Wiltshire Substance Misuse Health Needs Assessment

A Life Course Approach

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Part of the JSNA

Wiltshire Council
Where everybody matters

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Executive Summary

This document describes Wiltshire's Life Course Substance Misuse Health Needs Assessment (HNA), which reviews the county's drug and alcohol prevalence, risk factors, impact, current provision and recommendations.

The development of this HNA has been led by Wiltshire Public Health and utilised various methods including; national and local data analysis and primary research. The information gathered provides a picture of the population of Wiltshire and their current and future needs for the shaping of drugs and alcohol services.

Health Needs in Wiltshire

The total population of Wiltshire as of mid-year 2018 was 498,064 and is estimated to rise to 528,100 by 2028, with the number of over 65s being higher than those under 20. This does however not account for the 1% increase in population that we are expected to see due to the additional military personnel.

Nationally in 2016 44% of secondary school children reported having an alcoholic drink, whereas local reporting suggests this is 53% for Wiltshire. Local figures in 2017 also saw a slight increase in young people reporting having drunk alcohol at least monthly on 2015 reporting. Nationally 18% of 11-15 year olds reported using drugs in the last year whereas local reporting suggests just 8%. However 70% of young people who smoke tobacco have tried illegal drugs.

The theme of higher drinking levels for young people is also prevalent for adults. Over 18 alcohol consumption has is at 9.7litres annually. Local self-reporting suggests that 60% of Wiltshire adults are drinking too much alcohol. Whereas drug use within Wiltshire is below the national average with 0.44% of the population using either opiates or crack vs 0.88% nationally. Furthermore 49% of all new presentations to treatment in Wiltshire in 2018/19 was for alcohol.

Current Provision

The diagram overleaf displays the current provision in Wiltshire for drugs and alcohol support. The adult's service in 2018/19 had 1416 persons in treatment with 782 of them being new referrals. Within this client group there is just 31% females which is reflected nationally. Whereas the young people's service have a 50/50 gender split. In 2018/19 Motiv8 worked with 194 young people of which 127 were new referrals.

The paper also finds the transition period for a young person (in service) who reaches 18yr and still requires support/treatment from the adult service to be a daunting and challenging prospect. This crucial period in a young person's support and recovery can risk them disengaging and being lost to services.

The system is further complimented with in-hospital Alcohol Liaison Services and supported accommodation which offers housing to those abstinent and receiving opiate replacement prescriptions.

Risk Factors

A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury. This paper reviews the risk factors linked with substance misuse including Adverse Childhood Experiences (ACEs). Exposure and experience of ACEs in childhood can pose significant impact on adulthood meaning individuals are twice as likely to binge drink or 11 times more likely to use drinks. Other risk factors that can increase the likelihood of substance misuse are:

- Others substance misuse behaviour
- Care status
- Not in education, employment or training
- Domestic abuse
- Sexual exploitation
- Mental health
- Housing problems

Wiltshire's Service Model

Conclusion & Recommendations

Considering the local geography services are adequately serving local need and are striving to improve accessibility through the wider use of community settings and digital access. However, there are still wider opportunities to further enhance the substance misuse recovery system in Wiltshire.

The research has found two age groups of suggested need. There is a gap between suggested prevalence of drug use and numbers in service for those aged 20-24. There are several possible reasons for this, such as issues of movement from young to adult services or perhaps persons aged between 20 and 24 not recognising use at that age as problematic. There is a similar gap for alcohol for those aged 54+, again these persons may not be

recognising the possible issue. Both gaps need further research and actions put in place to reduce the difference.

There is also a further difference between males and females in service. The qualitative evidence collected through focus groups with adults currently in treatment also reflected on barriers for females accessing services. These reasons included the belief that children would be removed from them and also the inability to make time to look after themselves. They felt that there were pressures of managing a home that meant that often they didn't realise an issue had a substance misuse issue until it was upon them and then they weren't able to make the time to address it. Further initiatives to remove barriers and increase accessibility for females should be considered.

Within Wiltshire there is also an overrepresentation of mental health issues in treatment. Nearly 60% of adults in treatment for substance misuse have self-reported a mental health issue upon admission. Whereas nationally just 1 in 6 adults have reported a mental health issue in the last week. Further actions should be considered to improvement the co-working with mental health services.

Finally, national modelling from Local Alcohol Profiles England suggests that 1 in 3 adults within Wiltshire are drinking at increasing risk. Increased levels of drinking can place additional pressure on services in the short to long term. These include increased blue light calls, hospital admissions and the need for early assistance from support services. Campaigns should focus on address alcohol consumption within Wiltshire.

Background and definitions

Substance misuse is defined here as:

> **'the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs'**[1]

Psychoactive substance use can lead to dependence syndrome – a cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state[1].

Within this health needs assessment, we have considered both drugs and alcohol, appreciating that their use often shares similar root causes and can have equally devastating effects on the lives of individuals, families and communities. Also, poly-substance use is very common.

In recognition of the impact substance misuse has on individuals of all ages, from the unborn child affected by maternal use, to the older adult suffering from chronic ill health due to personal substance misuse, this Health Needs Assessment has taken a life course approach. Recognising that substance misuse commonly contributes to a wider network of vulnerabilities has also been central to this need's assessment.

Whilst substance misuse can have an impact at any age, certain groups are known to be more vulnerable to its effects. Furthermore, research and data related to this topic often refers to specific subgroups. For this reason, it has at times been necessary to form discussions around groups. The definition of a 'young person', 'adult' or 'older adult' varies between sources. The National Drug Treatment Monitoring System (NDTMS) uses the age of 18 to separate 'young people' and 'adults', since service provision is often divided in this way. However other sources such as the Crime Survey for England and Wales (CSEW) use the term 'young adults' to define the overlapping age group of 16-24 years old. The National Drug Strategy does not specifically define who they refer to as 'young people'. Due to this ambiguity, for the purposes of this document we have tried, where possible, to clearly define the age group we are discussing.

Purpose, scope and methodology

This life course health needs assessment draws on all three approaches. The epidemiological need considers the severity and size of the substance misuse problem. Corporate need looks at the perceptions of the service providers, commissioners and users while comparative need looks at the data in comparison to other localities/sub groups and national targets. It will also underpin the commissioning of a new substance misuse service and be used to shape future strategy.

The main objectives of the needs assessment are:

- To understand the prevalence, impact and develop a need led approach to address substance misuse in Wiltshire.
- To ensure that this assessment informs and directs the strategic vision and future service specifications.
- To understand and describe the population of Wiltshire.
- To understand and describe the risk and protective factors associated with substance misuse and consider them in the Wiltshire context where possible.

[1] World Health Organisation. (2017). Health Topics: Substance abuse.

- To understand and describe the prevalence of substance misuse in Wiltshire.
- To map current drug and alcohol service provision and identify potential service gaps.
- To assess demand upon current services.
- To understand the impact of moving from young persons to adult services.
- To determine whether the current substance misuse service provision meets the identified needs and demands of the local population.
- To understand and describe inequalities experienced by those using substances and consider how these may be addressed.

Glossary of Terms/Abbreviations

AA – Alcoholics Anonymous	DoH – Department of Health & Social Care	NDTMS – National Drug Treatment Monitoring System
ACEs – Adverse Childhood Experiences	DWP – Department for Work and Pensions	NEET – Not in Education, Employment, or Training
ACMD – Advisory Council on the Misuse of Drugs	EIF – Early Intervention Foundation	NHS – National Health Service
ALS – Alcohol Liaison Service	FAS – Foetal Alcohol Syndrome	NICE – National Institute for Health and Care Excellence
APMS – Adult Psychiatric Morbidity Survey	FASD – Foetal Alcohol Spectrum Disorder	NPS – New Psychoactive Substances
AUDIT – Alcohol Use Disorders Identification Test	GP – General Practitioner	NTA – The National Treatment Agency for Substance Misuse
AUDIT-C – modified shorted version of Alcohol Use Disorders Identification Test	HCV – Hepatitis C Virus	ONS – Office for National Statistics
AWP – Avon and Wiltshire Mental Health Partnership NHS Trust	HIV – Human Immunodeficiency Virus	PHE – Public Health England
BANES – Bath and North East Somerset	HMP – Her Majesty's Prison	PSHE – Personal, Social, Health and Economic education
BMA – British Medical Association	HNA – Health Needs Assessment	RUH – Royal United Hospital, Bath
CAMHS – Child and adolescent mental health services	HSE – Health Survey for England	STI – Sexually Transmitted Infection
CSE – Child Sexual Exploitation	LGBT – Lesbian/Gay/Bisexual/Transgender	UNICEF – The United Nations Children's Fund
CSEW – Crime Survey for England and Wales	MARAC – Multi-agency Risk Assessment Conference	WHO – World Health Organisation
DfE – Department for Education	MSM – Men who have sex with men	WSSMS – Wiltshire and Swindon Substance Misuse Services
DHI – Developing Health & Independence	NA – Narcotics Anonymous	UNDOC – United Nations Office on Drugs and Crime

Wiltshire Demographics

This chapter provides an overview of the Wiltshire population and considers the wider determinants influencing health and wellbeing.

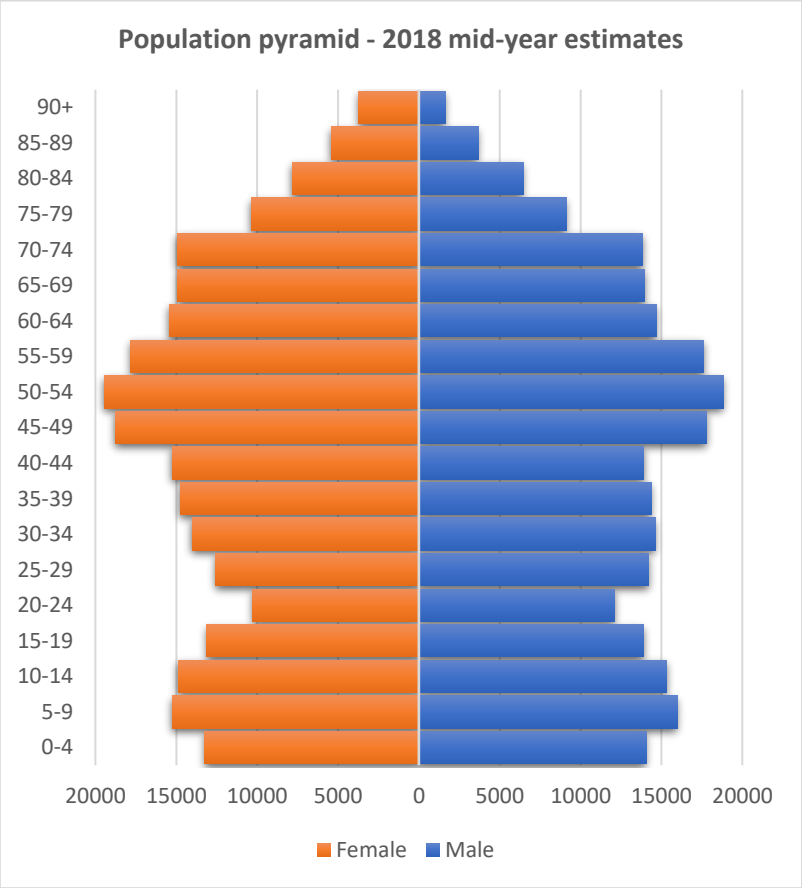
Population

The total population of Wiltshire as of mid-year 2018 was 498,064[2]. The population is estimated to rise to 528,100 by 2028[3].

As of 2018 23% of the population were between the ages of 0-19. Wiltshire has a higher than average proportion of over 65s, with 21% of adults (compared to 18% in England) number of people over the age of 65 will outnumber those under the age of 20.

Figure 1 depicts the most recent population pyramid of Wiltshire and table of figures.

Age	Male	Female	Total
0-4	14,060	13,247	27,307
5-9	15,975	15,244	31,219
10-14	15,329	14,876	30,205
15-19	13,900	13,102	27,002
20-24	12,120	10,277	22,397
25-29	14,214	12,545	26,759
30-34	14,622	14,026	28,648
35-39	14,384	14,759	29,143
40-44	13,907	15,249	29,156
45-49	17,787	18,767	36,556
50-54	18,841	19,435	38,276
55-59	17,621	17,804	35,425
60-64	14,688	15,446	30,134
65-69	13,963	14,895	28,858
70-74	13,829	14,937	28,766
75-79	9,104	10,357	19,461
80-84	6,455	7,843	14,298
85-89	3,666	5,431	9,097
90+	1,639	3,731	5,357



Deprivation

The inequalities in health outcomes due to deprivation have been well documented (Marmot, 2010). Overall Wiltshire is less deprived than many other local authorities in England,

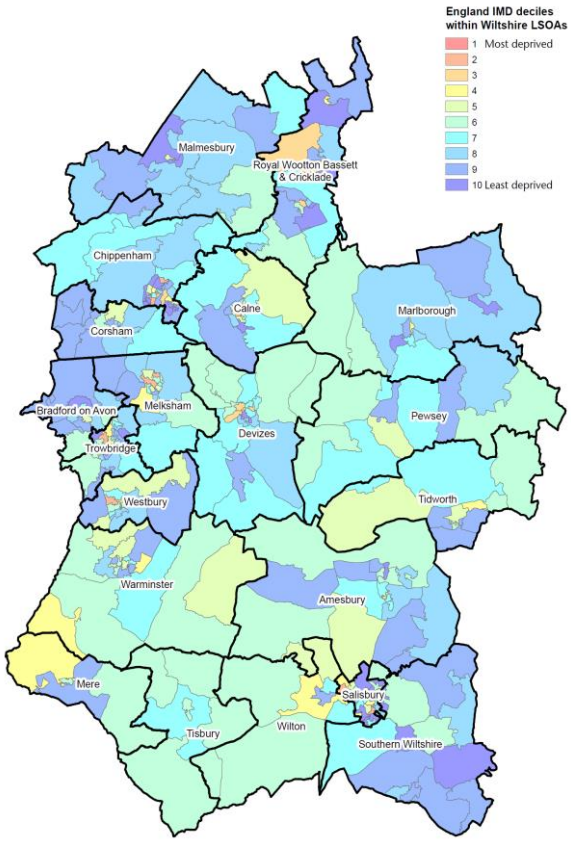
[2] Office for National Statistics. Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Mid-2018: 2019 LA boundaries (dataset).

[3] Office for National Statistics. Population projections for local authorities – 2016 based.

however, 4% of Wiltshire's population are considered to be living in the most deprived and second most deprived deciles in England[4].

The adjacent map shows all the locations within Wiltshire, shaded according to the national deprivation decile into which they fall. The most deprived areas are predominantly seen within the urban environments of Trowbridge, Salisbury, Chippenham and Melksham.

Figure 2: Map of deprivation within Wiltshire[5]



The overall life expectancy at birth for Wiltshire is higher than the England average for both males (80.8 years in Wiltshire; 79.6 years in England) and females (84.0 years in Wiltshire; 83.1 years in England). However there remains significant variation between life expectancy in the most deprived and least deprived deciles. In women the difference is 3.4 years, whereas in men it is even more significant at 5.9 years[5].

Employment rates in Wiltshire are above the national average. 81.1% of adults aged 16-64 in Wiltshire are in employment, compared to 78.2% in the South West, and 75.2% in England[6].

Black, Asian and Minority Ethnic Groups

Wiltshire is predominantly White British (93%). According to 2011 Census figures, ethnic minorities make up 6.6% of the population (31,256 people). Wiltshire has a lower proportion of ethnic minorities than the South West region as a whole (6.6% vs 8.2%) and a considerably lower proportion than for England as a whole (6.6% vs 20.2%). However, whilst the overall proportion of the population from ethnic minority groups in Wiltshire remains relatively low, it increased by 129% between 2001 and 2011 compared to 114% in the South

[4] Department for Communities and Local Government. The English Indices of Deprivation 2015
[5] Department for Communities and Local Government (2015). English Indices of Deprivation 2015: Wiltshire Report
[6] Public Health England. (2019a). Public Health Profiles: Wider determinants of Health.

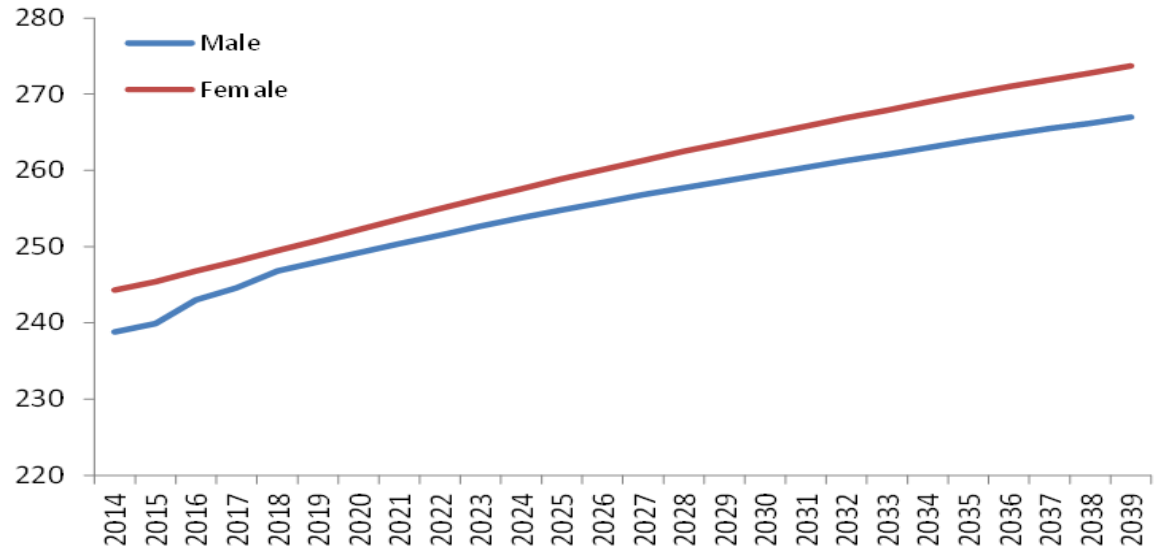
West and 74% in England[7]. Obtaining accurate information on ethnicity between censuses is difficult.

Projected Population Growth and the Military

Over the next 25 years the population of Wiltshire is expected to grow by around 12%, equivalent to an addition 58,000 people. This is illustrated graphically in figure 3.

The steeper rise of the male population between 2014 and 2019 reflects the impact of the military rebasing that is expected to occur. The Office for National Statistics (ONS) projections have not adjusted for accompanying spouses and children, and so are likely to be an underestimate of the true population. It is locally estimated there will be around 1,400 spouses and 1,800 children. Including additional military spouses and families would take the projected increase in population from 12% to at least 13%, or an additional 61,000 people in total.

Figure 3: Projected population growth for Wiltshire[8]



Conclusion

The population of Wiltshire is expected to grow over the next decade, with the majority of this growth seen in the older population. Overall Wiltshire is a relatively affluent county, with high levels of employment. However, there are pockets of significant deprivation, resulting in health inequalities.

[7] Office for National Statistics. (2016). 2011 Census aggregate data. UK Data Service (Edition: June 2016).
[8] Office for National Statistics. (2019b). Population projections for local authorities – 2016 based

National Prevalence of Alcohol and Drug use

This chapter provides an overview of the prevalence of substance misuse on a national scale. Alcohol and drug use are each discussed, with the prevalence amongst young people and adults also considered separately.

Alcohol

11-15 year olds

In a national survey of secondary school children in 2016, 44% of 11-15 year olds reported previously having an alcoholic drink. 10% had consumed alcohol in the last week, and 9% reported drinking enough to become drunk in the last 4 weeks, with these figures rising with age[9].

A change in the wording of questions in the 2016 survey means the most recent figures are not directly comparable with previous years. However, data from older surveys indicates a fall in the number of 11-15 year olds drinking alcohol between 2003 and 2014.

Girls were slightly more likely than boys to have had alcohol (in the last week or ever) and girls were more likely than boys to have been drunk (11% vs. 7%).

Pupils of white or mixed ethnicity were more likely to have had an alcoholic drink.

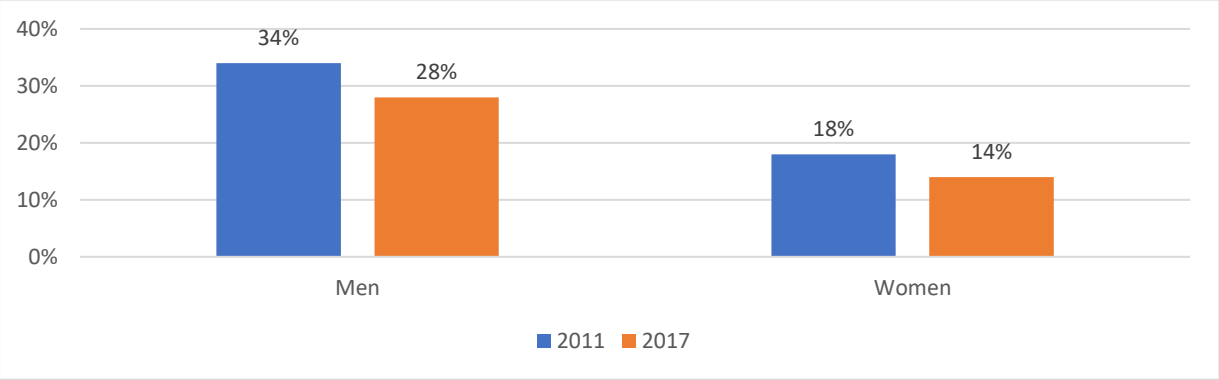
Pupils most commonly obtained alcohol from their parents (70%) or from friends (54%). Overall the most common place to drink alcohol was in their own home, however drinking at parties with friends became more common as the pupils got older. In keeping with this, children aged 11-13 most commonly reported drinking with their parents, whereas for those aged 14-15, friends were their most likely drinking companions.

Adults

Overall UK alcohol consumption decreased between 2004 and 2017 from 11.6 litres annually to 9.7 litres. However, there was a slight increase in total consumption again between 2014 and 2017[10], see figure 4.

According to the Health Survey for England (HSE) 2017 the proportion of adults drinking at harmful levels (above recommend drinking levels) fell between 2011 and 2017[11].

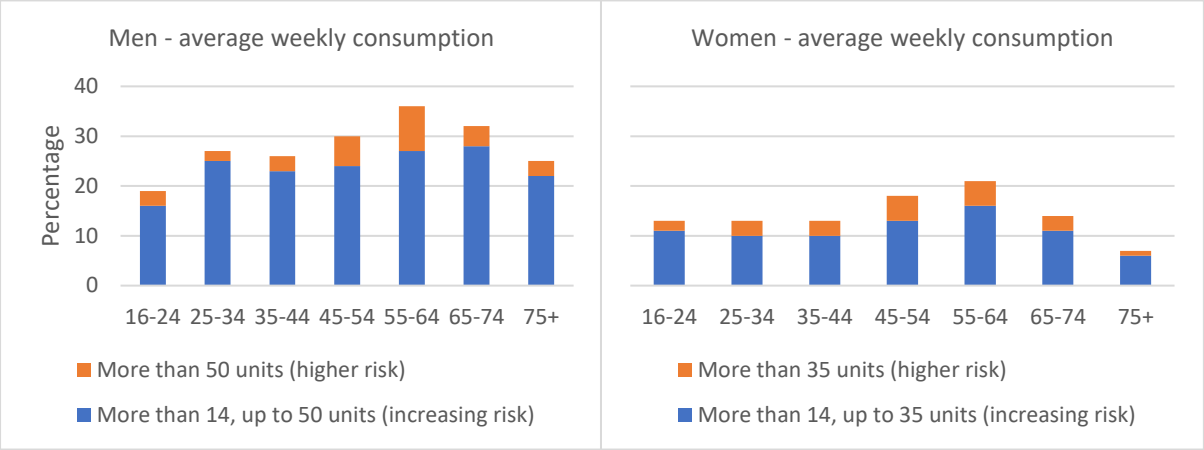
Figure 4: Proportion drinking at increased (>14 units/week) and higher (>50 units/week in men and >35 units/week in women) risk of harm by year[11]



[9] NHS Digital. (2018a). Smoking, drinking and drug use among young people, 2016. UK Data Service.
[10] Institute of Alcohol Studies. (2018). *Consumption of alcohol*
[11] NHS Digital. (2018) Health Survey for England 2017.

However, there remains significant variation between age groups, as shown by the graphs below (Figure 5) which illustrates the proportion of men and women drinking over the recommended limits on an average week (>14 units)[10]. For both men and women, those aged between 55-64 have the highest average weekly consumption and are also most likely to drink on more than 5 days of the week. Across all age groups men are more likely to be drinking at increased or higher risk levels.

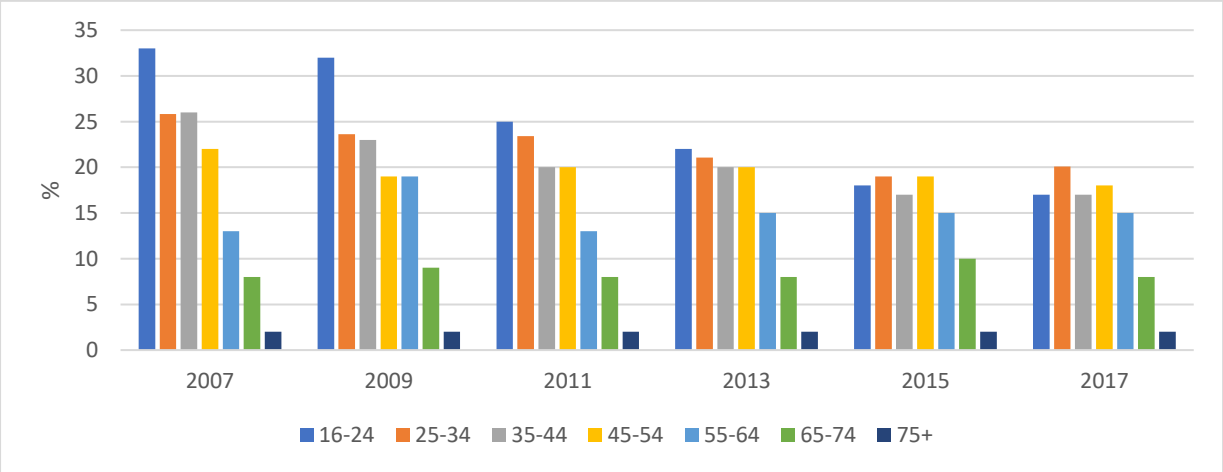
Figure 5: Male and Female average weekly alcohol consumption [10]



Within England, the South West region has the highest proportion of adults drinking over 14 units a week (24%)[10].

Binge drinking (defined as having over 8 units in one session for men, and over 6 units for women[12]) has typically been viewed as a practice of younger drinkers. Recent figures (figure 6) show a levelling out across the age groups, with relatively equal proportions of those between the ages of 16 and 64 reporting binge drinking in the last week. The question used i.e. only asking about consumption in the last week may actually underestimate the levels of binge drinking in those that may drink extreme amounts, but less frequently. For example 60% of those aged 16-24 drink less than weekly, compared to only 32-47% of older age groups[12].

Figure 6: Proportion who drank over 6/8 units in one sitting during the last week[12]



[12] NHS Digital. (2018) Health Survey for England 2017.

Whilst the HSE asked people about their average or most recent weekly alcohol consumption in units, the 2014 Adult Psychiatric Morbidity Study (APMS) used the Alcohol Use Disorders Identification Test (AUDIT) in their questionnaire (NHS Digital, 2016). The full AUDIT questionnaire can be seen in Appendix 1. The AUDIT questionnaire asks about alcohol use over the last year and has specific questions about binge drinking. It therefore may be more sensitive than the HSE at detecting those who are drinking at hazardous or harmful levels, but not necessarily on a weekly basis. By asking about the number of drinks it also removes the possibly of confusion regarding what constitutes a unit but doesn't take into account the varying alcohol content of what respondents might consider one drink. BMA data suggests those under the age of 35 were most likely to be drinking at hazardous or harmful levels (AUDIT score >8). Furthermore a significant proportion of men aged 55-64 were also drinking at these risky levels (31%).

The HSE showed that there is a strong correlation between higher household income, and the proportion of adults regularly drinking at levels associated with increased risk of harm (over 14 units per week). Similarly, the APMS showed that hazardous drinking (AUDIT score of 8 or more) was associated with being in employment. However, it found that those who reported the most harmful or dependent levels of drinking (AUDIT score 16 or more) were more likely to be in receipt of employment support, housing support or out-of-work benefits.

Alcohol in pregnancy

Data regarding alcohol consumption during pregnancy is limited and inconsistent[13]. ONS figures report that in 2017 11.3% of pregnant women in England had drunk alcohol in the last week[14]. In the 2010 Infant Feeding Survey, 40% of women reported drinking at some point during their pregnancy[15]. However due to the stigma associated with drinking in pregnancy, it is acknowledged that the true figure may be even higher than this.

Data on the incidence of Foetal Alcohol Spectrum Disorders (FASD) is even more limited. This is partly due to the fact that children suffering from FASD lie within a continuum, and can experience a range of impairments, making definite diagnosis challenging. The only data collected relates specifically to Foetal Alcohol Syndrome (FAS), which is the most clinically recognisable form of FASD and therefore fails to acknowledge those with the less well-defined, but not necessarily less severe, forms of the condition. Worldwide it is estimated that just under 1% of live births are affected by FASD, however this is based almost entirely on US data. Other studies have suggested that the prevalence of FASD may be as high as 2-5% amongst school-aged children in North America and Western Europe[12].

Drugs

11-15 year olds

In the 2016 national school survey 18% of pupils surveyed reported having taken drugs in the last year[11]. This was a significant increase from the 10% reporting drug use in 2014. In part, this was a result of the inclusion of nitrous oxide and new psychoactive substances for the first time. However, even when allowing for this, the figure was still high at 15%. If this is accurate it has significant implications, as between 2003 and 2016 there had been a steady decrease in the proportion of pupils reporting drug use. However, as there is no

[13] British Medical Association. (2007 – updated 2016). Alcohol and pregnancy: preventing and managing fetal alcohol spectrum disorders.
[14] Office for National Statistics. (2018). Adults drinking habits in Great Britain: supplementary data – 2017.
[15] NHS Digital. (2012). Infant Feeding Survey – UK 2010.

substantial evidence from other sources to back up these figures, they should be treated with caution, until data from further years is collected to establish whether they truly represent an increasing trend in use.

Table 2: trends in individual drug use in 11-15 year olds between 2002 and 2016 [11].

	2002	2004	2006	2008	2010 [3]	2012	2014	2016
Type of drug taken in the last year	%	%	%	%	%	%	%	%
Cannabis	*13.2*	*11.3*	*10.1*	*9.0*	*8.2*	*7.5*	*6.7*	*7.9*
Any stimulants	***6.2***	***5.4***	***6.2***	***4.9***	***2.7***	***2.6***	***2.1***	***2.7***
Cocaine	*1.3*	*1.4*	*1.6*	*1.7*	*0.9*	*0.9*	*0.9*	*1.3*
Crack	*1.0*	*1.1*	*0.8*	*0.7*	*0.3*	*0.5*	*0.3*	*0.4*
Ecstasy	*1.5*	*1.4*	*1.6*	*1.3*	*0.9*	*0.9*	*0.8*	*1.3*
Amphetamines	*1.2*	*1.3*	*1.2*	*0.9*	*0.8*	*0.7*	*0.7*	*0.5*
Poppers	*4.3*	*3.4*	*4.2*	*2.9*	*1.5*	*0.8*	*0.7*	*0.6*
Mephedrone	*:*	*:*	*:*	*:*	*:*	*0.7*	*0.5*	*0.3*
Any psychedelics	***1.8***	***2.3***	***2.2***	***2.1***	***1.6***	***1.1***	***1.3***	***1.7***
LSD	*0.7*	*0.7*	*0.7*	*0.7*	*0.4*	*0.4*	*0.5*	*0.9*
Magic mushrooms	*1.5*	*2.0*	*1.4*	*1.3*	*1.0*	*0.6*	*0.8*	*0.8*
Ketamine	*:*	*:*	*0.5*	*0.7*	*0.5*	*0.5*	*0.4*	*0.5*
Any psychoactive substances	*:*	*:*	*:*	*:*	*:*	*:*	*:*	***5.2***
Nitrous oxide	*:*	*:*	*:*	*:*	*:*	*:*	*:*	*4.0*
New psychoactive substances (previously known as legal highs)	*:*	*:*	*:*	*:*	*:*	*:*	*:*	*1.6*
Any opiates	***0.8***	***0.7***	***0.7***	***0.7***	***0.8***	***0.5***	***0.4***	***0.4***
Heroin	*0.7*	*0.7*	*0.5*	*0.5*	*0.3*	*0.4*	*0.2*	*0.3*
Methadone	*0.2*	*0.1*	*0.3*	*0.3*	*0.5*	*0.2*	*0.3*	*0.1*
Glue, gas, aerosols or solvents (volatile substances)	*6.3*	*5.6*	*5.1*	*5.0*	*3.8*	*3.6*	*2.9*	*4.4*
Tranquillisers	*0.4*	*0.4*	*0.4*	*0.5*	*0.2*	*0.4*	*0.4*	*0.5*
Other drugs	*0.4*	*0.4*	*0.2*	*0.3*	*0.4*	*0.2*	*0.3*	*0.9*
Any Class A drug	***3.7***	***3.9***	***4.3***	***3.6***	***2.4***	***2.2***	***2.0***	***3.2***
Any drug	*:*	*:*	*:*	*:*	*:*	*:*	*:*	***17.8***
Any drug (excluding psychoactive substances)	***19.7***	***17.6***	***16.5***	***15.0***	***12.5***	***11.9***	***10.3***	***15.2***
Any drug (excluding volatile substances)	***15.9***	***14.0***	***13.4***	***11.6***	***9.7***	***9.1***	***8.1***	***14.2***

The proportion of pupils reporting prior drug use increased with age. The proportion of girls (24%) and boys (25%) reporting previous drug use were similar. Pupils from a Black ethnic background were the most likely to have previously taken drugs.

Table 2 shows trends in individual drug use in 11-15-year olds between 2002 and 2016. 2016 was the first year that nitrous oxide and new psychoactive substances (previously known as 'legal highs') were included in the survey, therefore trends are not yet available.

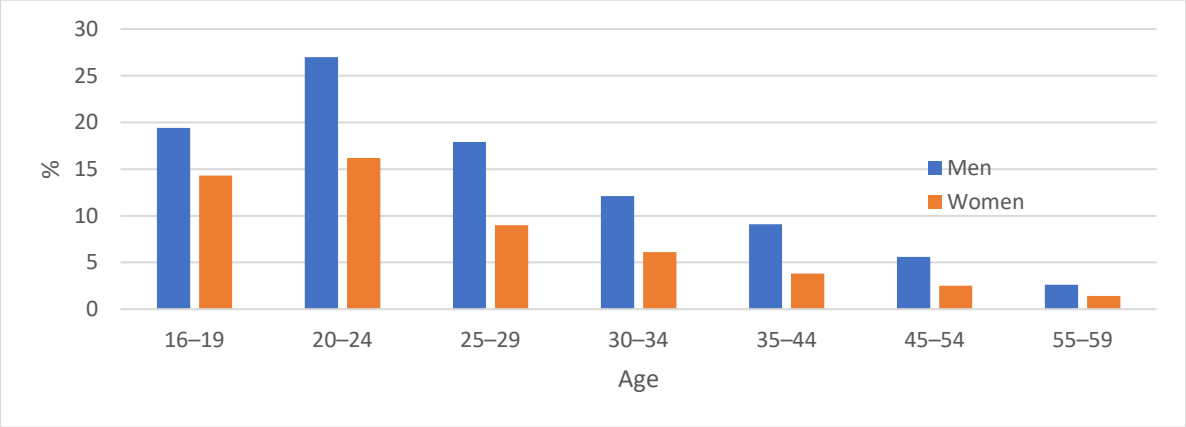
Adults

The 2017/2018 Crime Survey for England and Wales (CSEW) reported 9% of 16-59-year olds reported taking any drug in the last year. This figure has remained relatively stable over the last decade but has fallen from the 11.1% reporting drug use in 1996 (when these questions were first asked by the survey)[16].

Young adults are most likely to have taken drugs in the last year with16.9% 16-19-year olds and 21.8% 21-24-year olds). The reporting of recent drug use then declines with age. The overall reduction in drug use seen since 1996 is largely a reflection of falling rates of use amongst young adults. Between 1996 and 2017/2018 the proportion of 16-24 years olds reporting drug use in the last year has fallen from 29.7% to 19.8%. This masks the fact that there has been a smaller, but still significant, rise in drug use reported by those over the age of 45[16].

Men are around twice as likely to take drugs as women. When analysing drug use by gender and age group, the highest prevalence is in males aged 20-24 years. They were nearly 20 times more likely to have taken drugs than those with the lowest prevalence, older women.

Figure 7: Proportion reporting drug use in the last year by sex and age[17]



Rates of substance use are higher among lesbian, gay, bisexual and transgender (LGBT) groups than in the general population[18]. Chemsex (the use of recreational drugs to sustain, enhance, disinhibit or facilitate sexual interactions) has been primarily described within the MSM (men who have sex with men) community[19]. Data regarding this practice remains

[16] Home Office. (2018). Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales.
[17] Home Office. (2018). Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales.
[18] UK Drug Policy Commission. (2010). Drugs and Diversity: Lesbian, gay, bisexual and transgender (LGBT) communities – Learning from the evidence.
[19] Macfarlane, A. (2016). Sex, drugs and self-control: why chemsex is fast becoming a public health concern. Journal of Family Planning and Reproductive Health Care, 42(4): 291-294.

limited but there is significant public health concern regarding its association with high-risk sexual behaviour, including transmission of HIV and other STIs[20].

The table below illustrates trends in use for various types of drugs. Arrows denote a statistically significant increase or decrease in rates of reported use.

New psychoactive substances (NPS) were first included in the CSEW in 2014/2015. In May 2016, production and supply of these substances became illegal in UK under the Psychoactive Substances Act. In the most recent survey 0.4% of adults reported using an NPS in the last year. Evidence suggests however that the use of NPS is particularly prevalent amongst the prison and homeless populations. Since they are not captured by the

Table 3: Trends in drug use between 1996 and 2017[21]

	Drug types	Adults aged 16-59				Adults aged 16-24			
Class		2017/18	compared with:			2017/2018	compared with:		
		Proportion reporting use (%)	1996	2007/08	2016/17	Proportion reporting use (%)	1996	2007/08	2016/17
A	Any cocaine	2.7	↑			6.0	↑		
	Powder cocaine	2.6	↑			6.0	↑		
	Crack cocaine	0.1		↓	↑	0.1			
	Ecstasy	1.7			↑	5.1			
	Hallucinogens	0.7	↓		↑	2.3	↓		
	LSD	0.4	↓		↑	1.6	↓	↑	
	Magic mushrooms	0.4	↓			1.3			
	Opiates	0.1				0.1			
	Heroin	0.1				0.0			
	Methadone	0.1		↓		0.1			
A/B	Any amphetamine	0.5	n/a	n/a		1.5	n/a	n/a	
	Amphetamines	0.5	↓	↓		1.5	↓	↓	
	Methamphetamines	0.0	n/a	n/a		0.1	n/a	n/a	
B	Cannabis	7.2	↓			16.7	↓		
	Ketamine	0.8	n/a	↑	↑	3.1	n/a	↑	↑
	Mephedrone	0.1	n/a	n/a		0.2	n/a	n/a	
B/C	Tranquilisers	0.6			↑	1.2			
C	Anabolic steroids	0.2		↑		0.3			
	New psychoactive substances	0.4	n/a	n/a		1.2	n/a	n/a	
	Any Class A drug	**3.5**	↑	↑	↑	**8.4**		↑	
	Any drug	**9.0**	↓			**19.8**	↓		

[21] Home Office. (2018). Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales.

CSEW data, it is likely that the prevalence estimates presented are lower than the true value[20].

Between 2.6-3.6% of the adult population (>16 years) are estimated to be dependent on drugs. The majority (1.9-2.8%) are dependent on cannabis alone, with a smaller proportion dependent on other drugs (with or without cannabis dependence as well). The group with highest level of dependency is young men and those who are economically inactive or unemployed[22].

Conclusion

Alcohol

A significant proportion (44%) of 11-15 year olds in the UK have previously drunk alcohol. Prior to 2014 the number drinking appeared to be decreasing, however a change in the wording of national survey questions means the trends are less clear since then.

A significant proportion of men, young adults and those between 55-64 years of age continue to drink at levels which pose a significant risk to their health. Those drinking at hazardous/harmful but not dependent levels, are most likely to be in employment or from a higher income household.

The South West as a region has the highest proportion of adults drinking over the recommended 14 units per week.

Alcohol consumption in pregnancy remains poorly understood; data that is available is likely to underestimate its prevalence due to the associated stigma. Furthermore, the wide spectrum of conditions associated with foetal exposure to alcohol makes accurate diagnosis, and calculation of prevalence very challenging.

Drugs

The most recent national school survey[9] suggests an increase in the proportion of young people taking drugs, from 10% in 2014 to 18% in 2016. However further data collection is required to back up this figure as it deviates from trends seen up to this time.

Prevalence of drug use in adults has remained relatively stable over the last decade and is most common in males and those under the age of 30. Other groups such as the LGBT community, and those who are economically inactive/unemployed also show higher than average levels of drug use.

In both children and adult's cannabis remains the most commonly used drug.

Recommendations

- National evidence suggests a need for more harm reduction advice particularly targeting those in the 55-64 year old age group, and those from more affluent backgrounds, who may not identify as having a 'problem' with alcohol, or be aware of the cumulative harm of regular consumption over the recommended limits
- Nationally there is a need for further data collection/analysis with regards to alcohol consumption in pregnancy to gain a better understanding of its prevalence and what can be done to reduce risks to the unborn child

[21] Home Office. (2018). Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales.
[22] NHS Digital. (2016). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.

- There is a need to monitor emerging national trends in drug use amongst 11-15 year olds to ascertain whether reported increase seen in 2016 survey is validated (Smoking, Drinking and Drug Use among Young People in England 2018 is due for publication on 25th July 2019)
- PHE suggest there is an increase in Performance or Image Enhancing Drug use, a report should look into defining this understand its impact within Wiltshire.

Prevalence of drug and alcohol problems in Wiltshire

This chapter discusses the prevalence and characteristics of those using drugs and alcohol in Wiltshire. The number of individuals engaged with substance misuse treatment services gives an indication of the scale of the problem. However, to support further understanding we need to gather information about those that may have problems related to substance use, but not accessing services. Surveys such as the Young People's Health and Wellbeing Survey, and the council's AUDIT-C Twitter questionnaire have helped to build this picture.

Pregnancy through to early childhood

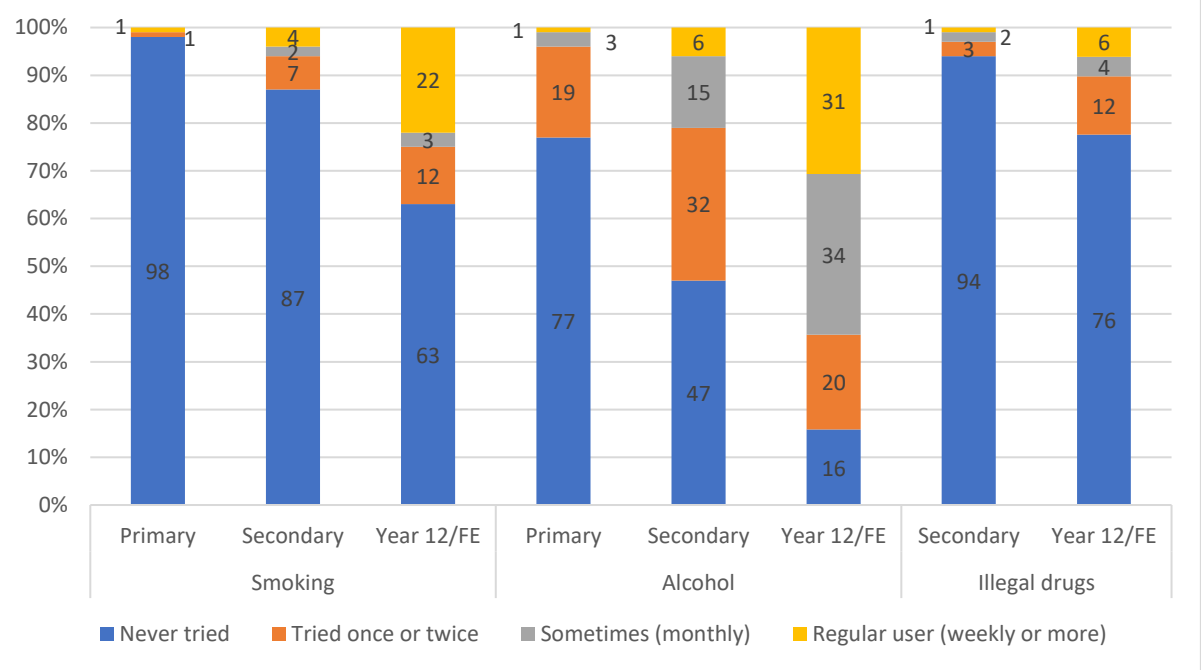
In 2017/18 there were 4,200 assessments carried out by children's services in Wiltshire. Of these, 963 (23%) assessments identified alcohol misuse and 949 (23%) drug misuse[23].
In terms of those in treatment in Wiltshire, over the course of 2018/19, less than 5 women entering adult treatment services were recorded as being pregnant at the start of their treatment journey. In addition to this, 372 new clients had contact with children, either being parents themselves or living with other children[24].
A limitation to this area of data includes establishing whether data is available pertaining to the prevalence of substance misuse amongst women under the care of Wiltshire maternity services.

Young People (<18 years)

The Wiltshire Children and Young People's Health and Wellbeing Survey 2017 was carried out in 95 schools and colleges across Wiltshire. Responses were obtained from 9,951 pupils from year groups 4, 5, 6, 8, 10 and 12. Questions related to substance misuse

Figure 8: Proportion of children and young people who smoke, drink or take illegal drugs in Wiltshire[25]

demonstrated the following:



[23] Department for Education. (2018a). Characteristics of children in need: 2017-2018.
[24] Public Health England - National Drug Treatment Monitoring System. (2019b). Adult Partnership Activity Report Quarter 4 2018-2019 – Wiltshire.
[25] Wiltshire Children and Young People's Health and Wellbeing Survey (2017)

There was a slight increase in the proportion of children reporting they drink alcohol monthly or more often between the 2015 and 2017 surveys. Children who identified as LGBT or who were young carers were significantly more likely to have tried illegal drugs.

Compared to the national school survey, where 44% of 11-15-year olds reported drinking alcohol in the past, 53% of Wiltshire's secondary school respondents reported having done so. However, the results are not directly comparable due to the inclusion of 16-year olds in the Wiltshire survey which is likely to bring the overall prevalence up.

In the national school survey 18% of 11-15-year olds reported having used drugs in the last year, with 10% reporting their use in the last month. In contrast only 6% of Wiltshire secondary school respondents reported having ever taken illicit drugs [24].

Smoking cessation is not formally included within the commissioned substance misuse service in Wiltshire, however it is often given as part of the harm reduction advice. Currently the official pathway for smoking cessation support for young people is via their GP.

The most notable result is in the secondary school sample, where 70% of the frequent smokers had tried illegal drugs, compared to 7% of the total Wiltshire secondary school respondents. This highlights the significance of early intervention and harm reduction advice.

It may be prudent to review how many young people attend stop smoking services to establish if this is the most accessible way to receive nicotine replacement patches.

Young people in treatment

New Referrals and Numbers in Service

In 2018/2019 there were 127 new presentations to young people's substance misuse services (for ages 11-18) in Wiltshire (PHE - NDTMS, 2019a).

The total number in service (rolling 12 month total) has gradually increased since the beginning of the operational year. This is in contrast to national figures which have shown a reduction in numbers in treatment. There is no obvious reason for this contrasting picture, however there has been a great deal of work done to promote the local service through both strategic and operational forums, including training opportunities.

Table 4: Numbers in treatment 2018-19[26]

Numbers in treatment (rolling 12 months)											
	April	May	June	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Local	169	167	180	183	184	191	198	200	197	189	194
National	15505	15337	15101	14339	14265	14386	14480	14445	14488	14457	14499

Client demographics

The greater proportion of males to females is similar to national figures, and those seen in adult services. In adults this is not surprising given the higher proportion of men reporting drug and alcohol misuse. However as outlined above the proportion of young people reporting drug and alcohol use is evenly spread between males and females, with females slightly more likely to report having had alcohol or been drunk in the past.

[26] Public Health England - National Drug Treatment Monitoring System. Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.

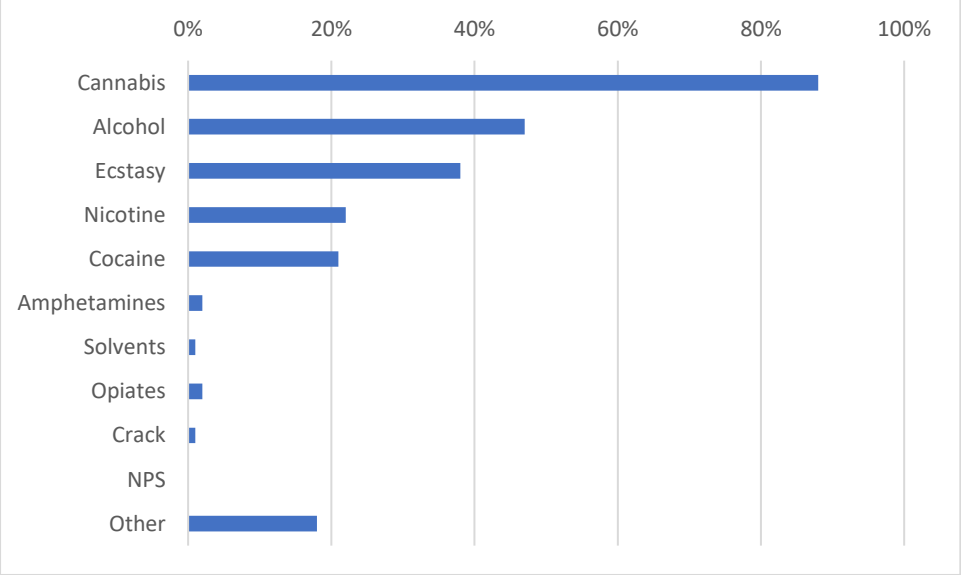
This infers there may be an unmet treatment need for young females which needs exploring further.

Age and gender	2015-16		2016-17		2017-18		2018-19	
	(n)	%	(n)	%	(n)	%	(n)	%
Under 13	1	1%	0	0%	0	0%	1	1%
Aged 13-14	31	20%	18	13%	29	18%	50	26%
Aged 15	50	32%	50	35%	47	29%	51	26%
Aged 16	41	26%	39	27%	47	29%	48	25%
Aged 17	32	21%	35	25%	40	25%	44	23%
Aged 18	0	0%	0	0%	0	0%	0	0%
Female	63	41%	58	41%	63	39%	72	37%
Male	92	59%	84	59%	100	61%	122	63%

Table 5: Wiltshire client demographics 2015-19[25]

Drugs misuse

Figure 9: Proportion of individuals in young people's services using each substance[27]

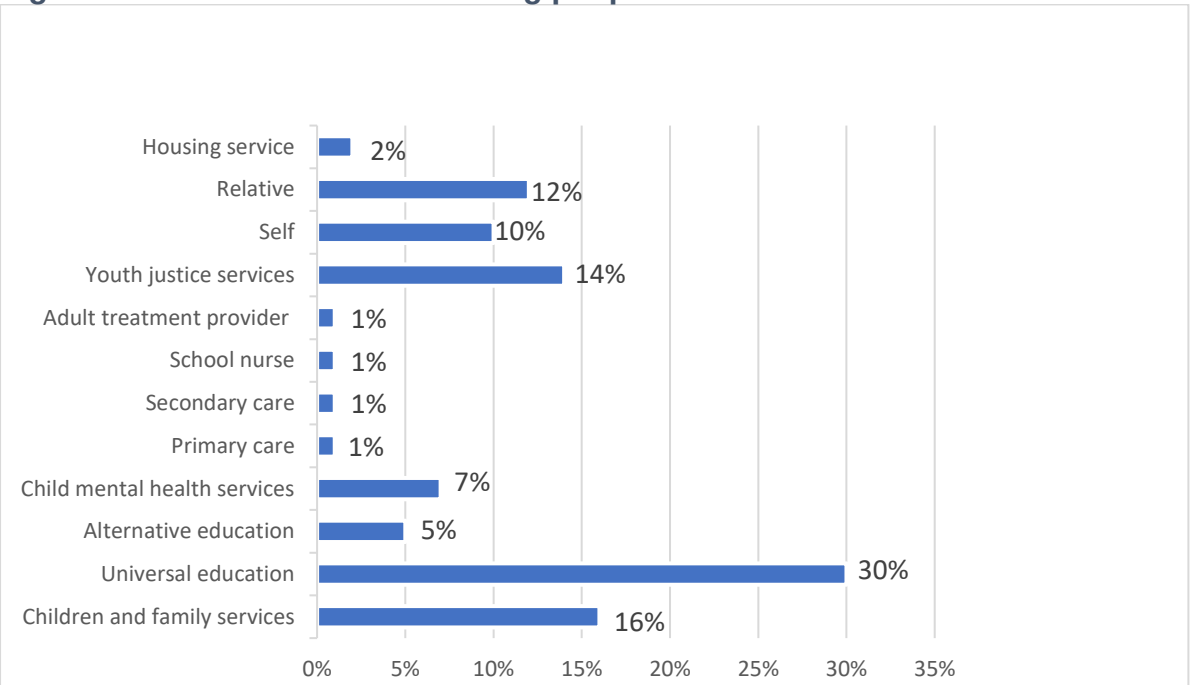


[27] Public Health England - National Drug Treatment Monitoring System. Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.

Referral sources

Universal education comprises the largest referrer to young people's mental health services. Children and family services, youth justice services, relatives and self-referral the next most common referral routes. Despite 32% of those in service having an identified mental health need, only 7% of referrals come from child and adolescent mental health services (CAMHS).

Figure 10: Referral sources - Young people's treatment services 2018-19 [26]



Adulthood through to the Elderly (>18 years)

As with young people, treatment figures only give us part of the picture when it comes to the overall prevalence of drug and alcohol use in Wiltshire.

Alcohol

In 2016-2017 PHE estimates around 1% of the adult population of Wiltshire were dependent on alcohol This is slightly lower than the estimated national prevalence of 1.35%[28].

A Twitter survey using the validated Audit-C questionnaire (see Appendix 1) was conducted by Wiltshire Council in both 2017 and 2018 giving further information about the county's drinking habits.

In total (combined 2017 and 2018 results) there were 365 respondents from within Wiltshire; 249 of these were women and 116 men. Although a small sample size, the data can be used as an indicator of possible trends.

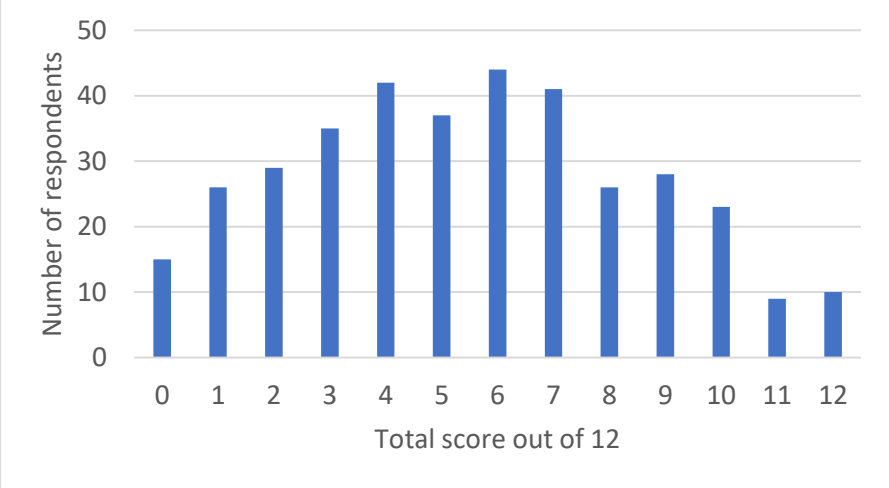
- 79 respondents (22%) reported on average over the last year they drank 4 or more times per week.
- 46 (13%) reported on an average drinking day they consumed 10 or more units of alcohol.
- 16 individuals (4%) reported they consumed 6 or more drinks on a daily or almost daily basis.

The distribution of total scores is shown in the graph below (figure 11). A score of 5 or more is considered significant for possible alcohol misuse. The higher the overall score, the

[28] Public Health England. (2017a). Alcohol dependence prevalence in England.

greater the chance of an alcohol misuse problem. 60% of those responding had a total score of 5 or more.

Figure 11: AUDIT-C scores from Public Health Wiltshire's Twitter questionnaire 2017-2019



There is clearly a possibility of participation bias, which should be given consideration. For example, people who do not drink alcohol at all, or are less concerned about their drinking habits, may have been less likely to take the survey. There is also the possibility people were not truthful in their responses. However, it is widely accepted that in general people under-report, rather than over-report their alcohol intake. Surveys were submitted anonymously (participants only needed to provide the first part of their postcode) which should have also helped to minimize concerns about reporting.

Drugs

In 2016-17 estimates for the prevalence of opiate and crack use suggested around 1,337 users of one, or both, of these drugs in Wiltshire. This represents a prevalence of approximately 0.44%, which is roughly half of the estimated prevalence for the South West region, and England as a whole[29].

Table 6: Estimated prevalence of use (% of population) 2017[28]

	Estimated prevalence of use (% of population)		
	Opiates and/or crack cocaine	**Opiates**	**Crack cocaine**
Wiltshire	0.44	0.38	0.35
South West	0.83	0.71	0.44
England	0.88	0.73	0.51

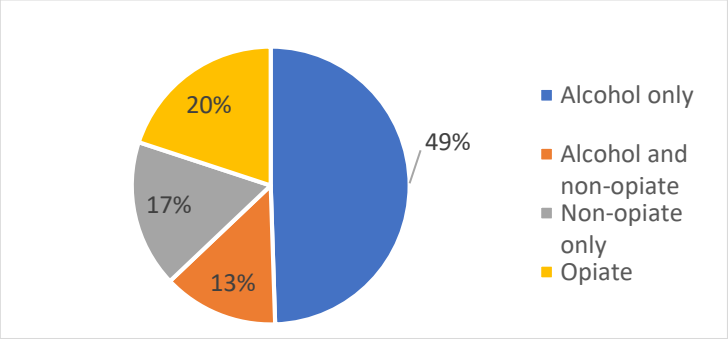
[29] Public Health England. (2017b). Opiate and crack cocaine use: prevalence estimates by local area.

Adults in treatment

New presentations to treatment providers

Data from Wiltshire's substance misuse treatment providers gives more information about the demographics of Wiltshire's adult drug and alcohol users 'in treatment'.

Figure 12: Wiltshire new presentations to treatment 2018/19 [30]



Over the course of 2018/19 there were a total of 782 new presentations to adult drug and alcohol services in Wiltshire. Half of those were seeking help for alcohol misuse alone[30]. Nationally the proportion seeking help for alcohol misuse alone is lower than this at 40%, with a larger proportion seeking help for opiates.

In the past 10 years, the total number of new presentations has fluctuated from 548 in 2012/13 to the highest number of 836 in 2017/18. The numbers presenting for each substance category have also varied, with the most significant change seen in the rise of people presenting for misuse of non-opiates.

Table 7: New presentations by drug type 2009-2019 [30]

Substance Category	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Alcohol only	340	344	310	232	359	398	426	391	402	387
Alcohol & non-opiate	65	82	108	98	112	113	124	98	119	105
Non-opiate only	19	41	45	46	84	82	107	119	144	134
Opiate	217	197	169	172	162	179	155	167	171	156
Total	641	664	632	548	717	772	812	775	836	782

Numbers in treatment

Table 8: 2018/19 treatment population by drug type[30]

Substance category	Numbers in treatment
Alcohol	538
Alcohol & non-opiate	154
Non-opiate only	180
Opiate	544
Total	**1416**

In the 2018/19 treatment year there were 1416 clients receiving treatment from adult substance misuse services in Wiltshire. Despite making up just 20% of new referrals, opiate clients make up nearly 40% of all clients in treatment during the year, suggesting that they remain in treatment longer than those requiring treatment for other substances.

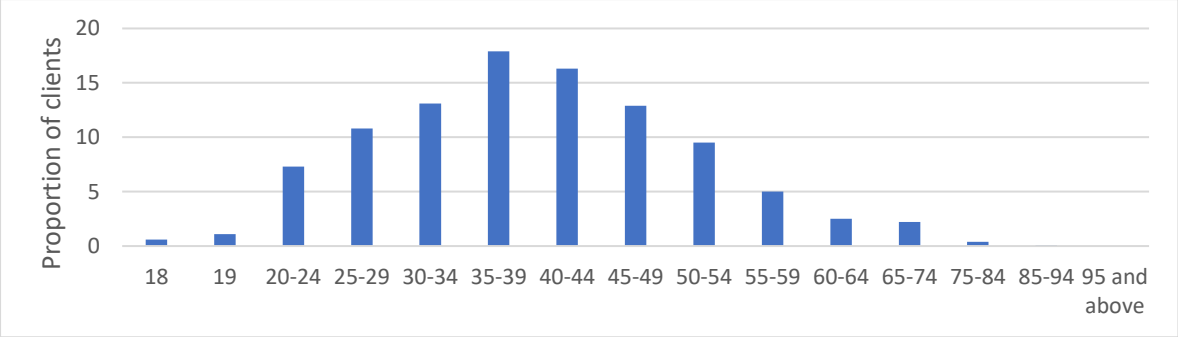
[30] Public Health England - National Drug Treatment Monitoring System. (2019b). Adult Partnership Activity Report Quarter 4 2018-2019 – Wiltshire.

Client demographics

Similarly, to the young people's services 66.7% of adult clients treated in 2018/19 were male and 33.7% were female. It is unclear whether this is as a result of a genuine difference in prevalence of substance misuse within the population, or whether there is an unmet need that needs further exploration.

The graph below demonstrates the age distribution of all of those in treatment in 2018/19.

Figure 13: Age of those in treatment 2018/19[30]



The proportion of individuals in treatment by age group varies by substance category as shown below (figure 14). In keeping with national trends, there are a higher proportion of older adults seeking treatment for alcohol misuse.

Figure 14: 2018/19 Age distribution by substance category [29]

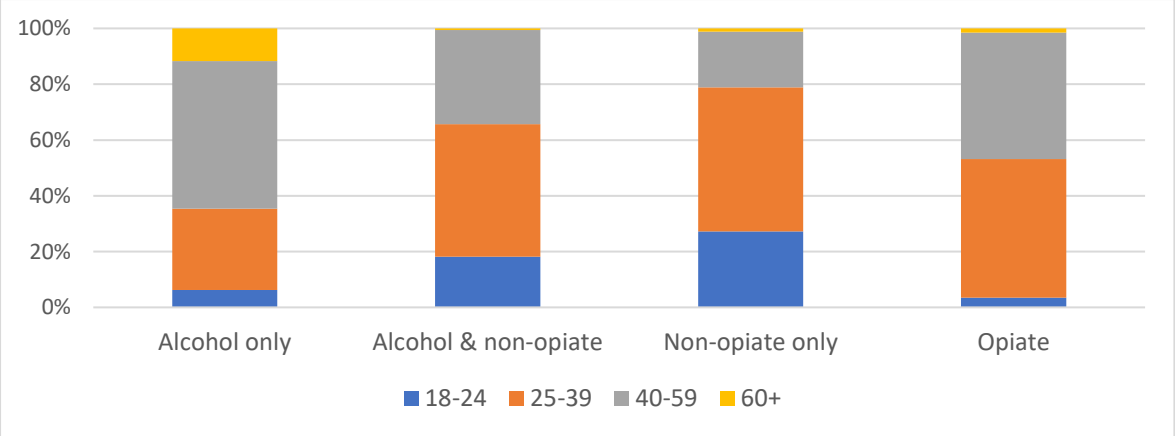


Table 10: 2018/19 Adult Treatment population by sexuality 2018/19[29]

Sexuality	Percentage of new presentations (2018/19)
Heterosexual	93.4 %
Gay/Lesbian	2.8%
Bi-sexual	2.6%
Person does not know/unsure	0.1%
Not stated	0.9%
Other	0.1%
Missing/inconsistent	0.1%

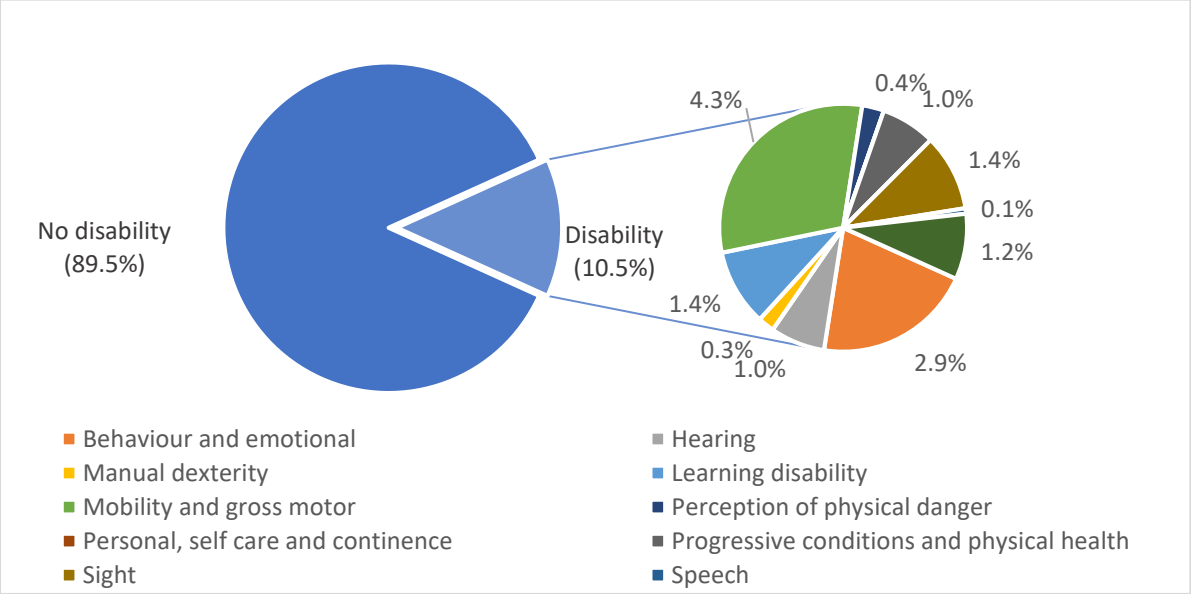
In 2017 2% of the general population identified as lesbian/gay/bi-sexual (LGB)[31]. In contrast, 5.4% of those presenting to drug and alcohol services in Wiltshire identified as such. This relative over-representation of LGB individuals is even more significant when looking at drug and alcohol use in young people.

The prevalence of disability in 2017 in the general population is cited as 8% in children, 18% in working

[31] Office for National Statistics. (2019). Sexual orientation, UK: 2017.

aged adults and 44% in adults over the state pension age[32]. Amongst the adult treatment population in Wiltshire 10.5% identified as having a disability.

Figure 15: Reported disabilities amongst new clients 2018/19[30]



Referral source

Just under 90% of referrals are self-referrals or are referred by family and friends. General practitioners and the criminal justice system refer the next largest proportion of clients.

Table 11: Referral Source 2018/19 [29]

Referral Source	Percentage of referrals (2018/19)
Self, family and friends	89.4%
Criminal justice	3.7%
GP	3.5%
Community based care	0.6%
Children and families	0.3%
Accident and emergency	0.0%
Hospital	0.7%
Other health/mental health	0.1%
Substance misuse services	1.3%
Other	0.4%

Conclusion

Treatment figures can give an idea of the prevalence of substance misuse in Wiltshire, however they fail to capture those with a substance misuse problem who have not sought help. National estimates suggest that Wiltshire has a lower than average number of individuals dependent on alcohol, or opiate and crack cocaine[33].

In the last year the Wiltshire Public Health team used their Twitter account to promote the AUDIT-C questionnaire and received a good number of responses. Conducting this survey

[32] Department for Work and Pensions. (2019). Family Resources Survey: financial year 2017/18.

both provides information with regards to the prevalence of alcohol misuse within the county but can also act as a trigger for those taking the questionnaire to seek help if required. Further responses to this survey should be encouraged to improve statistical validity of the data gathered.

In contrast to national figures, young people's treatment services within Wiltshire have seen an increase in new presentations over 2018/19. Data does not necessarily indicate an increased prevalence of substance misuse amongst Wiltshire's young people, therefore this may be in part due to the great deal of work done to promote the local service offer.

There is an overrepresentation of LGB client in the Wiltshire Adult service of 5.4% vs 2% in the general population.

Females are under-represented in both adult and young people's treatment services. Prevalence data suggests that substance misuse is more common in adult males, however the national school survey[33] indicated that in those of school age the prevalence of substance misuse is similar in young males and females. It is possible that there are differences in the way in which young males and females use substances that are not detected by the questions asked in the school survey and mean that there genuinely is a greater treatment need for boys. However, this finding warrants further investigation into the reasons behind the low proportion of females in young people's treatment services.

Recommendations

- Establish whether local data is available regarding the prevalence of alcohol and drug misuse amongst women under the care of maternity services
- Promote the use of AUDIT-C questionnaire across a wider range of primary care/community services locations, including those reaching older adults
- Explore reasons why there are less females engaged with young people's substance misuse services when estimates suggest prevalence of substance misuse is comparable between young males and females
- Consider the appropriateness of integrating smoking cessation services into the young person's substance misuse offer
- Raise awareness of substance misuse (in particular alcohol) as a problem in older adults within the professional community working with this age group – e.g. GPs, adult social care, care coordinators, secondary care
- Ensure referral pathways are clear between different agencies/organisations coming into contact with those known to be at high risk of substance misuse (e.g. child and adult mental health services, domestic abuse services)
- Explore the reasons for the difference between highlighted 'issue' of substance misuse between families and children assessment data and actual referrals.

[33] Public Health England - National Drug Treatment Monitoring System. Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.

Risk Factors

This chapter discusses some of the major risk factors that increase an individual's vulnerability to substance misuse. This includes both the likelihood of them initiating use, and the probability of persistent and escalating harmful use.

A risk factor is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury[34]. Safeguarding and vulnerability are concurrent themes that span the life course of those using substances. Many of the risk factors discussed below do not occur in isolation and instead there is a complex interplay between multiple vulnerabilities. The line is also often blurred between what is a risk factor *for*, and what is a result *of*, substance misuse. Many of the risk factors discussed below could equally be considered an impact of individual, family or societal substance misuse.

Adverse childhood experiences (ACEs)

Childhood experiences, both positive and negative, have a tremendous impact on future violence victimisation, perpetration and lifelong health and opportunity. As such, early experiences are an important public health issue.

Adverse Childhood Experiences (ACEs) have been linked to risky health behaviours, chronic health conditions, low life potential and early death. As the number of ACEs increases, so does the risk for these outcomes[35]. Exposure and experience of ACEs in childhood can pose significant impact on adulthood meaning individuals are twice as likely to binge drink or 11 times more likely to use drinks[36].

The highest prevalence of substance use in young people occurs among vulnerable groups who are more likely than others their age to adopt high risk behaviours and to experience poor health and social outcomes as a result[36]. Young people receiving help for substance misuse in Wiltshire, and nationally, report a high prevalence of ACEs.

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[34] World Health Organisation. (2006). Health Topics: Risk factors.
[35] Hughes, K., et al. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health, 2(8): e356-e366.
[36] Bellis, M.A., et al. (2014). Adverse childhood experiences: retrospective study to determine their impact on adult heath behaviours and health outcomes in a UK population. Journal of Public Health, 36(1): 81-91.

Berelowitz, S., et al. (2012). "I thought I was the only one. The only one in the world". The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Interim Report. London: Office of The Children's Commissioner, England.

Green, H., et al. (2005). Mental health of children and young people in Great Britain, 2004. Office of National Statistics.

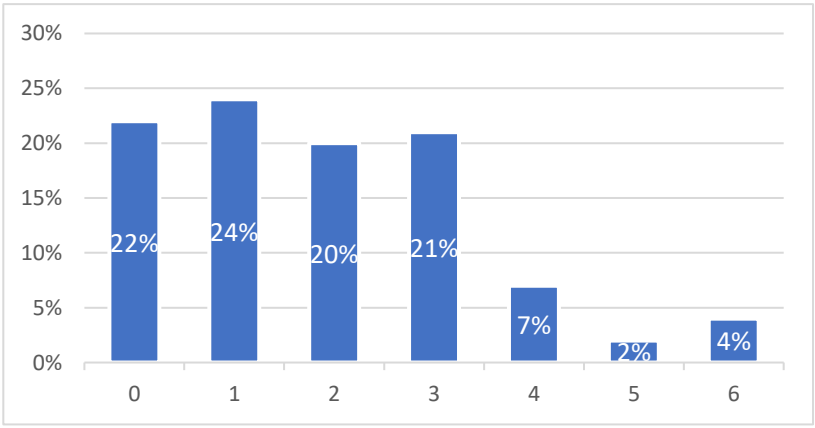
Ward, J., Henderson, Z. and Pearson, G. (2003). One problem among many: drug use among care leavers in transition to independent living. Home Office Research Study 260.

Adverse childhood experience	Proportion of young people in Wiltshire drug and alcohol services reporting specific ACE	Proportion of young people in national drug and alcohol services reporting specific ACE
Those whose parents and carers misuse drugs and alcohol	34%	22%
Looked after children	5%	11%
Children in need	13%	10%
Those who are not in education, employment or training	9%	15%
Those who experience/witness domestic abuse	20%	20%
Those who experience/are at risk of child sexual exploitation	6%	4%
Those with a mental health treatment need	32%	32%
Those who self-harm	32%	17%
Those who have housing problems	2%	1%
Those involved in antisocial behaviour/criminal activity	31%	30%

Table 12: Wiltshire and national breakdown of ACEs[37]

Importantly, ACEs tend to 'cluster' and those who belong to more than one vulnerable group have significantly higher levels of substance use than those who experience a single ACE[38]. In the 2003 Crime and Justice Survey, drug use among those in more than one vulnerable group was 39%, compared with 18% reporting just one vulnerability[39].

Figure 16: Proportion of young people in drug and alcohol treatment reporting multiple vulnerabilities [36]



[37] Public Health England - National Drug Treatment Monitoring System. (2019a). Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.

[38] Bellis, M.A., et al. (2014). Adverse childhood experiences: retrospective study to determine their impact on adult heath behaviours and health outcomes in a UK population. Journal of Public Health, 36(1): 81-91.

[39] Becker, J. and Roe, S. (2005). Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey. Home Office.

For those in young people's treatment services in Wiltshire over half were identified as having more than one wider vulnerability.

Affected by Others Substance Misuse Behaviour

Many reports have emphasised the vulnerability of young people whose parents and carers misuse drugs and alcohol[40] [41]. They may also be young carers themselves. The impact of parental substance misuse on children is extremely complex and has the potential to interrupt every aspect of their child's development from conception onward including physical health, education and cognitive ability, relationships and identity and their emotional and behavioural identity[39]. A combination of parental role modelling, childhood trauma and abuse, along with other social and environmental factors means that these young people are among the most vulnerable in terms of misusing substances themselves.

As outlined in Table 12, 34% of young people in treatment for substance misuse in Wiltshire have been affected by the substance misuse of others.

Children in Need and Looked After Children

Looked after children and young people experience a broad range of poor health outcomes in comparison with other young people and one of the factors which influences this is higher levels of substance misuse among this group. They are four times more likely to drink alcohol and six times more likely to use drugs than those in the general population. They also tend to start using drugs at an earlier age and are likely to use them more frequently and at higher levels than young people who are not in[42].

In 2017/18, 18 (5%) of children looked after continuously for the last 12 months in Wiltshire were identified as having a substance misuse problem, with 13 of these receiving an intervention[43]. As shown in Table 12, 5% of young people in substance misuse treatment were identified as being looked after.

Although not all Children in Need are automatically identified as being at the same level of vulnerability as those who are Looked After Children, some of the categories that define Children in Need emphasise their extreme vulnerability. These categories are[42]:

- significant harm, including physical abuse, sexual abuse, emotional abuse and neglect
- emotional and behavioural disabilities
- parental illness or disability e.g. parental substance misuse
- family in acute stress e.g. homeless family, unsupported single parent, death of carer
- family dysfunction e.g. domestic violence, inconsistent parenting, family breakdown
- unsafe sexual behaviour

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[40] Advisory Council on the Misuse of Drugs. (2003). Hidden Harm – Responding to the needs of children of problem drug users.

[41] Turning Point. (2011). Bottling it up: The Next Generation. The effects of parental alcohol misuse on children and families.

Adamson, J. and Templeton, L. (2012). Silent voices: supporting children and young people affected by parental alcohol misuse. Officer of the Children's Commissioner.

[42] Meltzer, H., et al. (2002). The mental health of young people looked after by local authorities in England. Office of National Statistics.

Ward, J., Henderson, Z. and Pearson, G. (2003). One problem among many: drug use among care leavers in transition to independent living. Home Office Research Study 260.

[43] Department for Education. (2018b) Children looked after in England including adoption: 2017 to 2018. National Statistics.

- socially unacceptable behaviour such as disorderly behaviour, offending and truancy.

In addition, many of this group are at risk of becoming looked after. For those children meeting the threshold for intervention from Children's Services, a single assessment is completed. This includes collecting information regarding substance misuse as illustrated in the table below with parental alcohol or drug misuse being the highest risks identified on single assessment

Table 13: Wiltshire Children's Services data 2015-16

Wiltshire Children's Services Single Assessments						
	2015-16		2016-17		2017-18	
Yearly total single assessments	5504		4484		4276	
	Number	**%**	**Number**	**%**	**Number**	**%**
Alcohol misuse: Child	153	2.8	170	3.8	159	3.7
Alcohol misuse: Parent or carer	733	13.3	692	15.4	713	16.7
Alcohol misuse: Other household member	144	2.6	149	3.3	142	3.3
Drug misuse: Child	334	6.1	306	6.8	274	6.4
Drug misuse: Parent or carer	517	9.4	595	13.3	579	13.5
Drug misuse: Other household member	163	3.0	235	5.2	180	4.2

Not in Education, Employment or Training (NEET)

The Office of National Statistics (ONS) defines NEET young people as those who are not in any form of education, training or employment, focusing on those aged 16-24[44]. The Institute of Health Equity[45] reviewed the evidence of the impact of being NEET on young people and concluded that there is a definite detrimental effect on physical and mental health, including adopting negative health behaviours like drug and alcohol use, and concluded that this risk is greater for those who become NEET at a younger age or for longer periods. They report that 11% of 16-24-year-olds who had been unemployed said that they had "turned to drugs or alcohol" because of their unemployment.

The IHE[44] also highlights the importance of introducing strategies to reduce school exclusions as these are often the young people who become NEET. Younger people not in education because of truancy or exclusion also have a significantly higher risk of substance misuse than those who have not. Data from the 2016 national school survey[46] shows that those who have truanted or have been excluded from school are nine times more likely to be frequent drug users than those who have not and are ten times more likely to have used

[44] Office for National Statistics. (2019d). Young people not in education, employment or training (NEET), UK: May 2010.
[45] Institute of Health Equity. (2014). Local action on health inequalities: Reducing the number of young people not in employment, education or training (NEET). Health Equity Evidence Review 3: September 2014.
[46] NHS Digital. (2018a). Smoking, drinking and drug use among young people, 2016. UK Data Service.

Class A drugs in the previous year. However, these figures are likely to be an underestimate because this is a school-based survey and therefore this may not be a valid methodology for collecting this data as, by definition, many truants and excluded pupils will be missing.

9% of individuals in young people's substance misuse treatment in Wiltshire were identified as NEET. This is lower than the national average of 15% of those in young people's treatment services.

Transitions to Adult Service

The transition between young people and adult services is an area where many young people disengage from the system. 24% of those leaving at 18 leave in an unplanned way, showing the need for a transition plan to maximise service users getting the required support. The average age of users in the adult service is around 40, but the most common initial drug use occurs aged 15-19, suggesting there is a wide gap between initial use and presentation later on, or possible disengagement using the young people service before re-presenting to adult services many years later[47].

During 2018/18 there were 19 people who disengaged from motiv8. 16 dropped out and 3 declined treatment. Many young people dropped out due to the change in social worker or other staff, showing that continuity is important, and something that may benefit young people from transition past 18 years[47].

Literature shows that having a mental health service that extends beyond 18 up to 25 can increase referrals by 68% and decrease the disengagement at 18 years old[48]. Young people have indicated that lack of continuity and consistency between young people and adult services make transitioning difficult, with this leading to a greater risk of negative outcomes such as substance abuse. Mental health data shows that young adults are less likely to be offered treatment compared to adolescents, showing the difference between the young people and adult services. Although the admission rate during the transition period is higher as the support from the services is not available. Having a transition service in place improves outcomes for young people.

Domestic Abuse

This includes both witnessing and being a victim of domestic abuse. In a 2009 study, around 1 in 5 young people reported having been exposed to domestic abuse in their lifetime[49]. Children exposed and living with the impacts of domestic abuse are at greater risk of substance misuse, teenage pregnancy and criminal behaviour than those raised in homes without abuse[50].

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[47] Public Health England - National Drug Treatment Monitoring System. (2019a). Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.

[48] Vostanis, P (2005) Patients as parents and young people approaching adulthood: how should we manage the interface between mental health services for young people and adults? Current Opinion in Psychiatry 18:449-454

[49] Bentley, H., et al. (2018). How safe are our children? The most comprehensive overview of child protection in the UK. London: NSPCC.

[50] UNICEF and The Body Shop International. (2006). Behind closed doors: the impact of domestic violence on children

Early Intervention Foundation. (2018). Why reducing parental conflict matters for the NHS.

Women exposed to extensive physical or sexual violence are twice as likely to have an alcohol problem and eight times more likely to be dependent on drugs[51]. This maybe due to substances being used to self-medicate from the trauma of the abuse suffered.

In Wiltshire, the support service Splitz are commissioned to deliver the specialist support to victims, families and perpetrators living with and impacted by the effects of domestic abuse. manage incidents of domestic abuse. Current data collected does not include how many individuals are referred or signposted to drug and alcohol services by this provider. However, over the last year 5 referrals were made into Splitz by the adult drug and alcohol services. A representative from adult drug and alcohol services also attend the weekly Multi-Agency Risk Assessment Conferences (MARAC) meetings and will support victims on a case by case basis. Furthermore, the Safeguarding Manager from adult drug and alcohol services meets with the Service Delivery Coordinator from Splitz twice a year to check that existing processes are working and there is a reciprocal agreement in place to fast-track each other's referrals where necessary.

Sexual Exploitation

There is strong evidence of firm links between sexual exploitation and problematic substance misuse[52] [53]. In the Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation (CSE), 41% of the cases submitted as evidence identified children having drug and alcohol problems as a result of CSE[49].

Studies of those involved in sexual exploitation through street-based sex work among people aged over 16 also found very high levels of problematic drug and alcohol use among this older group [54] [55] [56].

Brown[52] found that alcohol use was a strong barrier to women wishing to exit sexual exploitation through sex work. This study specifically focused on alcohol use, but this finding is likely to apply to dependent or heavy use of any substance.

Bindel[51] found that in their sample of women over the age of 18 who were involved in street-based sex work, 32% had been subjected to child sexual exploitation before the age of 18. This was frequently linked to coercion, drug misuse, exchanging drugs for sex and experiences of childhood violence.

Most of these studies are carried out with females as data suggests men exploited through sex work seem not to experience the same level of vulnerability to drug and alcohol use, with

[51] Scott, S. and McManus, S. (2016). Hidden Hurt: Violence, abuse and disadvantage in the lives of women. DMSS Research for Agenda.

[52] Berelowitz, S., et al. (2012). "I thought I was the only one. The only one in the world". The Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups. Interim Report. London: Office of The Children's Commissioner, England.

[53] Coffey, A. (2014). 'Real voices' – child sexual exploitation in Greater Manchester. An independent report by Ann Coffey MP.

[54] Bindel, J., Breslin, R. and Brown, L. (2013). Capital Exploits: A study of prostitution and trafficking in London. London: Eaves.

[55] Brown, L. (2013). Cycle of harm: Problematic alcohol use amongst women involved in prostitution. Alcohol Research UK and Eaves.

[56] Jeal, N. and Salisbury, C. (2004). A health needs assessment of street-based prostitutes: cross-sectional survey. Journal of Public Health, 26(2): 147-51

the exception of young and homeless males [57]. A separate Wiltshire Health Needs Assessment for male and transgender sex workers discusses this topic further.

Mental Health

The relationship between mental health and substance misuse is complex – mental health problems can be both a risk factor and an impact of substance misuse. Individuals may have:

- Mental health problems which have led to substance misuse
- Substance misuse problems which have led to mental health problems
- Mental health problems and substance misuse problems that occurred independently but then interact and exacerbate one another
- Other problems that have led to mental health and substance misuse problems, such as physical health conditions[58].

Of those presenting to young people's drug and alcohol services in Wiltshire in 2018/19, 32% had experience of self-harm and 32% were identified as having a mental health treatment need[59]. The corresponding figure in adult services was higher at 58.6%[60] and research suggests the true figure is likely to be even higher still[61]. This contrasts with the 1/6 of adults in the general population who report suffering from a mental health condition in a given week[62].

Individuals with a dual diagnosis of mental health and substance misuse problems are acknowledged to have some of the worst health, wellbeing and social outcomes[63]. NICE found that individuals suffering from dual-diagnosis often face multiple barriers to services and that care is frequently fragmented[64]. NICE and PHE emphasise the need for collaborative and integrated working between mental health and substance misuse services in order to help these particularly vulnerable individuals [60 61 65].

[57] Wilcox, A. and Christmann, K. (2008). Getting paid for sex is my kick: a qualitative study of male sex workers. In: Sex as Crime? Willan Publishing, London, UK, pp 118-136.
Balfour, R. and Allen, J. (2014). A Review of the Literature on Sex Workers and Social Exclusion. UCL Institute of Health Equity.
[58] National Institute for Health and Care Excellence. (2016a). Severe mental illness and substance misuse (dual diagnosis): community health and social care services. NICE Guideline Scope.
[59] Public Health England - National Drug Treatment Monitoring System. (2019). Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.
[60] Public Health England - National Drug Treatment Monitoring System. (2019b). Adult Partnership Activity Report Quarter 4 2018-2019 – Wiltshire.
[61] Public Health England. (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers.
[62] NHS Digital. (2016). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.
[63] National Institute for Health and Care Excellence. (2011). Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings. Clinical guideline.
[64] National Institute for Health and Care Excellence. (2016). Coexisting severe mental illness and substance misuse: community health and social care services. NICE guideline.
[65] Public Health England. (2017c). Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers.

Table 14: Turning Point housing data 2018/19

Row Labels	2013	2014	2015	2016	2017
Accomm with care support	21	31	28	21	28
Armed Forces Accommodation	1		9	26	11
Direct Access Hostel	10	32	26	10	4
Hostel	1	1	20	42	45
Mobile Accommodation		2	8	2	3
Other Homeless	17	17	25	20	3
Owner/ Occupier	123	192	176	166	166
Parents Home	3		26	35	72
Rough Sleeper	7	18	14	26	26
Settled Caravan			5	1	2
Settled with Friends/Family	1		38	113	95
Sheltered Accommadation	3	9	4	3	2
sofa surfing	26	19	30	39	27
Squatting			1	2	1
Temp Accomm (local auth)	10	18	13	4	6
Temp Accomm Family/Friends	94	162	155	57	78
Temp B&B				1	2
Temp Short Stay Hostel			3	5	1
Tenant Housing Assoc	235	148	140	139	131
Tenant HousingAssoc (Greensquare)	9	6	3		3
Tenant LA/ Reg Landlord	53	116	143	142	143
Tenant Private Landlord	132	148	191	151	173
(blank)	765	103	11	10	
Grand Total	**1511**	**1022**	**1069**	**1015**	**1022**

Housing Problems

This section builds upon the findings of the Wiltshire Homelessness Needs Assessment. As with many of the risk factors discussed, the relationship between substance misuse and housing problems is complex. Housing problems can occur as a result of substance misuse problems, but likewise individuals who become homeless may turn to drugs and alcohol as a coping mechanism.

Table 15 shows the housing status of clients supported by the commissioned Wiltshire adults? substance misuse service. In 2017, the service supported 26 rough sleepers (26 in 2016; 14 in 2015). Whilst this figure is relatively small, other data captured indicates a higher proportion of clients being supported who could be flagged ‘at risk’ of homelessness i.e. hostel accommodation, temporarily staying with friends/family, sofa surfing etc.

This data is supported by more recent figures from National Drug Treatment Monitoring System (NDTMS) which reported 16.6% of new presentations to adult substance misuse services in Wiltshire over the last year had housing problems, this is slightly lower than the national average of 18.7%. Breakdown by drug type shows that opiate users are over twice as likely to have housing issues than the overall client population with only 66% of those in

Wiltshire in secure housing.

Table 15: Accommodation breakdown 2018/19[66]

Accommodation status	Percentage of all new clients (Apr18-Mar19)	Percentage of new alcohol clients	Percentage of new alcohol and non-opiate clients	Percentage of new non-opiate clients	Percentage of new opiate clients
No fixed abode/urgent housing problem	7.3%	3.4%	6.7%	6.7%	17.9%
Housing problem	9.3%	5.9%	12.4%	9.0%	16.0%
No housing problem	83.2%	90.7%	80.0%	84.3%	66.0%

A further challenge identified by the Drugs and Alcohol service in Wiltshire relates to engagement with support. Anecdotally, it is reported how the chaotic lifestyles of homeless individuals often make it difficult for them to physically get to, and keep to, appointments.

Of those in supported housing schemes across Wiltshire substance misuse problems were identified as a priority support need for over 40%. 32% of customers were receiving specialist support for substance misuse. The breakdown by housing type is shown in the table below:

Table 16: Wiltshire housing breakdown by housing type for those identifying as having a substance misuse issue

Type of Accommodation	Total No. Customers	Customers where substance misuse was identified as one of two priority support needs (%)	No. customers taking up specialist substance misuse support
High Risk Offenders	22	0 (0%)	0
Single Homeless	262	160 (61%)	106
Young People 16 - 25	160	35 (22%)	42
Young Parents 16 - 25	27	2 (7%)	1
Total	471	197 (42%)	149

Unemployment

As with mental health and housing problems, the link between unemployment and substance misuse is not straightforward. Substance misuse problems may lead to loss of employment, or difficulty in securing work, but similarly unemployment and its relationship with wider socioeconomic deprivation may predispose individuals to substance misuse. As previously stated, drug dependence is most prevalent amongst those who are economically inactive, or unemployed. Hazardous drinking, by contrast, is most common amongst those in employment, however those drinking at the most harmful levels, or with probable dependence, are less likely to be in stable, well paid roles[67].

[66] Public Health England - National Drug Treatment Monitoring System. (2019). Adult Partnership Activity Report Quarter 4 2018-2019 – Wiltshire.

[67] NHS Digital. (2016). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.

Of the new clients starting treatment in Wiltshire in 2018/19, 39.8% were in regular employment. This is better than the national average of 27.5% of those in treatment [63]. As expected employment rates were highest amongst those misusing only alcohol, and lowest amongst those misusing opiates. Those using only alcohol had the highest likelihood of being retired, which is in keeping with trends in alcohol use across the different age groups.

Table 17: Treatment population employment status [63]

Employment status	Percentage of all new clients (Apr18-Mar19)	Percentage of new alcohol clients	Percentage of new alcohol and non-opiate clients	Percentage of new non-opiate clients	Percentage of new opiate clients
Regular employment	39.8%	45.0%	42.9%	46.3%	19.2%
Long term sick/disabled	26.7%	25.8%	19.0%	23.1%	37.2%
Unemployed and seeking work	15.7%	11.6%	22.9%	19.4%	17.9%
Retired from paid work	4.3%	7.5%	1.0%	0.7%	1.9%

Older Adults

The proportion of older adults (considered here to be those over the age of 65) with substance misuse problems is rising more rapidly than can be explained by the general ageing of the population as a whole[68]. Alcohol misuse in particular is a growing problem for this age group. Risky drinking in the UK is declining, except in the over 50s, where an upward trend is being seen in episodic heavy drinking[69].

Substance misuse is also often misdiagnosed in the older population, as signs and symptoms frequently overlap with other common conditions in this age group such as delirium, depression, dementia and falls. In addition, typical features such as cravings may be absent[70].

Although many of the risk factors seen in younger substance misusers such as mental health issues apply to this age group, it is also acknowledged that this population may experience unique vulnerabilities[65].

In older people, higher socio-economic status is associated with higher than average weekly consumption of alcohol. However, despite this, the risk of harm remains highest in those from areas of high deprivation[65].

It was previously believed that alcohol misuse problems originated in adolescence or early/ mid adulthood, however, it is now known that around one third of those over 65 with difficulties related to alcohol will have developed this after the age of 50. These people are less likely to have a family history of addiction problems but are more likely to have psychosocial risk factors. Social isolation, bereavement, financial strain and housing problems are all strong risk factors for alcohol misuse in the older population. Significant life events can often trigger substance misuse problems or result in escalating use. Retirement,

[68] Royal College of Psychiatrists. (2018). Our Invisible Addicts, 2nd Edition. College Report CR211.
[69] Rao, R. and Roche, A. (2017). Substance misuse in older people. BMJ, 358:j3885.
[70] McGrath, A., Crome, P. and Crome, I.B. (2005). Substance misuse in the older population. Postgraduate medical journal, 81(954): 228-231.

especially if not taken voluntarily, and the resultant loss of role and responsibility, has been associated with alcohol misuse in several studies[65].

Alcohol misuse is also associated with chronic illness with older adults more likely to self-medicate with alcohol for relief of stress, anxiety, pain and insomnia[65].

Chronic illness is more prevalent in this age group, and as a result older people receive the highest proportion of prescribed medication. Opiate based painkillers, benzodiazepines, 'Z' drugs and gabapentinoids all have the potential for misuse and addiction. This may be unintentional on the part of the patient, and it is suggested that around 10% are inappropriately prescribed. Rates of benzodiazepine prescriptions have fallen over the last 20 years but for those that remain on these drugs, the average patient age is 66, with 40% of prescriptions going to the over 80s. Unlike alcohol and other substance misuse problems, which are more prevalent in men, benzodiazepine addiction is most commonly seen in women. Women with low income, chronic pain, difficulty carrying out daily activities, social isolation and anxiety are most at risk[65].

Conclusion

There are a wide range of vulnerability factors that increase the likelihood of an individual initiating or experiencing harm from substance misuse. Many of these originate in childhood, and a significant proportion of those in treatment in Wiltshire report a history of Adverse Childhood Experiences. Furthermore, those that experience multiple vulnerabilities are at even higher risk of harm. Many vulnerabilities, such as mental health problems, being out of education or employment, or housing problems are common to both young people and adults. However, there are also risk factors that are unique to, or at least more commonly seen in, older adults such chronic disease and polypharmacy.

Whilst drug use and alcohol dependence are often associated with unemployment; drinking at hazardous levels (AUDIT score 8 or above) is actually more common in those in employment. Also, unlike drug use and alcohol dependence which are more commonly seen in younger adults, hazardous drinking remains prevalent and actually increases as people approach retirement age, before falling again in those over the age of 65.

With an overall aging population and a recognition of the increasing prevalence of substance misuse problems in older adults, services will need to consider how best to reach this group and be able to manage a population with an increased prevalence of physical comorbidities.

Recommendations

- Utilise the Vulnerability Framework to ensure agencies and organisations working with individuals experiencing vulnerabilities are proactive in identifying it as an issue and that clear and appropriate referral pathways are in place.
- Raise awareness amongst professionals and the public regarding the different risk factors for substance misuse (e.g. chronic pain, polypharmacy, bereavement) and presenting features in older adults
- Consider the impact of the increased military population on substance misuse services.
- Consider options for reducing transitions issues between young peoples and adult services. To inform future commissioning futures.
- To investigate the involvement of substances in the lives of those affected by CSE.

Impact of Substance Misuse

This chapter explores the impact that substance misuse can have on individuals, families, communities and society as a whole. It is widely acknowledged that substance misuse is associated with a wide range of health and social issues and has significant health and social care costs. As discussed above many things could be considered both a risk factor for, and an impact of, substance misuse. Unemployment, homelessness and mental health problems are just an example of some of those that have a complex relationship with substance misuse. These are discussed in more detail in the chapter 'Risk Factors', whereas here we consider the financial, physical health and social costs of substance misuse.

Financial Cost

The annual cost of alcohol related harm in England is estimated to be around £21.5 billion[71], whilst use of illicit drugs costs a further £10.7 billion[72]. These costs are incurred through a combination of lost productivity, crime, policing and pressure on the health service. Of the £10.7 billion attributed to illicit drug misuse:

- 8% is a result of NHS and drug treatment costs
- 10% is a result of enforcement
- 28% is a result of drug related deaths
- 54% is a result of drug-related crime[69]

It should be noted that these figures could not be localised to a Wiltshire level due to limitations in the methodology.

Morbidity and mortality

Alcohol

The World Health Organisation (WHO) places alcohol as the third biggest global risk for burden of disease and alcohol is identified as a causal factor in more than 60 medical conditions, as well as some cancers including breast, throat and liver. Short-term health risks include smoking, accidents, violent behaviour and risky sexual behaviour. The risk of alcohol-related harm increases with the amount drunk on a regular basis[73].

In 2017 there were 7,697 deaths in the UK which could be directly attributed to alcohol. Twice as many men died from alcohol specific conditions than women, and mortality rates were highest amongst those aged 60-64 years old. The number of alcohol-specific deaths in those aged over 55 has risen significantly since this data was initially collected in 2001. Although alcohol-specific mortality is generally low in those under the age of 30, drinking behaviour at this age contributes to cumulative harm and therefore impacts directly on outcomes for older groups[74].

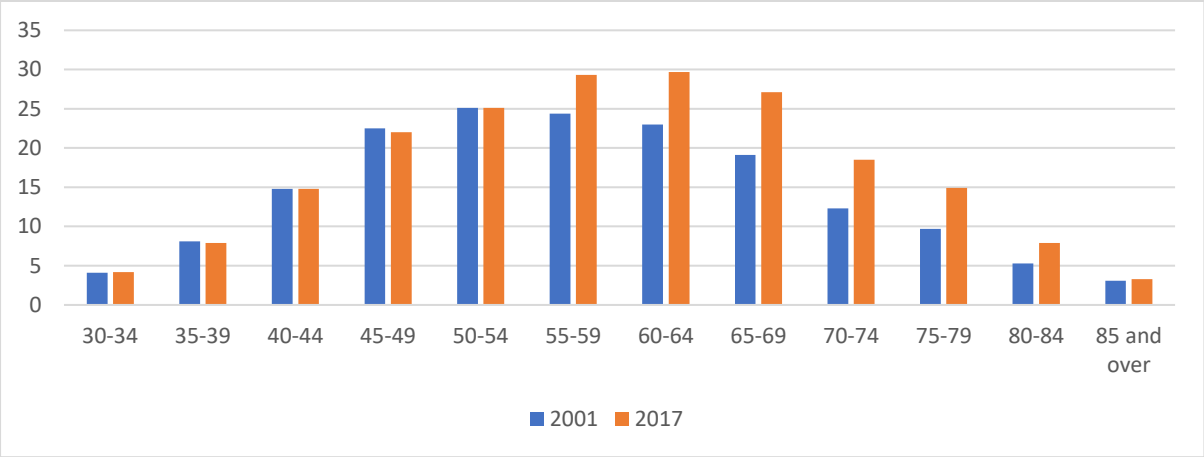
[71] Public Health England. (2016). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review.

[72] Public Health England. (2017d). An evidence review of the outcomes that can be expected of drug misuse treatment in England.

[73] NHS Digital. (2018b) Health Survey for England 2017.

[74] Office for National Statistics. (2018). Alcohol-specific deaths in the UK: registered in 2017.

Figure 17: Alcohol-specific deaths by age group (per 100,000 people) in the UK, 2001 and 2017[71]



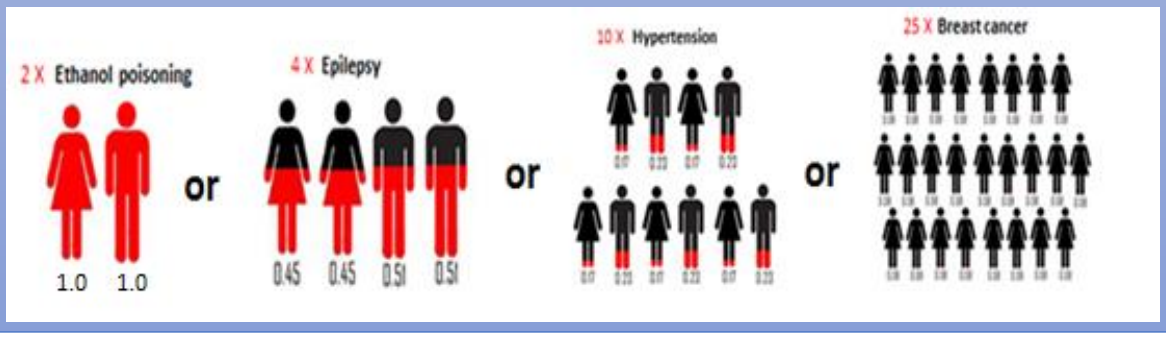
The alcohol specific mortality rate in Wiltshire is slightly lower than the national average at 7.7 per 100,000 population compared to 10.6 per 100,000 population[75].

There is an appreciation that whilst alcohol may be directly responsible for a certain number of deaths, it also contributes to a significantly larger number. By assigning an 'alcohol-attributable fraction' to various medical diagnoses (see below) it is estimated that in 2017 over 24,000 deaths in England, and over 200 in Wiltshire were a result of excess alcohol consumption[72].

Figure 18: Alcohol-attributable fractions explanation [76]

Alcohol-attributable fractions

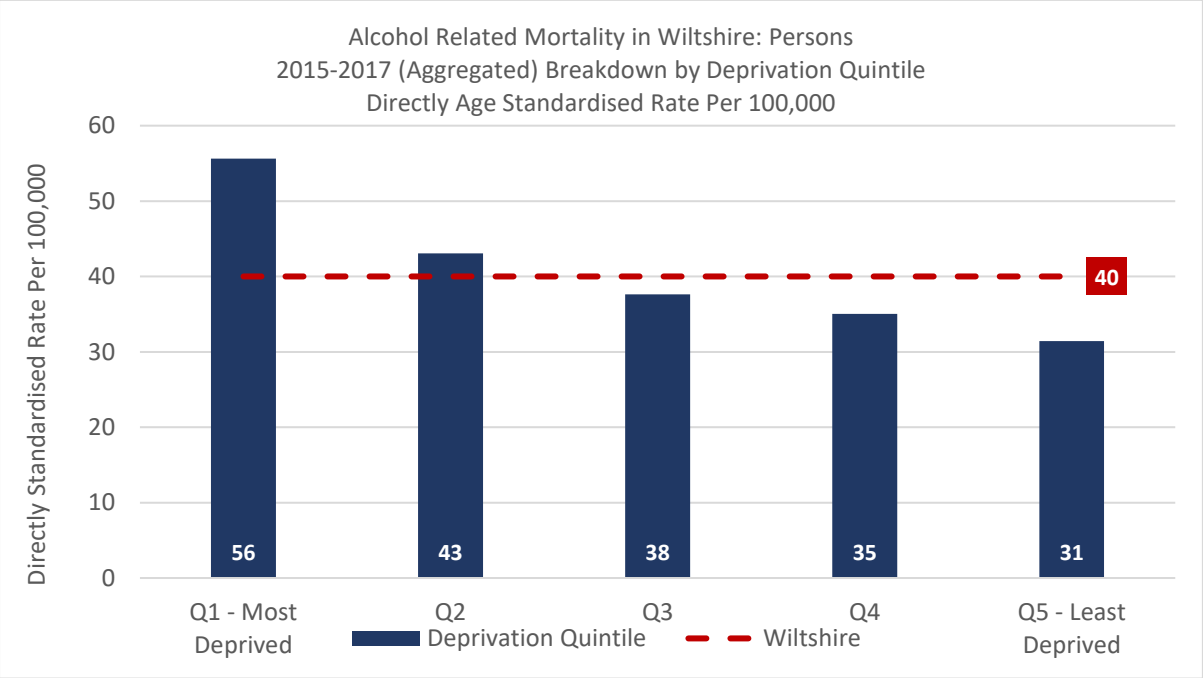
Significant research has gone into calculating 'alcohol-attributable fractions' (AAF) for a wide range of possible diagnoses. For example, the AAF for alcoholic liver disease is 1.0 – in other words it is whole responsible. On the other hand, alcohol is estimated to be the underlying cause of 27% of assaults, therefore the AAF for a diagnosis of assault is 0.27. The AAF of a condition may vary depending on the patient's gender or age. These fractions can be used alongside hospital clinical coding to calculate the total number of hospital admissions or deaths that are attributable to alcohol (Perkins and Hennessey, 2014).



[75] Office for National Statistics. (2019). Population projections for local authorities – 2016 based.
[76] Public Health England. (2017e). Local Alcohol Profiles for England 2017 user guide.

Men in Wiltshire are over twice as likely to die from an alcohol-related condition compared to women, and those living in the most deprived areas are also significantly more likely to do so.

Figure 19: Alcohol Related Mortality in Wiltshire: Persons 2015-2017 (Aggregated) Breakdown by Deprivation Quintile Directly Age Standardised Rate Per 100,000[73]



Drugs

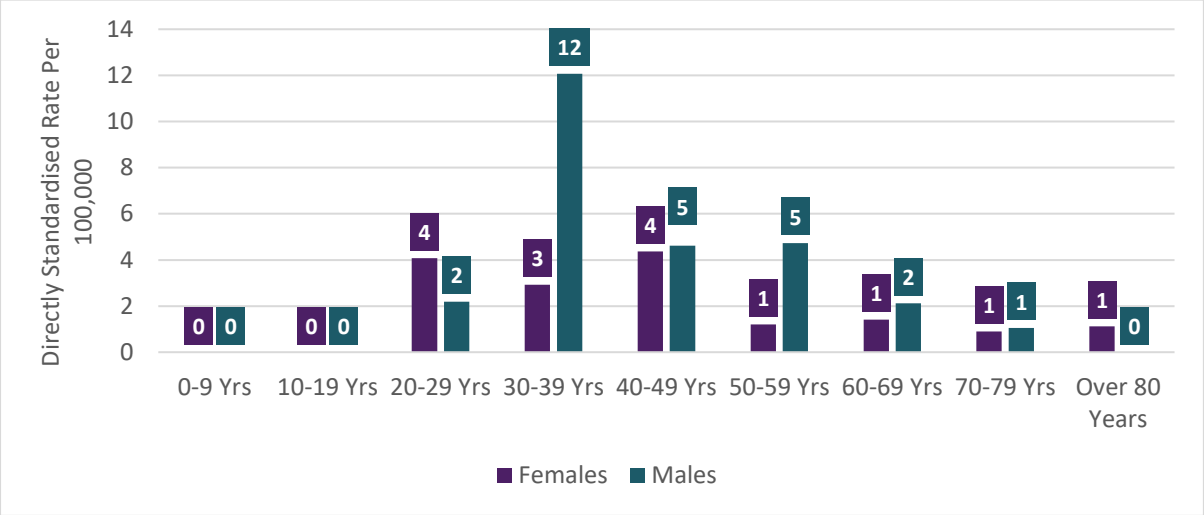
In 2017 there were 2,503 deaths in England and Wales related to drugs of misuse (4.39 per 100,000)[77]. Most deaths related to the 'use of drugs', occur among opiate users. Since opiate use is relatively unusual among younger people, those under 20 have the lowest rate of drug-related deaths in England, at 2.2 per million[74]. See figure 19 for the breakdown by deprivation, which shows highest alcohol related mortality in the most deprived areas.

In Wiltshire the overall mortality rate due to drug misuse is slightly lower than the national average, at 3.4 per 100,000. However, the mortality rate for males between the age of 30-39 is almost four times higher than this[74].

Nationally, deaths from drug misuse rose sharply between 2012 and 2016. This was largely a result of a significant rise in heroin-related deaths, attributed to an increase in heroin purity and subsequent overdoses following the 'heroin drought' of 2010-2011[74].

[77] Office for National Statistics. (2018). Deaths related to drug poisoning in England and Wales: 2017 registrations.

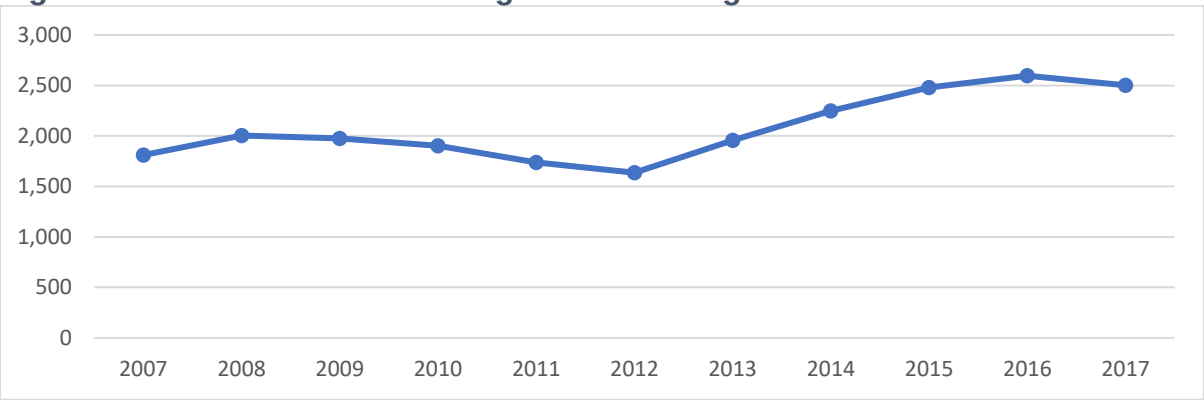
Figure 20: Mortality Rate Due to Drug Misuse in Wiltshire: Males and Females 2013-2017 (Aggregated) breakdown by 10 Year Age Band Directly Standardised Rate Per 100,000[74]



Although still far less common than deaths due to opiates, deaths from amphetamines also increased by over 50% between 2012-2017, and deaths from cocaine have more than tripled[74].

Between 2007 and 2016 the number of deaths in England and Wales where a new psychoactive substance appeared on the death certificate rose from 9 to 123. In 2017, the number of deaths fell significantly to 61. Data from further years is required before it can be determined whether this is a sustained reduction related to the Psychoactive Substances Act which made production and supply of NPS illegal from May 2016[74].

Figure 21: Total Deaths from drug-misuse in England and Wales[74]



Although deaths directly attributable to cannabis are rare, cannabis is known to cause smoking related diseases and its use presents significant risks to mental health, including psychosis. Younger users and those who are already vulnerable to mental ill health are at particular risk[78].

[78] NHS. (2017). Cannabis: the facts.

Hospital admissions

Alcohol

Alcohol and drug use have a significant impact on the number of Emergency Department attendances and admission to hospital beds. Alcohol in particular contributes to a huge range of acute and chronic health problems.

Alcohol-specific hospital admissions are those which are considered to be wholly as a result of alcohol use. In 2017/18 there were just over 300,000 alcohol-specific admissions to hospital in England (570 per 100,000). Over the same period there were 2,229 in Wiltshire, which at a rate of 453 per 100,000 is slightly lower than the national average.

As well as alcohol-specific admissions there are also those which may not be wholly attributable to alcohol, but where alcohol is a contributing factor. These are termed alcohol-related admissions and can be further categorised into 'narrow' or 'broad' definitions[79].

Alcohol-related admissions – 'Broad' and 'Narrow' definitions

Narrow – admissions where the primary diagnosis is partially attributable to alcohol (or a secondary diagnosis is an alcohol-attributable external cause e.g. assault).

This definition provides a narrower measure of alcohol harm that is less sensitive to the changes that have occurred in coding over the years and therefore enables fairer comparison between levels of harm in different areas and over time. It is also more responsive to change resulting from local action on alcohol.

Broad – admissions where the primary, or any of the secondary diagnoses, are partially attributable to alcohol (see above for explanation of 'alcohol-attributable fractions')

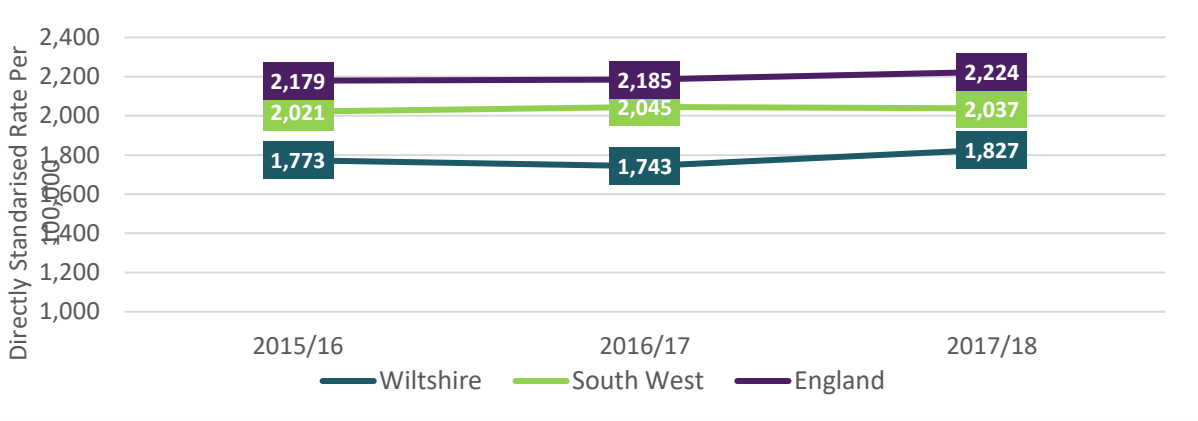
This definition is a better measure of the total burden that alcohol has on community and health services.

In 2017/18 the number of hospital admissions in England for alcohol-related conditions (broad definition) was 1,171,253[80].

Rates of alcohol-related admissions in Wiltshire are generally lower than the England and South West average.

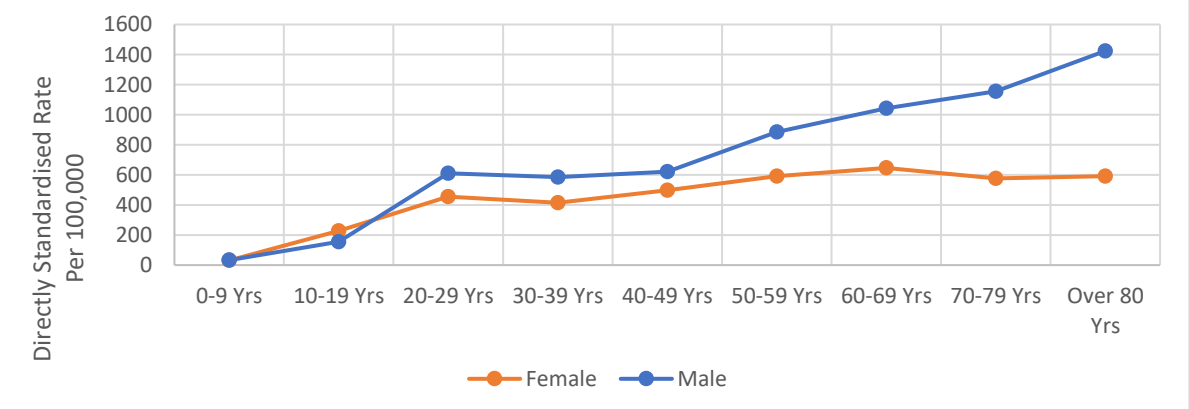
[79] Public Health England. (2017e). Local Alcohol Profiles for England 2017 user guide.
[80] Public Health England. (2019b). Public Health Profiles: Local Alcohol Profiles for England.

Figure 22: Admission Episodes for Alcohol Related Conditions (Broad Definition) Persons Wiltshire, South West and England Comparison 2015/16-2017/18 Directly Standardised Rate Per 100,000 [77]



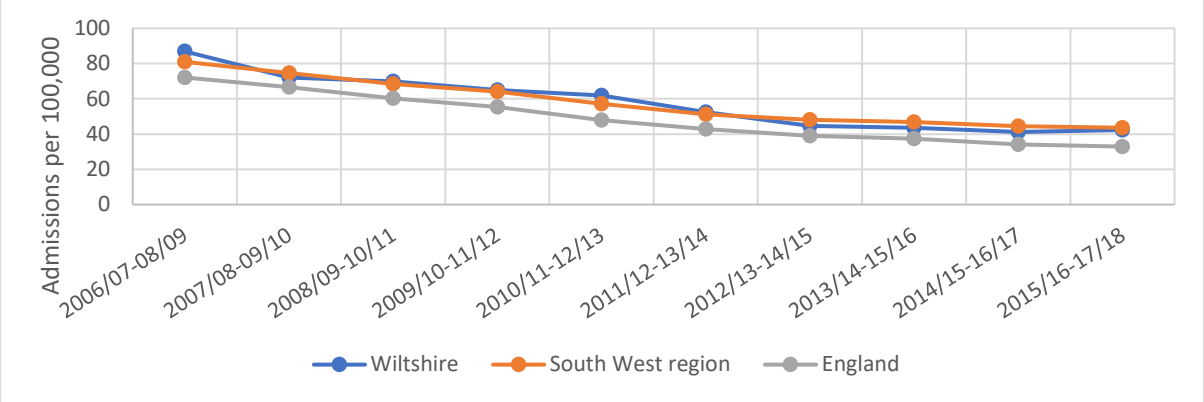
Overall men are almost twice as likely to be admitted for an alcohol related condition than women. In general alcohol-related admissions rise with age. This is unsurprising with the broad-definition given the higher probability of older adults having multiple diagnoses, each of which may have an alcohol attributable fraction. This is still generally the case when looking at the narrow definition too, however here there is a slight spike in admissions for those between the ages of 20-29. Within the 10-19 year age category there is also a slightly higher admission rate for females, further reinforcing the evidence that during childhood and teenage years alcohol problems affect both males and females far more equally than in later life (see figure 23).

Figure 23: Admission Episodes For Alcohol Related Conditions in Wiltshire (Narrow Definition) Males and Females 2015/16 - 2017/18 (Aggregated Average) Breakdown by 10 Year Age Band Directly Standardised Rate Per 100,000 [77]



Although still lower than rates for other age groups, the alcohol-specific admission rate for under-18s in Wiltshire is worth noting since it has been persistently higher than the national average at 42.2 per 100,000 compared to 32.9 (2015/16-2017/18). On a more positive note the rates of admission within this age group have decreased significantly over the last 10 years. The actual number of admissions in Wiltshire is also relatively low with just over 40 admissions per year in this age group on average (compared to the total 2,229 in Wiltshire as a whole).

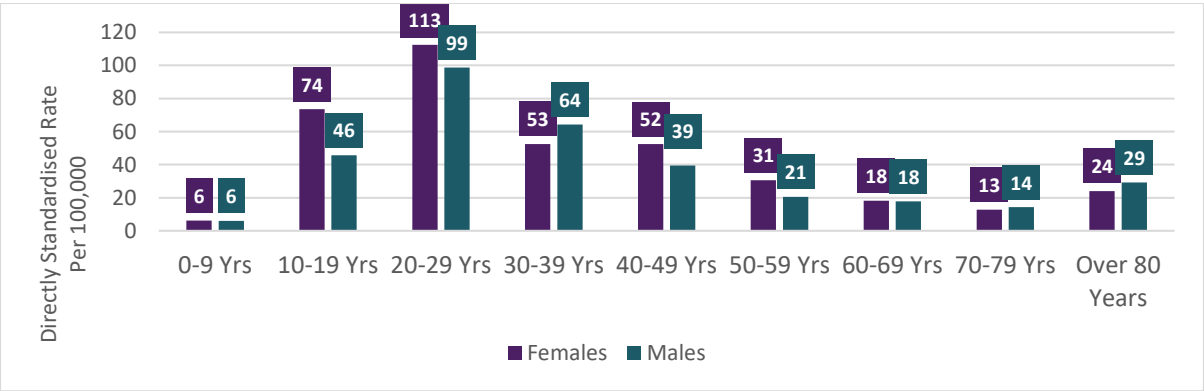
Figure 24: Admission rates for alcohol-specific conditions in the under 18s per 100,000 (pooled data over 3 years) [77]



Drugs

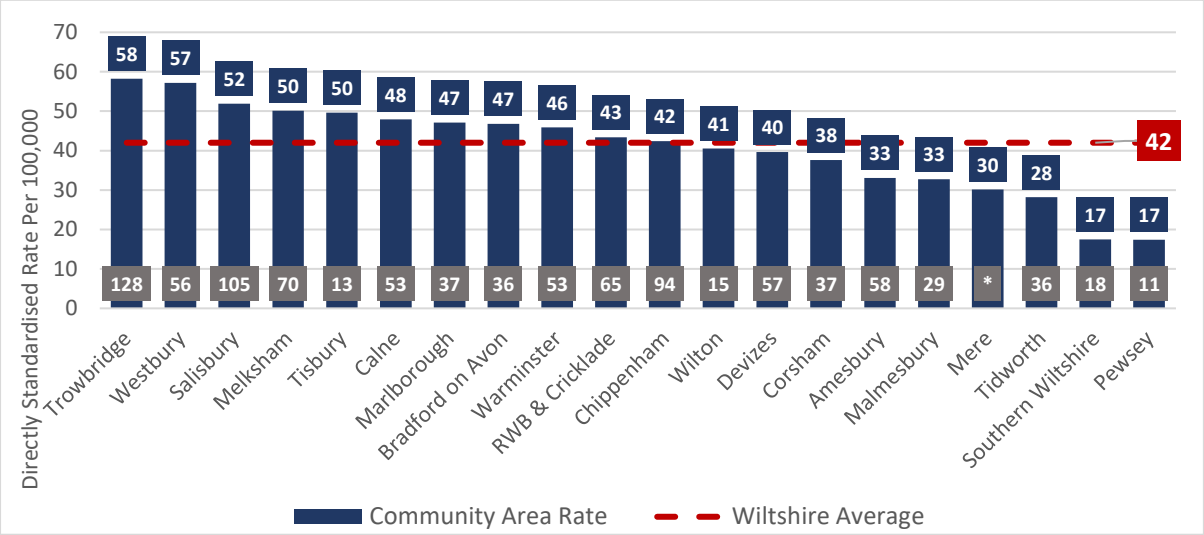
Unlike alcohol, the rate of admissions related to substance misuse in Wiltshire is higher in women than men (45 per 100,000 compared to 39 per 100,000) and most common in the 20-29 years age group.

Figure 25: Source: Hospital Admissions Due to Substance Misuse in Wiltshire Males and Females 2013/14 - 2017/18 (Aggregated) Breakdown by 10 Year Age Band Directly Standardised Rate Per 100,000 [77]



There is significant variation in the rate of drug-related admission across the region. Note that numbers in figure 26 marked * have been suppressed.

Figure 26: Hospital Admissions Due to Substance Misuse in Wiltshire Persons All Ages 2013/14-2017/18 (Aggregated) Breakdown by Community Area Directly Standardised Rate Per 100,000 (Including Number of Admissions) [77]



Criminal Justice System

The relationship between substance misuse and criminal activity is complex. Whilst substance misuse may be directly related to crime, such as with drug related offences, acquisitive offences, or alcohol-related violence; contact with the criminal justice system and substance misuse are also linked indirectly through their mutual association with social deprivation. Recent reports on substance misuse within the offender population tend to focus on the multiple vulnerabilities experienced by this group[81].

Wiltshire has one Category 3 men's prison, HMP Erlestoke. In 2018/19 there were 393 new entrants to the prison, 71 of whom (18%) began an intervention for substance misuse. In total there were 99 new treatment episodes started in the year (new entrants, those transferred from other establishments, and existing prisoners). 43% were opiate users, 31% used non-opiate drugs only, 13% used alcohol only and 12% used both alcohol and non-opiate drugs.

Within HMP Erlestoke a total of 177 people received treatment for substance misuse over the course of the year. There were 94 discharges from treatment, with the majority of these being due to transfer in custody (38%) and transfer out of custody (15%). However, 19% were discharged as they were considered to be drug or alcohol free. Unfortunately, 28% were unplanned exits from treatment due to the client dropping out. Of those being transferred or discharged with an ongoing treatment need, only 33% of those leaving prison, and 48% of those transferring prison commenced a new treatment journey within 3 weeks suggesting more is needed to strengthen referral pathways between different prison and community substance misuse treatment providers.

[81] Devitt, K. (2011) Young adults today: substance misuse and young adults in the criminal justice system. (Fact file; No. 1). Brighton: Young People in Focus.
Mentor & Alcohol Concern. (2013). Demon drink? A study of alcohol and youth offending in London.

In addition to substance misuse services operating within HMP Erlestoke, individuals involved with the criminal justice system may also be referred to the Criminal Justice Intervention Team (CJIT). In Wiltshire this is currently offered by the same provider as adult drug and alcohol services.

Criminal activity

In the last 2 years drug and alcohol related arrests in Wiltshire have remained relatively static.

Table 18: Wiltshire Police alcohol & drug related data [82]

	Year	
	2017	**2018**
Alcohol-related arrests	1862	1844
Drug-related arrests	856	907

Drug-related proven offences in those under the age of 18 have fluctuated over the last 5 years.

Table 19: Ministry of Justice, 2019

	2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Drug-related proven offences	11	66	38	32	53

County lines

County lines is defined as when a group establishes a network between an urban hub and county location, into which drugs (primarily heroin and crack cocaine) are supplied[83]. A branded mobile phone line is established in the market, to which orders are placed by introduced customers, commonly controlled by a third party remote from the market. The group exploits young and vulnerable persons to achieve the storage and/or supply of drugs, movement of cash proceeds and to secure the use of dwellings, with these individuals regularly travelling between the hub and the market. The group is inclined to use intimidation, violence and weapons.

A typical line can make in the region of £3000 per day, with some making in excess of £5000. Wiltshire Police estimates that the current markets may be around £27k a day in Wiltshire County only. Wiltshire Police estimates that 80-85% of heroin and cocaine in Wiltshire is supplied by county lines, with most originating from London and Bristol. 15 County Lines were identified as active in Wiltshire County between Nov 17-Oct 18. The risk emanating from County Lines has increased recently due to the increase in crack-cocaine usage locally and nationally and the increase in local Wiltshire young people involved in this trade. It is inferred these increases are and will be driving up serious violence incidents in the local area. A total of 47 children were identified last year as involved or at high risk of involvement with the heroin and crack-cocaine market. 38 out of these children were local to Wiltshire, 9 were out of force area. Many of these children do not perceive themselves as being exploited, making interventions difficult. Others may feel trapped with no choice but to carry on due to large debts and the threat of violence.

[82] Wiltshire Police alcohol & drug related data (2019) Wiltshire Police
[83] National Crime Agency (2019) County Lines

Local dealers and domiciled networks oversee a small fraction of the heroin/crack market, with none currently being taken out of the area. These groups are active mainly in the Swindon area and are emerging in Trowbridge. They have easier access to the children and local knowledge needed to intimidate these vulnerable young people. There has been an increase in violent incidents linked to these local networks recently and there is concern that the risk emanating from County Lines may increase in the immediate future.

Drug and drink driving

In the National Crime Survey for England and Wales 2017/18 6,.6% of drivers reported that in the last 12 months they had driven when they thought they might have been over the legal alcohol limit. 0.4% reported driving when they thought they might have been affected or under the influence of illicit substances[84].

In 2014-16 it was estimated that 26.4 of every 1000 road traffic accidents in England were related to alcohol. The corresponding figure for Wiltshire was significantly higher at 43.7 per 1000 accidents[85].

Social care system

In 2017-18, 40 females and 81 males discussed at the Wiltshire Adult Multi-Agency Safeguarding Hub were identified as having a substance misuse problem. This be benchmark data for further years.

Children and families

Parental substance misuse can affect children's development directly, through exposure to substances in utero, and also indirectly through its impact on parenting capacity. Furthermore, the association between substance misuse and social isolation, deprivation, crime and psychological ill health can all combine to create an environment that at the very least prevents children from achieving their developmental potential, and at the worst can put them at risk of significant harm. Pregnancy, and the first few years of life, are particularly crucial periods in with regards to neurological, physical and emotional development[86].

Public Health England estimates that between 2014/15 and 2016/17 there were around 800 alcohol dependent adults living with roughly 1430 children in Wiltshire. Comparing this with treatment figures for this period, this suggests an unmet treatment need of over 75%. Nationally this figure is even higher at nearly 80%[87].

There are even more children living with adults who are not necessarily dependent on alcohol but could be classed as 'high risk drinkers'. Estimating the number who fall into this category is even more challenging, as figures are only available at a regional level. For the South West, Public Health England estimates that there are between 20,000-42,000 higher risk drinking adults who live with at least one child, with between 18,000-37,000 children affected[83].

In Wiltshire, between 2014/15 and 2016/17 there were estimated to be around 330 adults with opiate dependency living with around 580 children. Treatment figures for this population suggest an unmet treatment need of around 60%, which increased from 40% over the 2 year period. Nationally the unmet treatment need for opiate dependent adults

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[84] Department for Transport. (2019). Reported drinking and driving (RAS51). Statistical data set.
[85] Public Health England. (2019b). Public Health Profiles: Local Alcohol Profiles for England.
[86] Rayns, G., Dawe, S. and Cuthbert, C. (2013). All Babies Count: spotlight on drugs and alcohol. London: NSPCC All Babies Count Spotlight.
[87] Public Health England. (2018). Parental alcohol and drug use: understanding the problem. Guidance. Available at:

who live with children is estimated to be just under 50%. Estimates for non-dependent parental drug use are not available[83].

In terms of those in treatment in Wiltshire, over the course of 2018/19, 372 new clients had contact with children, either being parents themselves or living with other children[88].

Table 20: Parental status [84]

	Number of new clients (2018/19)	Percentage of new clients
Parent living with own children	157/782	20.1%
Other child contact – living with children	11/782	1.4%
Parent not living with children	204/782	26.1%
Not a parent/no child contact	410/782	52.4%

The percentage of clients with some contact with a child (either living with, or a parent of a child living elsewhere) was similar between the various substance groups (from 45.2% of alcohol users to 54.5% of non-opiate users). However, those using opiates were the least likely to be living with a child (23.3%) and alcohol users the most likely (54.2%) [84]

Of those 372 clients in contact with children, 28% had some form of input from Children's Social Care.

Table 21: Treatment population contact with social care [84]

	Number of new clients (n=372) (presenting 1 Apr - 31 Mar)	Percentage of new clients
Early Help	17	4.6%
Child in Need	26	7.0%
Child Protection Plan	41	11.0%
Looked after child	20	5.4%
No early help	267	71.8%
Missing data	1	0.3%

Of those 311 clients who were living with a child/children during the year (new and existing clients) 102 (32.8%) successfully completed treatment. The successful completion rate varies between substance group.

Table 22: Living with children broken down by drug type [84]

Substance group	Number of successful completions/number living with children	Percentage
Opiate	13/109	11.9%
Non-opiate	21/49	42.9%
Alcohol	58/126	46.0%
Non-opiate and alcohol	10/27	37.0%

[88] Public Health England - National Drug Treatment Monitoring System. (2019b). Adult Partnership Activity Report Quarter 4 2018-2019 – Wiltshire.

The proportion of successful completions in those in contact with children within Wiltshire is slightly better than the national average for all substance groups apart from those using non-opiate and alcohol, where the national average is 38.3%.

Impact on Older Adults

Older people are more likely to experience adverse complications from substance misuse due to coexisting age-related disorders and polypharmacy. Furthermore, since ageing is associated with a reduction in total body water (and increase in fat to water ratio), and alcohol is water-soluble, for any given alcohol intake, the resulting blood alcohol concentration is likely to be higher in an older person, when compared to that of a younger individual[89].

Alcohol can result in brain damage via a variety of mechanisms, causing both temporary and permanent cognitive impairment. Older people with a history of alcohol misuse are also more likely to have cerebrovascular disease or have suffered a traumatic brain injury, including a history of chronic subdural haematoma. The most commonly encountered forms of alcohol-related brain damage and cognitive impairment are Wernicke-Korsakoff's Syndrome and Alcohol-Related Dementia. In England between 2015-17, hospital admissions for Wernicke-Korsakoff's Syndrome increased by 26% in those aged 16-65, but by 87% in those over the age of 65 (Royal College of Psychiatrists, 2018).

Falls are a serious health issue for older adults. A third of those over the age of 65 will fall at least once a year, and this proportion rises to a half for those over 80 (Anderson, 2008). Co-existing osteoporosis, age-related cerebral atrophy and sarcopenia increase the chance of serious injury when compared to younger fallers. Falls have significant consequences for the individual including: loss of confidence and independence; fractures; traumatic brain injury and mortality. They also result in a significant number of hospital admissions – 2,202 in Wiltshire over 2017/18[90] – and contribute to an increased need for social care. Substance misuse can significantly increase an individual's risk of falls as a result of short-term visual impairment, loss of coordination, amnesia, sedation and impaired judgement.

Hepatitis C (HCV) is another major public health concern in older adults with a history of injecting drug use, the most significant risk factor for contracting the virus. Many of those infected with HCV will remain asymptomatic for decades, only presenting once irreversible liver damage has occurred. In the United States those from the 'baby boomer' generation (born between 1946-1964), who have the highest rates of substance misuse in the older population, make up a quarter of the population but three quarters of all people with HCV[85].

[89] Royal College of Psychiatrists. (2018). Our Invisible Addicts, 2nd Edition. College Report CR211.
[90] Public Health England. (2019). Public Health Profiles: Wider determinants of Health.

Table 23: Overview of physical health problems related to substance misuse[85]

Physical health problems related to substance misuse	
Acute	Chronic
Intoxication: trauma – head injury/acute intracranial bleeds, fractures	Neurological: peripheral neuropathy, cerebellar damage, repeated head injury and chronic subdural haemorrhage
Overdose: respiratory depression and coma, arrhythmia, stroke, myocardial infarction	Falls: multiple factors increasing likelihood (e.g. loss of balance, poor coordination, impaired judgement, increased risk-taking, autonomic neuropathy, peripheral neuropathy, myopathy, osteoporosis)
Complications from withdrawal: seizures, dehydration, arrhythmias	Respiratory: bronchitis/emphysema/COPD, pneumonia, tuberculosis, lung cancer, 'crack lung', chronic rhinitis, anosmia, nosebleeds, septal perforation
Gastrointestinal/hepatic: haemorrhage, acute pancreatitis, alcoholic hepatitis	Gastrointestinal/hepatic: Chronic liver disease/cirrhosis, fatty liver disease, chronic pancreatitis, upper and lower GI cancers
Cardiovascular and cerebrovascular: myocardial infarction, aortic dissection, arrhythmia, venous thrombosis, stroke	Cardiovascular and cerebrovascular: congestive cardiac failure
Infectious: injection site abscess, infective endocarditis	Infectious: chronic blood borne viruses e.g. Hep B, Hep C and HIV

Conclusion

Drugs and alcohol impact widely on our communities. Whilst Wiltshire has lower than average rates of alcohol-related deaths and hospital admissions, as our population ages we need to ensure people are aware of the cumulative risks of alcohol and are supported to drink responsibly in order to prevent a rise in chronic conditions related to excess alcohol consumption. Whilst accounting for a low number of total admissions, we also need to continue to address the reasons for our higher than average admission rates amongst the under 18s. It is known with the exception of those drinking at the most harmful levels, alcohol consumption increases with household income. Our males aged 30-39 years have a mortality rate from drugs of over three times the average for the Wiltshire population. Interestingly it is our females aged 20-29 who present most commonly to hospital for drug related issues. Admission rates across the region vary, with Trowbridge having a statistically higher rate of drug-related admissions than the Wiltshire average.

Drugs and alcohol contribute to a significant proportion of the work of our police force and justice system. Road traffic accidents related to alcohol are particularly prevalent in our county.

Reaching those misusing substances who live with children is of upmost importance in order to safeguard those children from harm and break the cycle of intergenerational substance misuse.

With an ever-growing older population, professionals working in our county need to be vigilant for signs of substance misuse in those they are working with and appreciate the unique ways in which it may present.

Recommendations

- Provide targeted harm reduction activities aimed at male drug users (particularly those aged 30-39 years) to reduce the high mortality rate seen in this population
- Continue to address the wider determinants of health and inequalities which contribute to the higher rates of mortality seen in deprived areas
- Educate the public about the cumulative effects of alcohol and its association with a wider range of health problems (i.e. those conditions that may not be typically associated with alcohol use)
- Continue to work closely with children's services to ensure the safeguarding of all children in contact with those with substance misuse problems
- Continue to work alongside and support the police in raising awareness of and reducing the impact of County Lines
- To work collaboratively to reduce alcohol-related road traffic accidents within Wiltshire
- Continue to support NHS England's ambition to eliminate Hepatitis C by 2025 by ensuring all those with risk factors who come into contact with substance misuse services are tested and where appropriate, referred for treatment

Evidence Base for what works

This chapter gives an overview of the current evidence and guidance on addressing substance misuse. Research has shown that the combined benefits of drug and alcohol treatment amount to a total saving of £2.4 billion every year across areas such as crime, quality-adjusted life years improvements and health and social care. For every £1 invested in alcohol treatment there is an estimated £3 return, and for every £1 spent on drug treatment the return is around £4[91].

Evidence reviews and guidance have been produced by a range of UK organisations including Public Health England (PHE), The National Institute for Health and Care Excellence (NICE), The Department of Health (DoH), The Home Office and The Advisory Council on the Misuse of Drugs (ACMD). See Appendix 2 for a list of key documents from these and other organisations.

Prevention

Whilst there is clearly a need to provide treatment for those with a dependence on drugs and alcohol, effectively addressing substance misuse requires upstream preventative interventions to help reduce the number of people reaching the point of harmful use and dependency in the first place.

Preventative interventions that influence drug and alcohol use are often not substance misuse specific and may exist as a component of broader interventions. They aim to tackle the risk factors that increase the likelihood of someone suffering harm by building resilience, providing opportunities for alternative, healthier life choices, and by developing better skills and decision making.

Table 24: Overview of intervention types[92]

Universal	Addressing an entire population (e.g. TV audience, local community, school population) – designed to deliver prevention to large audiences with no prior screening for risk factors. The aim is to prevent or delay the onset of substance use.
Selective	Addresses specific sub-groups of people who are known to have risk factors for substance misuse either imminently or over their lifetime. Benefits of this approach is that vulnerable populations can be identified and resources targeted.
Indicated	Addresses individuals who are at particular risk, including those who might already use substances, but have not yet developed dependence. Interventions are targeted to prevent substance use escalating, and minimise harm.

Preventative interventions can be classified as ‘universal’, ‘selective’ or ‘indicated’.

The United Nations Office of Drug Control (UNDOC) published ‘International Standards on Drug Use Prevention’ in 2013. These were developed through a systematic assessment of the international evidence on prevention. PHE have summarised the UNDOC evidence and also highlight the corresponding relevant guidelines, programmes and interventions currently available in England[88]. PHE conclude that consistent and coordinated prevention activities delivered through a range of programmes and in a variety of settings (e.g. at home; in school; among peers; in the workplace; throughout the local community and in the media) seem most likely to lead to positive outcomes. The evidence also suggests that modifying

[91] Public Health England. (2018). Alcohol and drug prevention, treatment and recovery: why invest? Guidance.
[92] Public Health England. (2015). The international evidence on the prevention of drug and alcohol use: Summary and examples of implementation in England.

the environment where risky behaviour takes place can reduced harmful outcomes (e.g. controlling alcohol sales, density of outlet and alcohol price, or by imposing bans on smoking in public places). It appears that providing information about the health and social impacts of substance misuse is only effective when delivered alongside interventions which work to develop the skills and personal resources people need to avoid developing harmful substance use.

Interventions targeting young people can be considered preventative as they aim to address substance misuse at an early stage, thus preventing long-term harm. Cost analysis suggests that young people's drug and alcohol interventions result in £4.3 million in health savings and £100 million in crime savings per year. If just a 7-10% reduction in the number of young people continuing their dependency into adulthood is achieved, the lifetime societal benefits of treatment could be as high as £49-£159 million. This equates to a potential £5-8 benefit for every £1 invested[93].

Treatment for drug misuse

The effectiveness of well-delivered, evidence-based treatment for drug misuse is well established. Domestic and international evidence consistently shows that drug treatment impacts positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017).

Public Health England estimate that there is a £4 social return on every £1 invested in drug treatment[89].

In 2017, an independent expert working group produced 'Drug misuse and dependence: UK guidelines on clinical management' based on current evidence and professional consensus[94]. These guidelines consider both psychosocial and pharmacological approaches and acknowledge the importance of considering the social context in which people experience their substance misuse problem and participate in their recovery. Pharmacological treatment and harm reduction – namely opioid substitution and naloxone provision – have a strong evidence base for those with heroin and other opioid misuse problems. However, there is limited evidence for pharmacological interventions for individuals with problems related to misuse of other drugs. The guidance emphasises the importance of using substance misuse treatment as an opportunity to address an individual's wider psychological problems, wider psychological problems (including the impact of past traumas) and to provide support for them to gain meaningful employment and stable housing, alongside family and other social support. The 2017 guidelines list 10 key points that they consider to be essential elements of treatment provision.

1. The needs of all drug misusers should be assessed across the four domains of drug and alcohol misuse, health, social functioning and criminal involvement
2. Risks to the individual, to at-risk adults and to potentially affected children should be assessed
3. All drug misusers receiving structured treatment should have consented to their treatment and recovery care plan, which should be regularly reviewed

[93] Public Health England. (2018). *Alcohol and drug prevention, treatment and recovery: why invest?* Guidance.

[94] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group. (2017). Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health.

4. A keyworker – usually a consistent, named keyworker- should develop and review the care plan and may deliver elements of care
5. Drug testing can be a useful tool in diagnosis and assessment and in monitoring compliance and outcomes of treatment
6. Drug misuse treatment involves offering a range of psychosocial treatment and support interventions, not just prescribing
7. Identifying and responding to general healthcare needs is increasingly important and means working in partnership with primary and secondary care services
8. A proactive, flexible organisational ethos that actively involves service users and carers can support an effective and engaging therapeutic milieu, and can address stigmatisation and help promote positive service developments
9. All drug services need competence in identifying and addressing the effects of trauma on service users and the effects of intimate partner or other domestic violence
10. Aftercare support and pathways for rapid re-engagement in treatment are important to address risks of relapse and harm, and support recovery in the period after leaving treatment

Evidence-based harm reduction interventions include:

- Needle and syringe programmes
- Testing and vaccination to reduce spread of blood-borne viruses
- Provision of take home naloxone to reverse the effects of opioid overdose and reduce the risk of drug-related deaths

Needle and syringe programmes cost around £200 a year per injector, but can result in annual savings of:

- £22,000-41,000 for every prevented case of Hepatitis C
- £10,000-42,000 for every prevented case of HIV[89]

Treatment for alcohol misuse

It is estimated that identification of high risk drinking and brief advice in primary care can save the NHS £27 per patient per year. Hospital alcohol care teams reduce the demand for hospital services. The return on investment here can be £3.85 for every £1 spent. Assertive outreach teams that work with those placing the highest burden on emergency services due to their alcohol problems can achieve up to 62% cost savings[89].

In 2011, NICE published the clinical guideline 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence'[95]. This was produced alongside guidance on prevention of alcohol-use disorders and management of the physical complications of alcohol misuse (see Appendix 2).

The 2011 guideline covers the diagnosis and management of alcohol misuse in those over the age of 10 years and considers the different approaches that might be required depending on the level of dependence, characteristics of the user (e.g. age) and presence of comorbid conditions.

[95] National Institute for Health Care and Excellence. (2011b). Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Clinical guideline.

Conclusion

There is a significant amount of evidence that shows prevention and treatment of substance misuse not only works to help the individuals involved, but also benefits society and is cost-effective. Preventative work, including addressing substance misuse problems in young people, is vital in order to minimise the number of people developing harmful levels of use in the first place. This also requires consideration of the environment in which people consume substances in order to try and minimise the opportunities or ability for harm to occur. For those already using substances in a harmful way, treatment including harm reduction strategies such as needle-exchange and provision of naloxone, can reduce the impact of their use.

Recommendations

- Ensure prevention remains high on the strategic agenda for addressing substance misuse in Wiltshire

Current Provision

This chapter gives an overview of the policies, strategies and services in place for those with substance misuse problems nationally and locally.

National Strategies

2017 Drug Strategy

The 2017 Drug Strategy sets out the Government's aims and approach for tackling substance misuse[96].

Aims:

1) Reduce illicit and other harmful drug use
2) Increase the rates recovering from their dependence

Approach:

- Reducing Demand
  - Prevent the onset of drug use and its escalation at all ages, through universal action combined with more targeted actions for the most vulnerable. Place greater emphasis on building resilience and confidence among young people to prevent the range of risks they face
- Restricting Supply
  - Take a smarter approach to restricting supply of drugs: adapting to changes in criminal activity; using innovative data and technology; taking coordinated partnership action to tackle drugs alongside other criminal activity
- Building Recovery
  - Raise ambition for full recovery by improving both treatment quality and outcomes for different user groups; ensuring the right interventions are given to people according to their needs and facilitating the delivery of an enhanced, joined-up approach to commissioning and the wide range of services that are essential to supporting every individual to live a life free from drugs
- Global Action
  - Take a leading role in driving international action, spearheading new initiatives e.g. on new psychoactive substances, sharing best practice and promoting an evidence-based approach to preventing drug harms

In 2003, the National Drugs Helpline was rebranded into FRANK and an associated campaign 'Talk to FRANK' was established encouraging individuals to contact the helpline for advice regarding their own or others drug use. FRANK continues to operate an advice service via phone, text, live online chat and email, and has a comprehensive website with news, information and advice about substance misuse. Further information can be found at: https://www.talktofrank.com/.

National Alcohol Strategy

There has been no dedicated government alcohol strategy published since 2012. However, in May 2018 the Parliamentary Under-Secretary of State for Health and Social Care announced that a new strategy was being developed. The 2016 Modern Crime Prevention Strategy sets out the Government's planned approach for preventing alcohol-related crime and disorder by:

[96] HM Government. (2017). 2017 Drug Strategy.

- Improving local intelligence so that decisions taken about the sale of alcohol and the management of the evening and night time economy are based on reliable data and the latest evidence
- Establishing effective local partnerships where all those involved in the operation and management of the evening and night time economy work together so that people can enjoy a safe night out without fear of becoming a victim of alcohol-related crime or disorder, whilst also enabling local economies to grow
- Equipping the police and local authorities with the right powers so they can prevent problems and take swift and decisive action after they have occurred

Personal, social and health education

Personal, social, health and economic education (PSHE) is due to become compulsory in all state schools from September 2020. Updated draft guidance on what this should consist of was published by the Department for Education in February 2019.

Table 25: PSHE guidance[97]

By the end of Primary school pupils should know…	The facts about legal and illegal harmful substances and associated risks, including smoking, alcohol use and drug-taking
By the end of Secondary school pupils should know…	The facts about legal and illegal drugs and their associated risks, including the link between drug use, and the associated risks, including the link to serious mental health conditions.
	The law relating to the supply and possession of illegal substances.
	The physical and psychological risks associated with alcohol consumption and what constitutes low risk alcohol consumption in adulthood
	The physical and psychological consequences of addiction, including alcohol dependency
	Awareness of the dangers of drugs which are prescribed but still present serious health risks
	The facts about the harms from smoking tobacco (particularly the link to lung cancer), the benefits of quitting and how to access support to do so

Third Sector Organisations

A number of national voluntary sector and mutual aid organisations specialising in issues related to substance misuse operate alongside commissioned services. Several of these are aimed at supporting individuals with substance misuse problems – Alcoholics and Narcotics Anonymous being two of the most well-known. Others help those affected by others' substance misuse such as Adfam and Al-Anon. Many charities and independent organisations such as Alcohol Change UK and The Drinkaware Trust are also involved in national campaigns and policy development.

[97] Department for Education (2019) Education, Relationships and Sex Education (RSE) and Health Education: Draft statutory guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers

Locally Commissioned Services

Figure 27: Overview of the Wiltshire commissioned services for drugs and alcohol across the lifecourse

Motiv8

The current Wiltshire Young People's service – Motiv8, is provided for children and young people, up to their 18th birthday, who are resident within the Wiltshire Unitary Authority with problematic substance use, and for children, young people and families affected by parental substance use. Its primary objective is to improve the health, welfare and life chances of those vulnerable to, or experiencing, substance misuse. This is achieved by working directly with young people in an integrative partnership with, where appropriate, other service providers to create a balance between health interventions, education, prevention and therapeutic interventions. Children or young people need to choose to receive support from Motiv8. Motiv8 also provides advice and support to parents and carers of young persons with substance misuse needs and can refer to additional parental/carer support as appropriate.

The service provider refers young people whose needs cannot be met to appropriate specialist care, for example those, requiring in-patient and/or residential services.

The service may extend provision beyond the 18th birthday up to the age of 19 years should specific conditions apply, namely that:

- The young person continues to require substance misuse services;
- And the young person's needs are assessed and do not meet the threshold for adult drug and alcohol services;
- Or the young person's needs are assessed and agreed as being best met within a young person's service.

The above criteria may be applied in regard to looked after young people and those with learning difficulties or disabilities where the age range extends to 24 years. For those that are transitioning to adult services, the service should ensure that a comprehensive and a timely transition plan is in place.

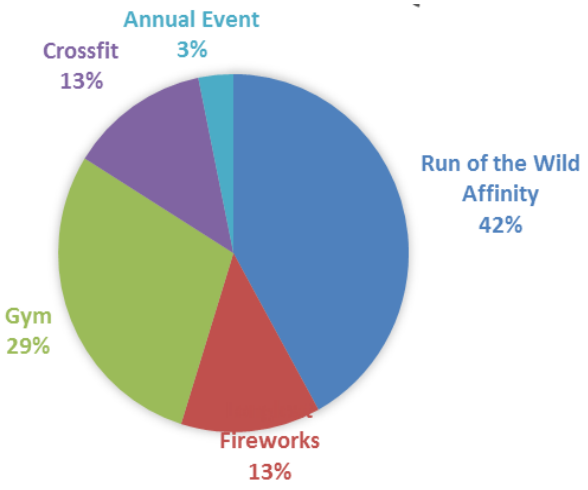
The service is divided into two distinct areas- Non-structured interventions (Tier 2) and Structured Treatment (Tier 3). It is not an 'emergency service' and is not expected to provide crisis level interventions to children, young people and their families. However, it is expected to react quickly and support a multiagency response to new and emerging risks such as changes in hazardous substance use and child protection concerns.

The service includes a Harm Reduction Team whose roles include:

- Provision of training on an appropriate screening tool and drug/alcohol education to organisations such as schools, youth services, young offender teams, looked after children etc.
- Working with police, health, youth service and the voluntary/community sector to reduce harm
- Promoting the service
- Provision of outreach services
- Delivery of targeted group work to those at risk and using substances
- Raising awareness within schools, colleges etc.
- Provision of brief 1:1 interventions
- Provision of advice and guidance
- Referral to partnership agencies
- Performing initial assessments

In total, 8960 young people were engaged in preventative and harm reduction advice for 2017/18. This was conducted through school assemblies, youth club provision, social media and outreach. Outreach is run by the Motiv8 Manager and a team of volunteers and currently occurs every other Friday. It is driven by client need and used a range of diversionary activities, shown in Figure 28, below

Figure 28: Motiv8 positive activities data



Working alongside the Harm Reduction Team is the Treatment Team who provide:

- Comprehensive assessments
- Psychosocial interventions
- Family work – non-structured and sign-posting
- Structured treatment
- Prescribing
- Multi-agency working including the Common Assessment Framework (CAF) multi-agency framework

- Identification of a need for residential treatment

Interventions delivered

Over the last year there were 194 young people in treatment across Wilshire. The proportion of those receiving the different forms of intervention offered is outlined below.

Table 26: Intervention type breakdown for Wiltshire young people[98]

Intervention type	Number receiving intervention	Percentage receiving intervention
Harm reduction	154	79%
Pharmacological	1	1%
Psychosocial	187	96%
Multi-agency working	108	56%

Of all of the psychosocial interventions delivered the majority were cognitive and behavioural interventions or motivational interventions.

Table 27: Psychosocial intervention breakdown for Wiltshire young people[99]

Psychosocial intervention sub-type	Number of interventions delivered	Percentage of all psychosocial interventions delivered
Cognitive and behavioural interventions	252	34%
Motivational interventions	272	37%
Multicomponent programmes	40	5%
Contingency management	82	11%
Counselling	99	13%

Of the multi-agency interventions delivered most related to education/training, or children's social care.

[98] Public Health England - National Drug Treatment Monitoring System. (2019a). Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.
[99] Public Health England - National Drug Treatment Monitoring System. (2019a). Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.

Table 28: Multi-agency intervention breakdown for Wiltshire young people[100]

Multi-agency intervention sub-type	Number of interventions delivered	Percentage of all multi-agency interventions delivered
Education/training	106	28%
Employment/volunteering	11	3%
Housing	16	4%
Generic family support	8	2%
Generic parenting support	2	1%
Mental health	64	17%
Offending	22	6%
Health	20	5%
Sexual health/pregnancy	7	2%
Meaningful activities	19	5%
Behavioural services	1	0%
Youth services	8	2%
Children's social care	99	26%

Outcomes

Treatment exits and discharge reasons – proportion of all exits which were planned/unplanned

Over the last year planned exits from treatment have increased in Wiltshire. This has primarily been due to an increase in those completing treatment but remaining an occasional drug user, rather than those exiting drug free. However, compared to the national average, there are still significantly more young people exiting treatment drug free in Wiltshire than there are nationally (46% compared to 32%). Less young people are dropping out of treatment in Wiltshire than nationally (5% compared to 13%) although a slightly higher percentage declined treatment in Wiltshire than nationally (5% compared to 1%)[96].

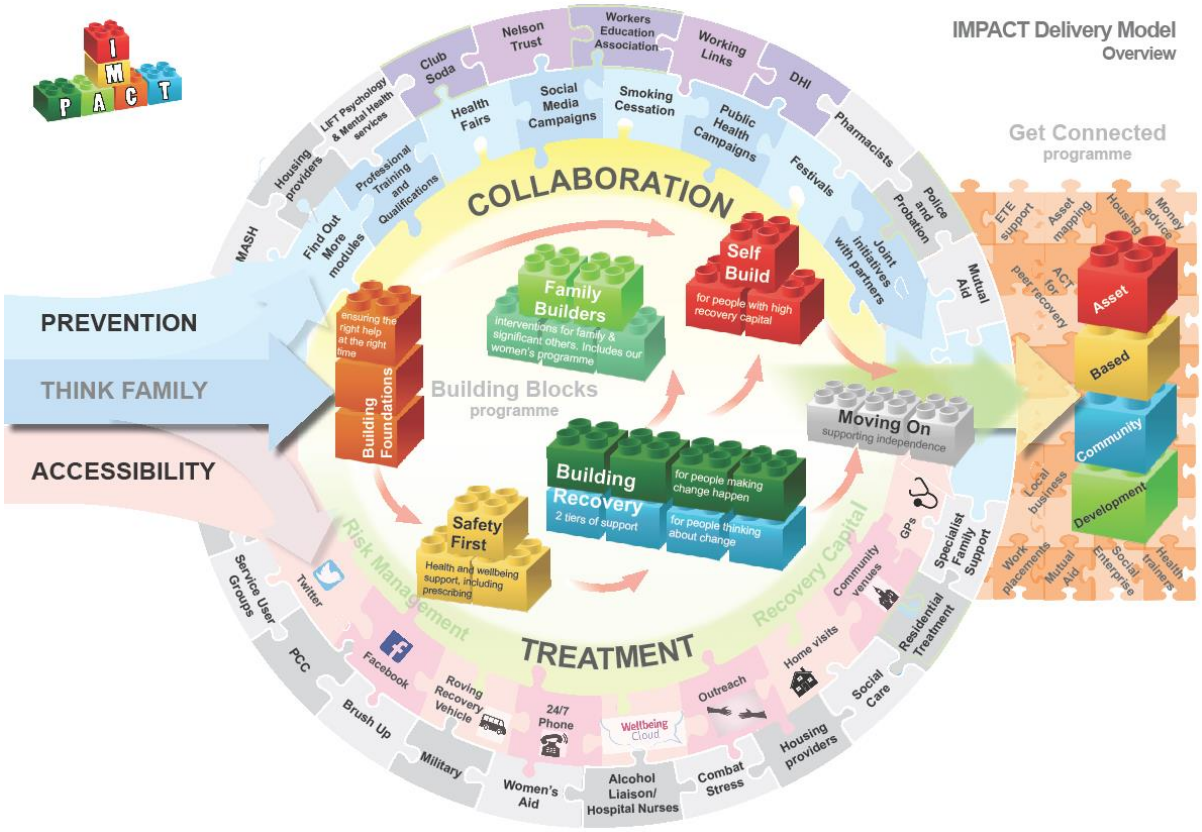
[100] Public Health England - National Drug Treatment Monitoring System. (2019). Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.

Table 29: Wiltshire young people Treatment exits and discharge reasons [96]

Treatment exit/discharge reason	2017/18	2018/19	National average
Planned	**76%**	**86%**	**80%**
Treatment completed – drug free	45%	46%	32%
Treatment completed – occasional user	31%	41%	48%
Unplanned/transferred	**24%**	**14%**	**20%**
Incomplete – treatment withdrawn by provider	0%	2%	1%
Incomplete – dropped out	12%	5%	13%
Incomplete – treatment declined by YP	1%	5%	1%
Transferred – not in custody	4%	1%	4%
Transferred – in custody	2%	1%	1%
Transferred – transition to adult services	5%	1%	0%

IMPACT

The current substance misuse service for adults in Wiltshire is known as 'IMPACT'. This is delivered as a joint service across both Wiltshire and Swindon. The delivery model for this service is illustrated by the diagram below.



The IMPACT model is built around four key themes:

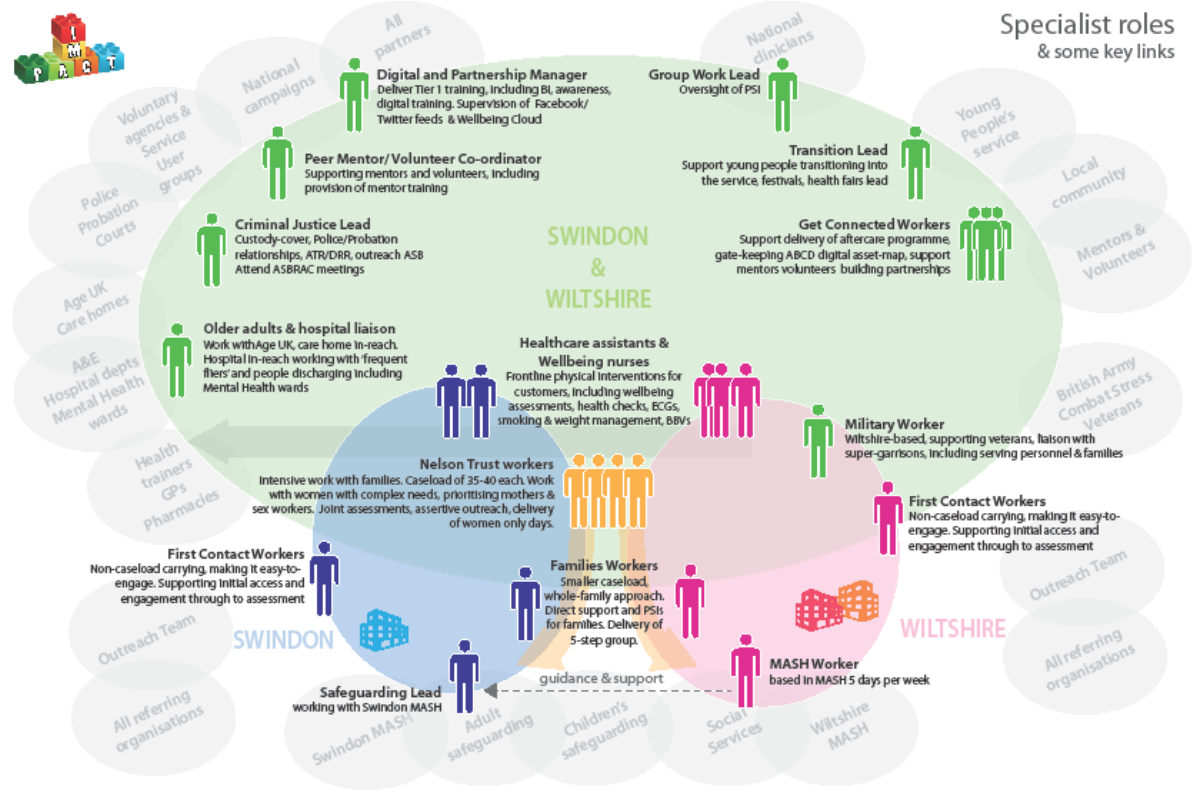
Prevention – work with Wiltshire and Swindon Communities to reduce the need for the Wiltshire and Swindon Substance Misuse Services (WSSMS). In turn this will reduce the reliance on other key services such as Adult Social Care, Hospitals and emergency services. This work will include generating key preventative messages within Wiltshire and Swindon community areas.

Accessibility - when people require assistance from WSSMS, the service will be easily accessible. This means understanding how people want to access services, such as establishing a network of satellite sites to meet customers using community buildings, coffee shops etc. This also requires the service to consider alternative ways to engage with the service including the use of social media, there are various message services available (such as FaceTime, WhatsApp etc). In addition, WSSMS should consider operating a key hour's telephone service.

Collaboration – the expectation is that WSSMS will work with other agencies to achieve the best outcomes for the customer. This means understanding and complementing co-requisite services such as social care, health, police, probation voluntary and community sector etc. This network of partners should always be growing and strengthening.

Treatment – when the customer requires treatment, they should be accessing the evidence based interventions. This specification requires the service to include certain key elements such as harm reduction, prescribing and psychosocial interventions. How these services are delivered is the decision of the service.

The IMPACT model aims to promote collaboration between different agencies via the use of specialist roles as illustrated below.



Coverage

The current service operates from two main hubs in Trowbridge and Salisbury, with 42 community venues across the county.

Across these 44 sites a range of services are provided:

Table 30: Services provided by Turning Point in Wiltshire

Service	Number of sites providing
1-2-1s	44
Prescribing	9
Blood-borne virus testing and vaccination	10
Group work	32
Creche	2
'Building Foundations'	26
'Safety First'	26
'Self Build'	36
'Building Recovery' (Tier 1)	37
'Building Recovery' (Tier 2)	31
'Family Builders'	35
'Moving On'	29
'Get Connected'	29

Outcomes

Locally, rates of successful completion (without re-presentation) are slightly above the national average for opiate clients, but at 7.1% over the last year, have fallen from 12.3% this time a year ago[101].

Table 31: Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months[97]

	Q4 17/18 (01/10/16-30/09/17 and 31/03/18)	Q1 18/19 (01/01/17-31/12/17 and 30/06/18)	Q2 18/19 (01/04/17-31/03/18 and 30/09/18)	Q3 18/19 (01/07/17-30/06/18 and 31/12/18	Q4 18/19 (01/10/17-30/09/18 and 31/03/19)	Compared to 1 year ago	Compared to national average
	%	%	%	%	%		
Local opiate	12.3	11.6(↓)	10.5(↓)	8.9(↓)	7.1(↓)	(↓)	(↑)
National opiate	6.6	6.5	6.3	6.1	6.0		
Local non-opiate	31.5	33.7(↑)	32.7(↓)	30.2(↓)	31.4(↑)	(↓)	(↓)
National non-opiate	36.6	36.9	36.4	35.7	35.2		
Local alcohol	44.3	44.7(↑)	41.1(↓)	38.4(↓)	36.6(↓)	(↓)	(↓)
National alcohol	38.6	38.9	39	38.5	37.8		

[101] Public Health England – National Drug Treatment Monitoring System. (2019c). *Diagnostic Outcomes Monitoring Executive Summary Quarter 4 2018-2019.*

Rates of successful completion for non-opiate clients are below the national average, however locally rates have remained relatively stable.

Alcohol completion rates are also slightly below the national average, these are also lower than a year ago when completion rates were better than the national average.

Table 32: Abstinence and reliably improved rates at 6 month review in the last 12 months[97]

		Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Compared to 1 year ago
		%	%	%	%	%	
Opiate	Abstinence	42.3	46.5(↑)	41.9(↓)	38.5(↓)	41.8(↑)	(↓)
	Reliably improved	32.1	28.2(↓)	30.6(↑)	30.8(↑)	26.9(↓)	(↓)
Crack	Abstinence	48.7	51.3(↑)	48.6(↓)	40.0(↓)	44.2(↑)	(↓)
	Reliably improved	20.5	17.9(↓)	20.0(↑)	22.5(↑)	23.3(↑)	(↑)
Cocaine	Abstinence	54.5	45.5(↓)	50.0(↑)	56.3(↑)	60.0(↑)	(↑)
	Reliably improved	9.1	18.2(↑)	14.3(↓)	12.5(↓)	6.7(↓)	(↓)
Alcohol	Abstinence	17.1	15.6(↓)	19.0(↑)	17.9(↓)	13.0(↓)	(↓)
	Reliably improved	13.7	13.3(↓)	12.0(↓)	15.2(↑)	17.4(↑)	(↑)
Injecting (at 6 month review in last 12 months)	Abstinence	51.1	50.0(↓)	45.7(↓)	44.1(↓)	53.1(↑)	(↑)
	Reliably improved	22.2	21.1(↓)	28.6(↑)	26.5(↓)	18.8(↓)	(↓)

Research has shown that clients who are retained in treatment for at least 12 weeks have better treatment outcomes (NTA, 2005). In Wiltshire, retention of opiate clients has improved slightly over the last year and has been consistently better than the national average. Retention rates for alcohol and "alcohol & non-opiate" clients have fluctuated a little but also remain just above the national average. Non-opiate clients are those least likely to stay until 12 weeks of treatment and in Wiltshire our retention rates are slightly worse than the national average for this treatment group.

Table 33: Proportion of new presentations who had an unplanned exit or transferred and not continuing a journey before being retained for 12 weeks[97]

	Q4 17/18 (01/01/17-31/12/17)	Q1 18/19 (01/04/17-31/03/18)	Q2 18/19 (01/07/17-30/06/18)	Q3 18/19 (01/10/17-30/09/18)	Q4 18/19 (01/01/18-31/12/18)	Compared to 1 year ago	National average	Compared to national average
	%	%	%	%	%			
Opiate	8.3	9.9(↑)	6.9(↓)	5.8(↓)	6.8(↑)	(↓)	16.7	(↓)
Non-opiate	21.1	22.2(↑)	24.2(↑)	27.6(↑)	26.2(↓)	(↑)	18.8	(↑)
Alcohol	12.9	13.9(↑)	14.0(↑)	12.8(↓)	11.5(↓)	(↓)	13.6	(↓)
Alc & non-opiate	17.1	17.6(↑)	15.9(↓)	11.5(↓)	13.9(↑)	(↓)	17.9	(↓)

The figures below show the proportion of new clients who left treatment before 12 weeks (the lower the number the better). It can clearly be seen that non-opiate clients are those most likely to leave treatment prematurely, and that Wiltshire has a higher rate of early exit amongst non-opiate clients than the national average.

As previously discussed, substance misuse is associated with multiple wider socioeconomic vulnerabilities including employment and housing problems. Therefore, one marker of success for a substance misuse treatment programme is an improvement in these factors.

In Wiltshire, 34% of new opiate clients reported housing problems. Of those that successfully completed treatment in the last year however, 97.3% reported no housing need. This has improved since the same time a year ago and is better than the national average[97]. This data does not specify how many of these clients obtained stable housing during, or as a result of, their treatment journey. However, 66% of new clients already had stable housing at the start of their treatment. Evidence shows that having stable housing is a significant predictor for success with substance misuse treatment. For those completing treatment for non-opiate substance misuse, an even higher proportion are in stable accommodation. At 98.1% this is again higher than the national average of 96.6%[97].

Nearly 30% of those successfully completing treatment for opiate misuse and 42.1% of those completing treatment for non-opiate use had worked for at least 10 days during the last month on their exit from treatment. These figures are both higher than the corresponding national averages, however whilst the employment rate in opiate clients appears to have increased over the last year (18.2% to 29.7%), the rate in non-opiate clients has fallen slightly (47.0% to 42.1%)[97].

Table 34: Housing and employment outcomes at successful completion of treatment[97]

		Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Compared to 1 year ago	National average	Compared to national average
		%	%	%	%	%		%	
Opiate clients	No reported housing need	93.2	95.0 (↑)	97.1 (↑)	97.1 (↔)	97.3 (↑)	(↑)	95.9	(↑)
	Working ≥ 10 days in last 28 at exit	18.2	12.5 (↓)	8.8 (↓)	14.7 (↑)	29.7 (↑)	(↑)	25.9	(↑)
	Volunteer-ing	4.8	10.0 (↑)	8.1 (↓)	7.9 (↓)	4.9 (↓)	(↑)	3.2	(↑)
Non-opiate clients	No reported housing need	94.9	98.1 (↑)	98.2 (↑)	99.1 (↑)	98.1 (↓)	(↑)	96.6	(↑)
	Working ≥ 10 days in last 28 at exit	47.0	43.9 (↓)	52.2 (↑)	46.8 (↓)	42.1 (↓)	(↓)	37.2	(↑)
	Volunteer-ing	2.4	3.1 (↑)	2.6 (↓)	2.6 (↓)	2.7 (↑)	(↑)	2.7	(↔)

Alcohol liaison service

The service offers brief interventions on the bedside to patients whose admittance is linked to their alcohol consumption. The service also aims to encourage patients on discharge to engage with community drug and alcohol services where appropriate. Wiltshire currently supports three Alcohol Liaison Services (ALS) in and around the county in:

- Salisbury District Hospital
- Royal United Hospital (RUH), Bath
- Great Western Hospital (GWH), Swindon

The Salisbury ALS is solely funded by Wiltshire Public Health. Salisbury Foundation Trust employ a nurse to fulfil the role. The approach within the hospital has been to set up a champion network so that there are staff on each ward who are trained in delivering brief intervention advice.

Within the RUH, BANES have employed a nurse via Avon & Wiltshire Partnership and 3 part time recovery workers through DHI. The team sit alongside the mental liaison service and operate the same service offering brief interventions. This service is part funded by Wiltshire Public Health.

The Swindon service is also part funded by Wiltshire Public Health and employs two nurses through AWP. Both the Swindon and Salisbury service have workers from Turning Point come and assist on visits when appropriate.

This year Wiltshire Public Health will review the three services to identify if there is good practice that can be shared and any benefit in the differing approaches.

Supported housing scheme (Julian House)

In April 2018 Julian House were commissioned to manage the drug and alcohol supported accommodation. This scheme offers short term support of no more than 2 years (on average 6 months) to those exiting treatment in need of accommodation. The aim is that the tenants can learn the skills required for managing a tenancy independently whilst remaining substance free. The scheme has a total of 21 units across Trowbridge, Calne, Chippenham, Devizes and Salisbury. 7 are scripted (Trowbridge and Calne) and the remainder are dry.

Shared Care

Wiltshire's shared care scheme operates from a network of GP practices and pharmacies. The GP shared scheme allows clients to have their clinical/medical needs addressed through their GP and psychosocial interventions provided through Turning Point. The approach is declining in number, this is mainly because commissioned services such as Turning Point now have the skills and expertise to offer a full service rather than having to have a supported clinical offer.

The shared care offer also extends to a number of services provided by pharmacies; supervised consumption, needle exchange and naloxone. The supervised consumption service allows clients to either collect or take opiate substitutes. The prescriptions for this are written by Turning Point or very occasionally the GP.

The pharmacies also play a pivotal role in the county's needle exchange service. This community-based service compliments the exchange offered by Turning Point. The scheme offers clean needles for both steroid and opiate or crack use, stimulant kits and sharp boxes for the return of used needles.

Since April 2019 the scheme has also extended to offer naloxone through the pharmacy network. Naloxone is an opiate blocking drug that can stop the effects of an opiate overdose.

This is also offered by Turning Point but we are aiming to expand the availability through the additional pharmacy provision.

Detox/Rehab facilities

Wiltshire has recently commissioned a framework of providers for drug and alcohol detox and rehabilitation services. The framework has 26 different units available, each with varying specialisms.

The rehab process is split into three sections. Detox is the clinical phase of becoming abstinent, carried out in a medical setting with supervision. The 'primary' part of the process is around understanding the personal reasons for the substance misuse and finally the 'secondary' is looking at ways to make sure the recovery carries on in the community.

Conclusion

Whilst the Government produced a national drug strategy in 2017, an up to date alcohol strategy is awaited. Changes to the status of PSHE education provides an opportunity to develop and strengthen substance misuse education in schools. Locally, a number of different services are commissioned to provide various aspects of substance misuse prevention and treatment across Wiltshire. These are supported by several third sector organisations such as those providing mutual-aid (e.g. Alcoholics Anonymous).

A significant proportion of the work done by Motiv8, the young people's service in Wiltshire, revolves around harm reduction. Outcomes for those in treatment have improved over the last year, and the percentage of planned exits, particularly those who exit drug-free, is now higher than the national average.

Adult treatment services have seen a slight decline in the proportion of successful completions over the last year. Despite this our successful completion rate for opioid users remains above the national average. Retention rates have largely improved over the last year and are above the national average for all but non-opiate clients where a high proportion leave in an unplanned way before 12 weeks. Housing and employment outcomes for those successfully completing treatment are better than national figures. This is not surprising in view of the relatively low rates of unemployment and homelessness in the county as a whole and it isn't immediately clear how many of these clients already had stable housing or employment at the start of their treatment journey.

Recommendations

- Ensure schools in Wiltshire are supported and encouraged to deliver a comprehensive PHSE curriculum including high quality drugs and alcohol education
- Continue to aim for high rates of successful, planned exits from children's treatment services – particularly focussing on as many drug-free exits as possible
- Explore reasons why rates of successful completion without representation in adults services have fallen over the last year and act to reverse this trajectory.
- Explore reasons why retention rates are particularly low for those presenting with non-opiate substance misuse and aim to improve this via targeted interventions
- Establish what proportion of those leaving service with stable employment or housing were without this at the start of their treatment journey to better understand the impact of substance misuse treatment on these indicators.
- Review the three ALS services to identify good practice that can be shared.

User and stakeholder feedback

Young people's services

Service users' feedback

In order to gain an insight into what young people felt about current service provision, one to one, semi structured interview's were conducted across the county, with 12 Young people ranging from 15 -17. These were conducted with their full consent, with their Motiv8 worker present and two facilitators. They were asked 10 core questions, the following information was identified;

Factors identified as positive or important by service users included:

- Continuity of care with a dedicated support worker
  - "*Having someone to talk to confidentially and knowing I can contact them again if required."*
  - *"Having the same worker as last time so already knew and trusted them."*
  - *"Getting the same worker so didn't have to get to know someone new."*
- Accessibility and flexibility/proactive working on the part of the support worker
  - "*Just having brilliant support. Keeping in contact when I was rubbish at attending meetings."*
  - *"It was great to have someone to talk to and you were here when I was ready to change."*
  - *"Helped me when I needed it, meeting in McDonalds."*
  - *"Even though I didn't want to see them, they kept inviting me to attend appointments, I didn't speak to them for ages but realised I could trust them and they had my interests at heart."*
  - *"'It was a voluntary service which meant I knew I didn't have to attend if I didn't want to."*
  - *"Was easy to get to appointments, made at time and place that suited me."*
- Positive activities and contingency management/rewards systems
  - *"Crossfit/Run of the Wild/Longleat"*
  - *"The physical stuff, Crossfit and the gym."*
  - *"The 28-day challenge, talking, quizzes."*
- Supportive listening on the part of the support worker
  - *"I was listened to and felt happy talking to [worker's name]"*
  - *"I felt that I was listened to and I felt that I was given advice on how to help deal with my problems."*
  - *"They listened well and were easy to talk to."*
- Emotional support and resilience building
  - *"'They helped put both Mum & me at ease by taking me seriously - I was very unhappy and they helped to set some achievable goals."*
  - *"[Worker's name] has helped me improve my confidence and cut down on drinking as she has helped me understand the risks of drinking too much."*
  - *"I did something really bad and I've never been so low in my life and the help I received made me realise how much I need professional people involved."*
- Getting factual information related to substance misuse
  - *"Very good service from the worker. I learned quite a bit"*
  - *"The facts were explained clearly to me."*
  - *"Lots of information and dangers of cannabis"*

Concerns from young people engaged with services included:

- Transition to adult services

- *"I am frightened about what happens next, I am not ready to go into adult services."*

Parents and carers feedback

Feedback from parent and carers was overwhelmingly positive:

- "*All good and gratefully received"*
- "[*The young person's] mother was apprehensive at first about him working with DYPS (sic) however when she witnessed the benefits that the relationship with [his worker] gave to [him] this changed…." (from social worker's report)*

When asked about gaps in services, parents and carers usually responded that there were none, but those who did answer, identified a lack of funding to engage the young people in additional positive activities.

Staff feedback

Identified gaps or challenges facing current provision*:*

- *"Agree that NEET/alternative education provision for young people may indicate a gap"*
- *"Domestic violence is an issue for young people"*
- *"Appropriate accommodation remains an issue for vulnerable young people with substance misuse problems"*
- *"Tier four treatment is a gap"*
- *"Transitions"*

They also highlighted the need for effective education in a variety of forms:

- *"Use of social media/internet"*
- *"Effective, evidence-based education (universal and targeted)"*

They highlighted the importance of being able to respond to a variety of substances within a range of interventions:

- *"NPS, polyuse, harm reduction and the recovery agenda"*

They identified the need for good service user involvement:

- *"Involve young people in review, consultation and development etc"*

They also asked for clarity in how positive outcomes are measured:

- *"What is specialist treatment/criteria/definitions for successful treatment outcomes?"*

Finally they identified a shortage in the resource for responding to young people's needs:

- *"Both aspects [of hidden harm work] are limited by [our] capacity to meet need and [we are] working with continual waiting lists"*
- *"Difficulty in linking in with young people who are in custody and looked after children far from home due to limited resource."*

Feedback from other professionals (workshop activity)

There were many positive aspects of the current service identified:

- "Stable local use, but increase in treatment suggesting more engagement"

- "Flexible service provision"
- "The service is well known"
- "Relationships with staff"
- "*'Extremely beneficial……This work could not have been done as effectively by another agency, who could not devote its time and resources to this subject."*
- *"Excellent communication from [the worker] and valuable input into case conferences and assessments"*
- *"Extremely beneficial. Having another agency directly involved with the family allowed information and concerns to be passed to me that may have otherwise not been obtained. Also, having another professional to reflect on these concerns and identify what the support needs were was very helpful."*

Suggestions were made regarding areas that might benefit from further work:

- *"Drug education delivered at primary and secondary level (quality varied)"*
- *"Transitions from young peoples to adult services."*
- *"Data – gender split insight"*
- *"Are we reaching the most vulnerable?"*
- *"We need to do more around parental engagement/education"*
- *"Outreach needs to be formally included and build up volunteer network"*
- *"Should smoking be formally included."*
- *"Referrals – improving partner engagement."*

Adult services

Service users' feedback

A focus group was conducted with a mixed group of service users in the later stages of treatment.

What service users felt worked well:

- *"The groups are effective"*
- *"Pain management services are improving to incorporate more psychological support"*
- *"Workers do try hard despite limited resources"*
- *"Communication from drug and alcohol services to the GP is good"*

Gaps/challenges/areas for improvement identified:

- *"Mental health wouldn't engage because of substance misuse"*
- *"Need to know to ask questions in order to get the answers from the service"*
- *"Infrequent opportunities to meet with key worker – in past used to meet much more frequently, now don't feel key worker really knows me"*
- *"Need to ensure messages are consistent"*
- *"GP knowledge of substance misuse is generally poor"*
- *"Wait times to seek mental health support"*
- *"Lack of narcotics anonymous"*
- *"Unsure what I'm supposed to do when this group finishes, still feel I need support but nowhere to go"*
- *"Too long a wait/lack of availability for detoxification – I ended up doing it myself which I knew was risky but was worried if I didn't do it then my drinking would escalate again"*

Specific themes discussed included:

- Barriers to accessing service for women:
  - *"Worried about losing children"*
  - *"Childcare"*
  - *"Anxiety, we worry more about things than men"*
  - *"Stigma – 'keep quiet or lose your kids'"*
  - *"Other priorities/responsibilities – too much else to do at home, attending services or addressing own health drops down list"*
  - *"Geography of Wiltshire, too far/cost to travel, infrequent public transport"*

- Reasons for not accessing service earlier:
  - *"Took me 16 years between realising I had a problem and getting around to contacting service"*
  - *"Hated the idea of groups as a younger adult – as I got older I got happier with them"*
  - *"Stigma"*
  - *"Worried about managing chronic pain without substances"*

Feedback from professionals (from within and outside commissioned service) (workshop activity)

Four key themes were discussed within the workshop:

- How do we maximise engagement in the 20-24 and 60+ year old age groups?
  - *Alcohol liaison for young people in hospital*
  - *Taking a 'trauma' based approach*
  - *Considering transport/mobility issues*
  - *Use those with lived experience*
  - *They need very different approaches – problems haven't yet occurred for 20-24 year olds, and those over the age of 60 may think there is no need to bother now*

- What can we do to reduce harmful/hazardous alcohol consumption in our communities?
  - *Journey mapping of individuals who do present to services – were there opportunities for us to have intervened earlier? Try to see if there are common trigger points for developing problem drinking and use these as pointers to intervene.*
  - *Embed MECC across all services*
  - *Need to consider how to get messages into the home – people are drinking patterns are more closed off now*
  - *Need to get messages across about wider health risks e.g. cancer, as people often just think of liver disease*
  - *Need to simplify messages regarding safe drinking – consider using number of drinks, or promote drinking water between alcoholic drinks, rather than units which are hard for people to understand*

- What can be done to increase accessibility for women?
  - *Adult service already offering creche facility*
  - *Female peer mentors, especially those with children to help relieve anxieties related to losing children*
  - *More outreach*
  - *Using locations women already frequenting such as schools to provide interventions*
  - *Consider why there is an opposite split in those accessing MH services – can we learn from each other?*

  - *How to ensure/reassure women they will be in a safe space – women have been known to be targeted in treatment and recovery groups for organised crime*
  - *Are there female only AA/NA groups?*
  - *Use technology/digital offer to support those unable to physically attend due to transport/childcare issues*
  - *Ensure digital offer is widely advertised and available (e.g. Facetime consultations) to ensure women are not put off seeking help simply through lack of knowledge about it being an option*

- How can pathways between different organisations (e.g. mental health) be improved?
  - *Ensure Turning Point are invited to sit on mental health multidisciplinary meetings and vice versa*
  - *Automatic flagging between mental health and drug and alcohol teams when individual is admitted to hospital or seen by the other service*
  - *Co-location of services*
  - *Expand and share asset mapping*
  - *Need a joint digital offer – many users will otherwise be accessing two different platforms when one could probably provide the support for both*

Conclusion

Service users identified several key aspects as important to them. Continuity of care, accessibility/flexibility and a proactive approach were all features young people identified as good about Motiv8. Young people also appreciated the diversionary activities offered.

Adult users also expressed a wish to have continuity of care, with more frequent opportunities to meet their case worker so as to build a trusting relationship. Transport and childcare were cited as particularly important for women service users, who stated that they often struggled to prioritise their substance misuse issues over other things they had going on in their lives.

A number of suggestions were made at the stakeholder workshops regarding how to improve access to women, raise the profile of services for young and older adults and improve links between substance misuse services and other providers such as mental health services.

Recommendations

- To facilitate regular awareness and educational GP training to further their knowledge on substance misuse issues.
- A review should be carried out of the new female focused changes by the service including creche facilities, female only days and female only workers to establish if they meet the needs identified.

Identified Gaps

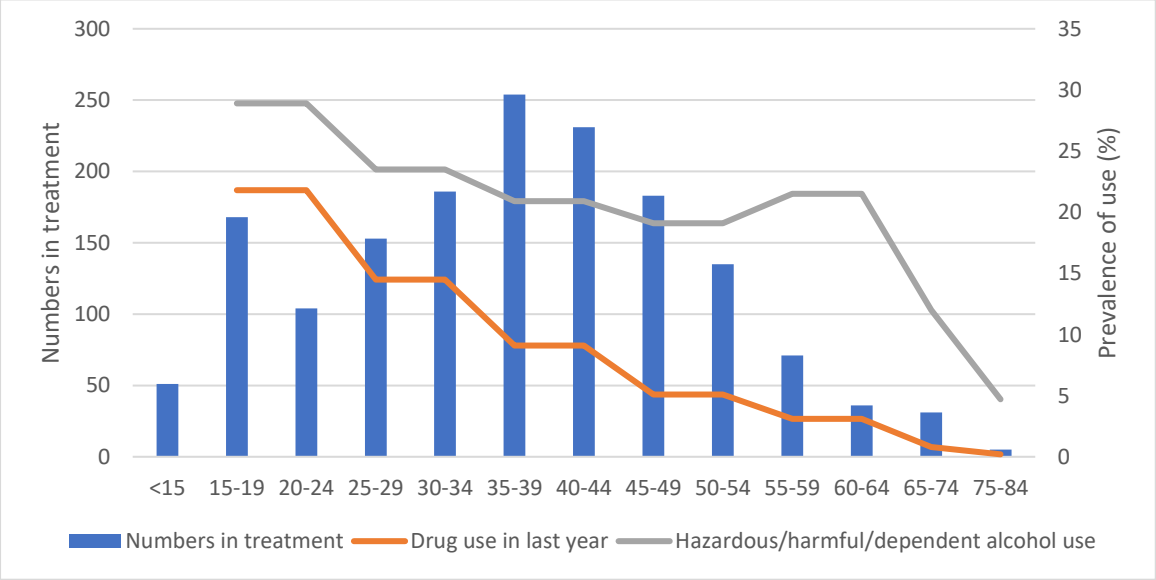
Young Adults (20-24 year olds) and Older Adults (>60 years)

The transition between young persons and adult services is an area where many young people disengage from the system. Local data [102]from the Motiv8 service demonstrates that 24% of those leaving at 18 leave in an unplanned way, showing the need for a transition plan to maximise service users getting the required support. The average age of users in the adult service is around 40, but the most common initial drug use occurs aged 15-19. This suggests that there is a wide gap between initial use and presentation later on, or possible disengagement using the young person's service before re-presenting to adult services many years later.

Information from the adult service[98] shows that only 25 service users (1.7%) were under 20 in 2018-19, despite the most common time to start using initial drugs being 15-19, suggesting there is likely to be a significant unmet treatment need for those between 18-20.

The following graph illustrates the number of people in treatment across Wiltshire by 5 year age groups (blue bars) (combined client numbers from young people's and adult's services). It clearly demonstrates a drop-off in the number in treatment between the age groups of 15-19 and 20-24, which corresponds with the time individuals would transition from young people's to adult services. The graph also illustrates the national estimated prevalence of drug use (orange line) and hazardous/harmful/dependent alcohol use (grey line) for the same age groups. Comparing these against the numbers in treatment it is clear that there is an unmet need for both drug and alcohol treatment for those in their early 20s, and alcohol treatment for those over the age of 54.

Figure 29: Numbers in treatment[103] compared with estimated drug use and excess alcohol use by age[104]



[102] Public Health England - National Drug Treatment Monitoring System. (2019a). Young People Quarterly Activity Report (Partnership) Quarter 4 2018-2019 – Wiltshire.
[103] Public Health England - National Drug Treatment Monitoring System. (2019b). Adult Partnership Activity Report Quarter 4 2018-2019 – Wiltshire.
[104] NHS Digital. (2016). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.

During 2018/19 there were 19 people who disengaged from motiv8. Change in key worker can cause instability, showing that continuity is important, and something that may benefit young people from transition past 18 years.

Literature shows that having a mental health service that extends beyond 18 up to 25 can increase referrals by 68% and decrease the disengagement at 18 years old (Maxwell, et al., 2019). Young people have indicated that lack of continuity and consistency between young people and adult services make transitioning difficult, with this leading to a greater risk of negative outcomes such as substance abuse. Mental health data[100] shows that young adults are less likely to be offered treatment compared to adolescents, showing the difference between the young persons and adult services. Although the admission rate during the transition period is higher as the support from the services is not available. Having a transition service in place improves outcomes for young people. There is little information about the benefits of having a substance misuse service which extends to age 20+, although it is a common trend in substance misuse services for many local authorities as they try to increase effectiveness for young adults. The transitions report for Wiltshire also found most young people were anxious, fearful and uncertain on leaving CAHMS, taking a perception that mental health services were uncaring.

Proportion of females in treatment

Local data suggests[99] that only a third of the adult treatment population are female, this is also reflected nationally by NDTMS data. However, local young people's data suggests a more equal split.

The qualitive evidence collected through focus groups with adults currently in treatment also reflected on barriers for females accessing services. These reasons included the belief that children would be removed from them and also the inability to make time to look after themselves. They felt that there were pressures of managing a home that meant that often they didn't realise an issue had a substance misuse issue until it was upon them and then they weren't able to make the time to address it.

The current IMPACT service has made provision to increase females in service which includes female only days, creche services and dedicated female only workers. However, due to the infancy of this changes the gender difference in treatment population still remains an identified gap.

Overrepresentation of mental health issues within treatment population

Local data[99] suggests that nearly 60% of adults in treatment for substance misuse have self-reported a mental health issue upon admission. Whereas nationally just 1 in 6 adults have reported a mental health issue in the last week. Furthermore, 32% of young people in treatment locally have reported a mental health issue and a third of all young people in treatment have self-harmed.

Local processes are in place to work with those presenting to substance misuse services in need of mental health support. However, scrutiny is required to ensure that these processes get the right support to the right people in a timely manner.

High drinking levels amongst the adult population

National modelling from LAPE[105] suggests that 1 in 3 adults within Wiltshire are drinking at increasing risk. That is at a level that scores 8 or higher on the Audit C test and means that individuals are at an increased risk of health harms as a result of their drinking. Locally run Audit C testing suggests this figure could be closer to 1 in 2 and local treatment data shows that 50% of all adult substance misuse referrals within Wiltshire are for alcohol.

Increased levels of drinking can place additional pressure on services in the short to long term. These include increased blue light calls, hospital admissions and the need for early assistance from support services.

Recommendation

- Wiltshire needs to consider ways in which to reduce alcohol consumption so that the population are drinking at safer levels.

[105] Public Health England. (2017e). Local Alcohol Profiles for England 2017 user guide.

Recommendations

Collated here are all the recommendations highlighted in each section of this paper:

- National evidence suggests a need for more harm reduction advice particularly targeting those in the 55-64 year old age group, and those from more affluent backgrounds, who may not identify as having a 'problem' with alcohol, or be aware of the cumulative harm of regular consumption over the recommended limits

- Nationally there is a need for further data collection/analysis with regards to alcohol consumption in pregnancy to gain a better understanding of its prevalence and what can be done to reduce risks to the unborn child

- There is a need to monitor emerging national trends in drug use amongst 11-15 year olds to ascertain whether reported increase seen in 2016 survey is validated (Smoking, Drinking and Drug Use among Young People in England 2018 is due for publication on 25th July 2019)

- Establish whether local data is available regarding the prevalence of alcohol and drug misuse amongst women under the care of maternity services

- Promote the use of AUDIT-C questionnaire across a wider range of primary care/community services locations, including those reaching older adults

- Explore reasons why there are less females engaged with young people's substance misuse services when estimates suggest prevalence of substance misuse is comparable between young males and females

- Consider the appropriateness of integrating smoking cessation services into the young person's substance misuse offer

- Raise awareness of substance misuse (in particular alcohol) as a problem in older adults within the professional community working with this age group – e.g. GPs, adult social care, care coordinators, secondary care

- Ensure referral pathways are clear between different agencies/organisations coming into contact with those known to be at high risk of substance misuse (e.g. child and adult mental health services, domestic abuse services)

- Explore the reasons for the difference between highlighted 'issue' of substance misuse between families and children assessment data and actual referrals.

- Utilise the Vulnerability Framework to ensure agencies and organisations working with individuals experiencing vulnerabilities are proactive in identifying it as an issue and that clear and appropriate referral pathways are in place.

- Raise awareness amongst professionals and the public regarding the different risk factors for substance misuse (e.g. chronic pain, polypharmacy, bereavement) and presenting features in older adults

- Consider the impact of the increased military population on substance misuse services.
- Consider options for reducing transitions issues between young peoples and adult services. To inform future commissioning intentions.
- To investigate the involvement of substances in the lives of those affected by CSE.
- Provide targeted harm reduction activities aimed at male drug users (particularly those aged 30-39 years) to reduce the high mortality rate seen in this population
- Continue to address the wider determinants of health and inequalities which contribute to the higher rates of mortality seen in deprived areas
- Educate the public about the cumulative effects of alcohol and its association with a wider range of health problems (i.e. those conditions that may not be typically associated with alcohol use)
- Continue to work closely with children's services to ensure the safeguarding of all children in contact with those with substance misuse problems
- Continue to work alongside and support the police in raising awareness of and reducing the impact of County Lines
- To work collaboratively to reduce alcohol-related road traffic accidents within Wiltshire
- Continue to support NHS England's ambition to eliminate Hepatitis C by 2025 by ensuring all those with risk factors who come into contact with substance misuse services are tested and where appropriate, referred for treatment
- Ensure prevention remains high on the strategic agenda for addressing substance misuse in Wiltshire
- Ensure schools in Wiltshire are supported and encouraged to deliver a comprehensive PSHE curriculum including high quality drugs and alcohol education
- Continue to aim for high rates of successful, planned exits from children's treatment services – particularly focussing on as many drug-free exits as possible
- Explore reasons why rates of successful completion without representation in adults services have fallen over the last year and act to reverse this trajectory
- Explore reasons why retention rates are particularly low for those presenting with non-opiate substance misuse and aim to improve this via targeted interventions

- Establish what proportion of those leaving service with stable employment or housing were without this at the start of their treatment journey to better understand the impact of substance misuse treatment on these indicators

- Review the three ALS services to identify good practice that can be shared

- To facilitate regular awareness and educational GP training to further their knowledge on substance misuse issues.

- A review should be carried out of the new female focused changes by the service including creche facilities, female only days and female only workers to establish if they meet the needs identified.

- PHE suggest there is an increase in Performance or Image Enhancing Drug use, a report should look into defining this understand its impact within Wiltshire.

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Appendices

Appendix 1 – AUDIT questionnaire

To the right is the full AUDIT questionnaire. The shortened AUDIT-C version asks only the first 3 questions with regards to alcohol consumption and then encourages individuals to continue and answer the full questionnaire if the score 5 or more.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Interpretation of results

AUDIT-C	Full AUDIT
• A total of 5 or more is a positive screen	• 0-7 indicates low risk
• 0-4 indicates low risk	• 8-15 indicates increasing risk
• 5-7 indicates increased risk	• 16-19 indicates higher risk
• 8-10 indicates higher risk	• 20 or more indicates possible dependence
• 11-12 indicates possible dependence	• Full AUDIT

Appendix 2 – Key guidance related to substance misuse prevention, treatment and recovery

Public Health England

1. Preventing drug and alcohol misuse: effective interventions – A summary of international evidence of effective alcohol and drug misuse prevention interventions and examples of their use in England https://www.gov.uk/government/publications/preventing-drug-and-alcohol-misuse-effective-interventions
2. Drug misuse treatment in England: evidence review of outcomes – A review of evidence on what outcomes can be expected of the drug treatment and recovery system in England, with advice on future policy https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf
3. Drug misuse and dependence: UK guidelines on clinical management – How clinicians should treat people with drug misuse and drug dependence problems https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
4. Alcohol and drug prevention, treatment and recovery: why invest? https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest
5. The public health burden of alcohol: evidence review – This review looks at the impact of alcohol on the public health and the effectiveness of alcohol control policies https://www.gov.uk/government/publications/the-public-health-burden-of-alcohol-evidence-review
6. Health Matters: tobacco and alcohol CQUIN – This professional resource focuses on preventing ill health caused by tobacco and alcohol use and makes the case for why NHS providers should implement the 'Screening and brief advice for tobacco and alcohol use in inpatient settings CQUIN'. https://www.gov.uk/government/publications/health-matters-preventing-ill-health-from-alcohol-and-tobacco/health-matters-preventing-ill-health-from-alcohol-and-tobacco-use
7. Alcohol, drugs and tobacco: commissioning support pack – Annual guidance on smoking, drinking and drug misuse commissioners of tobacco control, drug and alcohol services for adults and young people https://www.gov.uk/government/publications/alcohol-drugs-and-tobacco-commissioning-support-pack
8. Mutual aid toolkit for alcohol and drug misuse treatment – Evidence and guidance on the benefits of mutual aid in preventing and treating alcohol and drug dependency https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest
9. Safeguarding children affected by parental alcohol and drug use – A guide for local authorities and substance misuse services to help them work together to safeguard and promote the welfare of children https://www.gov.uk/government/publications/safeguarding-children-affected-by-parental-alcohol-and-drug-use
10. Better care for people with co-occurring mental health, and alcohol and drug use conditions: commission and provide services – Guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions

https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services

11. Older people and alcohol misuse: helping people stay in their homes – Guidance on how to prevent and reduce harmful drinking in older people https://www.gov.uk/government/publications/older-people-and-alcohol-misuse-helping-people-stay-in-their-homes
12. Routes to recovery from substance addiction – Manual for healthcare practitioners on building and carrying out an effective plan for recovery from substance addiction https://www.gov.uk/government/publications/routes-to-recovery-from-substance-addiction
13. Treating drug dependence recovery with medication/Medications in recovery: best practice in reviewing substance misuse treatment – Advice on best practice for reviewing individuals in substance misuse treatment https://www.gov.uk/government/publications/treating-drug-dependence-recovery-with-medication
14. Treating substance misuse and related harm: turning evidence into practice – How to use evidence of drug-related activity and harm to improve prevention and treatment of substance misuse and associated problems https://www.gov.uk/government/publications/treating-substance-misuse-and-related-harm-turning-evidence-into-practice
15. Alcohol: applying All Our Health – Evidence and guidance to help healthcare professionals reduce alcohol-related harm https://www.gov.uk/government/publications/alcohol-applying-all-our-health
16. Misuse of illicit drugs and medicines: applying All Our Health – Evidence and guidance to help health professionals identify, prevent or reduce drug-related harm https://www.gov.uk/government/publications/misuse-of-illicit-drugs-and-medicines-applying-all-our-health
17. Health Matters : preventing drug misuse deaths – Professional resource outlining how providers and commissioners can prevent deaths from drug misuse https://www.gov.uk/government/publications/health-matters-preventing-drug-misuse-deaths
18. Preventing drug related deaths/Understanding and preventing drug related deaths – Report on the causes of the rise in drug related deaths and how to prevent future deaths https://www.gov.uk/government/publications/preventing-drug-related-deaths
19. Providing take-home naloxone for opioid overdose – Advice for local authorities on providing more naloxone to reduce overdose deaths from heroin and other opioids https://www.gov.uk/government/publications/providing-take-home-naloxone-for-opioid-overdose

National Institute for Health and Care Excellence (NICE)

1. Alcohol-use disorders: diagnosis and management of physical complications https://www.nice.org.uk/guidance/cg100
2. Nalmefene for reducing alcohol consumption in people with alcohol dependence https://www.nice.org.uk/guidance/ta325
3. Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings https://www.nice.org.uk/guidance/cg120
4. Coexisting severe mental illness (psychosis) and substance misuse: community health and social care services https://www.nice.org.uk/guidance/ng58
5. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence https://www.nice.org.uk/guidance/cg115

6. Alcohol-use disorders: prevention https://www.nice.org.uk/guidance/ph24
7. Alcohol: school-based interventions https://www.nice.org.uk/guidance/ph7
8. Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors https://www.nice.org.uk/guidance/cg110
9. Drug misuse prevention: targeted interventions https://www.nice.org.uk/guidance/ng64
10. Drug misuse in over 16s: psychosocial interventions https://www.nice.org.uk/guidance/ng64
11. Drug misuse in over 16s: opioid detoxification https://www.nice.org.uk/guidance/cg52
12. Drug use disorders in adults https://www.nice.org.uk/guidance/qs23
13. Needle and syringe programmes https://www.nice.org.uk/guidance/ph52
14. Naltrexone for the management of opioid dependence https://www.nice.org.uk/guidance/ta115
15. Methadone and buprenorphine for the management of opioid dependence https://www.nice.org.uk/guidance/ta114

World Health Organisation (WHO)

1. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence https://apps.who.int/iris/bitstream/handle/10665/43948/9789241547543_eng.pdf;jsessionid=894589D19CE5B58FC6CFFC6B3AE81323?sequence=1
2. Global strategy to reduce the harmful use of alcohol https://apps.who.int/iris/bitstream/handle/10665/44395/9789241599931_eng.pdf?sequence=1
3. Treatment and care for people with drug use disorders in contact with the criminal justice system: Alternatives to conviction or punishment http://www.unodc.org/documents/UNODC_WHO_Alternatives_to_Conviction_or_Punishment_2018.pdf
4. International Standards for the Treatment of Drug Use Disorders https://www.who.int/substance_abuse/activities/msb_treatment_standards.pdf?ua=1&ua=1
5. Guidelines for the identification and management of substance use and substance use disorders in pregnancy https://www.who.int/substance_abuse/activities/msb_treatment_standards.pdf?ua=1&ua=1
6. Community management of opioid overdose https://apps.who.int/iris/bitstream/handle/10665/137462/9789241548816_eng.pdf?sequence=1

British Medical Association (BMA)

1. Tackling alcohol-related harm http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a23_1/apache_media/5XCI46SMRP4XJKAQ7TJUKL3YL1R16I.pdf
2. Alcohol and pregnancy: preventing and managing fetal alcohol spectrum disorders http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a23_1/apache_media/K9N3CEYUYJTB453YC4RGHU85JSTQMM.pdf
3. Alcohol misuse: tackling the UK epidemic http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a23_1/apache_media/J5R9NF8EDMLPEE1TPP5PIGUAJLKYKY.pdf

4. Drugs of dependence: The role of medical professionals https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/illicit-drug-use/full-report
5. Evidence-based interventions for managing illicit drug dependence https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/illicit-drug-use

Department of Health (DoH)

1. Drug misuse and dependence: UK guidelines on clinical management https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

Advisory Council on the Misuse of Drugs (ACMD)

1. Reducing opioid-related deaths https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf
2. Prevention of drug and alcohol dependence https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/406926/ACMD_RC_Prevention_briefing_250215.pdf

Home Office

1. The Government's Alcohol Strategy https://www.gov.uk/government/publications/alcohol-strategy
2. Drug Strategy 2017 https://www.gov.uk/government/publications/drug-strategy-2017