies
- Attendance at referral appointments<sup>334</sup>

## Evidence for effective treatment

### Children and young people

#### Motivational interviewing

One randomised controlled trial, which looked at group based motivational interviewing for young people (14-18 years), showed a potential impact on re-offending.<sup>335</sup> The trial compared 6 sessions of group based MI with six educational sessions (usual care) in those who had been referred to a teen court following a first offence (alcohol or cannabis related offence). 193 participants took part and of those that completed the six sessions, just over one in four youths in the usual care group had committed another offense (28%) compared to less than one in five (19%) among the intervention group. However, alcohol or drug use maintained or decreased slightly in each group with no significant difference between the two groups.

It should be noted at baseline there were significant differences between the intervention and usual care group, also this study took place in America where the criminal justice system is considerably different to the UK and the demographics of the study population are not the same as would be expected in UK settings.

Notably, this study was conducted in Santa Barbara in the US. This is an area where marijuana/cannabis is allowed on prescription for medical reasons. These individuals were excluded from this study, although they may have attended the same groups as the control participants. This is a very different system to the one operating in the UK and could impact on the ability to apply findings to local populations.

Overall there is very little high quality evidence specifically pertaining to substance misusing groups within the criminal justice system outside of prison settings for young people or adults. The existing evidence largely comprises of US based studies where the criminal justice system and demographics of the study groups differ to UK, which could hamper transferability of findings. The evidence does not currently give a clear direction as to which interventions should be provided to those within the criminal justice system that goes beyond mainstream services.

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<sup>334</sup> CPFT. Liaison and Diversion: Providing a service in police custody suites and courts throughout Cambridgeshire and Peterborough (Powerpoint presentation)

<sup>335</sup> D'Amico et al. (2013) A Randomized Controlled Trial of a Group Motivational Interviewing Intervention for Adolescents with a First Time Alcohol or Drug Offense. Substance Abuse Treat 45(5).

## Adults Psychosocial interventions

### Cognitive Behavioural Therapy (CBT)

A study by Carroll et al. (2006)<sup>336</sup> compared CBT/motivational enhancement therapy (MET) with a counselling based intervention based on the 12-step approach<sup>337</sup> and a strong focus on abstinence. These approaches were also compared with the addition of contingency management (CM) – offering financial reward for positive progress (negative urine samples and attendance at sessions in this case). Participants were 18-25 year olds and were referred for treatment for marijuana dependence by the Office of Adult Probation to a Substance Abuse Treatment Unit in America. Participants treated with the combination of CM and MET/CBT had significantly more consecutive marijuana-free urine specimens than those treated with MET/CBT without CM or individual drug counselling (DC) without CM

### Web-based options

MAPIT (Motivational Assessment Program to Initiate Treatment) is a web-based tool for offenders on probation, incorporating motivational interviewing theory. The tool is currently being trialled with 600 people on probation in the US.<sup>338</sup> MAPIT aims to increase motivation for substance misuse treatment and is accessed in two 30 minute sessions.<sup>338</sup> The tool suggests a range of coping strategies and supports goal setting and incorporates text message reminders of the goals set. Initial testing suggests those on probation could be amenable to using the tool, however, the impact on substance misuse outcomes will be evaluated via a randomised controlled trial (RCT).

### Female offenders

A 2015 Cochrane review<sup>339</sup> looked at the effectiveness of a range of interventions in female offenders that drug use. The review found that any psychosocial treatment, compared to treatment as usual, was associated with a reduction in re-incarceration but not on arrests or drug misuse.<sup>339</sup> This review included studies that were undertaken with incarcerated populations and of the 9 studies included, only three were community based. Two of these studies were considered to be psychosocial interventions (case management and collaborative behaviour management) and were therefore included in the aforementioned analysis.

### Brief interventions

Newbury-Birch et al. (2016)<sup>340</sup> recently conducted a rapid review of studies looking at brief interventions (BI) for alcohol use at various stages of the criminal justice system. They included face-

<sup>336</sup> The Use of Contingency Management and Motivational/Skills-Building Therapy to Treat Young Adults with Marijuana Dependence (2006). *J Consult Clin Psychol*. 74(5): 955–966.

<sup>337</sup> The 12 step approach was pioneered by *Alcoholics Anonymous* and is 12 guiding principles to recovery from alcoholism. The 12 principals have since been adapted by other programmes.

<sup>338</sup> Walter et al. (2014) MAPIT: Development of a web-based intervention targeting substance abuse treatment in the criminal justice system. *Journal of Substance Abuse Treatment* 46, 60–65.

<sup>339</sup> Perry et al. (2015) Interventions for female drug-using offenders (Review). Cochrane Collaboration. The Cochrane Library 2015, Issue 6.

<sup>340</sup> Newbury-Birch et al. (2016) A rapid systematic review of what we know about alcohol use disorders and brief interventions in the criminal justice system. *International Journal of Prisoner Health*. Vol. 12(1), 57-70.

to-face interventions that lasted three hours or less either in one session or spread over a period of time. They would usually be conducted with individuals who have been screened for their alcohol use and identified as at risk of harm. Studies included were not consistent in terms of the outcomes that they were measuring and were not always randomised controlled trials (RCTs), although they always had a comparison group.

The two studies identified based in custody suites,<sup>341 342</sup> that conducted BIs following arrest, showed no impact on re-offending following the intervention compared to a control group. However, both studies were identified to have a high risk of bias and were based on two phases of the same trial. Similarly, one study showed no significant impact on drinking or offending following a BI in a Magistrates Court setting.<sup>343</sup>

One probation based cluster RCT showed intervention groups were significantly less likely to re-offend following brief advice (36%) or brief lifestyle counselling (38%) compared to a control (50%) of receiving feedback following screening after 12 months. There was no change in drinking behaviour.<sup>344</sup>

### Pharmacological intervention

A 2015 Cochrane review was conducted to investigate the effectiveness of pharmacological interventions, such as buprenorphine, methadone and naltrexone, for illicit drug use in offenders.<sup>345</sup> In particular, their impact on drug use and criminal activity. Overall the review found, when compared to non-pharmacological treatment, there is low quality evidence that agonist treatments (such as methadone) are not effective in reducing drug use or criminal activity.<sup>345</sup> The review did find moderate evidence for the impact of antagonist treatment (naltrexone) on criminal activity, but not on drug use when compared to no pharmacological treatment.<sup>345</sup>

Only five of the 14 studies included took place in community settings, the remainder were secure settings. The variability and the small number of trials meant that subgroup analysis based on settings to establish variation on intervention effectiveness was not possible. Overall there was a relatively small number of studies identified (14 trials with 2,647 participants) and these largely comprised of male offenders, limiting transferability to female offenders in particular.<sup>345</sup>

A further 2015 Cochrane review looked specifically at the effectiveness of a range of interventions in female offenders that drug use.<sup>339</sup> The review only identified one pharmacological intervention which compared buprenorphine to a placebo in a community based intervention following release from residential treatment. There was no significant effect of the pharmacological intervention compared to the placebo. There were too few studies identified in the review to analyse variation by treatment setting.

<sup>341</sup> Kennedy et al. (2012). Evaluation of alcohol arrest referral pilot schemes (Phase 1), Occasional Paper No. 101, Home Office, London.

<sup>342</sup> McCracken et al. (2012). Evaluation of Alcohol Arrest Referral Pilot Schemes (Phase 2), Home Office, London.

<sup>343</sup> Watt et al. (2008), Drunk and dangerous: a randomised controlled trial of alcohol brief intervention for violent offenders, *Journal of Experimental Criminology*, Vol. 4(1), 1-19.

<sup>344</sup> Newbury-Birch et al. (2014), Alcohol screening and brief interventions for offenders in the probation setting (SIPS Trial): a pragmatic multicentre cluster randomised controlled trial. *Alcohol & Alcoholism*, Vol. 49(5), 540-48.

<sup>345</sup> Perry et al. (2015) Pharmacological interventions for drug-using offenders (Review). The Cochrane Collaboration.

## Intensive supervision

A systematic review conducted by Holloway et al. (2006)<sup>346</sup> investigated the effects of different kinds of intervention for problematic drug use on criminal behaviour. Meta-analysis showed that post-release supervision and maintenance prescribing were effective in reducing criminal behaviour, but this was across studies that were not necessarily solely made up of offenders. This review only included studies where individuals were using heroin, crack or cocaine.

A meta-analysis by Perry et al. (2009)<sup>347</sup> only included studies investigating the effect of interventions on offenders and covered any type of substance misuse. The meta-analysis found that of 4 studies identified comparing intensive supervision with routine parole/probation, only the re-offending outcome was less likely in the intervention group and not the substance misuse outcomes. When intensive supervision and increased surveillance were compared to intensive supervision alone, meta-analysis gave non-significant results. Of 13 community based interventions identified, 10 only reported on criminal measures and not substance misuse outcomes.

Guydish et al. (2004)<sup>348</sup> also looked at case management but specifically in the female substance misusing probation population. The study found that usual probation, when compared to a more intensive approach with the aim of increasing access to services, did not show any significant difference in outcomes. At any time point measured (six or 12 months) a considerable proportion of participants were incarcerated, in addition the demographics of the population differ to the expected UK probation population with, for example, over half of the participants being of African American ethnicity (57%)<sup>348</sup>.

Dakof et al. (2010)<sup>349</sup> also explored the use of Intensive Case Management (ICM) for female substance misusing offenders compared to the 'Engaging Moms Programme' (EMP). The EMP has been trialled within the family drug courts system in America. Drug courts look to social and therapeutic solutions as opposed to purely legal interventions for those offenders who misuse substances. Family drug courts specifically aim to work with parents who use drugs or alcohol in an attempt to keep families together.<sup>350</sup> The presence of drug courts varies across the UK.

EMP is based on multi-dimensional family therapy with individual and family sessions that may focus on areas of motivation, parenting skills and relationships.<sup>349</sup> This differs to the ICM approach which in this study incorporated an advocacy, coordination and supervisory role.<sup>349</sup> Improvements were seen across a number of outcomes at 18 month follow-up including alcohol use across both groups. Although the study reports a positive impact on alcohol use with larger effect sizes in the EMP group, when comparing groups there was not a significant difference between the two groups. It is important to consider that this was a relatively small study (69 participants) and there was not a true

<sup>346</sup> Holloway et al. (2006) The effectiveness of drug treatment programs in reducing criminal behavior: A meta-analysis. *Psicothema* 2006. Vol. 18(3), 620-629.

<sup>347</sup> Perry et al. (2009). The Effectiveness of Interventions for Drug-Using Offenders in the Courts, Secure Establishments and the Community: A Systematic Review. *Substance Use & Misuse*, 44:374-400.

<sup>348</sup> Guydish et al. (2004) A Randomized Trial of Probation Case Management for Drug-Involved Women Offenders. *Crime Delinq.* 57(2), 167-198.

<sup>349</sup> Dakof et al. (2010) A Randomized Pilot Study of the Engaging Moms Program for Family Drug Court. *Subst Abuse Treat.* 38(3), 263-274.

<sup>350</sup> Corram. Family Drug and Alcohol Court. <http://www.coram.org.uk/supporting-parents/family-drug-and-alcohol-court> (accessed 14.6.165)

(non-drug court) control group. In addition this was an American study focusing on family drug courts, which are not found in all areas of the UK.

## **Diversion**

‘Diversion’ refers to the process of identifying people who commit crimes and also use drugs to direct them into drug treatment as part of, or instead of, their sentence.<sup>351</sup> Typically this will take place following an arrest. A 2015 review assessed whether or not diversion and aftercare strategies for class A drug-using offenders are likely to be clinically effective or cost-effective compared with no diversion or aftercare. 16 studies were included in the review, of which four were UK based. Notably, a large proportion of the studies were reporting on interventions with methamphetamine using offenders in the US. The studies were also largely of poor methodological quality.

The limited meta-analysis that was possible showed a potential small impact of interventions on drug use outcomes in terms of the primary drug use and use of other drugs. The study also looked at cost-effectiveness of diversion and aftercare. There were no relevant studies identified but the study did also carry out economic modelling based on the UK drug intervention programme (DIP). There was considerable variation in net costs reported and overall analysis showed that the likelihood that diversion is cost-effective is just over 50%. There is a recognised paucity of evidence in this area though so no strong conclusions can be drawn in terms of cost-effectiveness or cost savings.

## **Combining probation and substance misuse treatment services**

One identified study evaluated the impact of placing a treatment provider into probation services. The intervention included probation officers and treatment services staff working together to deliver services including cognitive behavioural group therapy sessions.<sup>352</sup> The probation officer is aware of the offender’s drug treatment progress and can reinforce goals. This would be in contrast to typical services that may be offered on a different site, which could result in less communication between treatment and probation services.

The study did not measure substance misuse outcomes but re-offending levels were lower in the combined group, however, the greater hospitalisation and intensity of supervision meant financial costs were higher.<sup>352</sup> Overall the intervention was \$6,293 more expensive than traditional probation per client per year.

## **Dual diagnosis**

As previously mentioned a large proportion of offenders with substance misuse problems will also have a mental illness. A Cochrane review looked specifically at the effectiveness of interventions working with substance misusing offenders, particularly looking at substance misuse and reoffending outcomes. Of the 8 studies included, six were based in incarcerated settings. One of the studies

<sup>351</sup> Hayhurst et al. (2015). The effectiveness and cost-effectiveness of diversion and aftercare programmes for offenders using class A drugs: a systematic review and economic evaluation. *Health Technology Assessment* 19(6).

<sup>352</sup> Alemi et al. (2006) Costs and Benefits of Combining Probation and Substance Abuse Treatment. *J Ment Health Policy Econ* 9, 57-70.

compared assertive case management with treatment as usual in a mental health drug court.<sup>353</sup> The study showed no significant reduction in criminal activity and no data was collected on the substance misuse outcomes. The review also deemed the evidence to be of very low quality.

## NICE guidelines

NICE Guidance on the 'Mental health of Adults in Contact with the Criminal Justice System' is currently in development and will be published in February 2017. Drug and alcohol problems are included within the scope of the guidance.<sup>354</sup> This guidance will follow a review of the evidence specific to the criminal justice system in terms of the structure and systems for the delivery of health and social care services. The guidance will cover:

- Identification and assessment, interventions and their adaptation to the criminal justice system.
- The organisation and provision of services for people with mental health problems in contact with the criminal justice system.
- Training or education needed to enable health, social care and criminal justice professionals and practitioners to provide good-quality services.

## What is this telling us?

Upon consideration of the assessment of need, the evidence base for interventions, feedback from stakeholders and current service provision, the following key findings have been identified:

- Communication and information sharing

There are a number of challenges relating to communication or information sharing barriers.

- In particular in relation to the START team receiving notification of potential clients prior to release from prison, and widening these notifications beyond opioid users. *Identification and Engagement*. Although those who misuse substances may be identified within the prison setting, there is a requirement for those working within the prisons to notify the local START team of clients prior to release. The process has been improved with the presence of a member of the START team engaging with clients prior to their release, however, this still requires the prison to inform the team of those in need of support. Generally the service will only be notified of those clients that are opiate users, so those using other substances will not be identified. Furthermore there is a reliance on the clients to engage voluntarily with the substance misuse service upon release, so there will be a proportion that do not engage.

New Psychoactive Substances (NPS)

<sup>353</sup> Cosden et al. (2003) Evaluation of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law* 21(4), 415–27.

<sup>354</sup> NICE (2014) National Institute for Health and Care Excellence: Scope. Accessed via: <https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726> (accessed 20.05.16).

- The annual report of HM Chief Inspector of Prisons highlighted the increasing problem of novel psychoactive substances. It is very difficult to measure the prevalence of NPS use. In addition, as prison services are not notifying community substance misuse services of users of substances other than opioids, they will not be approaching those who are using NPS. It remains to be seen whether there are changes in NPS usage or reporting following the introduction of new legislation on 26th May 2016. The legislation makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances.
- Link up between services – Following on from the above point, there is a need to ensure there is link up between services. The criminal justice system is an area where there are multiple stages and organisations involved, with care being commissioned and provided by different organisations along the pathway. Inevitably there be a need to continually ensure that services are as linked up as possible.
- Issues for the Youth Offending Service and CASUS
- Confidentiality and timeliness. There is also a challenge in terms of communication between the YOS and CASUS with issues of confidentiality and timeliness adding barriers. A formal information sharing agreement may help with this process. There can be challenges in sharing information between services as some individuals that are accessing the youth offending team, may require input from CASUS. In some cases the transfer of information between services may be problematic. The recent report referred to above reviewed the provision of specialist substance misuse treatment in the Cambridgeshire Youth Offending Service.<sup>355</sup> Recommendations from report included:
  - There is a need for formal pathways to be drawn up between the YOS and CASUS.
  - A formalised agreement is necessary between the YOS and CASUS regarding the information that needs to be shared with details of the timescales in which this information is needed.
- Looked After Children. Some children that are looked after by the local authority may come into contact with a number of services and find themselves relaying information to each organisation. This was identified as a challenge by the YOS Substance Misuse Team, although some of this can be alleviated through indirect work via the case worker.
- Engagement of Young People. Although the service reports that engagement with young people is less of a challenge than for other services because of the statutory requirement in some cases, where voluntary engagement is required this remains a difficulty. In addition, when a mental health need is identified it is still voluntary for the young person to attend Child and Adolescent Mental Health Services.

<sup>355</sup> Magilton, S. (2016) Review of the Provision of Specialist Substance Misuse Treatment in Cambridgeshire Youth Offending Service and CASUS. Cambridgeshire DAAT.

- Duration of Engagement with the Service. Some individuals may have a short order but complex needs. Linking the individual to community services within the short timeframe can be challenging.
- Engagement of schools – It is important to recognise the importance of engaging the education system as initial signs from those working with schools suggest that attitudes are changing as schools change. This will require engagement with schools to understand the best way to address this issue. A challenge identified by both CASUS and the YOS Substance Misuse Team was working with different school policies. Both services identified that increasingly schools were implementing zero tolerance policies where a pupil that was found to be in possession of drugs is automatically excluded. Both providers reported there was an increase in this type of policy or that schools were becoming increasingly less engaged in substance misuse support as there was a change towards academy status. It is important to consider this issue as a whole in terms of drugs and alcohol, not just those with a dual diagnosis or engaging with the criminal justice system.
- NICE Guidance – NICE Guidance for the ‘Mental health of Adults in Contact with the Criminal Justice System’ will be published in February 2017 and it will be important to ensure that the recommendations are reflected upon and consideration is given to them in terms of implementation in a local context.
- Building the evidence base – There is little evidence of effective interventions for those beyond that of mainstream services for those in contact with the criminal justice system. A lot of the research that is available is American based and often prison based too, therefore it is important to ensure that local interventions are evaluated in terms of outcomes, patient experience and cost effectiveness where possible to contribute to the growing evidence base.



## CHAPTER 11: Housing and Homelessness

There is well documented evidence of the impact of inappropriate housing and homelessness on substance misuse. There is a close relationship between housing, homelessness, mental health and substance misuse. Many people may be misusing substances and will not experience any housing issues. Vulnerable people who become homeless may be exposed to drug and alcohol cultures that can lead to the starting to misuse substances. Substance misuse can increase the risk of homelessness that reflects unemployment, relationship breakdown and other socio-economic issues. It is a cyclical effect. Appropriate, affordable and stable housing, the avoidance of rough sleeping and the provision of support to help sustain a tenancy can all help prevent substance misuse and improve treatment outcomes.

### What the data is telling us

#### Headlines:

It is forecast that the population in Cambridgeshire is set to increase by 25% over the next 20 years. This puts pressure on the availability of affordable housing and there has been a marked resultant increase in house prices especially in Cambridgeshire and South Cambridgeshire.

“Statutory homelessness” means that a household meets certain criteria, in these cases local authorities have a duty to provide housing. However drug and alcohol dependence may be considered an intentional act and this will exclude a person from support.

Until 2014/15 the level of homelessness in Cambridgeshire was in line with the English figure. However in 2014/15 there was an increase across Cambridgeshire, in Cambridge and Huntingdonshire the increase statistically significantly higher than the English figure.

In 2014 the “Homeless Link” survey found in a survey of 2,500 people that 39% stated they took drugs or were recovering, 36 had taken drugs in the preceding month, in comparison to a national figure of 5%. 27% reported that they have or were recovering from an alcohol problem.

There are a number of housing options in Cambridgeshire for those who misuse drug and alcohol and are homeless. These include a range of hostels that also provide access to varying levels of support for drug and alcohol misuse or other socio-economic problems.

## Population Growth and Housing

In Cambridgeshire substance misuse and housing needs to be considered in the context of population growth and housing pressures.

Cambridgeshire was the fastest growing county authority between 2001 and 2011 and is expected to continue to grow. Forecasts suggest that the population of Cambridgeshire is set to continue to increase by 25% over the next 20 years with the number of people living in the county being expected to increase from 627,000 in 2012 to 769,000 in 2031. The majority of the increase is anticipated to be in Cambridge and South Cambridgeshire.

**Table 64: Table: Dwelling change (all tenures) and net affordable housing need 2011 to 2031**

District	Dwelling change 2011 to 2031	Affordable housing need 2011 to 2031 Based on 2011/12 data
Cambridge	14,000	14,418
East Cambridgeshire	13,000	3,517
Fenland	12,000	3,527
Huntingdonshire	17,000	7,212
South Cambridgeshire	19,000	9,011
Cambridgeshire	75,000	37,684

Source; SHMA 2013<sup>356</sup>

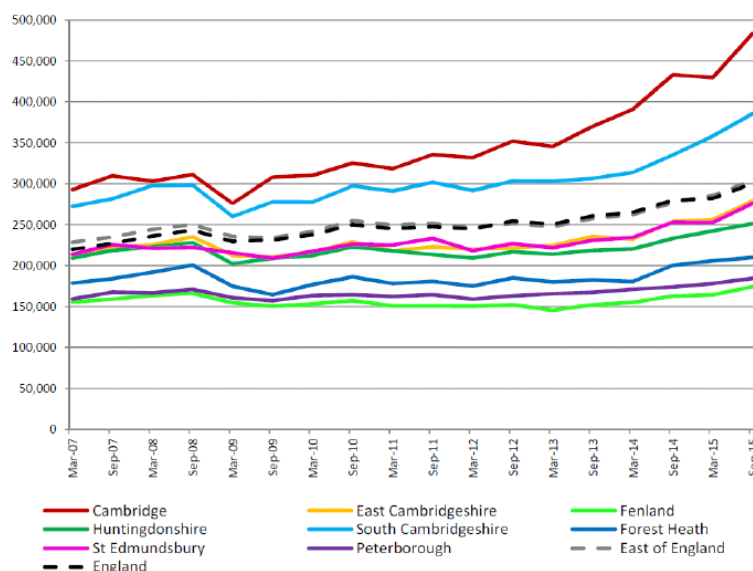
Affordability of housing is a key issue for Cambridgeshire. Those people on lower incomes find it particularly hard to access the private housing market. This is due to a number of factors including housing demand, a historic need for more affordable housing, changes to the benefit system, difficulty raising a mortgage and/or a deposit, and general availability of homes especially in the right location and of the right type.

Increased demand for housing and limited supply have resulted in increasing housing prices, most acutely felt in Cambridge City and South Cambridgeshire. The highest average house price in Cambridge of £483,000 (1) is up by £50,629 compared to September 2014. South Cambridgeshire saw a slightly bigger increase, up by £50,790, and the average rise across England in the past year was more than £20,000, the East of England was more than £26K.

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<sup>356</sup> <http://www.cambridgeshireinsight.org.uk/file/2109/download>

**Figure 83: Trends in average house prices, 2007 to 2015**



Source: New Housing Developments and the Built Environment 2015/16 JSNA.  
Housing Market Bulletin  
<http://www.cambridgeshireinsight.org.uk/Housingmarketbulletin>

## Other Barriers to Accessing Housing

Pressures are created by a growing population due to people moving into the area for work and family reasons, and new households forming from the local resident population. An increase in demand for housing results in fierce competition, and rises in house prices. A lack of affordable housing which is aimed at people unable to afford on the “private market” (i.e. homes to purchase or rent from a private landlord) adds extra pressure for people on lower incomes.

The Housing LIN 2016<sup>357</sup> report confirms that while local authorities have a duty to people and families assessed as statutorily homeless, there is a sequence of judgements made before accepting them as homeless. These criteria include are summarised in Figure ?:

<sup>357</sup> Older people and alcohol misuse: Helping people stay in their homes, Dr Alison Giles for the Housing Learning & Improvement Network, March 2016

**Figure 84: What is statutory homelessness? A brief summary**

Homelessness legislation defines what level of help should be offered to households in different situations. To be able to decide if someone is homeless, the Council investigates and secures proof that the person is:

Homeless or threatened with homelessness; and

Eligible for assistance; and

Has a priority need; and

Did not become homeless intentionally; and

Has a local connection with the district.

Someone may be homeless if they:

Have nowhere to live in the UK or anywhere else in the world; or

Are staying somewhere where they have no legal right to remain; or

Have a home but are afraid of violence, abuse, harassment or threats.

Some are not eligible for help with housing in the UK, for example if they are:

Subject to immigration control and have limited rights to remain in the UK; or

An asylum seeker; or

Not subject to immigration control but have recently returned to live in the UK. This can apply to British citizens who have lived abroad for some time.

Groups in priority need include those who:

Have dependent children living as part of the household

Are pregnant woman or have a pregnant woman living in the household

Have become homeless because of a fire, flood or other emergency

Are 16 or 17 years old and social services does not have responsibility for you

Are aged 18 to 20 and used to be in care

Are assessed as being vulnerable because they are less able to find and keep accommodation of their own.

Who is intentionally homeless?

Someone is considered to have made themselves homeless intentionally if they did something (such as act in an anti-social way), or failed to do something (such as not pay their rent), that resulted in them losing their home. If someone is in priority need but became homeless intentionally, the Council does not have a responsibility to offer help with housing; however they will offer advice on finding accommodation.

Someone has a 'local connection' if they:

Have lived in the district for a certain amount of time.

Have a permanent job in the district.

Have members of family<sup>358</sup> who have lived in the district for a specified length of time.

Have a local connection for another special reason.

If someone has a priority need, is unintentionally homeless and do not have a local connection, they will usually be referred to a Council in an area where they do have a local connection.<sup>359</sup>

<sup>358</sup> "Members of family" as defined in the legislation

The various types of accommodation and support services form part of a “pathway” out of homelessness for vulnerable groups including those with substance misuse needs. However local stakeholders have indicated that within the affordable housing “market”, pressures may be exacerbated by housing providers (that is, councils and housing associations) that may through risk assessments exclude those who may not be able to maintain a tenancy, and this can include those who are misusing substances. Losing a home because of a drug and alcohol dependency may be considered an intentional act which would exclude a person from being eligible for housing. Also drug and alcohol dependence is not considered to be a vulnerability, although mental illness and associated physical and sensory impairments do fall into this category. In addition, housing authorities and providers have concerns about housing substance misusers based on examples of the creation of disruptive substance misuse cultures within housing units.

For people not meeting the criteria and who are effectively homeless the only option may be rough sleeping which is also associated with increasing the risk of substance misuse. There are however outreach services which support people with substance misuse needs who are rough sleepers.

Table ? and Figure? indicate the numbers and rates of the statutory homeless households in Cambridgeshire in 2015/16.

**Table 65: Statutory homeless households, Cambridgeshire, 2015/16**

Local Authority	Acceptances				In temporary accommodation			
	Number	Rate per 1,000	Lower 95% CI	Upper 95% CI	Number	Rate per 1,000	Lower 95% CI	Upper 95% CI
Cambridge	172	3.6	3.1	4.2	79	1.7	1.3	2.1
East Cambridgeshire	58	1.6	1.2	2.0	8	0.2	0.1	0.4
Fenland	121	2.9	2.4	3.4	16	0.4	0.2	0.6
Huntingdonshire	247	3.4	3.0	3.9	108	1.5	1.2	1.8
South Cambridgeshire	121	1.9	1.6	2.3	55	0.9	0.6	1.1
Cambridgeshire	719	2.7	2.5	2.9	266	1.0	0.9	1.1
NN - Oxfordshire	323	1.2	1.1	1.3	194	0.7	0.6	0.8
England	57,750	2.5	2.5	2.5	71540	3.1	3.1	3.1

NN - CIPFA nearest neighbour for Cambridgeshire

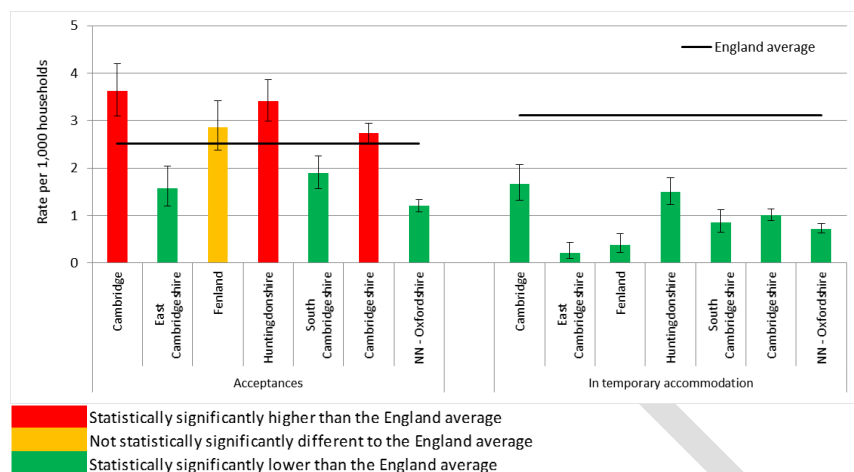
CI - Confidence interval

Source: Department for Communities and Local Government

Across Cambridgeshire there is variation in levels of homelessness with the highest being in Cambridge and Huntingdonshire, both being statistically higher than the England and Oxfordshire average (Figure ??).

<sup>359</sup> From Housing and Health JSNA 2013, at <http://cambridgeshireinsight.org.uk/housing-jsna-2013>

Figure 85: Statutory homeless households, Cambridgeshire, 2015/16



NN - CIPFA nearest neighbour for Cambridgeshire

Error bars represent 95% confidence intervals

Higher values can reflect better recording and so RAG rating should be interpreted with caution

Source: Department for Communities and Local Government

Between 2010/2011 and 2015/16, the level of homelessness in Cambridgeshire has remained stable and in line with the England average but above that of Oxfordshire (Table Figure ??). However in 2014/15 and 2015/16 there was an increase in Cambridge and Huntingdonshire making them and the county statistically significant higher than the England average.

Table 66: Statutory homeless households - acceptances (rate per 1,000 households), Cambridgeshire, 2010/11 - 2015/16

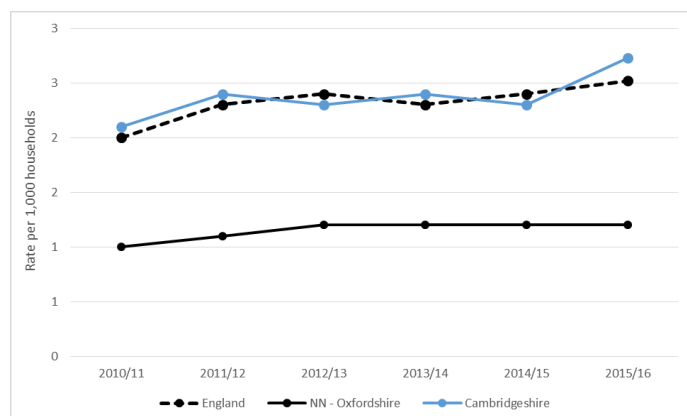
Year	District					Cambridgeshire	NN - Oxfordshire	England
	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire			
2010/11	n/a	n/a	n/a	n/a	n/a	2.1	1.0	2.0
2011/12	2.5	4.3	1.9	2.5	1.6	2.4	1.1	2.3
2012/13	2.7	2.9	1.8	2.6	1.6	2.3	1.2	2.4
2013/14	2.8	2.5	2.3	2.0	2.0	2.4	1.2	2.3
2014/15	3.0	1.5	2.1	3.0	1.4	2.3	1.2	2.4
2015/16	3.6	1.6	2.9	3.4	1.9	2.7	1.2	2.5
	Statistically significantly higher than the England average							
	Not statistically significantly different to the England average							
	Statistically significantly lower than the England average							

NN - CIPFA nearest neighbour for Cambridgeshire

Higher values can reflect better recording and so RAG rating should be interpreted with caution

Source: Department for Communities and Local Government

**Table 67: Statutory homeless households - acceptances (rate per 1,000 households), Cambridgeshire, 2010/11 - 2015/16**

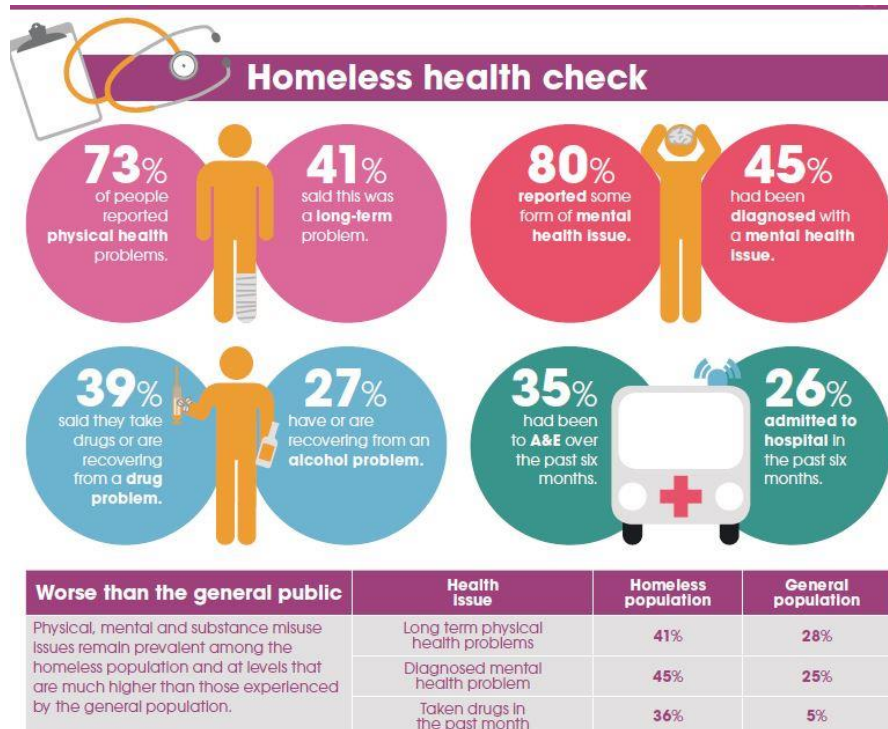


### Homelessness and Substance Misuse

In 2014 Homeless Link published an audit that it had undertaken of 2,500 homeless people<sup>360</sup> from around the country. This highlighted the range of health needs including substance misuse and mental health needs.

<sup>360</sup> Homeless Link The unhealthy state of homelessness (2010)

Figure 86: Homeless Health Check



Around a third of the homeless people who took part in the audit reported a high level of drug and alcohol use amongst the homeless which corresponds to findings in other research.<sup>361</sup> Some 39% of audit participants said they take drugs or are recovering from a drug problem, and 36% had taken drugs in the month before completing the audit. By comparison, national figures at that time indicated that only 5% of the general public took drugs in the past month. Cannabis appears to be the most commonly used drug and 25% stated that they used heroin prescription drugs not prescribed for them.<sup>362</sup>

27% of homeless people taking part in the audit reported that they have or are recovering from an alcohol problem. However, the data in **Table?** on the regularity and amount homeless people drink implies that these needs may be more common. 39% of homeless men and 25% of women who took part in the audit drink twice or more a week, and around two-thirds of homeless men and women drink more than the recommended amount each time they drink. By comparison, one-third of the

<sup>361</sup> Homeless Link Annual review of homelessness services in England (2014)

<sup>362</sup> Drugscope <http://www.drugscope.org.uk/resources/faqs/faqpages/how-many-people-usedrugs>



general public drink more than recommended amount on at least one day each week. Males appear to be more likely to drink more frequently than females.

**Table 68: How often do you have an alcoholic drink?**



Frequency	All	Men	Women
Every day	15.6%	17.6%	10.9%
2-3 times per week	5.2%	6.0%	3.5%
4-6 times per week	13.7%	15.3%	10.3%
2-4 times per month	15.8%	22.7%	29.1%
Monthly or less	24.8%	15.7%	16.6%
Never	24.9%	22.8%	29.7%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: Homeless Link's Health Needs Audit

### The Cambridgeshire Situation- Accommodation options offers countywide

There is a range of accommodation options that are on offer for the homeless is varied and includes variable support for substance misuse. Table ? details the accommodation options and the offered support.

Feedback from District Council Housing leads and housing providers indicate that throughout the county there are issues related to substance misuse and homelessness along with the level of support that is provided to people when they are receiving housing support. The issues differ to some degree across the county.

**Table 69: Types of Accommodation and their offers**

Types of service/tenure	Access- self-refer/referral	Assessment/ criteria /thresholds	Core offer	Additional support	Specific SM support	Exclusion criteria	Other
<b>Local Authority/Large Scale Voluntary Transfer (LSVT) = where local former council housing has been passed to another body following a tenant vote</b>	Any single adult or family is entitled to apply for housing via local authority register held at district level. Access is restricted by having local connection to an area.	Applications are awarded on priority based categories. There is an element of choice and motivation of people to seek housing via Choice Based Lettings (CBL). Homelessness cases get extra priority under special priority needs criteria, in line with legislative guidance	General needs housing includes family houses, older people's accommodation, flats and bedsits.	Some local authorities provide floating support to their vulnerable tenants e.g. Cambridge City Council	Floating support will help people with substance misuse problems to manage their tenancy and link in treatment services.	If people have been made intentionally homeless in the past they may not be eligible for housing. e.g. if they were evicted for rent arrears	Councils or Housing Associations have housing officers and anti-social behaviour teams who may support/manage behaviour of those with SM issues.
<b>Housing association</b>	All districts have other local and national housing associations working in their area. In most cases access is still via housing register see above.	Usually via local authority systems above which include housing association stock on register. Some limited accommodation may be provided separately.	As above.	Limited as tenants will be expected to manage their own accommodation. Some support may be provided by landlords on a limited basis. See also floating support section below which tenants may be eligible for.	Support may assist in cases where tenancy is at risk but not substance misuse specific.	As above.	As above housing and anti-social behaviour officers will focus on tenants at risk.
<b>Supported Housing</b>	Access varies widely may be self-referral but may be restricted e.g for clients with social care needs.	Usually aimed at different client groups e.g. offenders or for people with mental health problems. Access based on need for service.	Housing-related support or care to help manage independent living.	Some residents may be able to buy in extra support if entitled to care via self-directed support.	Very few services would provide SM support.	Most schemes would exclude use of alcohol and all would exclude use	Many service users have drug and alcohol problems and need help from treatment services. Staff would be

						of drugs on premises.  Some people may be banned due to past behaviour.	expected to be able to support clients with SM problems. Some services will not allow people with substance misuse problems.
<b>Hostels &amp; Homelessness Assessment Centres</b>	Operate a mixture of referral and self referral. Where demand is high access is via street based outreach services (Cambridge only)..	Usually residents have underlying support needs as well as being homeless. Where spaces are limited access is decided by vulnerability.	Support to people who are street homeless and have no other options left. Provide referral into other accommodation types and support around wide range of presenting support needs.	Some schemes will develop leads on different areas like SM, access to employment and support around mental health.	A number of hostels across the county have received a high level of training around substance misuse and have developed their expertise.	As above.	Some hostels can now manage community alcohol detoxes on site in partnership with Inclusion. See sections below for specialist projects e.g. Controlled Drinkers Project and Abstinence House.
<b>LA Hostels and Bed and Breakfast</b>	Can only be accessed via local council housing advice and options teams or Social Care Teams.	Used by councils where emergency housing is required and whilst homelessness status is researched. Some people are also placed in emergency accommodation via adult social care teams.	Emergency accommodation whilst homelessness status is investigated and longer-term suitable accommodation is sought.	No or minimal support is provided by landlords but residents likely to be receiving support from relevant agencies.	None provided.	Those not meeting criteria.	Service users will be able to access treatment services.

<b>Housing Advice Services</b>	Self or agency referral.	Depends on the service.	Some advice services offer specific advice on housing/homelessness and debt advice.	May offer appointments but also drop-ins.	None		
<b>Private Sector Leasing/Deposit Bond Schemes.</b>	May accept self-referrals or via District Council	Must have an ability to manage a private rented tenancy.	To help people access private rented sector as an alternative to social housing	May offer help/guarantee for deposits for accommodation which can be a barrier for some homeless people.	None provided more suitable for people in recovery or those with stable SM.	Those deemed not suitable for managing a private sector tenancy.	Guidance has been produced by South Cambs District Council on different private sector leasing options across Cambridgeshire.
<b>Outreach – Homeless</b>	Services proactively look for people who need help, may also take appropriate self-referrals.	CGL – Any verified rough sleeper.  Inclusion – Help homeless people with substance misuse issues.  Both services Cambridge City only.	CGL - Outreach Team Cambridge works with people sleeping rough in Cambridge City. Inclusion undertake outreach work to homeless people who misuse drugs and alcohol in hostels.	Both services will make referrals to a range of associated housing and support services.	CGL - have an extensive experience of working with substance misuse. Inclusions service is primarily aimed at addressing substance misuse.	CGL - Those who are not sleeping rough.  Inclusion – Need to be ready to contemplate addressing substance misuse.	Will support people with a wide range of areas to promote and sustain recovery.
<b>Floating Support</b>	Self-referrals most services now work across different types of housing or tenure.	Those who need housing related to support to maintain or increase independence in their tenancy	Support to people in their homes focussed on independent living skills.	Will make referrals to other services as appropriate.	Will support people with substance misuse to try and prevent homelessness.	Those with personal care needs.	Some services may specialise with certain client groups.

The following is summary of the different types of accommodation and support that are offered across all districts. The majority are found in Cambridge. **A full list of accommodation options and the additional support that is provided is found in Appendix 1 and Appendix 2.**

- Social housing options including social and council housing – As above this is accessed via each district housing advice. People may present as homeless or they may already be in accommodation and apply to the housing register. Priority on the register is influenced by health/social needs and time on the register. All areas now operate Choice Based Letting Schemes which require those on the housing list to proactively bid for housing. Additional support is in place for more vulnerable groups. Having a substance misuse issue does not in itself prevent access to social housing but landlords will need to be satisfied a person will be able to manage a tenancy successfully before it is granted. Some people have difficulty accessing social housing if they have been deemed intentionally homeless in the past, which may be linked to substance misuse.
- Floating support – This is provided across the county, some support is multi-disciplinary and other support is only provided to specific client groups e.g. those with mental health problems. There are no dedicated substance misuse floating support services but multi-disciplinary services are open to people with substance misuse issues. People with significant substance misuse issues will be at greater risk of losing their accommodation and the provision of floating support can help to reduce this risk.
- Supported housing – There is a very broad range of supported housing across the county. The distribution of different types of housing is very variable and is linked to historical factors which have influenced the locations and type of services. Supported housing tends to be most concentrated in the cities and market towns and is aimed at different client groups. There is very little housing aimed at substance misuse clients (see section below – more specific options available in different districts)
- Private sector leasing – All districts have had a drive in recent years to access more private rented housing as demand for social housing has outstripped supply. This has had mixed results. In areas of high housing demand like Cambridge access to private rented housing aimed at the more affordable end of the market has been challenging to find as there is strong demand from tenants with higher incomes, in other areas private rented housing has been easier to find. Councils have in place rent deposit schemes which help raise a deposit or bond for people who don't have sufficient funds available. There is a wide range of quality and costs in private rented tenancies and less protection for vulnerable individuals.
- Local authority hostels – All districts traditionally had hostels funded to support families in priority need with in-house support provided on site. These schemes now tend to operate only via visiting support.
- Domestic abuse provision – three of Cambridgeshire's districts provide domestic abuse refuges and outreach/floating support is provided across the county. Service users will be referred to relevant treatment services if they need support around substance misuse.

### Snapshots from the accommodation options

The table above describes the range of housing options that can be accessed by the homeless and what support is available for clients with substance misuse issues. The following are snapshots and feedback from the hostels who provided information for the JSNA. Specific data is not always available but feedback from staff is included.

#### Fenland

The Fenland homelessness rate is statistically similar to the England average but it is one of the two areas in the county where indicators of alcohol misuse are higher than the county and other district rates. It also is the most deprived area in the county with poorer health outcomes than the rest of Cambridgeshire. Wisbech has been the main focus for addressing alcohol in particular due to issues related to housing and community safety. A multi-agency alcohol project is working from early prevention/harm reduction approaches through to targeting specific street drinkers who are drinking problematically in public areas. A monthly meeting takes place where the most prolific street drinkers are discussed and relevant substance misuse and other interventions are offered. There is particular close working with the Luminus Project which offers temporary housing which is helping to act as a gateway to treatment services.

#### Luminus Night Shelter and Hostel

In its 2015 report the Luminus Night Shelter in Wisbech reported that it had supported 21% (23) of its homelessness clients with drug misuse and 29% (32) with alcohol misuse.

Table ? indicates the breakdown into age groups. Over 75% are male and largest numbers using the hostel come from the older age groups.

**Table 70: Luminus Night Shelter, Wisbech – homelessness clients**

Criteria		Total
Number of Clients	Full Total	112
	Male	86 (76.8%)
	Female	26 (23.2%)
Ages	18-25	12 (10.7%)
	26-35	37 (33%)
	36-45	32 (28.6%)
	46+	31 (27.7%)
	Under 21	suppressed

In terms of nationality 46 were from the UK and 66 were from Eastern Europe, mainly Lithuania and Poland with a small number for Portugal.

There is a similar picture when looking at the Luminus hostel clients with 51% receiving support for drug misuse (45) and 38% receiving support for alcohol misuse.

The following is a case study completed by a worker at one of the Luminus hostels in Fenland that indicates the complexity of needs that clients may have

### Case Study

- Forty six year old single man who is British. Previous history of drug and alcohol mis-use.
- Learning difficulties, undiagnosed, very poor literacy skills. Under the Community Mental Health Team who work with him only periodically and are quite dismissive because of the drink issue.
- Since 2014 he has had two detoxes, neither of which had much impact.
- Excellent support network through his mother where he spent most weekends.
- Living in our longer term flats because of a high support need.
- Has a tendency to lie and even when he knows that have difficulty with his version he would still continue.

### SUPPORT NEEDS

- Assistance to deal with day to day issues including paying bills.
- Support given when accompanying him to CMHT appointments, doctor & Inclusion, good rapport built with his Inclusion Worker.
- Safeguarding issues surround his vulnerability and being exploited by associates in the community, also has very little regard for his own safety and his awareness is impaired by the drink.
- When under the influence have had to deal with medical issues which have resulted in him being taken to hospital on a number of occasions.

### IMPACT AND OUTCOMES

- Following a second detox there was a quick reversion to his previous lifestyle. It seemed to me he needed distance from his drinking pals.
- Pondering on his situation I researched the internet and gave him and his mum information of a rehabilitation centre called Betel.
- Our resident said he wanted to go and at each meeting was asked if he had changed his mind, on the basis that he hadn't we continued.
- Working from February through to August meetings were held with his mother present.
- The admission rules demanded he come off the mind altering drugs.
- A plan was talked through with the GP and a gradual reduction was agreed.
- There seemed to be a problem with the reduction so I wrote to the GP.

- Further action was then taken by them.
- Towards the beginning of August he was clear of all three of his mind altering drugs and given a date of 14<sup>th</sup> August to enter the programme.
- His mother and I sorted out his affairs as the time to move came closer
- Arrangements were made to drive him there; two members of staff and his mother accompanied him to Betel on the 14<sup>th</sup> August.

### **Operation Pheasant- Fenland**

Operation Pheasant was formed on 2012 and its membership comprise of Cambridgeshire Police and Fenland District Council, Cambridgeshire Fire and Rescue and the Gangmasters' Licensing Authority. Its purpose is to tackle exploitation, associated criminal activity and poor housing management practice. One of the areas identified by Operation Pheasant is the provision of temporary homes for workers by rogue landlords and gangmasters. These were severely overcrowded with many safety hazards. These Houses of Multiple Occupation are associated with street drinking and rough sleeping, both high risk factors for (?) alcohol and drug misuse. For example residents are unable to relax in their homes due to overcrowding and "hot bedding" which is a term used for sharing bed on rota system.

Evidence cited in Cambridgeshire's recent Migrant JSNA indicates excessive alcohol consumption is higher among Eastern European communities. Street drinking is commonplace in the Eastern European population in Wisbech as part of social gatherings, but can create community tensions. Eastern European migrant workers are utilising alcohol services but a lack of trust in health services is proving to be a barrier for engagement as well as perceptions that alcohol consumption is a 'way of life' and not a risk to health. Currently Fenland District Council is proposing to introduce selective licensing which would mean that landlords would have to secure a licence to let houses and these houses would need to meet certain standards including a limit on occupancy levels.

### **Fenland Community Safety Partnership Project**

The Wisbech Alcohol project has been established through the Fenland Community Safety Partnership project to address alcohol misuse in Fenland. Its focus is on improving recording of street drinking, increasing front line officer and local business training and improved promotion activity to highlight the harms from alcohol and services which are available. An increased number of referrals to the Treatment Services (Inclusion) has been noted in Fenland, with a 63% increase Jan-Dec 2015 compared to Jan-Dec 2014.

### **Cambridge City Snapshot**

Cambridge City like Fenland has indicators that suggest higher levels of substance misuse. Cambridge City also has the highest accommodation prices and there are issues with the supply of housing. Over the years a complex web of accommodation and supported housing schemes have developed.



Although these can be found in other areas of the county they are most developed in Cambridge City.

### Abstinence House

The Abstinence House located at “Jimmy’s” which is one of the homeless ness hostels in Cambridge City. It is a partnership initiative designed to provide a route out of homelessness for people who have a history of homelessness and alcohol misuse. The pilot project is a collaboration project between alcohol treatment and housing providers that are working together in an innovative way, to secure better outcomes for service users. Its objectives include reducing the demand for GP and other health services by substance misusers.

#### What is the Abstinence project?

- The Abstinence House Project is centred on a 3 bed shared house.
- Residents have to be alcohol free and are selected from suitable candidates typically living in homeless accommodation in Cambridge City.
- The stay is intended to be 6 months to 1 year long
- Potential residents are either dry from alcohol having been detoxed or undertake a detoxification immediately before moving into the project.
- For those detoxing (usually in inpatient detoxification beds or via community detoxes in their homelessness accommodation) beds are held empty at the Abstinence House. The lost rental income is covered by Cambridge City Council and Cambridgeshire County Council.
- Professional support around alcohol is provided by Inclusion Drug and Alcohol Treatment Service (Inclusion) working in partnership with Jimmy’s who provide housing related support and help secure move-on.
- Residents have to remain alcohol free to stay in the move-on house evidenced by breath tests equipment if required
- Peer support is provided if required by the service users by the following organisations Cambridge Link Up, Sun Network and Inclusion.

Typically a homeless person with a history of alcohol use may have periods where they make good progress in addressing their alcohol misuse but they are surrounded by others who may still be drinking at high levels. Some may even undertake detoxification but then return to temporary or insecure housing where they may quickly relapse.

### Case Study

AL had led a very chaotic lifestyle for many years prior to October 2014 when, with the support of Jimmy's Assessment Centre, he chose to address his drug and alcohol issues through a methadone script and detox respectively. His lifestyle resulted in AL becoming an offender – his convictions being for burglary, shop lifting, and begging. He reports that having been a drug user for some 30 years he did enjoy some stability when a friend offered him a room/tenancy in a property in Chatteris.

However the loss of that accommodation when the property was sold resulted in his return to Cambridge, when the fact he had to sleep rough led to a return to his drug use and heavy drinking as a means of coping with his predicament. He did eventually secure a flat in the north of the city, but by his own admission his greed for drugs resulted in him allowing drug dealers to operate out of his property in return for a free supply of drugs for his own consumption. Eventually that free supply was curtailed and the need to purchase his drugs again meant that AL fell into arrears with his rent and was subsequently evicted. This lifestyle had resulted in a very strained relationship with his elderly mother.

AL spent just over a year in the Abstinence House and has been very successful in addressing his substance misuse issues and he has now moved into more permanent accommodation releasing a space in the Abstinence House. AL has now been abstinent from alcohol continually since October 2014. This is the most settled period AL has had in managing his alcohol misuse in around 30 years. When asked to give a personal view of the help he received AL said:

"I have never felt this good before, I do not even want to drink. I have a great relationship with my Mum, she is 91 and I am so glad I am able to help her. The house is great and I do not know where I would be without it. Thank you for this opportunity"

DRAFT

**Table 71: The benefits to persons involved in the abstinence project**

Previous periods alcohol free	<p>2 residents have been drinking/using substances for 20-30 years with some short alcohol free periods.</p> <p>1 resident had a history of alcohol misuse and had spent a many months in prison up to a year before going in.</p> <p>1 resident had lived with his family but was asked to leave due to escalating alcohol use.</p>	<p>1 resident now alcohol free Since Oct 2014. Other since Dec 2014 both require minimal support around alcohol now and have moved out to more settled long-term accommodation.</p> <p>The resident had a 5 month period dry in the Abstinence House. Then relapsed and returned to drinking and another 3 month spell in prison followed by sleeping rough and a return to hostels.</p> <p>The resident has been in the house and alcohol free since July 2015 and requires minimal support to stay dry.</p>
Hospital visits	<p>Out of data collected for 3 residents. There was a total of 15 hospital visits in the year before moving into the move-on house 1<sup>st</sup> of Feb 14 – 1<sup>st</sup> of Feb 15.</p>	<p>2 of the residents have had no returns to hospital since becoming dry.</p>
GP Visits	<p>1 resident had 22 visits to his GP 1 year before moving in a frequency rate of every 2-3 weeks.</p> <p>1 resident had 14 visits to his GP over a 3 month period before moving into the dry house a frequency rate of 1 per week.</p>	<p>The resident has now reduced frequency of visit to the GP to every three months, reducing the GP costs from £814 per year to £333 per year.</p> <p>Frequency rate has now reduced to once per month.</p>
Success in managing accommodation	<p>1 resident stayed in supported housing 6 months before moving in</p> <p>1 resident stayed in supported housing for 7 months before moving in</p> <p>1 resident was in prison for a 9 month period before moving into the house costing £2800 per month.</p>	<p>Since moving into the house the costs have reduced to just over £500 per month.</p> <p>.</p>
Progress on Outcomes Stars	<p>Previous to going into the Abstinence House residents would typically achieve quite low scores.</p>	<p>Once moved into the outcomes typically improve leading to the following benefits – addressing alcohol use, improving accommodation options, improved budgeting, improved physical health and making better relationships with family members.</p>

The key outputs from the project can be summarised as follows

- The combination of support around housing and treatment has given an opportunity of a prolonged settled spell alcohol free and from periods of homelessness and sleeping rough.
- Visits to hospital have been zero whilst in the move-on house. For the baseline period, one year before moving to the house, and including the hospital visit following the relapse there were 16 visits to hospital across the three patients and some ambulance call-outs.
- Residents always tended to be in more expensive accommodation before becoming dry ranging from £500 to £1000 per week with the Abstinence House towards the lower end at around £500.

Partners report that the project has strengthened links between supported housing and treatment. However there are very few agreements in place to ensure an integrated partnership approach is taken. The numbers are small but the information indicates that the project can provide “routes out of homelessness”. It is an approach that suggests it helps substance misusers avoid the cycle of addiction and rough sleeping, and homelessness that results in making much more frequent visits to their GP. Having the funds set aside to cover voids for short periods is key to engaging housing providers in this work and giving the flexibility to match up clinical interventions with successful housing options. The pilot is funded until the end of March 2017.

### Other Accommodation Projects

Consultation with other accommodation providers identified the following.

#### Winter Comfort- Cambridge City

- Around 160 clients per week use the service and staff estimate that 60% of them have drug and alcohol issues and that many of these have multiple treatment attempts. Increase in clients using NPS?? has been observed
- Increase in the number of migrants who have been affected by the benefit changes and have been sleeping rough which has led to problematic drinking increasing

#### Cambridge Cyrenians

- The Cambridge Cyrenians accommodate 68 single men and women in 12 projects across the city. The focus is on small projects as it based on the thinking that this enables residents to feel they have more of an investment in their accommodation and they are encouraged to be involved in the running of the hostels which they are using. There is specialist accommodation for ex-offenders and a women only house. The organisation reports that it is receiving an increasing number of women.
- Thirty eight of the bed-spaces are short stay and residents are expected to move on within two years. The rest are long-stay residents, which means that they have been assessed as having complex needs that will require supported housing for some time. This is often due to mental health issues and alcohol dependence.

- Staff report that alcohol dependence is key issue. Recently the organisation lost a number of its beds and this has affected its capacity to provide accommodation for many people with alcohol issues.
- Historically the Cyrenians have tended to accommodate the older homeless, many of whom those misusing alcohol. Those with mental health issues have also been supported and this increasing with 80% of short stay residents assessed as having mental health issues at the time of the writing, but only one was receiving support from the mental health services.
- All of the residents with drug misuse issues are receiving treatment from Inclusion, but for residents with alcohol misuse issues very few are in treatment. Staff report that residential accommodation.

### Evidence for the Relationship between Substance Misuse Housing and Homelessness

The Scottish Drugs Forum (2007)<sup>363</sup> provided evidence of higher levels of drug and alcohol dependence among those with housing problems and particularly those who are hostel dwellers or street homeless.

In 2006<sup>364</sup> Shelter's report concluded that there is a clear relationship between homelessness and drug use. Subsequent reviews of homelessness among single people have identified a number of risk or trigger factors for their homelessness, including drug and alcohol misuse. Other studies indicate the experience of homelessness may in itself precipitate increased substance misuse

Many studies indicate how homeless people with a history of alcohol or drug misuse may have periods where they make good progress in addressing their misuse but they are surrounded by others who may still be misusing at high levels. Some may undertake an inpatient detoxification but then return to temporary or insecure housing where they may quickly relapse.

In addition secure, appropriate housing is an essential base from which other support can be accessed.

Anderson 2002<sup>365</sup> also concluded that in order to come off benefits and re-enter employment treatment is a first step followed by recovery that includes addressing housing issues.

The Chartered Institute of Housing 2012,<sup>366</sup> Milby et al 2010<sup>367</sup> and Rutter 1994<sup>368</sup> all conclude that as a general rule, evidence indicates stable housing is beneficial to those with drug or alcohol dependence achieving reducing substance misuse and achieving drug- and alcohol-related recovery outcomes.

<sup>363</sup> Scottish Drugs Forum (2007) Drugs and poverty: a literature review. Edinburgh: Scottish Drugs Forum

<sup>364</sup> Safe as Houses: An inclusive approach for housing drug users, Shelter 2006

<sup>365</sup> Anderson, T. L., Shannon C., Schyb, I. and Goldstein, P. (2002). 'Welfare reform and housing: Assessing the impact to substance abusers'. *Journal of Drug Issues*, 32(1):265-295.

<sup>366</sup> Chartered Institute of Housing (CIH) (2012) The role of housing in drugs recovery: A practice compendium. Coventry: CIH

<sup>367</sup> Milby, J. B., Schumacher, J. E., Wallace, D., Vuchinich, R., Mennemeyer, S. T. and Kertesz, S. G. (2010) Effects of Sustained Abstinence Among Treated Substance-Abusing Homeless Persons on Housing and Employment. *American Journal of Public Health*, May 2010, Vol. 100, No. 5, pp913-918

<sup>368</sup> Rutter, D. (1994) Keys to Change: a study of the role of local authority housing in care and rehabilitation of drug and alcohol users in the London borough of Lambeth. London: Home Office

## Interventions

Substance dependence is commonly characterised as a chronically relapsing condition, and housing and support provision needs to be able to cater for dependent users across a wide spectrum of patterns and levels of use. However, many have access only to the most insecure housing or lack the support they need to maintain their accommodation, and are therefore excluded from provision.

The Government 2010<sup>369</sup> recognised the role of housing in supporting recovery. It stated that recovery required a ‘whole systems approach’ including housing alongside health, probation, education and wider support services.

The Scottish Government 2008<sup>370</sup> state that there is emerging evidence that housing environments which provide support and encourage sobriety can reduce the risk of relapse among those with drug or alcohol dependence who are trying to be abstinent, however, there is also evidence that there is an increased risk of overdose deaths among heroin users who relapse and therefore lose their housing and support.

The Chartered Institute of Housing 2012<sup>371</sup> indicates there is emerging evidence that rent deposit schemes can improve a range of intermediate recovery outcomes, and that housing ‘floating support services’ may be effective at helping some substance misusers sustain housing.

## What is this telling us?

There is a clear relationship between housing, homelessness and the prevention and treatment outcomes.

- The various providers of accommodation for the homeless report that a large proportion of their clients have a known substance misuse issue.
- In Cambridgeshire there are a range of housing options available that include additional support including the “supporting people” programme from different services. This plays an important part in preventing relapse and promoting recovery. This partnership approach could be further bolstered. Although the ending of the supporting people programme and removing the ring fence on its funding has not helped to retain a view of the funding of floating support services.
- There are number of innovative partnership projects across the county that should be evaluated and inform ongoing service development.
- However there is an ongoing pressure on the available housing/hostels available for those with substance misuse issues. There are barriers that prevent many clients securing accommodation that have been reported by local stakeholders.

<sup>369</sup> HM Government Drugs Strategy *Reducing demand, restricting supply, building recovery: supporting people to live a drug free life*. 2010

<sup>370</sup> The Scottish Government (2008) *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem*. Edinburgh: The Scottish Government

<sup>371</sup> Chartered Institute of Housing (CIH) (2012) *The role of housing in drugs recovery: A practice compendium*. Coventry: CIH

## **APPENDIX 1 – HOMELESSNESS SCHEMES IN CAMBRIDGESHIRE AND PETERBOROUGH AS AT JUNE 2016**

Attached as a separate document to the report. It is available at

**(Website address needed)**

## **APPENDIX 2 – PROFILE OF HOMELESSNESS ACCOMMODATION IN CAMBRIDGESHIRE AND PETERBOROUGH AS AT JUNE 2016**

Attached as a separate document to the report. It is available at

**(Website address needed)**



## **APPENDIX 3 – COMMUNITY ENGAGEMENT FEEDBACK AND SUMMARY OF THE COMMUNITY CONSULTATION BY EVENT/ORGANISATION METHOD**

### **Appendix 3a - Community Engagement Feedback**

A range of community engagement events were undertaken including two stakeholder workshops, ( see Appendix 3 b) an online survey and the treatment services Inclusion and Gainsborough user surveys. Views were sought on experiences of services in Cambridgeshire, main factors influencing substance misuse, what initiated substance misuse, what has helped or prevented service users from getting help and what individuals feel is important for the future. In total 255 survey responses were received, it would not be possible to tell if individuals had responded on multiple occasions.

#### **Online Survey**

Across responses the following themes were identified:

- Alignment and integration of services and in particular mental health services with substance misuse services is required.
- Recognising and understanding dual diagnosis and service provision for these individuals is very effective in addressing the issues.
- There is a challenge of engaging individuals including high risk drinkers.
- Length of waiting times for treatment and the impact this may have on recovery is an important factor.
- Accessibility of services including the distance to travel needs to be considered when planning services.
- There is a need for a 24 hour helpline and crisis support to avoid relapse and hospital admissions.
- Housing support and need for accommodation for those who drink is considered to be necessary.
- The importance of a supportive network/peer support (family, friends, others who are going through/been through recovery) is considered to be important.
- Support after structured treatment is valued.
- The relevance of stigma and pride/embarrassment in terms of seeking help.
- Awareness and education in terms of new substances and patterns of their use is required.
- Parental/carer drug and alcohol misuse and the effect upon children and young people.
- Lack of services for those with alcohol related brain damage.
- Making every contact count across all sectors, not just drug and alcohol services to ensure misuse is identified and an appropriate intervention is made.

Key influences on initiation and continuation of substance misuse:

- Friends
- Family
- Socialising
- Loneliness
- Boredom
- Coping with emotions and mood
- Mental illness
- Abuse/trauma including domestic violence and childhood abuse
- Work culture
- Work stress
- Relationship breakdown.

In terms of the future, family, job, health, sobriety and helping others were all consistently mentioned across responses.

#### User Surveys

A survey was also conducted with those using the Cambridgeshire drugs and alcohol services and 75 responses were received.

- Of those responding to alcohol service questions, 52% were males and the average age of respondents was 46.9 years.
- Of those responding to drug service questions, 68% were males and the average age of respondents was 38.7 years.
- Most of the respondents were White British (alcohol service 96%, drug service 96%).
- The majority of respondents felt their treatment needs had been met by the services (alcohol service 69%, drug service 84%).
- The majority of respondents were happy with their experience of the services (very happy: alcohol service 75%, drug service 60%).
- The vast majority of respondents felt they had always been treated with dignity and respect (alcohol service 96%, drug service 100%).
- Most respondents felt actively involved in and make decisions about their treatment always (alcohol service 81%, drug service 76%).

APPENDIX 3b Summary of the Community Consultation by event/organisation/method

Cambridge Community Event	Wisbech Community Event	Community focus groups service users, ex service users and others, various locations	Inclusion service user responses	Gainsborough Foundation service user responses	Non Service User Responses (SUN Network)	Online Survey Responses	Stakeholder Event 5.7.16
Value of peer support was emphasised	Promotion of out of hours service and the need for 24 hour "crisis" helpline	Main influences: like it, fun, friends, accessible, curiosity, physical pain relief, control mood, consider part of growing up, social, loneliness	Main influences: Emotions, coping strategy, abuse/trauma, friends, boredom, stress, mental health (depression, anxiety), habit.	Main influences: social, unemployed, stress, loneliness	Main influences: Friends, family, mental health (depression/anxiety), abuse (childhood and domestic), habit, stress, work stress, work culture, bereavement, boredom, loneliness/isolation, lack of family support/structure, relationship breakdown.	Main influences: Friends, fun, confidence, mental health (anxiety), abuse (domestic, physical), work stress, loneliness, coping, socialising.	Dual diagnosis -uncertainty about how effective services are at recognising/understanding the condition. Willingness to engage high risk drinkers is not always apparent. Delivery of community detoxification needs to be developed.
Value of post structured treatment support was emphasised	Integration between drugs and alcohol and mental health services	How did it start? Parents, friends, ggs/parties.	What helps: Key Worker, methadone, 1-1 support, group support, acupuncture	What helps: Gainsborough helps people to understand their alcohol addiction in terms of family history and culture a person grows up in, honest approach, teaches awareness, no waiting list seen immediately, home detoxification is best as more comfortable in home environment e.g. can eat and sleep when a person wants, support given post detoxification, GP understanding of issues, shows empathy, support for emotional issues from staff and GP, recovery champions have been through Gainsborough treatment, they understand and are always available.	What helps: Addiction, Alcoholics Anonymous, NA, OP, Inclusion, Antabuse, Groups, Recovery Café, Gainsborough. 1-1 support.	What helps: Alcoholics Anonymous, Rehabilitation.	Awareness/education of new substances and patterns of use needs to be developed. Dependence is an issue/need to develop social capital as an invest to save approach Making every contact count across all sectors More accommodation for those who drink Greater integration of services (including mental health) Parental substance misuse Services for those with dual diagnosis Services for alcohol related brain damage
Need for consistency in services across the county and a greater awareness of the treatment service inclusion in the rural areas	Ineligibility for mental health services	Influences: Emotions/mood, dealing with problems, sleep, mental health, habit, enjoyment, boredom, loneliness, social, change in life circumstances.	Not working: 24h on call helpline not available, too little testing, access/distance clients have to travel to services.	Not working: nothing noted	Not working: Pride, embarrassment/stigma, speed of help (inclusion), service join up (mental health).	Not working: Waiting times for inclusion/detox, lack of crisis support (including mental health support), lack of join up with mental health services, stigma, embarrassment.	
Mental health - increase alignment and integration of services	Value of peer support	What helps: Housing, others experiences, family, friends, cost, health, prison, counselling		Future: getting their lives back, functioning as before, job, family, sobriety	Future: Job/education, health, family, money, sobriety.	Future: sobriety, helping others, family, health.	
Addressing the needs of those over the age of 60 needs to be undertaken.	Wider factors important - housing and network of support	Doesn't work: Housing, not knowing where to go, pride, embarrassment, judgemental attitudes, friends, mental health services, stigma, feel out of place in services (perceived), rumours at school					
Frequency with which service users have to re-tell their story is annoying and there is need for more communication between services.	Stigma	Future: Job, home, getting substance misuse under control.					
Promotion of out of hours service and the need for 24 hour "crisis" helpline							
There is increasing mental health need	Unequal provision across the county						
There is gap in services for Alcohol related dementia							
Stigma							
Homelessness							

## APPENDIX 4 - GLOSSARY

### Defining alcohol misuse

**Alcohol dependence:** A cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations

**Alcohol-related harm:** Physical or mental harm caused either entirely or partly by alcohol. If it is entirely as a result of alcohol, it is known as 'alcohol-specific'. If it is only partly caused by alcohol it is described as 'alcohol-attributable'.

**Alcohol-use disorders:** Alcohol-use disorders cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence. See 'Harmful' and 'Hazardous' drinking and 'Alcohol dependence'.

**Alcohol-use disorders identification test (AUDIT):** AUDIT is an alcohol screening test designed to see if people are drinking harmful or hazardous amounts of alcohol. It can also be used to identify people who warrant further diagnostic tests for alcohol dependence.

**Higher-risk drinking:** Regularly consuming over 50 alcohol units per week (adult men) or over 35 units per week (adult women).

**Increasing-risk drinking:** Regularly consuming between 22 and 50 units per week (adult men) or between 15 and 35 units per week (adult women).

**Lower-risk drinking:** Regularly consuming 21 units per week or less (adult men) or 14 units per week or less (adult women). It is also known as 'sensible' or 'responsible' drinking.

\* Proposed new guidelines to limit the health risks associated with the consumption of alcohol, which would affect these definitions, have recently been consulted upon  
<https://www.gov.uk/government/consultations/health-risks-from-alcohol-new-guidelines>

**Responsible authority:** Responsible authorities have to be notified of all licence variations and new applications and can make representations regarding them. The Licensing Act 2003 lists responsible authorities. They include the police, environmental health and child protection services, fire and rescue and trading standards.

**Screening:** Screening involves identifying people who are not seeking treatment for alcohol problems but who may have an alcohol-use disorder. Practitioners may use any contact with clients to carry out this type of screening.

## Defining drug misuse

Drug Misuse: The use of a substance for a purpose not consistent with legal or medical guidelines (WHO, 2006). It has a negative impact on health or functioning and may take the form of drug dependence, or be part of a wider spectrum of problematic or harmful behaviour (DH, 2006).

## General Definitions

Abstinence: Refraining from drug use or (particularly) from drinking alcoholic beverages, whether as a matter of principle or for other reasons. The term "current abstainer", often used in population surveys, is usually defined as a person who has not drunk an alcoholic beverage in the preceding 12 months; this definition does not necessarily coincide with a respondent's self-description as an abstainer.

Alcohol Diversion Scheme: Offered to those at first police contact following minor public disorders. Commissioned through the police and allows avoidance of arrest, and thus criminal record, for attendance at an awareness session (covering effects of behaviours etc.).

Alcohol/drug-specific conditions refer to conditions in which alcohol/drugs is causally implicated in all cases. Short-term effects, such as alcohol poisoning, are included in this category, as is alcoholic liver disease, for example.

Alcohol/drug-related conditions include all alcohol/drugs-specific conditions plus a proportion of other conditions in which alcohol is known to be causally implicated in some cases. This category includes a proportion of cases of cardiovascular disease and cancer, and unintentional injuries, for example.

N. B. Broad and narrow definitions of alcohol-related hospital admissions: Narrow measures only include alcohol-related conditions based on the primary code for the hospital record (the main reason for admission) or where there is an alcohol-related external cause. Broad measures also count alcohol/drug-related conditions included in secondary codes (other diagnoses that affect treatment). Broad measures are considered a better reflection of alcohol burden on the community and services but the narrow measures are considered better for comparing areas and making comparisons over time as they are less sensitive to variation in coding practice.

Alcohol-related brain damage: this is an umbrella term for the alcohol-related conditions that affect brain function. They include Wernicke-Korsakoff syndrome, alcohol related dementia and other forms of alcohol-related cognitive impairment.

Alcohol-related mortality (deaths): When the underlying causes of death are regarded as those being most directly due to alcohol consumption. The definition is primarily based on chronic conditions associated with long-term abuse of alcohol/deaths and, to a lesser extent, acute conditions. Apart from poisoning with alcohol (accidental, intentional or undetermined), the definition excludes other external causes of death, such as road traffic and other accidents.

**Autism, Aspergers:** Autism is a spectrum condition. All autistic people share certain difficulties, but being autistic will affect them in different ways. It is a lifelong developmental disability that affects how people perceive the world and interact with others. Aspergers is one of the disorders on the autism spectrum. People with Asperger syndrome also have mental health issues or other conditions, meaning people need different levels and types of support.

**Brief advice:** This can comprise either a short session of structured brief advice or a longer, more motivationally-based session (that is, an extended brief intervention – see also below). Both aim to help someone change their behaviour and it is especially associated with attempts to reduce alcohol consumption (sometimes even to abstain) and can be carried out by non-alcohol specialists.

**Cambridgeshire Child and Adolescent Substance Misuse Service (CASUS)** CASUS is part of Cambridgeshire and Peterborough NHS Foundation Trust. The team is staffed by nurses, substance misuse practitioners, social workers as well as a child and adolescent psychiatrist. The team sees young people who have concerns about drugs and alcohol (including legal/chemical highs, volatile substances/gases as well as illegal drugs). It offers specialist treatment, interventions, support and information for all types of substance use.

**Child and Adolescent Mental Health Services (CAMHS):** CAMHS are specialist NHS children and young people's mental health services.

**Conditional Caution:** Police custody based caution with added requirement for offender to attend substance misuse service. This is voluntary and forms part of the national Drug Interventions Programme initiative (DIP).

**Court orders:** This is an official proclamation by a court that defines the legal relationships between the parties to a hearing, a trial, an appeal or other court proceedings.

**Criminal Justice Intervention Team – Part of the Drugs Intervention Programme (DIP)** which is focuses on reducing drug related crime. CJIT aims to help individuals who misuse specific class A drugs out of crime into treatment and other support.

**Detoxification:** The process by which an individual is withdrawn from the effects of a psychoactive substance. As a clinical procedure, the withdrawal process is carried out in a safe and effective manner, such that withdrawal symptoms are minimized.

**Dependence:** The state of needing or depending on something or someone for support or to function or survive. As applied to alcohol and other drugs, the term implies a need for repeated doses of the drug to feel good or to avoid feeling bad.

**Drug Interventions Programme Initiative (DIP):** Initially rolled out in April 2003 to areas of high crime and then to the whole of England in 2005. DIP's aim is to identify and engage with drug using offenders at every stage of the criminal justice system and provide services tailored to clients' specific needs, addressing issues such as housing, education, employment, finance, family relationships and health as well as offending behaviour and drug use.

**Drug related deaths:** The definition of a drug misuse death is (a) deaths where the underlying cause is drug abuse or drug dependence and (b) deaths where the underlying cause is drug poisoning and

where any of the substances controlled under the Misuse of Drugs Act 1971 are involved (International Classification of Diseases CD-10 codes as above). Drug misuse death statistics from the Office of National Statistics are based on an enhanced dataset including additional information from coroners.

Dual diagnosis: A general term referring to comorbidity or the co-occurrence in the same individual of a psychoactive substance use disorder and another psychiatric disorder.

Extended brief intervention: This is motivationally-based and can take the form of motivational-enhancement therapy or motivational interviewing. The aim is to motivate people to change their behaviour by exploring with them why they behave the way they do and identifying positive reasons for making change. In this guidance, all motivationally-based interventions are referred to as 'extended brief interventions'.

Harmful use: A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use.

Harm reduction: In the context of alcohol or other drugs, describes policies or programmes that focus directly on reducing the harm resulting from the use of alcohol or drugs. The term is used particularly of policies or programmes that aim to reduce the harm without necessarily affecting the underlying drug use; examples include needle/syringe exchanges to counteract needle-sharing among heroin users.

Hazardous use: A pattern of substance use that increases the risk of harmful consequences for the user. Some would limit the consequences to physical and mental health (as in harmful use); some would also include social consequences. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.

Hospital admission episodes: These take into account that a person may experience multiple hospital admissions.

Hospital Liaison Schemes: These aim to liaise between acute services and community services, usually mental health, drugs and alcohol community services.

Illicit drugs: As defined by the Misuse of Drugs Act 1971 (Class A, Class B and Class C controlled drugs): <http://www.legislation.gov.uk/ukpga/1971/38/contents>

Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. It was created to offer patients a realistic and routine first-line treatment, combined where appropriate with medication which traditionally had been the only treatment available. The programme was first targeted at people of working age but in 2010 was opened to adults of all ages.

**Incremental Cost-Effectiveness Ratio (ICER):** An ICER is a statistic used in cost-effectiveness analysis to summarise the cost-effectiveness of a health care intervention. It is defined by the difference in cost between two possible interventions, divided by the difference in their effect.

**Local Outcome Comparator Areas** were devised to improve comparisons between local clusters. Each local area is compared to 32 other areas that are most similar to them in terms of the complexity. Cambridgeshire's nearest neighbours for statistical comparison were assessed by the Chartered Institute of Public Finance & Accounting (CIPFA) – they are Oxfordshire, Surrey, Buckinghamshire, Hampshire, Gloucestershire, Hertfordshire, Warwickshire, West Sussex, Leicestershire, Worcestershire, North Yorkshire, Somerset, Essex, Dorset and Suffolk. Oxfordshire is the comparator area used in the JSNA.

**Looked after children:** The term 'looked after' has a specific legal meaning. It refers to children and young people who are provided with accommodation on a voluntary basis for more than 24 hours. This compares with the term 'in care' which refers to those who are compulsorily removed from home and placed in care under a court order.

**Local Alcohol Profiles for England:** These are produced by Public Health England and provide local data alongside national comparisons to support local health improvement.

**Medicines misuse:** The broadest definition of misuse in this context is the use of medications for other purposes or ways than prescribed or intended. This includes taking someone else's prescription medications, increasing the dose of prescribed medications without a doctor's consent, and the use of medications as an alternative to illegal drugs.

**National Drug Treatment Monitoring System (NDTMS):** The National Drug Treatment Monitoring System (NDTMS) collects, collates and analyses information from and for those involved in the drug treatment sector. The NDTMS is a development of the Regional Drug Misuse Databases (RDMDs), which have been in place since the late 1980s.

**Over-the-counter medicines (OTCs) or 'general sales medicines'** are available for sale directly to consumers.

**Out of court orders:** Out-of-court disposals allow the police to deal quickly and proportionately with less serious, often first-time offending which could more appropriately be resolved without a prosecution at court and include for example Community Resolutions – adults (18+) and youths, Cannabis Warnings – adults (18+), Penalty Notices for Disorder – adults (18+), Youth Cautions – youths (10-17), Simple Cautions – adults (18+), Conditional Cautions – adults (18+) and youths (10-17).

**Pharmacy only medicines:** These are available for purchase in the UK under the supervision of a pharmacist. (NB Independent prescribers include doctors, dentists, nurse prescribers, pharmacists and optometrists. Some other healthcare staff may be supplementary prescribers within their competence, working within a clinical management plan agreed with the independent prescribers).

**Prescription-only medicines (POMs):** These are pharmaceutical treatments that must be prescribed by a suitably qualified healthcare professional and are not available for sale to the general public.



Pre-sentence Report: Should take into account previous offences including trigger behaviours including drugs and alcohol. If drugs and alcohol involvement/history then report writer should approach treatment service for recommendation i.e. whether a community based intervention is suitable.

Public Health England (PHE): PHE is an executive agency of the Department of Health in the United Kingdom that began operating on 1 April 2013. Its formation came as a result of reorganisation of the National Health Service (NHS) in England outlined in the Health and Social Care Act 2012. It took on the role of the Health Protection Agency, the National Treatment Agency for Substance Misuse and a number of other health bodies.

Quality-adjusted Life Year (QALY): A QALY is a generic measure of disease burden, including both the quality and the quantity of life lived. It is used in economic evaluation to assess the value for money of medical interventions. One QALY equates to one year in perfect health.

Referral Order: A community sentence most often used by the courts when dealing with 10 to 17 year olds, particularly for first time offenders who plead guilty. Referral orders require that an offender must agree a contract of rehabilitative and restorative elements to be completed within the sentence.

Required Assessment: On arrest, test for drug use with a mandatory referral to drug treatment. Not mandatory to engage with the service though.

The National Institute for Health and Care Excellence (NICE): NICE provides national guidance and advice to improve health and social care.

Voluntary Referral: Anybody may voluntarily request a referral to the drug and alcohol services.

Youth Offending Services (YOS): Youth offending teams are part of local authorities and are separate from the police and the courts. Youth offending teams work with young people that get into trouble with the law. They look into the background of a young person and try to help them stay away from crime through a variety of interventions.

Youth Rehabilitation Order: An order imposed by a Court which is able to be given to young people under the age of 18 years old when they are being sentenced for having committed a criminal offence. The order will usually contain one or more requirements which must be adhered to by that young offender, for example a drug treatment requirement.