KENT PUBLIC HEALTH OBSERVATORY

Drug Needs Assessment

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| 1. Executive Summary

1.1 Synopsis

Drug Needs Assessment (NA) has been developed to inform commissioning of community-based alcohol and drug misuse treatment services in Kent. It is envisaged that this Drug NA will guide the development of relevant partnerships by the Kent County Council (KCC) – Kent Substance Misuse Alliance, a partnership of key stakeholders to work together to tackle alcohol and drug related harms. It also provides an evidence base to support the development of services which best meet the needs of the Kent population. The Drug NA is focused on the needs of Kent inhabitants aged 18 years and over who use illicit drugs or other substance misuse in a manner of irregular harmful misuse or dependence, regardless of whether they are already in contact with treatment services. There is a separate treatment needs assessment to assess the drug and alcohol treatment needs. The Drug NA would also not have been possible without input from stakeholders who offered their time, experience and wisdom to the project. This accompanying report also outlines recommendations for consideration in future commissioning of services.

1.2 Key findings

- Individuals with drug misuse face substantial associated socioeconomic and health inequalities, including higher rates of premature morbidity and mortality.
- What is notable is the increasing trend in reported drug use in 25-29 year olds. All those under 30 showed an increase in reported drug use over the 5 year period
- Among young adults aged 16 to 24, about 8.7% had taken a Class A drug in the last year. Both Class A and any drug use among adults aged 16-59 has stayed relatively stable at .2% (Class A) and 10% (any drug) over the last 20 years. For younger cohort – class A usage has stayed relatively stable (10%) but overall usage has reduced since 1996. Recent years have seen an increase compared with the 2011/12 estimate (6.2% to 8.7%), with the 2018/19 estimate the highest since 2002/03 (8.9%). This is mainly driven by an increase in powder cocaine and ecstasy use.
- Cannabis was the most commonly used drug, 7.6% of adults aged 16 to 59 reported that they had used it in the previous year (2017/18). This is similar to the previous year (7.2%) but significantly lower than a decade ago (8.7% in 2005/06) and the start of the measurement in 1996 (9.4%).
- National drug use rates among older adults aged 44-59 has increased over time. This is thought to mainly reflect increased cannabis use, but reported use of powder cocaine has also increased.
- UK government reports have estimated that near 100% of opioid dependent users nationally also smoke, and research has suggested that drug users are more likely to die from smoking-related illnesses than drug use.

1.3 The Recommendations from the Drug Needs Assessment

Recommendation: Increasing drug misuse among older ages, alongside an aging general population, highlights a need to ensure treatment services are accessible to older service users, and tailored to their needs. For example, older service users may be more resistant to attend drug treatment services alongside younger people, and may benefit from dedicated treatment times and/or locations, and awareness campaigns of services should be available at locations that may be more visible to older service users, such as health-care centres or pubs. Given that most older drug users commence drug use before the age of 40, preventive strategies should be particularly mindful of initiation of drug use in younger age groups, and target preventive strategies at the under 40 population. (Please see section 5.8 - Older service users - ageing substance misuse population)

Recommendation: Facilitate close input from mental health services during substance misuse treatment and as part of follow-up care to maximise potential for recovery and reduce substance-misuse associated health inequalities. To reach individuals in the community for whom untreated mental health issues are a barrier to seeking substance misuse treatment there should be shared intelligence between mental health services and substance misuse treatment services (for example through inclusion of mental health services in any substance misuse strategic working group), streamlined referral pathways, and joint outreach work to shared high-risk groups (such as the homeless). (Please see section 7.1)

Recommendation: Consider close cooperation with children's support services and charities during provision of substance misuse treatment to mitigate the impact on children who have a parent in structured treatment, and to support the identification of high-risk groups such as children living in toxic-trio households, i.e. domestic risk factors including domestic abuse, substance misuse and mental health illness. Further, explore if there is a need and/or adequate provision of child-care support for parents for whom child-caring responsibilities may be a barrier to fully engaging with treatment services. (Please see section 5.3)

Recommendation: Outreach and awareness efforts of substance misuse treatment services should target the most deprived districts in Kent, particularly east Kent, notably Canterbury, Dover and Thanet, where current levels of need from drug-associated harm are higher. Prioritise Thanet. (Please see figures 17 & 26)

Recommendation: Establish close ties and joined up pathways between local criminal justice and prison systems and community treatment services, with specific regard to individuals who enter or leave prison services, or who are given community substance misuse treatment orders. This may help address a large area of need in increasing successful and timely pick-up rates by community substance misuse treatment services of service users released from prison. This is likely to not only support recovery of service users, but also benefit the broader community and criminal justice system by acting to prevent criminal reoffending associated with substance misuse. (Please see table 5)

Recommendation: There are substantial overlapping communities of need across several public health services, such as relatively high rates of substance misuse alongside sexual health issues. Close collaborative working and streamlined referral pathways between different public health services could therefore ensure a more holistic approach to care management, by for example offering needle exchange services in sexual health centres and by utilising client contact with substance misuse treatment services as a vital opportunity to offer testing for sexually transmitted infections. Further, the data suggest a particular missed opportunity to incorporate HIV testing into other points of contact with services, or to offer novel self-testing opportunities for clients. (Please see section 7.3 – sexual health and HIV)

Recommendation: Close partnership working with agencies that support sex workers from the private, public and voluntary sector. It would be helpful for partnership work to also facilitate monitoring of uptake of substance misuse treatment support in this high-risk group. Further, it is vital that close communication is maintained with Children's Social Services as part of partnership working. Reducing substance dependency among sex workers would likely not only affect sex workers themselves, but also affected children given that the majority of sex workers have reported that a need to support their children is a driver of sex work. (Please see section 5.9)

Recommendation: Parents who misuse drugs or alcohol have reported fear of engagement from social services as an important barrier to accessing treatment services. This particularly relates to concerns with regard to whether their children would be taken into care if it was found that the parents misuse drugs or alcohol. A component of partnership working with Children's Social Services should therefore include to consider how the negative perception of the role of social services can be improved among this community.

Recommendation: Close partnership working with relevant organisations in the public, private and voluntary sector, such as Kent Police, local fire services, adult and children social

care services, and charities focused on issues such as county lines, child drug exploitation and modern slavery. Partnership working facilitates a holistic approach to substance misuse treatment and the development of services which are responsive to a changing social environment. Moreover, it is important to enhance data quality, accessibility to data and data sharing pathways across partnership work to combine intelligence.

Recommendation: This needs assessment highlights the gap between service demand and the unmet needs of drug misuse treatment and recovery services in Kent. In order to address these there must be strengthened preventative pathways, a better access to services, and increased equity. An increased focus on vulnerable people entering and staying engaged in treatment, particularly those with long-term co-occurring conditions, both physical and mental health, complex social needs is a key recommendation of this report.

Recommendations for Kent Substance Misuse Alliance (All Partners):

- For all partners - Whilst developing any strategy and related delivery plans, continued priority should be given to a strategic approach that makes explicit goals for early help/intervention, prevention approaches, mental health promotion, meeting the needs of those with multiple / complex needs, health protection, treatment, implementation of evidenced cost-effective interventions, quality assurance, housing, employment and the improvement and widening of whole family approaches.
- For all partners: There should be an increase in opportunities for routine screening for drug misuse in key areas such as police custody, prison.
- Any strategies and delivery plans should be mindful of recommendations of the Prisons Needs Assessment and national guidance to maintain the health and wellbeing needs of offenders and those in the criminal justice system.
- Continue to work alongside and support the police in raising awareness of and reducing the impact of county lines, particularly supporting vulnerable people.
- 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.

Recommendations for Prevention to Treatment pathways

- For Kent Public Health: Prioritise deep dive needs assessment for inpatient detox and rehab.
- For All Services: align and co-ordinate social prescribing, recovery and social support so that those recovering from addictions have access to all community resources.

- Public Health & All Partners: Each partner agency to have clearly defined links and action for the Kent and Medway Drug and Alcohol Strategy.
- Highlight the vulnerability, social care needs and safeguarding and frailty needs of vulnerable people who are drug misusers in line with Care Act responsibilities. This should be clearly assessed and care planned via multi agency meetings.
- For Public Health: A review of primary care provision to manage long-term conditions to improve health outcomes and prevent premature death for those with drug misuse problems should be undertaken.
- For Providers: To facilitate regular awareness and educational GP training to further their knowledge on substance misuse issues.

2. Introduction to Kent Drug Needs Assessment

There are many drugs and substances that can be misused and cause harm to a person and not all of these are illegal to buy (e.g. glue and solvents). This needs assessment covers harms from illicit drugs. Harms from prescribed medication will not be covered in this report. Illicit drugs do include prescription medication exchanged illegally – however data is poor on this. Over the last 15 years the use and availability of illicit drugs has changed – particularly with the changes in geo-politics, supply routes, use of new illicit drugs (novel psychoactive drugs), and the use of the 'dark web' to obtain drugs. This needs assessment covers these in chapter 3 but evidence suggests recreational drug use has been on a declining trend over the last 10 – 20 years. Use of Class A drugs remain problematic and in general, is not declining.

Illicit drug misuse continues to be a key issue in Kent. Recreational illicit drug use is still pervasive with around 10% of adults reporting drug use within the past year.[1] There are strong links between the prevalence of problem drug use and levels of deprivation, drug related hospital admissions and mortality[2]. Typically, individuals who regularly use Class A drugs, in particular opioids, are often involved in other criminal activity.

Illicit drug use has a financial cost to a wider range of social issues, a cost to crime, a cost to safeguarding and family support, a cost to health harms including blood borne viruses, mental health, cardiovascular disease and homelessness. The economic impact of substance misuse is difficult to estimate due to the range of impacts and illicit nature of drugs. The cost to society from drug misuse is estimated to be in the region of £10 - £15 billion annually, the majority of which is crime related[3, 4]. There are also well-recognised and serious consequences for the children of problem drug users, including the risk of abuse or neglect and the disruption of family life. Expenditure on NHS services and drug treatment services are estimated to be circa £500m.

The Kent Joint Strategic Needs Assessment is a continual process that examines the health and wellbeing needs of the local population. This is a report of the assessment of the needs

[1]https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2020

[2] Shaw C, Hurst A, McVeigh J, Prof. Bellis M A. Eds. 2009 *Indications of Public Health in the English Regions 10: Drug Use.* Liverpool: North West Public Health Observatory

[3] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

[4]https://webarchive.nationalarchives.gov.uk/20140727020135/http://www.nta.nhs.uk/uploads/whyinvest2final.pdf

of adults (aged over 18 years) in Kent for drug and alcohol. This needs assessment only focusses on drugs. Separate needs assessments are also available for:

- Alcohol Needs Assessment https://www.kpho.org.uk/health-intelligence/lifestyle/alcohol#tab1
- Homelessness / Rough Sleeping Needs Assessment https://www.kpho.org.uk/health-intelligence/population-groups/minority-groups#tab1
- Children and Young People Drug & Alcohol Needs Assessment (0-25 years old) https://www.kpho.org.uk/health-intelligence/lifestyle/alcohol#tab1
- Mental Health Needs Assessment https://www.kpho.org.uk/health-intelligence/disease-groups/mental-health#tab1
- Domestic Abuse Needs Assessment https://www.kpho.org.uk/health-intelligence/population-groups/domestic-abuse#tab1
- Drug & Alcohol Treatment Services Needs Assessment (Work in progress but due to be published here: https://www.kpho.org.uk/health-intelligence/lifestyle/drugs-and-substance-misuse#tab1)

2.1 Outcomes from Previous needs assessment

2.1.1 Priorities from the 2014/15 Health Needs Assessment on Drug related harm.

The previous drug needs assessment (2014/15) identified several key areas for improvement: touch on the old needs and new information: These are still live issues.

- The illicit drug market has considerable financial value. To reduce the crime and disorder via the disruption of related criminal activities (such as County Lines) sometimes associated with substance misuse, for example through policing interventions and licensing policies can have a considerable impact. There is a need to ensure that activity is co-ordinated to ensure that enforcement actions are effective in reducing substance misuse and related crime and disorder and maximise community safety, while ensuring there is an optimal night-time economy.
- Services should take into account the geographical spread of vulnerable and high-risk populations; an effort to reach under-represented groups and district populations in treatment is required.
- There is a real risk of individuals becoming increasingly marginalised as an inadvertent result of housing legislation and welfare reform. Housing and employment strategies should be mindful of accommodation needs of those with drug misuse issues.

- Those who use new psychoactive substances (NPS), rarely seeking help from substance misuse services but often presenting to A&E departments with complicated and unclear symptoms as a consequence of their drug use.
- The ageing population of those with drug and alcohol misuse issues who are more prone to co-existing poor health and premature death, with a hesitation to seek medical help for their developing health conditions, and then presenting to treatment at much later stages of illness with a corresponding poorer prognosis.

2.1.2 CONTEXT: Kent Substance Misuse Strategies.

There have been comprehensive partnership wide strategies covering prevention, Treatment and Recovery and Supply in Kent that have mirrored National strategies and guidance. The strategy is currently in development. A draft strategy is available upon request. A link to the previous strategy can be found here (https://www.kent.gov.uk/__data/assets/pdf_file/0010/79219/Kent-Drug-and-Alcohol-strategy.pdf).

2.2 Methodology for needs assessment

A variety of data sources are used for this assessment, including hospital episode data, ONS and Kent treatment service data. The data sources will be cited. Where possible, analysis will be split by West Kent (covering the NHS geography of West Kent CCG and Dartford Gravesham and Swanley CCGs and the treatment provider CGL) and East Kent (covering the East Kent NHS: areas in Swale, Ashford, Canterbury & Coastal, South Kent Coast and Thanet CCGs whose treatment provider is the Forward Trust). Where possible data will also describe Kent as a whole, NHS Integrated Care Partnership (ICPs) or district level presentations. Further iterations of this data and analysis will be tailored to new NHS configurations, e.g., Integrated Care Partnership (ICP) and Primary Care Networks (PCNs) over time.

| 3. Drug Misuse in Context: Policy, Legislation, Strategy, Evidence of effectiveness, and Economic review

3.1 National policies:

3.1.1 National Drug Strategy 2021 – From harm to hope: A 10-year drugs plan to cut crimes and save lives

This is a 10-year plan for real change, with an ambition to reduce overall use towards a historic 30-year low. Commitments are made across government to break drug supply chains while simultaneously reducing the demand for drugs by getting people suffering from addiction into treatment and deterring recreational drug use.

This will help us to Level Up by stopping the cycle of crime driven by addiction, keeping violence out of neighbourhoods across the country and saving lives through reducing the number of drug related deaths and homicides. The plan is supported by record investment of nearly £900 million of dedicated funding over the Spending Review period, taking the total investment over 3 years to £3 billion.

The 10-year plan is also the formal, substantive response to the Independent Reviews of Drugs led by Dame Carol Black and accepts all of her key recommendations.

The plan sets out 3 core priorities: break drug supply chains, deliver a world-class treatment and recovery system, and achieve a shift in the demand for recreational drugs.

This will be achieved by:

- continuing to roll-up exploitative and violent county lines and strengthen our response across the drug supply chain, making the UK a significantly harder place for organised crime groups to operate.
- investing a further £780 million to rebuild drug treatment and recovery services, including for young people and offenders, with new commissioning standards to drive transparency and consistency.
- strengthening the evidence for how best to deter use of recreational drugs, ensuring adults change their behaviour or face tough consequences, and with universal and targeted activity to prevent young people starting to take drugs.

Local partners working together on our long-term ambitions will be key to the strategy's success, and we will develop a new set of local and national outcome frameworks to measure progress against our key strategic aims through which government and public services can he held to account at both national and local levels.

Full details of the drug strategy can be found here:
https://www.gov.uk/government/publications/from-harm-to-hope-a-10-year-drugs-plan-to-cut-crime-and-save-lives

3.1.2 Dame Carol Black Review (Part 2)

Dame Carol Black published her report on July 8,2021, on part two of her independent review of drugs, focusing on drug prevention, treatment and recovery. A government response to the report is expected soon. The review makes it clear that the drug treatment and recovery system in England is not able to operate to the standard needed to address current challenges. However, despite these challenging circumstances, services and local authorities continue to work hard to meet the needs of the communities they serve, and there are some great examples of good practice and innovation around the country. The report proposes changes to commissioning, strengthened accountability and increased funding for treatment services, as well as improvement in employment and housing support which is so critical in helping people sustain recovery. Changes to how the system operates, particularly in relation to accountability and transparency, are as essential as additional investment if we are to make a real and sustained difference.

3.1.3 National Drug Strategy 2017

The National Drug Strategy was published in July 2017 and included the four main priorities:

1 Reducing demand
The new strategy focuses on a targeted approach for high priority population groups including vulnerable young people, NEETs, offenders, families, women with experience of extensive physical and sexual violence, sex workers, homeless population, veterans and older drug users. (aged above 45)

The strategy is also targeting evolving and emerging threats including New Psychoactive Substances (NPS), chemsex, image and performance enhancing drugs, misuse of and dependence on medicines and mental health problems.

2 Restricting supply
Priorities to restrict supply are oversea transit routes, drugs at the UK Border, domestic cannabis production and drug gangs & related exploitation. The strategy also focuses on tackling specific crime types including drug driving, ASB, drug-related offending and prisons.

3 Building recovery
Priorities include the pathway from custody to recovery, physical and mental health improvements but also peer–led recovery. Employment, meaningful activities and families, are further key priorities to support and sustain recovery.

4 Global Actions
This priority is focusing on shaping international policy and practice including:

- Reducing transmission of HIV/AIDS

- Increasing access to controlled medicines
- Promoting human rights

3.1.4 Orange Book - UK guidelines of clinical management of drug misuse and dependence

All drug treatment providers are responsible for delivering drug treatment within the context of the UK guidelines of clinical management of drug misuse and dependence ("Orange Book").[5]

The new guidelines were published in 2017 and replaced the document in place since 2010.

It specifies that drug and alcohol treatment services need to provide trauma-informed practice.

Providers need to consider the principles of trauma-informed care and related staff competencies in addressing related patient needs.

Trauma encompasses an event or events that are experienced by the individual as physically or emotionally harmful, cause significant distress and have enduring effects on their development, functioning and wellbeing (affecting social, emotional, cognitive, behavioural, physical and/or spiritual functioning). Service users may use substances to self-medicate trauma-related symptoms, and some individuals will have severe reactions, leading to symptoms of trauma-related disorders and other mental disorders.

3.1.5 Independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity[6]

This review makes a number of recommendations for Government which are intended to help improve the employment rates for those with substance misuse addiction. The review recommends improving welfare and health services, building new evidence, and focussing on the role of employers - all with the aim of increasing job outcomes for people with addictions.

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf

[6] Black, Dame Carol (2016) An Independent Review into the impact on employment outcomes of drug or alcohol addiction, and obesity. Written statement - HCWS314 [Accessed on: 15/04/2020] [Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573891/employment-outcomes-of-drug-or-alcohol-addiction-and-obesity.pdf

3.1.6 Novel Psychoactive Substances [7]

The 2010 Drug Strategy highlighted the importance of tackling New Psychoactive Substances (NPS). In 2016 the Psychoactive Substances Act was introduced; the aim of the Act was to prohibit and disrupt the production, distribution, sale and supply of NPS in the UK. It is now an offence to produce, supply, offer to supply, possess with intent to supply, import or export psychoactive substances.[8] However, the possession of a psychoactive substance for personal use is not an offence.

3.1.7 Prevention of drug and alcohol dependence: Briefing by the Recovery Committee[9]

The Advisory Council on the Misuse of Drugs produced a briefing paper examining evidence of 'what works' is improving.

Some emerging evidence from the report shows:

- mass media campaigns on their own are ineffective and have shown an increase in drug use.
- In a school setting drug education alone has been found to be ineffective.
- Skills based programmes have been shown to be effective in preventing alcohol, tobacco and some types of illegal drug use.
- 'Environmental prevention'[10]; the use of policies/strategies/laws to reduce exposure to risk taking activities, e.g. the introduction of drug driving laws in 2015.

3.1.8 PHE review on drug misuse treatment outcomes in England[11]

This covers what should be expected from drug treatment services in England. Best practice shows having in place the following: prevalence estimates and profiles of treatment populations; tackling drug-related harms; the impact of housing, employment and social deprivation on treatment outcomes; changes needed to support an ageing cohort of heroin users and new patterns of drug use; evaluating effectiveness of services. The review also includes information on the social and economic costs of drug misuse and value for money of treatment services to assist in social return on investment, for example, it suggests that every £1 invested in drug treatment results in a £2.50 benefit to society.

[7] HM Government (2015) Drug Strategy 2010: 'A balanced approach' Third annual review
[8] Home Office (2015a) Blanket ban to clamp down on 'legal highs' [Accessed on 15/04/2020] [Available at: https://www.gov.uk/government/news/blanket-ban-to-clamp-down-on-legal-highs]
[9] ACMD (2015a) Prevention of drug and alcohol dependence: Briefing by the Recovery Committee February 2015
[10] Foxcroft D (2013) Can Prevention Classification be Improved by Considering the Function of Prevention? Prevention Science DOI 10.1007/s11121-013-0435-1
[11] Public Health England, "Drug misuse treatment in England: evidence review of outcomes," 2017

3.1.9 The National Institute for Health and Care Excellence (NICE) Guidelines[12]

Commissioners and substance misuse services in Kent comply with NICE guidelines on drug misuse, including the NICE clinical pathways, to ensure high quality practices for alcohol and drug prevention, identification and assessment and treatment.

- NICE – Needle and syringe programmes http://www.nice.org.uk/guidance/ph52
- NICE Drug misuse – opioid detoxification http://www.nice.org.uk/guidance/cg52
- NICE – Drug misuse – psychosocial interventions http://www.nice.org.uk/guidance/cg51
- NICE – Psychosis with coexisting substance misuse: Assessment and management in adults and young people http://www.nice.org.uk/guidance/cg120
- NICE – Drug use disorders quality standard http://www.nice.org.uk/guidance/qs23
- NICE – Tackling drug use http://www.nice.org.uk/advice/lgb18/chapter/Introduction

3.2 Evidence of what works for Substance Misuse

This section contains information on key research findings, clinical guidance and good practice.

The quality of evidence for substance misuse services is patchy. This is due to a lack of systematic large-scale studies on the efficacy on different aspects of addiction and rehabilitation. However, a model of assessment of the evidence has been developed in the USA and used proactively in many countries. The following paper is useful for understanding the different levels of evidence available:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3678283/

In Summary of the best evidence: it shows that abstinence, substitution therapy (when available), some pharmacology treatment options, behavioural and psychotherapeutic, family based and skills-based therapies in combination yield cost effective solutions. The below is a summary of some of the best evidence available. However, a lack of evidence does not mean 'do nothing'; as stated above, longitudinal high-quality trials on substance misuse recovery are generally not available.

3.2.1 The Lancet Series 2019 - Drug Use

This Series [13] focuses on opioids, cannabinoids, stimulants, and new psychoactive substances. The Series authors review the evidence on the epidemiology of drug use and related harms and interventions (treatment and policies) to address them. They highlight

[12] National Institute for Health and Care Excellence, "NICE pathways," [Online]. Available: https://pathways.nice.org.uk/.
[13] https://www.thelancet.com/series/drug-use

issues that are likely to become increasingly important in the next decade. More details of this Lancet series could be found in appendix 1.

3.2.2 Case management

Case management is a client-centered approach to improve the co-ordination and continuity of service delivery. It is an intervention that supports individuals by helping them identify the most appropriate services available, facilitates linkage with services and promotes continued retention in services by monitoring participation, coordinating activities of multiple services when present and, when necessary, and advocating for continued participation.[14]

3.2.3 Substance misuse services for an ageing population

Substance misuse services should be accessible to the whole population, including older people. The number of older people in the UK is increasing; however, there are very few substance-misuse services that cater specifically for older populations.[15] There is a need to think strategically and plan effectively to design new services or modify existing services.[16] A very small number of reports have explored the experiences of older people who were in contact with substance misuse services; the following summarises the main findings from these reports:

Type of support available: Some older service users may feel stigma because of their substance misuse problems, they may feel more comfortable receiving one-to-one support.[17] However, some older service users may benefit from taking part in social groups and activities, discovering that there are other people like them also receiving support.[18] Individuals with mobility issues may benefit from the use of home visits to access support.[19,20]

Workforce development: Practitioners should receive robust training to gain a full understanding of the needs of older people with drug problems and are supported to meet them.[21, 22]

Measuring outcomes: Positive outcomes for older people are likely to be different than younger cohorts. Examples include the management of older people in service due to

[14] Rapp RC, Van den Noortgate W, Broekaert E, Vanderplasschen W. The efficacy of case management with persons who have substance abuse problems: a three-level meta-analysis of outcomes. J Consul Clin Psychol. (2014) 82:605–18. doi: 10.1037/a0036750
[15] Wadd, S (2014) The Forgotten People: Drug Problems in Later Life, Substance Misuse and Ageing Research Team (SMART), University of Bedfordshire
[16] Sivaraman, P; Wattis, J; Curran, S. (2011) Substance misuse in the elderly, www.gerimed.co.uk
[17] Drugscope (2014) It's about time: Tackling substance misuse in older people
[18] Drugscope (2014) It's about time: Tackling substance misuse in older people
[19] Drugscope (2014) It's about time: Tackling substance misuse in older people
[20] Wadd, S (2014) The Forgotten People: Drug Problems in Later Life, Substance Misuse and Ageing Research Team (SMART), University of Bedfordshire
[21] Drugscope (2014) It's about time: Tackling substance misuse in older people
[22] Sivaraman, P; Wattis, J; Curran, S. (2011) Substance misuse in the elderly, www.gerimed.co.uk

problems with prescription and OTC drugs, but who may also have long term conditions; a positive outcome for this group may be improved levels of health and wellbeing.[23] However, research has found that older people can and do benefit from treatment and in some cases have better outcomes than younger people.[24,25]

Safeguarding: Older people with substance misuse problems may also be vulnerable to exploitation, therefore safeguarding is of key importance.[26]

Multi-agency working: Close liaison between all professionals, disciplines and agencies involved in the care of the patient is very important.[27, 28]

3.2.4 Hospital in-reach services

Public Health England has stated that drug treatment services should be actively assessing and managing overdose (including suicide) risks; a possible method to do this is to develop hospital in-reach services. Data presented by PHE stated that during 2015/16, 1% of referrals into treatment services came from hospital/Accident and Emergency (nationally it was 2%).[29] However, existing literature of the effectiveness of hospital in-reach services for drug misuse is very limited; no examples could be sourced.

3.2.5 Reducing addiction to medicine misuse

Public Health England produced a guide[30] for NHS and Local Authority Commissioners to assist with commissioning treatment for dependence on prescription and over the counter medicines. The guide highlighted the following areas of focus:

Prevention: Primary and secondary healthcare, public health and social care working together to:

- Ensure that psychological and other treatments are available as an alternative to prescribing medication.
- Ensure that the public are aware of problems that can arise with these medicines and why their availability may be limited.
- Ensure that doctors, pharmacists, social care staff and others are aware of current guidance regarding these medicines and are alert to any developing problems in patients.
- Monitoring and responding to prescribing and purchasing patterns.

[23] Drugscope (2014) It's about time: Tackling substance misuse in older people
[24] Royal College of Psychiatrists (2011) Our Invisible Addicts
[25] Sivaraman, P; Wattis, J; Curran, S. (2011) Substance misuse in the elderly, www.gerimed.co.uk
[26] Drugscope (2014) It's about time: Tackling substance misuse in older people
[27] Royal College of Psychiatrists (2011) Our Invisible Addicts
[28] Drugscope (2014) It's about time: Tackling substance misuse in older people
[29] PHE (2016b) Adults - drugs JSNA support pack: key data
[30] PHE (2013c) Commissioning treatment for dependence on prescription and over-the counter medicines: a guide for NHS and local authority commissioners

Who and Where: Most patients with dependence on prescription or OTC medicines will present to primary care; patients and sometimes their GPs may be unaware that there is problem with a prescription or OTC medicine. Addiction to Medicine outreach services could be located in primary care settings to identify problems and signpost to treatment services.

How: Primary care practices can be expected to respond to ATM problems as part of their regular patient care. Specialist responses will usually be commissioned as part of the drug and alcohol misuse treatment system. It is also important to ensure that pain management, mental health, and drug and alcohol treatment services work together and provide coordinated and integrated responses to patients.[31]

3.2.6 Social impacts and recovery

There is a large body of evidence from the UK which shows association between social exclusion and problem drug use. A large proportion of problem drug users have been socially excluded as children and young people; high proportions live in inappropriate housing and are poorly educated and in receipt of benefits.[32, 33]

The effect of parental drug use on children is also a concern, frequently leading to problems in childhood and later life.[34]

Government welfare reforms represent a significant and challenging development within the area of drug and alcohol misuse field with the large number of problem drug users in need of housing and employment support.

3.2.7 Housing

It is known that drug and alcohol misuse rates tend to be higher among homeless people and there are well-documented barriers to health care for rough sleepers.[35] It is likely that there are a significant number of homeless people in Kent who are misusing substances and who are not receiving or engaging with treatment.

A secure and safe housing environment facilitates and sustains recovery. Individuals who have both addiction problems and homelessness or the risk of homelessness are more likely

[31] PHE (2013c) Commissioning treatment for dependence on prescription and over-the counter medicines: a guide for NHS and local authority commissioners

[32] Seddon, T. 2006. Drugs, Crime and Social Exclusion. *British Journal of Criminology,* 4(46), pp. 680-703. As found in in UK drug situation (2014) UK Focal Point. London.

[33] National Drug Treatment Agency for Drug and alcohol misuse, No date. *Why Invest? How drug treatment and recovery services work for individuals, communiites and society.* [Online]
Available at: http://www.nta.nhs.uk/uploads/whyinvest2final.pdf
[Accessed 13 December 2015]

[34] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3725219/

[35] Thomas, B. (2011) Homelessness: A silent killer - A research briefing on mortality amongst homeless people. London: Crisis.

to have a wider range of needs across Health, Social Care, drug and alcohol misuse and criminal justice.[36]

Services should be reviewed to ensure that barriers to treatment are removed as far as possible to attract and increase referrals to support services among those with the most severe housing and drug and alcohol misuse need.

It is recommended that work is undertaken by Housing Commissioners and Providers to encourage the needs of drug and alcohol misusers to be taken into account when developing their homelessness prevention strategies.

Homeless people need good-quality housing to facilitate recovery and independent living.[37]

3.2.8 Employment

Unemployment among drug users remains an area of concern within the UK.[38] The unemployment rate among UK recipients of opioid substitution therapy was significantly higher than many European countries[39].

3.2.8.1 The Work Programme

The Work Programme[40] is part of a Government strategy to support long-term unemployed people gain sustainable employment. There are calls for any contracted work programmes (welfare-to-work) to have a sharper focus upon unemployed people with multiple challenges such as drug and alcohol addiction, illiteracy, innumeracy, homelessness and weak employment history.[41]

To promote more effective approaches to the Education, Training and Employment (ETE) needs of people in drug treatment, the National Drug Treatment Agency (NDTA) published a Pathway to employment joint working protocol with Jobcentre Plus *'Employment and Recovery: a good practice guide'*.[42]

3.2.8.2 Pathway to Employment

Many drug and alcohol services in London are working with training and employment support services to create positive pathways to employment for their service users and

[36] Thomas, B. (2011) Homelessness: A silent killer - A research briefing on mortality amongst homeless people. London: Crisis.

[37] *HM Government. No health without mental health: A cross-government mental health outcomes strategy for people of all ages, 2011.*

[38] Drugscope, 2013. *State of the sector ,* London: Drugscope

[39] European Quality Audit of Opioid Treatment (EQUATOR) project

[40] Department of Work and Pensions, 2012. *The Work Programme,* London: Department of Work and Pensions

[41] House of Commons Work and Pensions Committee, 2015. *Welfare-to-work,* London: The Stationery Office

[42] National Drug Treatment Agency, No date. *Why invest? How drug treatment and recovery services work for individuals, communities and society,* London : National Drug Treatment Agency

included is a helpful directory. To further promote this, the work focus is directly on engaging and influencing London employers and educational establishments.[43]

Reports evaluating two initiatives, 'Pathways to Employment' in England and the 'Peer Mentoring Scheme' in Wales which tackled the problem of unemployment among drug users were published in 2014.

3.3 Economic review

Figure 1 shows estimated social and economic costs of treatment of Kent clients. The estimated crimes prevented per year after starting treatment for drug clients in Kent are 78,230. The gross benefits of social and economic benefits of drug clients in Kent are worth £27 million after starting treatment.

Figure 1: Estimated social and economic costs of treatment of Kent clients in 2017/18:

Estimated % reduction in offending after starting treatment	Drug Clients	-28%
	Alcohol Clients	-53%
Estimated crimes prevented per year after starting treatment for Kent	Drug Clients	78,230 (280,749 before treatment)
	Alcohol Clients	2,956 (5,590 before treatment)

Average crime related cost per client in Kent	Drug clients - Before starting treatment	Drug clints - After starting treatment	Alcohol clients Before starting treatment	Alcohol clients After starting treatment
Social costs	£ 3,403	£ 2,454	£ 604	£ 285
Economic costs	£ 28,337	£ 20,441	£ 1,744	£ 822
Social and Economic costs	£ 31,739	£ 22,895	£ 2,349	£ 1,107

Gross Benefits for Kent	**Drug clients**	**Alcohol clients**	**Total**

[43] National Drug Treatment Agency, No date. *Why invest? How drug treatment and recovery services work for individuals, communities and society,* London : National Drug Treatment Agency

Social costs	£ 2,909	£ 980,697	£ 3,890,488
Economic costs	£ 24,232,524	£ 2,831,052	£ 27,063,575
Social and Economic costs	£ 27,142,315	£ 3,811,749	£ 30,954,063

Substances Misuse Services	64%	KCC Commissioned
Mental Health Services	60%	NHS Commissioned
Employed in Social Care	16%	KCC
Homeless People	55%	KCC & District

Source: Public Health England. Adults - alcohol commissioning support pack 2017/18: key data

More details of the economic review - Crime & Economic Costs to Society could be found in appendix 2.

| 4. Demography and epidemiology of drug use in Kent

4.1 Drug misuse in the general population

4.1.1 Drug classifications

In the UK, illegal drugs are classified into three main categories. They can be Class A, B or C, with Class A attracting the most serious punishments and fines.[44] Figure 2 shows a list of what type or 'class' the drug is:

Figure 2: List of Class A, B, and C drugs

Class	Drug
A	Crack cocaine, cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)
B	Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (for example mephedrone, methoxetamine).
C	Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP), khat

4.2 Trends of illicit drug use in adults aged 16-59 years in the UK

The Crime Survey for England and Wales[45] (CSFEW) provides estimates of drug use among adults aged 16 to 59 within the general household population of England and Wales. Key findings from the 2018/19 survey showed that:

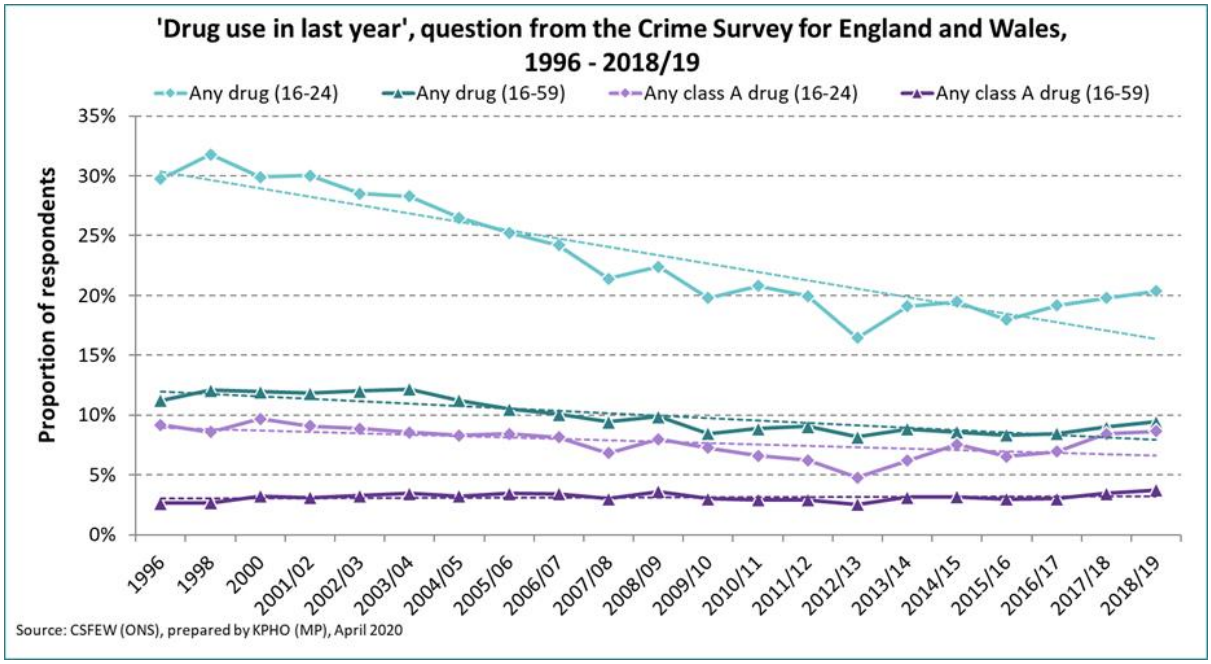
- **Around 1 in 11 (9.4%) adults aged 16 to 59 had taken a drug in the last year**; this is similar to the previous year's (9.0%, in the 2017/18 CSEW). There has been an upward trend since the 2015/16 survey (8.3%). The latest estimate is similar to the 2008/09 CSEW (9.9%) but lower than in 1996 (11.2%), when the time series began.
- **Around 1 in 5 (20.3%) adults aged 16 to 24 had taken a drug in the last year**, this is similar to the previous year's (19.8%, in the 2017/18 CSEW). There has been an

[44] https://www.gov.uk/penalties-drug-possession-dealing
[45] https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

apparent upward trend in last year's drug use among adults aged 16 to 24 since 2015/16 (18.0%). The latest estimate was lower than in 1996 (29.7%) but is similar to a decade ago (22.4% in 2008/09 CSEW).

- **Around 1 in 25 (3.7%) adults aged 16 to 59 had taken a Class A drug in the last year**. This has increased compared with the 1996 survey (2.6%) and is similar to the previous year's estimate (3.5%, in the 2017/18 CSEW). While there is some fluctuation from year-to-year, there has been a general upward trend in Class A drug use since the 1996 survey.
- **Among young adults aged 16 to 24, about 8.7% had taken a Class A drug in the last yea**r. From Figure 3 below we can see that both Class A and any drug use among adults aged 16-59 has stayed relatively stable at 2 to 3% (Class A) and 10% (any drug) over the last 20 years. For the younger cohort – class A usage has stayed relatively stable (10%) but overall usage has reduced since 1996. Recent years have seen an increase compared with the 2011/12 estimate (from 6.2% to 8.7% of 16-24 year olds taking a class A drug), with the 2018/19 estimate the highest since 2002/03 (8.9%). This is mainly driven by an increase in powder cocaine and ecstasy use.

Figure 3: UK Long Term Trends in drug use by Age Bands and Drug Category



Other key findings from the CSFEW 2018/19 survey[46] are:

- **Cannabis (Class B) was the most commonly used drug**, 7.6% of adults aged 16 to 59 reported that they had used it in the previous year. This is similar to the previous year (7.2%) but significantly lower than a decade ago (8.7% in 2005/06) and the start of the measurement in 1996 (9.4%);
- **The next most commonly used drug in the last year was powder cocaine (Class A)** (2.9% of adults aged 16 to 59 years); however, in 16 to 24-year-olds it was the third most commonly used drug (6.2%) after cannabis (17.3%) and ecstasy (4.7%);
- About **2.4% of adults aged 16 to 59 were classed as frequent[47] drug users**, this increased to 4.9% for young adults (aged 16 to 24 years old);
- Cannabis was the drug most likely to be frequently used (36.7% of cannabis users were classed as 'frequent' users). This compares with a lower percentage of 'frequent' users of powder cocaine (14.4%) and ecstasy (Class A) (3.5%).
- The majority of ecstasy and powder cocaine users aged 16 to 59 reported having taken the drugs once or twice a year rather than more frequently. (73.8% for ecstasy and 52.0% for powder cocaine users)
- **Being young, male, living in an urban area and frequent visits to pubs, bars and nightclubs, and alcohol consumption** were identified as key factors which increased the likelihood of using a drug in the last year.
- **Younger people were more likely to take drugs than older people**. The level of 'any drug' use in the last year was highest amongst 16 to 19-year-olds (18.4%) and 20 to 24-year-olds (21.7%), although prevalence was lower for aged 16 to 19-year-olds compared with in 2014/15 (18.9%).
- **The level of any drug use declined with age in general, with prevalence in the oldest age category at 1.7% of 55 to 59-year-olds**.

[46] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832533/drug-misuse-2019-hosb2119.pdf

[47] Frequently defined as taking a drug more than once a month in the last year.

4.2.1 Extent and trends in drug use by age group

Figure 4: Proportion of 16 to 59-year-olds using any drug in the last year by age group, 2014/15 to 2018/19

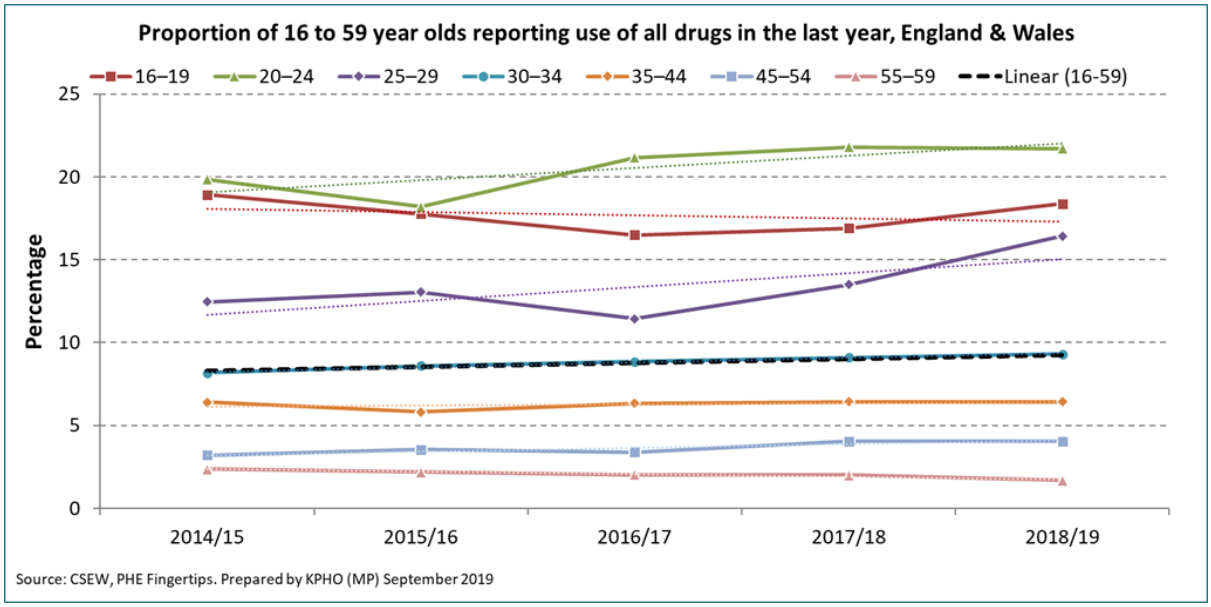


Figure 4 above shows the recent trends in the proportion of 16 to 59-year-olds reporting use of all drugs, broken down to age bands. The key findings are as follows:

- Younger people were more likely to take drugs than older people. The level of 'any drug' use in the last year was the highest amongst 20 to 24-year-olds (21.7%), followed by 16 to 19-year-olds (18.4%).
- What is notable is the increasing trend in reported drug use in 25–29-year-olds. All those under 30 showed an increase in reported drug use over the 5-year period.
- The level of any drug use declined with age in general, with prevalence in the oldest age category at 1.7% of 55 to 59-year-olds.

4.2.2 Extent and trends in drug use by sex and age

Figure 5: Proportion of 16 to 24 and 25 to 59-year-olds using any drug in the last year by sex, 1996 to 2018/19:

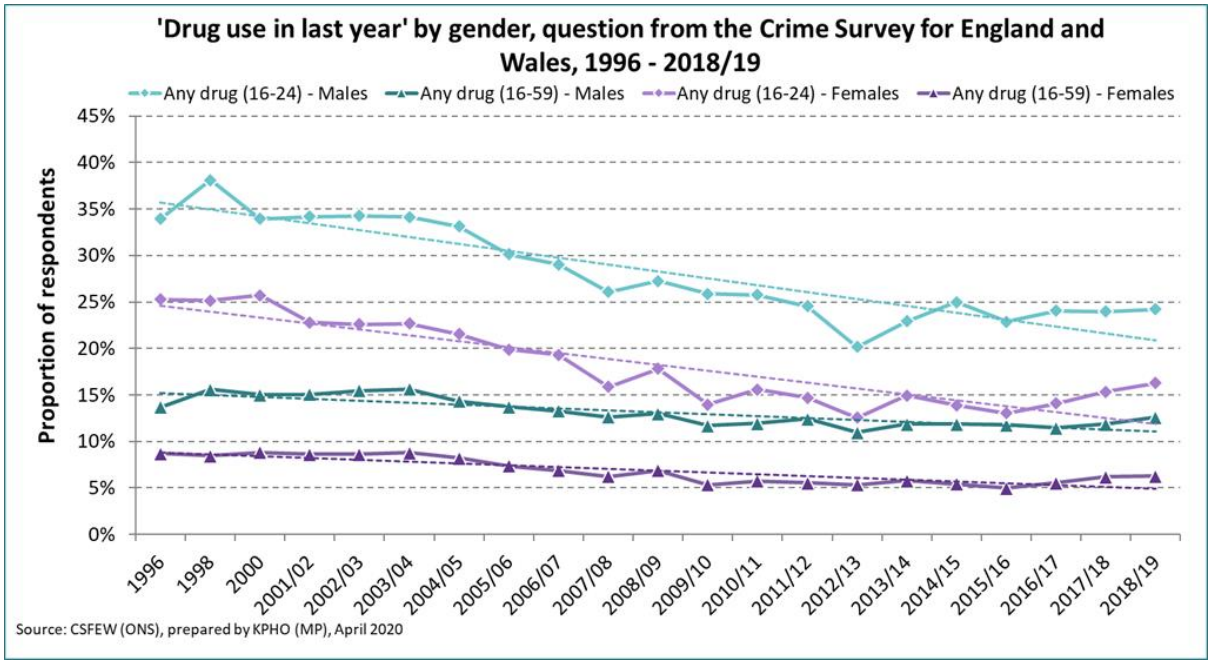


Figure 5 is showing the trend in the proportion of 16 to 59 and 16 to 24-year-olds over time by gender. The key findings are as follows:

- Between the 1996 and 2018/19 surveys, there has been an overall decline in the last year's use of 'any drug' among 16 to 24-year-old men (from 33.9% to 24.2%) and women from the same age group (from 25.3% to 16.3%).
- In recent years: 2016-2019 – both males and females of all ages are reporting greater drug use then the previous 5 years.
- The largest % increase in the last 3 years is highest among females 16-24. (however, this is not a statistically significant increase).

4.2.3 Estimated prevalence for drug misuse in Kent

The Crime Survey for England and Wales[48] (CSFEW) provides estimates of drug use among adults aged 16 to 59 within the general household population of England and Wales. We used these estimates and applied to Kent. Figure 6 shows the expected prevalence of drug use in last year for Kent adult population.

[48] https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2017-to-2018-csew

Figure 6: Expected prevalence of drug use in last year for Kent adult population

Estimated drug use in last year for Kent adult population	Cocaine	Heroin	Cannabis	Any Drug Use	Any Class A drug use
Crime Survey 2018/19 prevalence	2.9%	0.06%	7.6%	9.4%	3.7%
Prevalence applied to Kent population aged 16 – 59 (863,399)	25,251	560	65,830	81,313	32,190

Liverpool John Moores University[49] publishes estimates of Opiate and/or Crack Use (OCU) at local authority level. Kent has shown a small increase in estimated OCU use between 2011/12 and 2016/17, but due to low numbers, confidence ranges are wide and consequently this is not shown to be statistically significant.

Figure 7: Estimates of prevalence for opiate and crack use (OCU)

Local prevalence estimates of Opiate and/or Crack Users (OCU)	**OCU**	**Lower bound 95% CI**	**Upper bound 95% CI**	**Rate per 1,000**
Kent 2016/17	5,647	2,993	8,493	5.9
Kent 2014/15	5,198	3,163	7,156	5.5
Kent 2011/12	5,028	4,558	5,851	5.4
South East 16/17	35,135	31,476	39,983	6.2
England 16/17	313,971	309,242	327,196	8.9
Local prevalence estimates of Opiates	**Opiate users**	**Lower bound 95% CI**	**Upper bound 95% CI**	**Rate per 1,000**
Kent 2016/17	4,642	2,899	6,432	4.9
Kent 2014/15	4,401	2,759	6,086	4.7
Kent 2011/12	4,101	2,622	5,660	4.4
South East 16/17	29,176	26,655	32,545	5.1
England 16/17	261,294	259,018	271,403	7.4

[49] https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations

Local prevalence estimates of Crack	Crack users	Lower bound 95% CI	Upper bound 95% CI	Rate per 1,000
Kent 2016/17	3,580	2,103	5,377	3.7
Kent 2014/15	3,398	2,780	4,206	3.6
Kent 2011/12	2,422	967	4,041	2.6
South East 16/17	21,891	19,987	24,464	3.8
England 16/17	180,748	176,583	188,066	5.1

Source: Adults – drug commissioning support pack 2020-21: key data

Key findings:

- The current estimate of the numbers of OCU in Kent at 5,647 (or a rate of 5.9 per 1,000 population) in 2016/17, albeit with a large confidence range between 3,000 to 8,500. This is lower than the estimated England rate of 8.9 per 1,000 and the South-East at 6.2 per 1,000.
- The current estimate of the numbers of Opioid in Kent at 4,642 (or a rate of 4.9 per 1,000 population) in 2016/17, with a large confidence range between 2,900 to 6,400. This is lower than the estimated England rate of 7.4 per 1,000, and the South-East at 5.1 per 1,000.
- The current estimate of the numbers of Crack in Kent at 3,580 (or a rate of 3.7 per 1,000 population) in 2016/17, with a large confidence range between 2,100 to 5,380. This is lower than the estimated England rate of 5.1 per 1,000 and the South-East at 3.8 per 1,000.

More details in relation to the substance misuse treatment services, please see Substance Misuse Treatment Services Needs Assessment. (Currently work in progress but due to be published here: https://www.kpho.org.uk/health-intelligence/lifestyle/drugs-and-substance-misuse#tab1)

Figure 8 shows the trend of proportion of 16-59 years old reporting drug use in lifetime in Kent (1996-2018/19). Overall self-reported lifetime drug use has increased since modern comparable records began in 1996 but has declined since 2007 and remained at similar levels for the past three years. Class A lifetime use has increased across all three comparative time periods, 1996, 2007 and 2016/17 to 2017/18. Modelled estimates for drug use in Kent based on this nationally reported data are shown below, however the overall depravation profile of Kent is less than the England average, so these numbers could be slight overestimates.

Figure8: Proportion of 16-59-year-olds reporting drug use in lifetime in Kent

Proportion (%) of 16 to 59 year olds reporting use of drugs ever in their lifetime	1996	2008/09	2016/17	2018/19	Kent estimated 2018/19
Class A					
Any cocaine	3.15	9.31	9.66	10.77	92,577
Powder cocaine	3.00	9.13	9.59	10.68	91,839
Crack cocaine	0.72	1.05	0.86	0.83	7,165
Ecstasy	3.83	8.54	8.95	9.88	84,924
Hallucinogens	7.78	9.34	8.22	8.53	73,317
LSD	5.44	5.54	4.61	4.95	42,589
Magic mushrooms	5.31	7.41	6.74	6.90	59,347
Opiates	0.73	0.89	0.71	0.67	5,790
Heroin	0.62	0.72	0.55	0.53	4,523
Methadone	0.30	0.38	0.38	0.39	3,395
Class A/B					
Any amphetamine	n/a	12.32	9.22	8.87	76,228
Amphetamines	9.31	12.16	9.12	8.77	75,362
Methamphetamine	n/a	0.90	0.57	0.52	4,461
Class B					
Cannabis	23.26	30.98	29.59	30.25	260,032
Ketamine	n/a	1.73	2.32	3.10	26,657
Mephedrone	n/a	n/a	1.84	1.70	14,592
Class B/C					
Tranquillisers	3.10	3.16	2.93	2.85	24,477
Class C					
Anabolic steroids	1.08	0.56	1.08	1.09	9,399
Other					
New psychoactive substances			2.37	2.46	21,168
Amyl nitrite	6.55	9.81	n/a	n/a	
Glues	2.3	2.41	n/a	n/a	
Self-reported drug use in lifetime					
Any Class A drug	9.62	15.47	14.99	15.99	137,436
Any drug	30.36	36.78	34.21	34.25	294,417

Source: Crime Survey for England & Wales

Other illicit drugs such as cannabis, powder cocaine and amphetamines are common substances that may require lifestyle advice or treatment for dependence.

With the exception of cocaine, overall use has decreased over time, however the APMS reports a substantial number of people showing signs of dependence. Questions in the APMS are designed to assess drug dependence symptoms, including daily use for 2+ weeks,

sense of need, inability to abstain, increased tolerance and withdrawal symptoms. The figures below summarise self-reported signs of dependence from the APMS reported nationally and estimates the numbers of people that could be affected in Kent.

Figure 9: Signs of drug dependence by drug and age band, modelled to Kent population

'Signs of drug dependence in last year' from APMS and modelled Kent estimates	% age 16-24	Kent estimate age 16-24	% age 25-34	Kent estimate age 25-34	% age 35-44	Kent estimate age 35-44	% age 45-54	Kent estimate age 45-54
Cannabis	7.5%	12,732	3.9%	6,805	2.6%	4,827	1.3%	2,946
Amphetamines	0.2%	362	0.1%	222	0.3%	558	0.2%	497
Cocaine	0.9%	1,521	0.9%	1,615	0.3%	543	0.1%	236
Crack			0.6%	1,056			0.1%	130
Ecstasy	0.9%	1,492	0.1%	155	0.2%	398		
Heroin/methadone			0.6%	1,055	0.6%	1,171	0.1%	258
Tranquilisers			0.2%	296	0.4%	803	0.1%	128
Males - any drug	11.8%	10,180	6.6%	5,701	4.0%	3,639	2.3%	2,485
Females - any drug	4.6%	3,857	3.4%	3,004	2.5%	2,380	1.0%	1,107
Total - any drug	**8.3%**	**14,037**	**5.0%**	**8,705**	**3.2%**	**6,019**	**1.6%**	**3,592**
'Signs of drug dependence in last year' from APMS and modelled Kent estimates	**% age 55-64**	**Kent estimate age 55-64**	**% age 65-74**	**Kent estimate age 65-74**	**% all ages**	**Kent estimate all ages**		
Cannabis	0.8%	1,457	0.2%	352	2.6%	38,993		
Amphetamines					0.1%	2,137		
Cocaine					0.4%	5,369		
Crack					0.1%	1,714		
Ecstasy					0.2%	2,710		
Heroin/methadone	0.1%	89	0.1%	156	0.3%	3,862		
Tranquilisers	0.1%	248	0.1%	117	0.1%	2,063		
Males - any drug	1.3%	0	0.3%	0	**4.3%**	**31,596**		
Females - any drug	0.8%	0	0.3%	0	**1.9%**	**14,955**		
Total - any drug	**1.0%**	**0**	**0.3%**	**0**	**3.1%**	**46,551**		

Key findings:

- Up to 2.6% of adults (all ages) showed signs of dependence on cannabis, this comprises 38,993 people in Kent.
- Young males are the most likely to show signs of drug dependence in last year, at around 11.8% of 16-24-year-olds; this comprises of 10,180 people in Kent.
- Cocaine dependence is most prevalent in 25-34-year-olds (0.9%) which comprises of 1,615 people in Kent. But young males aged 16-24 also have high rates (0.9%), which comprises 1,521 people in Kent.

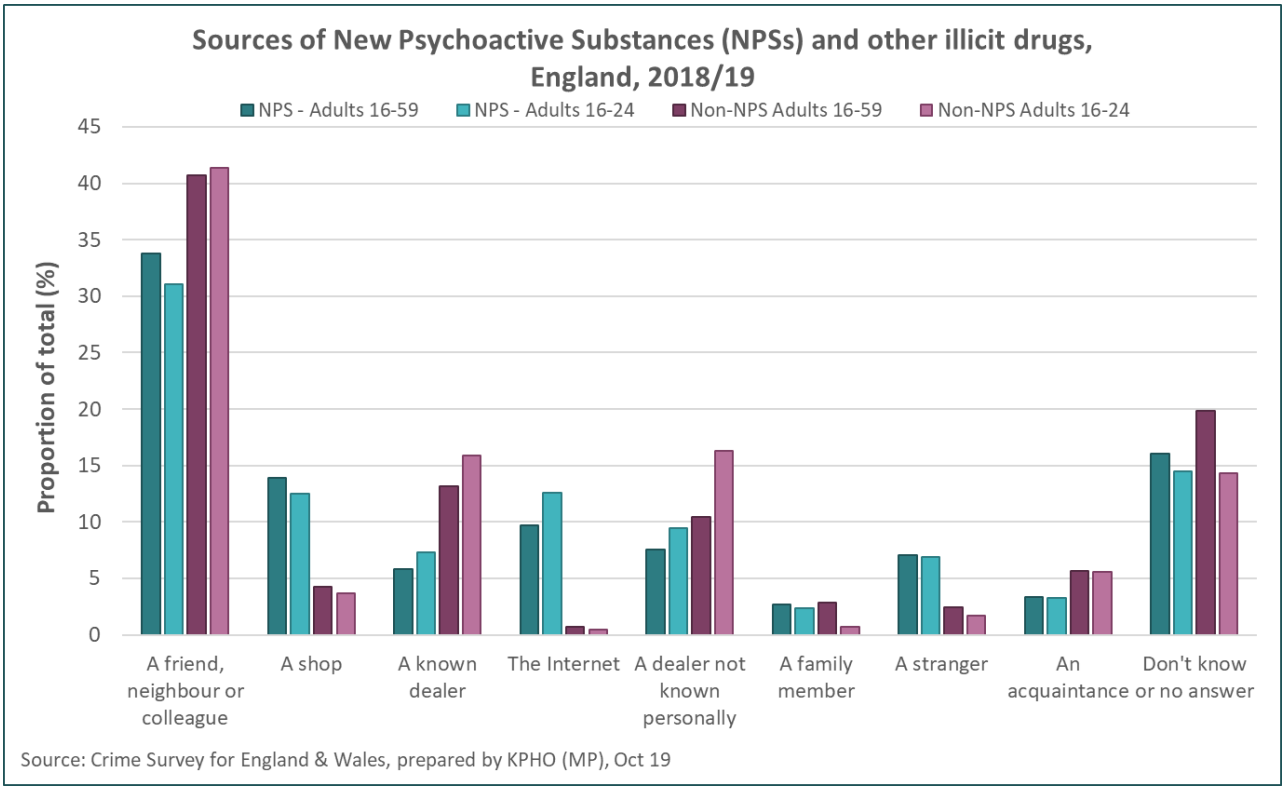
4.3 Emergent drugs / New Psychoactive Substances (NPSs)

NPSs are a collective group of synthetic substances typically designed to mimic more established illicit drugs.[50] Formerly known as 'legal highs', these were banned with the introduction of the Psychoactive Substances Act 2016[51] although their use is still relatively widespread and problematic, particularly amongst certain groups in the population, e.g. use of synthetic cannabinoids (spice) in prisons. The results of the CSFEW identified that the use of NPS was quite low in the general population, less than 1% (0.5%) had used an NPS in the previous year. **However, the use of NPS was higher among the following groups:**

- **Young adults aged 16 to 24** (1.4% had taken an NPS in the previous year);
- **Young men aged 16 to 24** (1.6% had used an NPS in the last year);
- **Poly drug use**: (Use of other drugs: 87.3% of those who had used NPS in the last year had also used another drug in the previous year);
- **Certain lifestyle factors** (use of NPS were highest in those who regularly visit pubs or nightclubs, consumed alcohol in the previous month and use of another drug in the last year).

Figure 10: Immediate sources of NPS or nitrous oxide and other drugs used on the last occasion, adults aged 16 to 59, 2018/19:

[50] https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations
[51] http://www.legislation.gov.uk/ukpga/2016/2/contents/enacted/data.htm



As shown in figure 10 above, 'last year' NPS users aged 16 to 59 most commonly obtained them from a friend, neighbour or colleague (33.8%), a shop (13.9%), or the Internet (9.7%). Non-NPS drugs were more commonly obtained from a friend, neighbour or colleague (41%) or a dealer (13%).

4.4 Image and Performance Enhancing Drugs (IPEDs)

The range of enhancement substances known as image and performance enhancing drugs (IPEDs) includes anabolic steroids, growth hormones, peptide hormones and other drugs to increase muscularity and modify appearance, they can be taken orally or injected.[52] The CSEW estimates that approximately 54,000 people had taken anabolic steroids during the last year; the proportion of 16 to 59-year-olds reporting that they had used anabolic steroids during the last year has remained fairly stable at 0.2%[53]. However, IPED users make up a significant proportion of people using needle and syringe programmes and many have complex health needs. [54]

Those who inject are at increased risk of blood-borne viruses and injecting related problems. A 2013 survey[55] of men using IPEDs found that:

[52] Bates, G; and McVeigh, J. (2016) Image and Performance Enhancing Drugs: 2015 Survey Results, Liverpool John Moores University.
[53] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/564760/drug-misuse-1516.pdf
[54] PHE (2015) Providing effective services for people who use image and performance enhancing drugs.
[55] PHE (2013a) Steroid users at risk of HIV, hepatitis B and hepatitis C

- 1 in 18 injectors had been exposed to hepatitis C;
- 1 in 11 have ever been exposed to hepatitis B;
- 1 in 65 have HIV.

4.5 Addiction to medicines

Addiction To Medicines (ATM) can be defined as the misuse of or dependence on Prescription-Only (POM) or Over-The-Counter (OTC) Medicines.[56] Public Health England defined three distinct but overlapping populations using these medicines[57]:

- Those who use POM and OTC medicines as a supplement or alternative to illicit drugs or as a commodity to sell;
- Those who overuse prescription or OTC medicines to cope with genuine or perceived physical or psychological symptoms;
- Those for whom the prescribed use of a medicine inadvertently led to dependence, sometimes called involuntary or iatrogenic addiction.

A study investigating the extent and nature of addiction to medicines in Cheshire and Merseyside which questioned GP and pharmacy staff about their observation and actions regarding ATM.[58] The following groups were identified at greater risk of ATM:

- Middle-aged women and men seek potentially addictive medicines for chronic pain and sleep problems;
- Young people were identified as a vulnerable group, most likely due to risky behaviour and use of maladaptive coping strategies for stress, anxiety and depression;
- Former prisoners have been identified as being at particular high risk of abusing OTC and POM, this is likely due to adverse life experiences and health problems relating to anxiety, pain and poor sleep than the general population;
- Adverse childhood experiences, life trauma or current/past addiction problems.

The CSFEW 2018/19 survey[59] reports 6.4 % of adults aged 16 to 59 had taken a prescription-only painkiller for “medical reasons” in the last year. This was similar to the

[56] Bates, G; Cochrane, M; Pendlebury, M; Mackridge, A. (2015) The extent and nature of addiction to medicines in Cheshire and Merseyside, Liverpool John Moores University
[57] PHE (2013) Commissioning treatment for dependence on prescription and over-the-counter medicines: a guide for NHS and local authority commissioners
[58] Bates, G; Cochrane, M; Pendlebury, M; Mackridge, A. (2015) The extent and nature of addiction to medicines in Cheshire and Merseyside, Liverpool John Moores University
[59] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832533/drug-misuse-2019-hosb2119.pdf

estimate of 7.0 per cent in the 2017/18 survey. No significant differences were seen by age, but those under 25 years old were less likely to use them, and females slightly less than males. Those with longstanding illness or disability are more likely to report usage, as are those with lower life satisfaction scores.

It was reported in 2017/18 that 9% of drug treatment clients in Kent were treated for illicit prescription medication use, and a further 5% for legal use. For comparison, England had 11% illicit use and 3% legal use.

| 5. Vulnerable groups

5.1 Trauma informed care

5.1.1 Treating Childhood Trauma of people with substance misuse.

'Adverse Childhood Experiences' is the terminology that explains the cumulative impact of negative experience in childhood that impact on the developing brain that lead to difficulties in later life. New neurological and medical evidence points to changes in brain development from childhood trauma that slows down an adult's ability to make changes or take in information. This is why an understanding of these issues in Adult Substance Misuse Treatment is vital. This new understanding of the impact of trauma on an adult is called 'Trauma Informed Care' or 'Trauma Informed Practice'.

Adults who have had two or more of the issues (described in figure 2) will need more time, different behavioural support and care than people who have not experienced such events. These impacts are cumulative in impact and 16% of the Kent adult population (circa 200,000) will have trauma resulting from two or more Adverse Childhood Experiences (ACEs) and 9% (circa 115,000) will be highly impacted by their childhood trauma (figure 3).

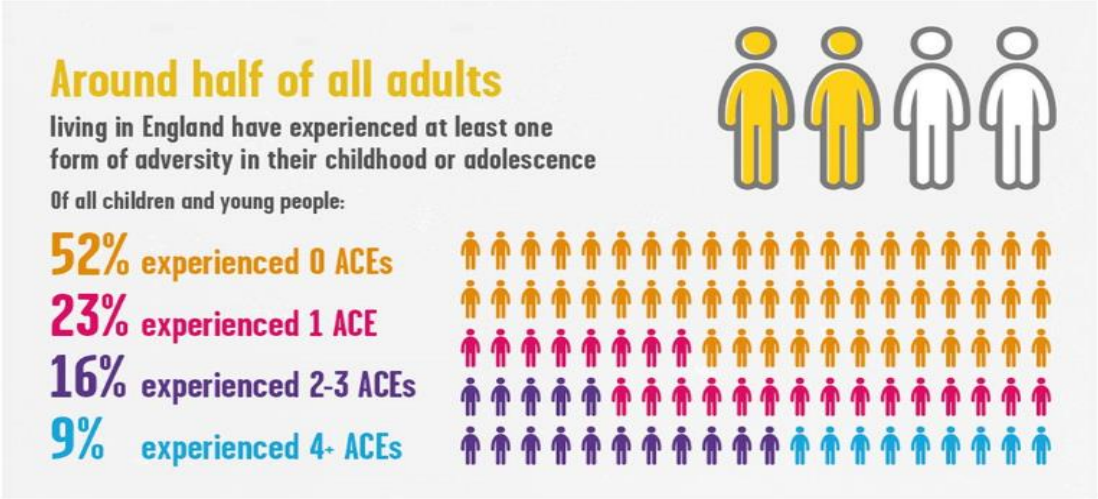
5.2 Risk Factors and Wider Determinants for Substance Misusers

5.2.1 Risk Factors from Trauma

Figure 11: Forms of adverse childhood experiences

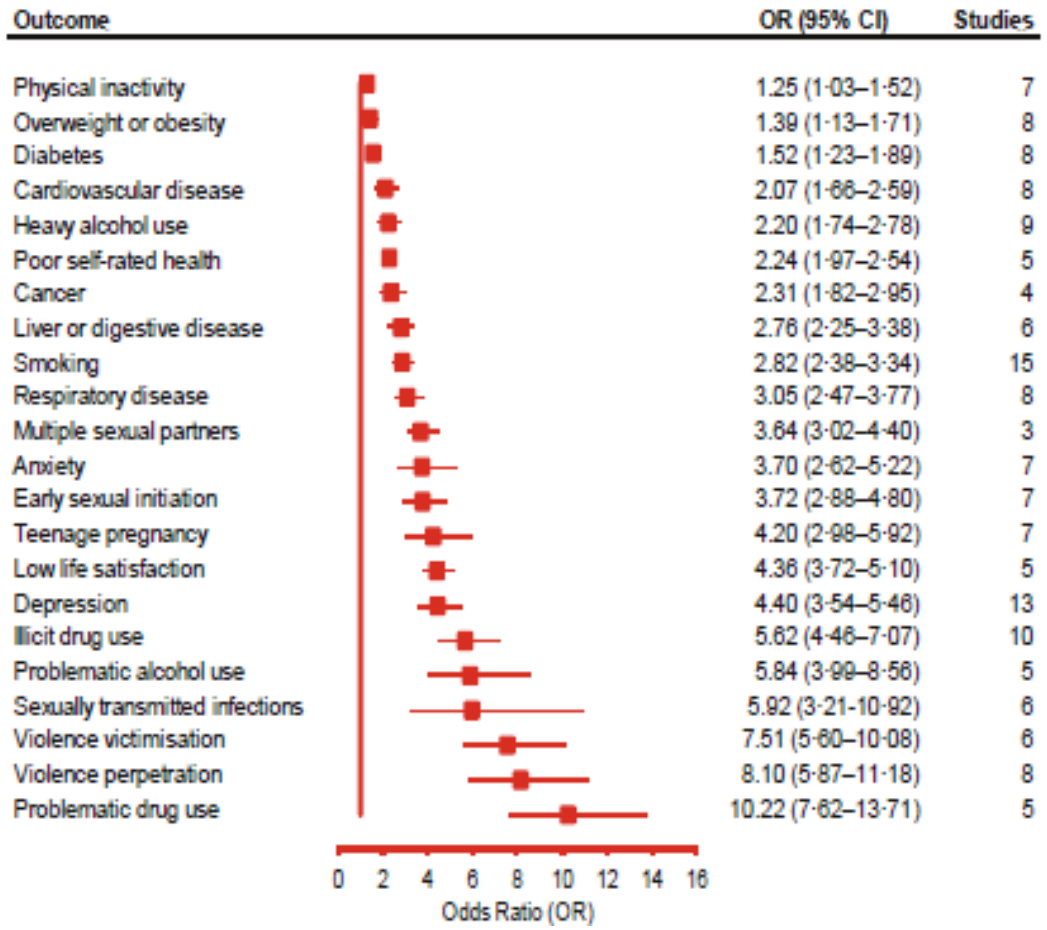
Data source: Bellies 2013[60]

Figure 12: ACEs in adults in England



Data source: Bellies 2013[7]

Figure 13: Likelihood and Risks of Poor Outcomes in Adulthood from having 2+ ACE[61]



[60] *http://www.wales.nhs.uk/sitesplus/documents/888/Wales%20Public%20Health%20Conference%20MAB%20Draft%20%5BRe.pdf*
[61] *Hughes et al 2017 https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30118-4/fulltext*

Source: Hughes *et al* (2017)[8]

Recent studies (Figure 13) have found that having multiple ACEs is a major risk factor for many health conditions. The outcomes most strongly associated with multiple ACEs are violence, mental illness, and substance use. To help people suffering these conditions it is important to have interventions that can tackle ACEs such as good staff training and supervision. To sustain improvements in health requires a focus on prevention of ACEs, resilience building as well as ACE-informed service provision. Hughes *et al* (2017)[8] found that by age 69 years old, 80% of people exposed to 4+ ACE had a major mental and physical condition.

Compared with people with no ACEs, Adults with 4+ ACEs are: [62]

4 times more likely to be a high-risk drinker
6 times more likely to have had or caused unintended teenage pregnancy
6 times more likely to smoke e-cigarettes or tobacco
6 times more likely to have had sex under the age of 16 years
11 times more likely to have smoked cannabis
14 times more likely to have been a victim of violence over the last 12 months
15 times more likely to have committed violence against another person in the last 12 months
16 times more likely to have used crack cocaine or heroin
20 times more likely to have been incarcerated at any point in their lifetime

Workforce

In a recent public health study in the North of England, many professionals (both outside and inside mental health services) admitted that they did not feel equipped in talking about traumatic events in people's lives and did not feel they had the time to do so. Yet the evidence from service users showed that even a short conversation about what had led up to the situation they were in made a significant difference to their wellbeing (Sweeney et al 2016).[63]

[62] *Public Health Wales National Study on ACE 2017*
[63] *Sweeney et al 2016 https://www.emeraldinsight.com/doi/full/10.1108/MHRJ-01-2015-0006*

5.3 Family with drug misuse: hidden harm

Drug misuse among adults with children, or who live with children, is likely to have serious adverse effects on the health and development of these children and has been associated with harmful effects at each age from conception through to adulthood. Further, such children are more likely to themselves misuse drugs later in life. In 2011 the Advisory Council on the Misuse of Drugs (ACMD) produced a report focused on children under the age of 16 in the UK who live with a parent or guardian who misuses drugs.[64] The ACMD estimated that between 250,000 and 350,000 children in the UK have a parent who is a problem drug user, which equates to approximately one child per problem drug user. In 2012, estimates based on a further analysis of the 2007 National Psychiatric and Comorbidity Survey reported that 6.7% of infants (out of 186 parents) were found to be living with a parent using illicit drugs, and 12.4% lived with a hazardous drinker.[65]

In Kent, for presentations to drug treatment services, 13% (n=182) of new presentations were recorded to be living with children and 15% (n=223) reported being parents who were not living with their children. In total, 433 children were reported to be living with drug service users entering treatment in 2020/2021. These proportions are similar to nationally reported rates, and demonstrate a need to consider close cooperation with children's support services and charities during provision of substance misuse treatment services, to consider the effect on children of a parent entering treatment, and the potential impact of child-caring responsibilities on adherence to structured treatment services.

5.4 Family with drug misuse: toxic trio

'Toxic trio' describes a combination of domestic abuse, mental illness and substance misuse within a domestic household, and is an important indicator of children and young people at heightened risk of harm. These components often interact, with one influencing the development of another. For example, an individual with harmful substance use may be more likely to encounter and get into a relationship with a violent and/or volatile person. Similarly, a personal history of being a victim of domestic abuse may lead someone to engage in substance misuse, or mental illness may be a consequence or cause of substance

[64] Advisory Council on the Misuse of Drugs. 'Hidden harm' report on children of drug users. 2011. https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users Last accessed 28/02/2022.
[65] Manning V. NSPCC. Estimates of the number of infants (under the age of one year) living with substance misusing parents. https://www.nspcc.org.uk/globalassets/documents/research-reports/estimates-number-infantsliving-with-substance-misusing-parents-report.pdf Last accessed 28/02/2022.

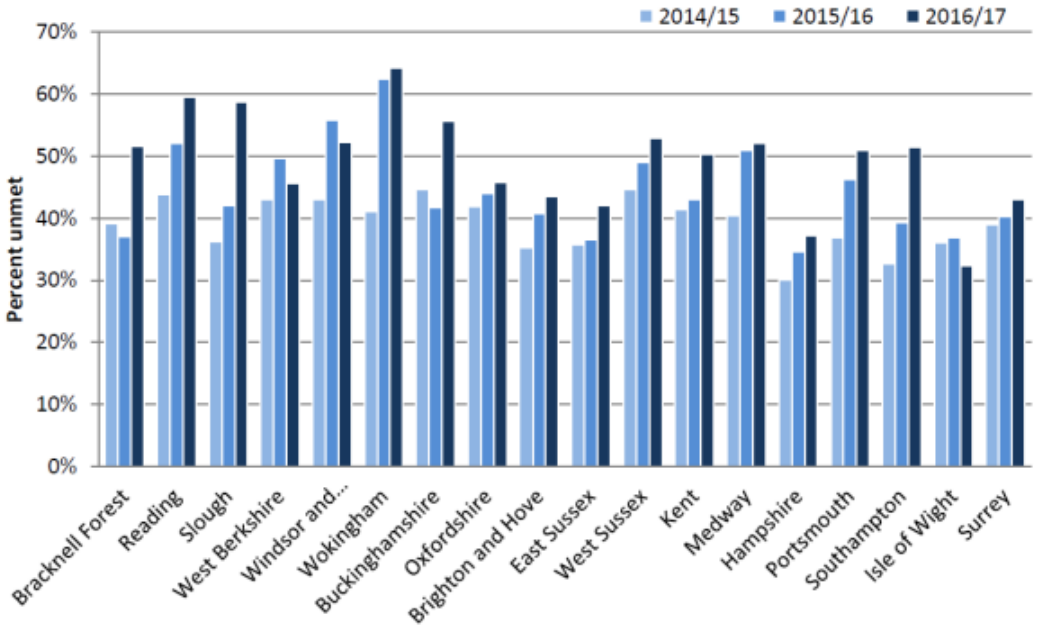
misuse.[66] Kent Domestic Abuse Needs Assessment 2021 Update noted that 1 in 10 refuge clients in 2020/21 had mental health and alcohol and/or drug misuse support needs as well as experiencing domestic abuse.[67] The update also highlighted the gap in service provision that "there is a challenge when people come into refuge and they are being supported with their mental health when they come in from a different area it can be difficult to keep that support going. We do speak to those who are supporting them, but once they move in they can all of a sudden be told that we are not supporting you any more because you have moved out of area and there is quite a gap in that support, it has a real effect on those people, need continuity of care. That goes for addiction as well, sometimes they can be without substance misuse prescriptions which is not good. We have to step in and chase these thing up."

5.5 Family with drug misuse: treatment need

Parental drug misuse can have important adverse impact on children living within the same household.[68] Using data from NDTMS alongside local prevalence estimates of drug dependence, rates of met need have been calculated by dividing the number of opiate users who are in treatment, who live with one child or more, by the estimated prevalence. Figure 12 shows the trend over time in unmet treatment need for opiate dependent parents from 2014/15 to 2016/17.

Figure 14: Trend over time from 2014/15 to 2016/17 in estimates of treatment need met for opiate dependent parents in the South East of England 2014/15 to 2016/17. Kent is shown to exceed the national average in meeting treatment need estimates, with a small increase over time from 2014/15 to 2016/17.[69] These data estimates on treatment need should be considered in the context of structured community-based treatment, and do not capture tier 2 level treatment, or treatment from hospital primary care services not recorded via NDTMS.

[66] https://www.wirralsafeguarding.co.uk/toxic-trio/ Last accessed 28/02/2022
[67] https://www.kpho.org.uk/__data/assets/pdf_file/0011/128468/Domestic-Abuse-Needs-Assessment-2021-Update.pdf
[68] Public Health England. Parental drug and alcohol use: south east local authorities. Last accessed 28/02/2022
[69] Public Health England. Parental drug and alcohol use: south east local authorities. Last accessed 28/02/2022



More details of treatment need can be found in treatment need assessment. (Work in progress but due to be published here: https://www.kpho.org.uk/health-intelligence/lifestyle/drugs-and-substance-misuse#tab1)

5.6 Needle and Syringe Programmes (NSPs)

Needle and syringe programmes, also known as Needle Exchange, directly reduce the harm caused to people who inject drugs by reducing the prevalence and spread of blood-borne viruses in the population.[70] Viruses are spread through the sharing of needles and syringes and the sharing of injecting equipment such as filters, mixing containers and water. Viruses commonly spread are Hepatitis B, C and HIV.[71]

The following groups are at increased risk of being:

- Drug injecting population (typically injecting opiate and crack cocaine);
- Users of performance and image enhancing drugs.

Public Health England estimate that 18% of the drug injecting population who were in contact with specialist services reported sharing needles and syringes, 39% reported that they had shared other injecting equipment.[72] We do not have exact numbers of injecting users in Kent, although it is estimated there are 4,600 opiate users in Kent, of which 1,600 were in treatment for opiate use in 2018/19. It was reported that around a third of those in

[70] National Treatment Agency (2013) Preventing drug related deaths and blood-borne viruses
[71] NICE (2014) Needle and syringe programmes, PH52
[72] PHE (2019) Hepatitis C in the UK; 2019 report. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/831155/Hepatitis_C_in_the_UK_2019_report.pdf

treatment are currently injecting (around 500), this could mean around 200 would be sharing equipment and 100 sharing needles.

5.7 Substance misuse – Children and Young People

In line with previous trends, the Crime Survey for England and Wales 2017/2018 estimated that national drug use was highest among younger age groups, as shown in Figure 5, and prevention and treatment services may therefore be most effective if targeted at these groups. Younger people were more likely to take drugs than older people. The level of 'any drug' use in the last year was the highest amongst 20 to 24-year-olds (21.7%), followed by 16 to 19-year-olds (18.4%). What is notable is the increasing trend in reported drug use in 25-29 year olds. All those under 30 showed an increase in reported drug use over the 5 year period. The level of any drug use declined with age in general, with prevalence in the oldest age category at 1.7% of 55 to 59-year-olds.

5.8 Older service users - ageing substance misuse population

Little is known about the prevalence of substance misuse in older people. The CSFEW only includes responses from people up to the age of 59 years old. People over the age of 60 were not asked about substance misuse. However, the survey has shown that of those who were aged 55 to 59 years, drug use in the last year has substantially increased between 1996 (1.0%) and 2018/19 (1.7%).[73]

Wadd et al[74] reports that there are more than 2,000 people aged 60 and over receiving treatment for a drug problem in the UK and more than 400 injecting drug users aged 60 and over in treatment in England alone. However, many more people in this age group are likely to be experiencing drug problems because only a minority will be in treatment. Illicit drugs most commonly used by those aged 60 and over in treatment are opiates only (65%), opiates and crack cocaine (18%) or crack only (2%).

The following have been identified as risk factors for older people and substance misuse[75]:

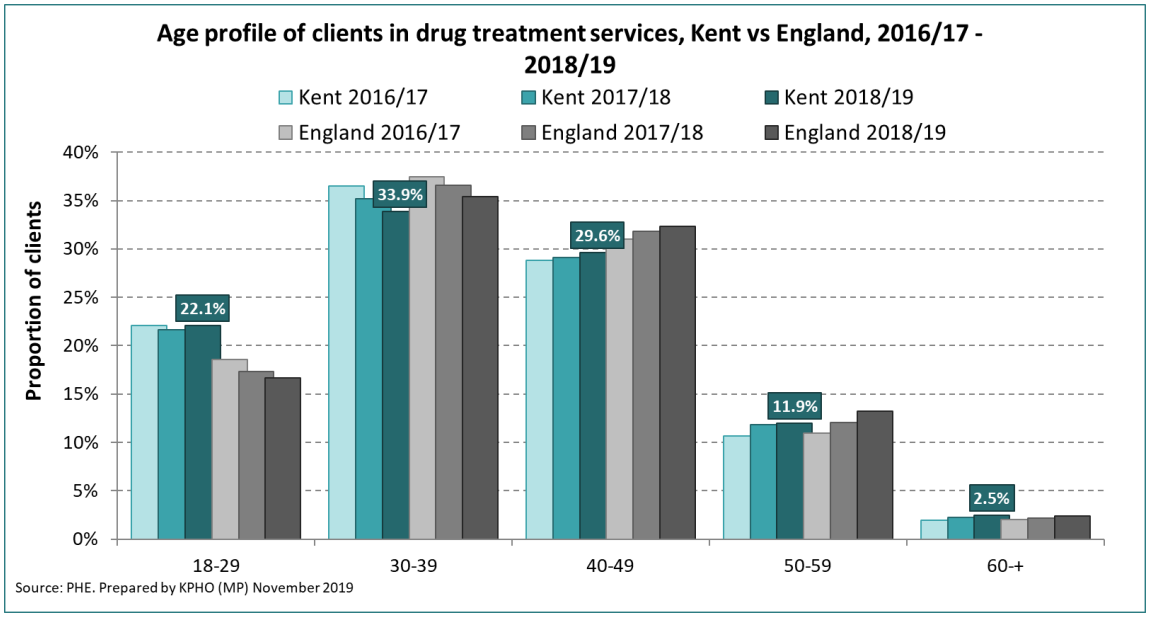
- Aged 50-65 (rather than 60 years plus)
- Genetic predisposition
- Male (illicit drugs); Female (misuse of prescribed medication)
- Mental health disorders (panic disorder, suicidal ideations)

[73] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832533/drug-misuse-2019-hosb2119.pdf
[74] Wadd, S (2014) The Forgotten People: Drug Problems in Later Life, Substance Misuse and Ageing Research Team (SMART), University of Bedfordshire
[75] Sivaraman, P; Wattis, J; Curran, S. (2011) Substance misuse in the elderly, www.gerimed.co.uk

- Unmarried, separated, divorced or widowed
- Low education and income status
- Recent alcohol and tobacco use
- Involvement with criminal justice system
- Chronic pain and medical illnesses
- Long term use of psychotropic medications.

The age profile of people in treatment is rising. Nationally, those aged 40 and over now account for 44% of the 152,964 people in treatment for opiate use.[76] In Kent, the number of those aged 40 and over in treatment is 924 (see figure 15 below). The proportion of older heroin users aged 40 and over, in treatment with poor health has been increasing in recent years and is likely to continue to rise. An ageing cohort of heroin users (many of whom started to use heroin in the 1980s and 1990s) is now experiencing cumulative physical and mental health conditions. Older heroin users are also more susceptible to overdose. It is important to help these people access appropriate general healthcare services. All indications suggest that it is challenging to help people with complex needs and a long treatment history to achieve recovery".[77]

Figure 15: Age profile of clients in drug treatment services, Kent vs England, 2016/17-2018/19



[76] Public Health Institute (2016) Integrated Monitoring System: Annual Report; Cheshire and Merseyside 2015/16
[77] PHE (2017) An evidence review of the outcomes that can be expected of drug misuse treatment in England

5.9 Sex workers

Regional, national, and international reports have highlighted that substance misuse is often a key driving factor in an individual getting involved, and remaining in, sex work.[78] The Office for National Statistics has estimated that there were approximately 72,800 sex workers in the UK in 2015, of which 88% were estimated to be female, 6% male, and 4% transgender.[79, 80] Further, being a parent is thought to be common among sex workers, with a report finding that 74% of off-street sex workers reported a need to do sex work to help support their household and children.[81, 82] Concomitantly, the prevalence of sex work is believed to have risen alongside austerity, benefit sanctions, and increased housing costs. Substance misuse in sex workers can make it more difficult for an affected individual to tackle other challenges often faced by sex workers, including housing needs, healthcare, or employment challenges, thereby effectively 'trapping' sex workers in an environment enabling drug dependency. Concomitant substance misuse may also heighten inherent risks of sex work, as individuals with substance dependency needs are less likely to be 'selective' of service users, less likely to obtain regular health checks and are rendered more vulnerable to sexual exploitation.[83] The prevalence of drug use among sex workers is unknown and difficult to characterise. A study of 71 women in 2004 reported that 95% of female sex workers were problematic drug users.[84] However, there are substantial concerns over the generalisability of surveys targeted at engaging the most vulnerable women (for example, 2 out of 3 were also homeless), and such surveys may therefore not reach female sex workers who are not drug users.

For male sex workers 'chemsex' was a particular risk. Chemsex is a diverse and complex phenomenon – but a behaviour in which a wide variety of men engage. Chemsex will be experienced at different times or points in men's lives and through use of a range of drugs with complex consequences. The drugs most commonly used in chemsex are GBL, methamphetamine and /or mephedrone. The use of drugs prolongs the sexual experience and may involve more partners – which will increase the likelihood of STI transmission and

[78] Brighton and Hove City Council Public Health Intelligence Team. Sex work in Brighton and Hove. 2016.http://www.bhconnected.org.uk/sites/bhconnected/files/Sex%20Work%20Rapid%20Needs%20Assessment %20-%20key%20findings.pdf

[79] Brooks-Gordon B, Mai N, Perry G, Sanders T. Production, Income, and Expenditure from Commercial Sexual Activity as a measure of GDP in the UK National Accounts. Report for Office of National Statistics (ONS), 2015.

[80] http://prostitutescollective.net/2016/11/facts-sex-work/

[81] Home Office. Paying the Price: A Consultation Paper on Prostitution 2004. https://prostitution.procon.org/sourcefiles/paying_the_price.pdf

[82] http://prostitutescollective.net/2016/11/facts-sex-work/

[83] Brighton and Hove City Council Public Health Intelligence Team. Sex work in Brighton and Hove. 2016.http://www.bhconnected.org.uk/sites/bhconnected/files/Sex%20Work%20Rapid%20Needs%20Assessment %20-%20key%20findings.pdf

[84] Jeal N, Salisbury C. A Health Needs Assessment of Street-based Prostitutes: Cross-sectional Survey. J Public Health (Oxf) 2004;26(2):147-51

or blood borne viruses (BBV). The impact on mental health includes: anxiety and acute paranoia, whilst the impacts on physical health include: disrupted sleep patterns, overdose and sexual consent. More details of chemsex and sexual health could be found in Kent Sexual Health Needs Assessment (link here please).

5.10 County Lines, drug trafficking and modern slavery

'County lines' is used to describe a method used by urban gangs to expand their drug networks from urban areas to rural parts of counties, potentially bringing high crime levels, violence and exploitation to rural communities. County lines gangs typically exploit children or vulnerable adults, such as individuals with financial struggles or mental health issues, to store and transport drugs (mainly crack cocaine and heroin) using methods of intimidation, building debt, violence or coercion.[85]

A dedicated mobile phone line is usually established to order drugs and this phone line is typically operated by a third party remotely.[86] County lines activities often also involve taking over the homes of vulnerable adults to sell or store drugs, commonly known as 'cuckooing'. The latest National Crime Agency report on 'county lines' drug exploitation and supply in 2017 assessed the issue of county lines using information provided by all 43 territorial forces in England and Wales. Thirty-eight (88%) of forces reported evidence of county lines, 25 (58%) forces reported that local drug users were being used to transport drugs by being complicit or coerced and 61% of forces reported exploitation of drug users.[87]

Based on figures from 19 forces which provided actual numbers of county lines, a conservative estimate was generated of at least 720 county lines in England and Wales, based on each force which reported evidence of county line activity having at least one county line. However, this figure is likely to represent a substantial underestimate as many regions will have several lines.

The principal commodity distributed via county lines is believed to be crack cocaine and heroin, and the rail network is a principal method of accessing markets and transporting

[85] Carey MP, Carey KB, Meisler AW. Psychiatric symptoms in mentally ill chemical abusers. Journal of Nervous and Mental Disease, 1991;179:136–138

[86] National Crime Agency. National Briefing Report- County Lines violence, exploitation and drug supply, 2017. http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply2017/file

[87] National Crime Agency

vulnerable juveniles. County lines are anticipated to increase as a drug distribution method, as increasing numbers of criminal gangs adopt the strategy.[88]

Modern slavery is 'the illegal exploitation of people for personal or commercial gain'.[89] This can incorporate several facets of criminal activity, including for example, human trafficking, slavery, sexual exploitation, and forced labour, often enforced by means of coercion, deception or violence. Perpetrators of modern slavery include organised crime groups in addition to individual persons. Accurately characterising figures affected by modern slavery is difficult at both a regional and national level; the Global Slavery Index has estimated that on any given date there were 136,000 people living in modern slavery in the UK in 2016, equivalent to a prevalence of 2.1/1000 people.[90] Similarly, the UK Home Office estimated that there were approximately 10,000-13,000 modern slavery victims in 2014, but this was noted by the UK National Crime Agency as a likely substantial underestimate, in part due to under-reporting.[91]

The National Crime Agency in 2017 identified 5,145 potential victims of modern slavery referred via the National Referral Mechanism, representing a 35% rise in referrals from 2016 (however of note, changes made to recording methodology has meant that 2017 totals are not directly comparable to prior years). Females represented 47% of referrals, and 41% of referrals were for children aged under 18. The most common nationalities of referred potential victims of modern slavery in 2017 were UK nationals, Albanian, Vietnamese, Chinese and Nigerian.[92]

Independent research commissioned by The Salvation Army and the Black Country Women's Aid charity in England and Wales demonstrated close ties between substance misuse and modern slavery, reporting that victims were often coerced to engage in substance misuse and that drugs or alcohol were often used as 'payment' for labour to strengthen dependency and their grip of exploitation.[93] The charities further emphasised that victims of modern slavery are encountering support services in increasing numbers with concomitant drug or substance misuse.

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[88] National Crime Agency. National Briefing Report- County Lines violence, exploitation and drug supply, 2017. http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply2017/file

[89] Thames Valley Police. https://www.thamesvalley.police.uk/advice/protecting-yourself-and-others/modernslavery

[90] The Global Slavery Index. https://www.globalslaveryindex.org/2018/findings/country-studies/united-kingdom/

[91] National Crime Agency. Law enforcement steps up response to modern slavery, Government of the United Kingdom. 2017. http://www.nationalcrimeagency.gov.uk/news/1171-law-enforcement-steps-up-response-tomodern-slavery

[92] National Crime Agency. National Referral Mechanism Statistics - End of Year Summary 2017, Government of the United Kingdom. 2018;1.1:1-88.

[93] The Salvation Army. The links between substance misuse and modern slavery. July 2018. https://www.salvationarmy.org.uk/victims-modern-slavery-trapped-forced-drug-and-alcohol-use

It is therefore vital that these victims of modern slavery also have access to support from alcohol and drug treatment services to mitigate their risk of facing return into slavery for fear of losing access to drugs.

| 6. Drug-related crime

6.1 Crime and the criminal justice system

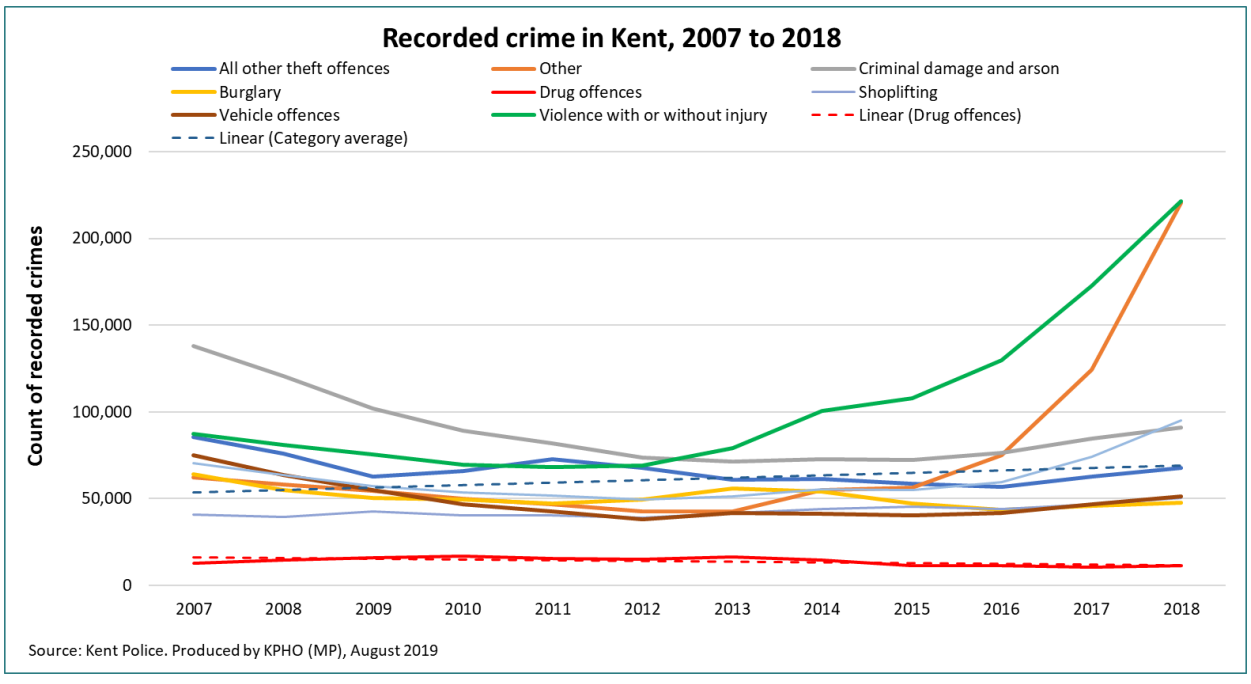
In the UK although drug use is not a crime; the possession (carrying), production, dealing and trafficking of drugs are offences under the Misuse of Drugs Act (1971).[94] It is not possible to provide accurate data on the number of drug-related offences as police records do not contain this information. For the latest period in 2015, the CSEW reports that drug offences have decreased by 17%.[95]

A Home Office programme called 'Drug Testing on Arrest' (DToA) is being extended across Kent.[96] If an offence is thought to be linked to the use of heroin, cocaine or crack cocaine, it authorises the request for taking of a sample for analysis. If this is found to be positive, a referral to drug treatment services can be made. The request may be refused and is not applicable to those under 18 years of age.

6.2 Recorded crime in Kent

Overall recorded crime has been increasing, in particular violent crime, however drug related crime and other crimes typically associated with problem drug users, e.g. burglary and vehicle offences has been gradually declining since 2007.

Figure 16: Crime: Recorded crime and drug-related offences trend



[94] Home Office, 1971. *Drugs of Misuse Act.* [Online]
Available at: http://www.legislation.gov.uk/ukpga/1971/38/contents
[95] CSEW, 2015. *Drug Misuse: findings from the 2014/15 Crime Survey for England and Wales; 2nd Edition.* [Online] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/462885/drug-misuse-1415.pdf
[96] Home Office, 2011. *Drug Testing on Arrest,* London: Home Office

6.3 Drug-related offences

During 2015/16, there were 147,557 drug crimes in England and Wales recorded by the Police, the majority of these offences were for the possession of drugs (122,155 offences). **The number of recorded offences had reduced by 13% when compared to 2014/15**.[97]

There were 167,059 drug seizures in England and Wales during 2014/15. This was a reduction of 14% when compared to the 2013/14 figure (194,346). During 2014/15, there were 29,705 Class A drug seizures, a reduction of 10% when compared to the previous year. The most common Class A drug seized was cocaine (15,815 seizures).

There were 132,253 Class B drug seizures during 2014/15, a reduction of 17% when compared to the previous year (158,732). Most Class B drug seizures were for cannabis (124,408 seizures), the number of seizures during 2014/15 was 13% lower than 2013/14.

Class C drug seizures increased between 2013/14 and 2014/15, from 5,618 to 6,244 in 2014/15, an increase of 11%. The most common Class C drug seized was benzodiazepine (2,122 seizures).

Figure 17 below shows the breakdown of drug related offences in 2019 for each Kent district. The total of 3,562 offences was an increase of 523 on the 2018 recorded levels, an increase of 17.2%.

[97] ONS (2016b) Crime in England and Wales: year ending Mar 2016

Figure 17 - Kent Police Recorded Offences at district / borough level in 2019

Drug related Offence Sub Group	Ashford	Canterbury	Dartford	Dover	Gravesham	Maidstone	Medway	Sevenoaks	Shepway	Swale	Thanet	Tonbridge And Malling	Tunbridge Wells	Grand Total
OTHER DRUG OFFENCES	0	0	1	0	0	4	1	1	1	0	1	2	0	**11**
POSSESS OF CONTROL DRUGS (EX CANNABIS)	33	51	25	23	33	85	85	25	44	23	116	34	31	**608**
POSSESS OF CONTROL DRUGS (CANNABIS)	89	175	94	86	115	221	248	96	113	76	322	131	99	**1865**
TRAFFICKING IN CONTROLLED DRUGS	0	0	1	3	2	2	3	0	1	2	3	0	1	**18**
TRAFFICKING OF DRUGS	33	96	57	61	103	107	213	28	47	62	112	61	80	**1060**
2019 Total	**155**	**322**	**178**	**173**	**253**	**419**	**550**	**150**	**206**	**163**	**554**	**228**	**211**	**3562**

6.4 Drug Driving

It is against the law to drive under the influence of illegal drugs, or if there are certain drugs above a specified level in the driver's blood. During 2015 the drug driving law changed to make it easier for the police to catch and convict drug drivers. It is now an offence to drive with any of 17 controlled drugs above a specified level detected in blood, including both illegal and medical drugs. The limits set for each drug is different, and for illegal drugs the limits set are extremely low but have been set at a level to rule out any accidental exposure (i.e.: from passive smoking).[98]

Locally, Kent Police recorded numbers of driving-related drug offences in 2018 and 2019 in figure 18 Results are based on all Kent Police driving-related drug arrests in 2018 and 2019.

Figure 18: Driving-related drug arrests in Kent, 2018 and 2019

Reason for Arrest	2018	2019	Grand Total
DRIVING – CAUSING DEATH BY CARELESS DRIVING WHEN UNDER THE INFLUENCE OF DRINK OR DRUGS	1	3	**4**
DRIVING – EXCESS DRUGS	42	290	**332**
DRIVING – IN CHARGE – UNFIT THROUGH DRINK/DRUGS	39	205	**244**
DRIVING – UNFIT THROUGH DRINK/DRUGS	82	623	**705**
Grand Total	**164**	**1121**	**1285**

Please note, *this* ***data is based on Arrests that have been made for such, NOT a count of the Offences that have been committed.*** *The Universe system used to extract this type of information does not allow for "Offences" to be retrieved, only "Arrests".*

Furthermore, this data cannot be broken down by the district in which the Arrest has taken place due to constrains within the Universe system.

[98] Department for Transport (2016) Drug driving. https://www.think.gov.uk/themes/drug-driving/

6.5 Prison Populations

Compared to the general population, offenders are more likely to misuse drugs and/or alcohol, smoke, have mental health problems, report having a disability, self-harm, attempt suicide and die prematurely.[99]

Offenders in the community are generally expected to access the same healthcare services as the rest of the local population. Since April 2013, NHS England has been responsible for commissioning all healthcare services for prisoner, including drug and alcohol services but excluding emergency and out-of-hour services. An agreement exists between the Offender Management Service (OMS), NHS England (NHSE) and Public Health England (PHE) to co-commission and deliver healthcare services in English prisons.[100]

The Chief Inspector has stated that NUD use within prisons "are now the most serious threat to safety and security of jails".[101]

In his report, the Chief Inspector of Prisons set out important differences between drug misuse in prisons and the community:

- a declining number of prisoners needing treatment for opiate misuse reflects trends in the community, although many of those requiring opiate treatment in prison have complex dependence, social, physical and mental health issues
- prisoners are more likely to use depressants than stimulants to counter the boredom and stress of prison life
- the use of synthetic cannabis and diverted medication reflects a response to comparative weaknesses in security measures
- Often the price of drugs is higher and the quality poorer in prison, reflecting greater difficulty of supply

At present, some synthetic cannabis is legal to possess in the community, but all forms are banned in prison. It is cheap to buy or manufacture in large quantities in the community. The price for drugs such as opiates and cannabis in prisons is much greater than in the community.

The report goes on to describe the consequences of drug misuse in prisons:

- the health consequences of synthetic cannabis use have been particularly severe because of its inconsistent composition and unknown effects
- some prisons have required so many ambulance attendances that community resources were depleted

[99] https://www.gov.uk/guidance/healthcare-for-offenders
[100] NHS England, 2015. *National Partnership Agreement: National Offender Management Service, NHS England, Public Health England for the Co-Commissioning and Delivery of Health Care Services in Prisons in England 2015-16,* London: NHS England
[101] HM Insectorate of Prisons, 2015. *Changing patterns of drug and alcohol misuse in adult prisons and service responses,* London: HM Insectorate of Prisons

- inspectors heard credible accounts of prisoners being used as so-called 'spice pigs' to test new batches of drugs
- debts are sometimes enforced on prisoners' friends or cell mates in prison, or their friends and families outside
- drug misuse damages rehabilitation

Likewise, the Prison Reform Trust identified offenders as a major 'at risk' group. There are observed links between a drug user offending and a troubled childhood. Prisoners are more likely to have taken drugs in the past year if they had experienced abuse as a child or observed violence in the home.[102] Other key findings from the report are described in figure 19 below:

Figure 19 - Prison Reform Trust report

Reported drug use	**Proportion**
Reported drug use in the 4 weeks prior to being taken into custody	64%
Offenders who 'ever' used heroin, reported first using it in prison	19% (1 in 5)
Mortality	
The risk of death is very high during the first and second weeks, following release from prison. During the week following release, 95% of this increased mortality is due to drug-related conditions.	
Compared to the general population:	
male prisoners are 29 times more likely to die	
female prisoners are 69 times more likely to die	

Kent prisons

National research estimates that 55% of prisoners, misuse drugs (PRT, 2013). In Kent, 55% of prisoners were unknown to community treatment services compared with 47% nationally.

In Kent, 882 (22%) out of 3958 prisoners are in for drug related offences in the 7 Kent prisons, as at December 2021.[103] Please find below a trend of prisoners who are in for drug

[102] Prison Reform Trust, 2013. *Prison the Facts,* London: Prison Reform Trust
[103] https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-july-to-september-2021

related offences, with a small increase in the proportion of prisoners for drug offences over the last 2-3 years.

Figure 20: Trend of prisoners are in for drug related offences in Kent

Date (Quarter)	2015-09	2015-12	2016-03	2016-06	2016-09	2016-12	2017-03	2017-06	2017-09	2017-12	2018-03	2018-06	2018-09
Prison Population	4,338	4,318	4,239	4,279	4,287	4,334	4,343	4,366	4,347	4,280	4,198	4,251	4,304
% in for Drug offences	20.9%	21.1%	20.5%	20.3%	19.9%	19.0%	18.8%	18.2%	18.7%	18.6%	18.6%	19.1%	19.7%
Date (Quarter)	**2018-12**	**2019-03**	**2019-06**	**2019-09**	**2019-12**	**2020-03**	**2020-06**	**2020-09**	**2020-12**	**2021-03**	**2021-06**	**2021-09**	**2021-12**
Prison Population	4,274	4,198	4,228	4,280	4,176	4,196	3,981	3,975	3,874	3,907	3,864	3,943	3,958
% in for Drug offences	19.3%	19.0%	20.2%	19.6%	20.0%	20.3%	19.9%	20.9%	21.6%	21.9%	21.8%	21.8%	22.3%

The Focal Point Report[104] says 30 – 40% of prisoners have problematic drug use on entering prison - this equates to between 1,257 to 1,676 in Kent.

52% Nationally tested positive or admitted to drug use on entry, this is 2,179 (round to 2,200) in Kent.

Of which, 38% cannabis (1,592 in Kent), 15% heroin (629) and 29% cocaine (1,215).

During imprisonment, users self-reported or were tested with the following:

- 18% any drug - 754 in Kent
- 13% Cannabis - 545
- 7% heroin -293
- 9% buprenorphine - 377
- 10% synthetic cannabinoids (Spice) - 419

Kent has seven prisons and the combined population is 3,692 prisoners. (See figure 21 below)

[104] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/713101/Focal_Point_Annual_Report.pdf

Figure 21: Kent Prisons - Capacity

HM Prison	Category	Capacity
Cookham Wood	Male young offenders 15-18	188
East Sutton Park	Female Adult and Young Offender Institution (YOI) Open Prison	96
Sheppey Cluster (Elmley)	Male Category B/C/D*	1,232
Maidstone	Male Category C* and Foreign Nationals	600
Sheppey Cluster (Standford Hill)	Male Category D*	464
Sheppey Cluster (Swaleside)	Male Category B*	1,112
Total		**3,692**

Source: https://www.doingtime.co.uk/the-prisons/kent-sussex-prison-region/

* Category B prisoner who are defined as "Those who do not require maximum security, but for whom escape needs to be made very difficult like".
Category C who are defined as "Those who cannot be trusted in open conditions but who are unlikely to try to escape".
Category D prisoners are defined as "Those who can be reasonably trusted not to try to escape, and are given the privilege of an open prison."

Locally, according to data from NHS England / NHS Improvement Health & Justice - South East team, from 1 January to 4 May 2020, there were 524 triage assessments across the Kent prisons. Those that were admitted for substance misuse wanted to engage in treatment.

From 1 January 2020 to 4 May 2020, we had 1,570 clients in structured treatment across the Kent prisons. Figure 22 below shows the breakdown by drug choice:

Figure 22: Break down of clients in structured treatment across Kent prisons by drug choice

Primary Substance	Number	% of total
Alcohol unspecified	330	21%
Amphetamine (pharmaceutical)	1	0%

Amphetamines Unspecified	13	1%
Benzodiazepines Unspecified	9	1%
Buprenorphine	10	1%
Buprenorphine prescription	3	0%
Cannabis Herbal	46	3%
Cannabis Herbal (Skunk)	1	0%
Cannabis unspecified	244	16%
Cocaine Freebase (crack)	170	11%
Cocaine Hydrochloride	1	0%
Cocaine unspecified	184	12%
Codeine unspecified	3	0%
Gabapentin	1	0%
GHB/GBH	1	0%
Heroin illicit	398	25%
Ketamine	4	0%
Lysergide (LSD)	1	0%
MDMA	3	0%
Mephedrone	1	0%
Methadone prescription	6	0%
Methadone unspecified	3	0%
Morphine Sulphate	1	0%
NPS Other – effects different to available classifications or not stated	25	2%
NPS Other – predominantly cannabis	62	4%
Opiates unspecified	6	0%
Other Opiates	35	2%
Other Psychoactive Drugs	1	0%

Other Stimulants	1	0%
Steroids Unspecified	7	0%
Tramadol Hydrochloride	1	0%

Source: NHS England / NHS Improvement Health & Justice – South-East

These figures highlight the need for continuity of care when individuals are entering or leaving the criminal justice system. Continuity of care should be assured when individuals are a part of the commissioning community and receiving criminal justice treatment services. Moreover, the ambiguous legal status of some NUD suggests that it is possible that individuals who are dependent on NUD may not be referred to treatment by the Criminal Justice System (CJS).

The health and wellbeing needs of offenders in Kent prisons are addressed in a separate Health Needs Assessment (https://www.kpho.org.uk/__data/assets/pdf_file/0015/56310/Young-Offenders-JSNA-Chapter-Summary-Update-2015.pdf).

7. Comorbidities and hospital admissions

7.1 Mental health conditions

Mental illness comorbidity alongside substance misuse is common, and associated with heightened risk of psychiatric inpatient admissions, suicidal behaviour, and poorer treatment outcomes from both psychiatric and substance misuse care. In a cross-sectional prevalence survey among patients of Community Mental Health Teams (CMHTs) and substance misuse services in four urban UK centres, 44% of CMHT team patients reported a problem with harmful drug or alcohol use in the preceding year, and 75% of drug treatment services users reported a psychiatric disorder in the preceding year.[105]

In Kent, among adults who entered drug treatment services in 2018/2019, 56% (n=864) were identified as having a mental health treatment need, compared to 53% nationally, and representing 53% of opiate users, 57% of non-opiate drug users, and 59% of alcohol and non-opiate drug users. Rates were higher among females compared to males - 70% versus 50% respectively. However, 75% of the 56% (n=864) of service users with a mental health treatment need were recorded to be receiving treatment from mental health services, compared to 71% nationally, as shown in figure 23 below. [106]

[105] Weaver T, Madden P, Charles V, et al. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. British Journal of Psychiatry 2003;183(4):304-313

[106] South East - Kent - Adults – Drug commissioning support pack - key data 2020-21

Anecdotal evidence from the Kent community drug and alcohol treatment services suggests that among service users in treatment, large numbers experience ongoing mental health needs but find it difficult to access mental health services due to their substance misuse problems. Further, it is possible that those individuals with concomitant mental health issues and substance misuse that are already receiving mental health treatment may be most likely to access substance misuse treatment services.

These figures may therefore underestimate the true mental health need alongside substance misuse in the community as untreated mental health issues among individuals with alcohol and drug misuse may be a factor, hindering service users from engaging with substance misuse treatment services.

Figure 23: Clients identified as having a mental health treatment need and receiving treatment for their mental health

Treatment	Local	Proportion of service users with mental health needs (%)	National proportion of service users with mental health needs (%)
Already engaged with the Community Mental Health Team/Other mental health services	205	24	20
Engaged with IAPT	*	<5	1
Receiving mental health treatment from GP	399	46	48
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	49	6	2
Has an identified space in a health-based place of safety for mental health crises	*	<5	1
Total individuals receiving mental health treatment	649	75%	71%

Data source: South-East - Kent - Adults – Drug commissioning support pack - key data 2020-21
IAPT= improving access to psychological therapies

*= Raw data removed where small counts may be identifiable

7.2 Co-occurring conditions / Dual diagnosis

Co-occurring conditions / Dual diagnosis is a term to describe the situation where someone has a combination of mental health difficulties and substance misuse problems. Research has shown that most users of drug and alcohol services also experience mental health problems.[107] It is estimated that approximately 40% of people with psychosis have misused

[107] PHE (2020) Co-existing substance misuse and mental health issues [Accessed on 18/05/2020] [Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth/]

substances at some point in their lives, this is at least double of what is seen in the general population.[108] It is not clear how many people in the UK have a dual diagnosis, partly due to some people in this group having never used services or received relevant care.[109] The difficulty often for service users, is that clients may present with varying levels of mental health from low level to acute, but have not been formally diagnosed.

Given the wide scale prevalence and incidence of mental health co-occurring with substance misuse this topic has its own needs assessment and call to action. Mental illness should not be a barrier to care or treatment to substance misuse and substance misuse should no longer be a barrier to care and treatment to mental health support.

There are three key drivers to tackle this national and local issue; The NHSE quality standards for co-occurring conditions[110], the PHE[111] and NICE guidance[112], and the Mental Health Long Term Plan[113].

Also, locally, a series of productive meetings between providers and commissioners created a draft working protocol which is now in its final stages of development (see appendix).

7.2.1 Why do these disorders often co-occur?

Although substance use disorders commonly occur with other mental illnesses, this does not mean that one caused the other, even if one appeared first. In fact, establishing which came first or why can be difficult. However, research suggests three possibilities for this common co-occurrence:

- **Common risk factors can contribute to both mental illness and substance use disorders.** Research suggests that there are many genes that can contribute to the risk of developing both a substance use disorder and a mental illness. For example, some people have a specific gene that can make them at an increased risk of mental illness as an adult, if they frequently used marijuana as a child. A gene can also influence how a person responds to a drug as to whether or not using the drug makes them feel good. Environmental factors, such as stress or trauma, can cause genetic changes that are passed down through generations and may contribute to the development of mental illnesses or a substance use disorder.

- **Mental illnesses can contribute to drug use and substance use disorders.** Some mental health conditions have been identified as risk factors for developing a substance use disorder.[114] For example, some research suggests that people with

[108] NICE (2011) Psychosis with substance misuse in over 14s: assessment and management, CG120

[109] NICE (2016) Coexisting severe mental illness and substance misuse: community health and social care services, NG58

[110] https://www.nice.org.uk/guidance/qs188

[111] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

[112] https://www.nice.org.uk/guidance/ng58

[113] https://www.longtermplan.nhs.uk/areas-of-work/mental-health/

mental illness may use drugs or alcohol as a form of self-medication.[115] Although some drugs may help with mental illness symptoms, sometimes this can also make the symptoms worse. Additionally, when a person develops a mental illness, brain changes may enhance the rewarding effects of substances, predisposing the person to continue using the substance.[116]

- **Substance use and addiction can contribute to the development of mental illness.** Substance use may change the brain in ways that make a person more likely to develop a mental illness.

7.2.2 How are these comorbid conditions diagnosed and treated?

The high rate of comorbidity between substance use disorders and other mental illnesses calls for a comprehensive approach that identifies and evaluates both. Accordingly, anyone seeking help for either substance use, misuse, addiction or another mental disorder should be evaluated for both and treated accordingly.

Several behavioural therapies have shown promise for treating comorbid conditions. These approaches can be tailored to patients according to age, the specific drug misused and other factors. They can be used alone or in combination with medications. Some effective behavioural therapies for treating comorbid conditions include:

- Cognitive Behavioural Therapy (CBT) helps to change harmful beliefs and behaviours.
- Dialectical Behavioural Therapy (DBT) was designed specifically to reduce self-harm behaviours including suicide attempts, thoughts or urges, cutting and drug use.
- Assertive Community Treatment (ACT) emphasises outreach to the community and an individualised approach to treatment.
- Therapeutic Communities (TC) are a common form of long-term residential treatment that focus on the "resocialisation" of the person.
- Contingency Management (CM) gives vouchers or rewards to people who practice healthy behaviours.

Effective medications exist for treating opioid, alcohol, and nicotine addiction and for alleviating the symptoms of many other mental disorders, yet most have not been well studied in comorbid populations. Some medications may benefit multiple problems. For example, bupropion is approved for treating both depression (Wellbutrin) and nicotine

[114] Baigent M. Managing patients with dual diagnosis in psychiatric practice. Curr Opin Psychiatry. 2012;25(3):201-205. doi:10.1097/YCO.0b013e3283523d3d

[115] Santucci K. Psychiatric disease and drug abuse. *Curr Opin Pediatr.* 2012;24(2):233-237. doi:10.1097/MOP.0b013e3283504fbf

[116] Santucci K. Psychiatric disease and drug abuse. *Curr Opin Pediatr.* 2012;24(2):233-237. doi:10.1097/MOP.0b013e3283504fbf

dependence (Zyban). More research is needed, however, to better understand how these medications work, particularly when combined in patients with other comorbidities.

7.3 Sexual health and human immunodeficiency virus

Individuals who misuse drugs are thought to experience heightened risks to their sexual health including sexual assaults, sexually transmitted diseases and unintended pregnancies. For example, drug use may cause a state of intoxication and disinhibition, which may result in an individual taking part in sexual activities they may later regret, they may have sexual activity coerced upon them in a non-consensual manner, or individuals with drug dependence may engage in the sex industry to help fund their addiction, as discussed above. Further, substance misuse is also associated with less frequent attendance at cervical screening and irregular use of contraceptive safeguards.[117, 118] In addition to these risks, users who share needles or other drug injecting equipment are at particularly high risk of blood-borne viruses. For these individuals, facilitating needle exchange and sterile equipment (see section 4.6), as well as provisions of opioid substitution therapy or antiviral treatment could be a cost-efficient approach to protect both drug users and the broader community.

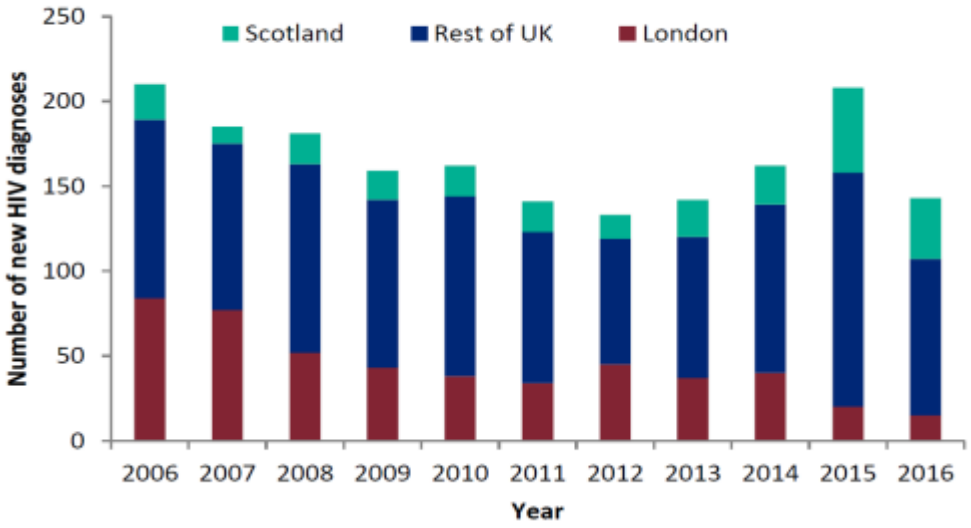
National data exists on human immunodeficiency virus (HIV) infection rates associated with intravenous drug use.[119] There were 145 new HIV diagnoses associated with intravenous drug use in 2016 in the UK, lower than the national 2006-2015 average of 168 new diagnoses per year, as shown in Figure 24. Although the majority of intravenous drug users in the UK who live with HIV know of their diagnosis and are utilising HIV treatment services, the occurrence of late diagnoses remains an issue. Just over half (51%) of new HIV diagnoses in 2016 among intravenous drug users occurred at a late stage of HIV infection, which is associated with a ten-fold increased risk of death within a year of diagnosis compared to those who are promptly diagnosed. Further, a late diagnosis is likely to mean a prolonged period during which infected individuals expose others to an increased transmission risk. Most intravenous drug users who reported that they had either not been tested or had not been tested in the preceding two years, reported that within the preceding year they had seen their GP, received a prescribed drug substitute, or used a needle and syringe exchange programme, suggesting a missed opportunity to incorporate HIV testing into other points of contact with healthcare services.

[117] Bowden-Jones O. Joining up sexual health and drug services to better meet client needs. 2017. https://core.ac.uk/download/pdf/132547534.pdf

[118] Hwang LY, Ross MW, Zack C, et al. Prevalence of sexually transmitted infections and associated risk factors among populations of drug abusers. Clin Infect Dis 2000;31:920–926

[119] Public Health England. Shooting Up: Infections among people who inject drugs in the UK, 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663003/Shooting_Up_2017_report.pdf

Figure 24: Yearly national average of new HIV diagnoses associated with intravenous drug use in London, Scotland and the rest of the UK[120]



7.4 Hepatitis and liver

Hepatitis is the term used to describe inflammation of the liver. It is usually the result of a viral infection or liver damage caused by drinking alcohol.

There are several types of hepatitis, some types will pass without any serious problem, while others can be long lasting (chronic) and cause scarring of the liver (cirrhosis), loss of liver function and, in some cases, liver cancer.

Some types of hepatitis are below[121]:

- Hepatitis A - Hepatitis A usually passes within a few months, although it can occasionally be severe and even life-threatening. There's no specific treatment for it, other than to relieve symptoms like pain, nausea and itching. There is vaccination against Hepatitis A.
- Hepatitis B - Most adults infected with Hepatitis B are able to fight off the virus and fully recover from the infection within a couple of months. But most people infected as children develop a long-term infection. This is known as chronic Hepatitis B and can lead to cirrhosis and liver cancer. Antiviral medication can be used to treat it. In the UK, vaccination against hepatitis B is recommended for people in high-risk

[120] Public Health England. Shooting Up: Infections among people who inject drugs in the UK, 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663003/Shooting_Up_2017_report.pdf

[121] https://www.nhs.uk/conditions/hepatitis/

groups, such as: healthcare workers, people who inject drugs, men who have sex with men and children born to mothers with Hepatitis B.

- Hepatitis C - Hepatitis C is caused by the Hepatitis C virus and is the most common type of viral hepatitis in the UK. In the UK, it's most commonly spread through sharing needles used to inject drugs. This is known as chronic hepatitis C and can cause cirrhosis and liver failure. Chronic Hepatitis C can be treated with very effective antiviral medications, but there's currently no vaccine available.
- Hepatitis D - Hepatitis D is usually spread through blood-to-blood contact or sexual contact. Long-term infection with Hepatitis D and Hepatitis B can increase your risk of developing serious problems, such as cirrhosis and liver cancer. There's no vaccine specifically for Hepatitis D, but the Hepatitis B vaccine can help protect you from it.
- Hepatitis E - Hepatitis E is generally a mild and short-term infection that does not require any treatment, but it can be serious in some people, such as those who have a weakened immune system. There's no vaccine for Hepatitis E.
- Alcoholic Hepatitis - Alcoholic hepatitis is a type of hepatitis caused by drinking excessive amounts of alcohol over many years. Stopping drinking will usually allow your liver to recover, but there's a risk you could eventually develop cirrhosis, liver failure or liver cancer if you continue to drink alcohol excessively.
- Autoimmune Hepatitis - Autoimmune hepatitis is a rare cause of long-term hepatitis in which the immune system attacks and damages the liver. Treatment for autoimmune hepatitis involves very effective medicines that suppress the immune system and reduce inflammation. It's not clear what causes autoimmune hepatitis and it's not known whether anything can be done to prevent it.

7.5 Blood Bourne Viruses

Blood borne viruses are of particular concern amongst People Who Inject Drugs (PWID), with Hepatitis B, C and HIV the infectious diseases of particular concern due to their virulence and transmissibility by injection.

Hepatitis C, in particular, is the focus of an international campaign to eradicate by 2030 [122] and current and ex-injectors are at significantly increased risk and may account for as much as 90% of the transmission, and an estimated 50% of PWID currently or have previously been infected with the virus [123]. Drug services are now required to supply sterile injecting equipment and to offer antibody and PCR tests to clients who currently or have previously injected.

122 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/798270/HCV_in-England_2019.pdf

123 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/825117/hpr2919_UAM-PWID.pdf

Figure 25: Sociodemographic breakdown of registered Hepatitis C nationally in 2018:

Category	Metric	Proportion of sample with data for that variable (%)
Age (Mean + SD, years)	50.6 + 11.8	99.5
Sex (% male)	70.3	98.7
Ethnicity (%)	N/A	89.0
White	79.1	N/A
Asian/Asian British	10.6	N/A
Black African/Caribbean/Black British	4.6	N/A
Mixed/Multiple Groups	1.0	N/A
Other	4.7	N/A
Country of Birth (%)	N/A	71.3
UK	70.9	N/A
Non-UK	29.1	N/A
Postcode	N/A	22.4

Data source: Hepatitis C patient registry and treatment outcome system as at 30 April 2018

Nationally, the current profile of those registered with Hepatitis C have an average age of 50 and 70% are male. A higher proportion of some ethnic minorities are infected, with 30% being born outside of the UK.

Figure 26: Blood-borne virus in Kent substance misuse services, 2018/19:

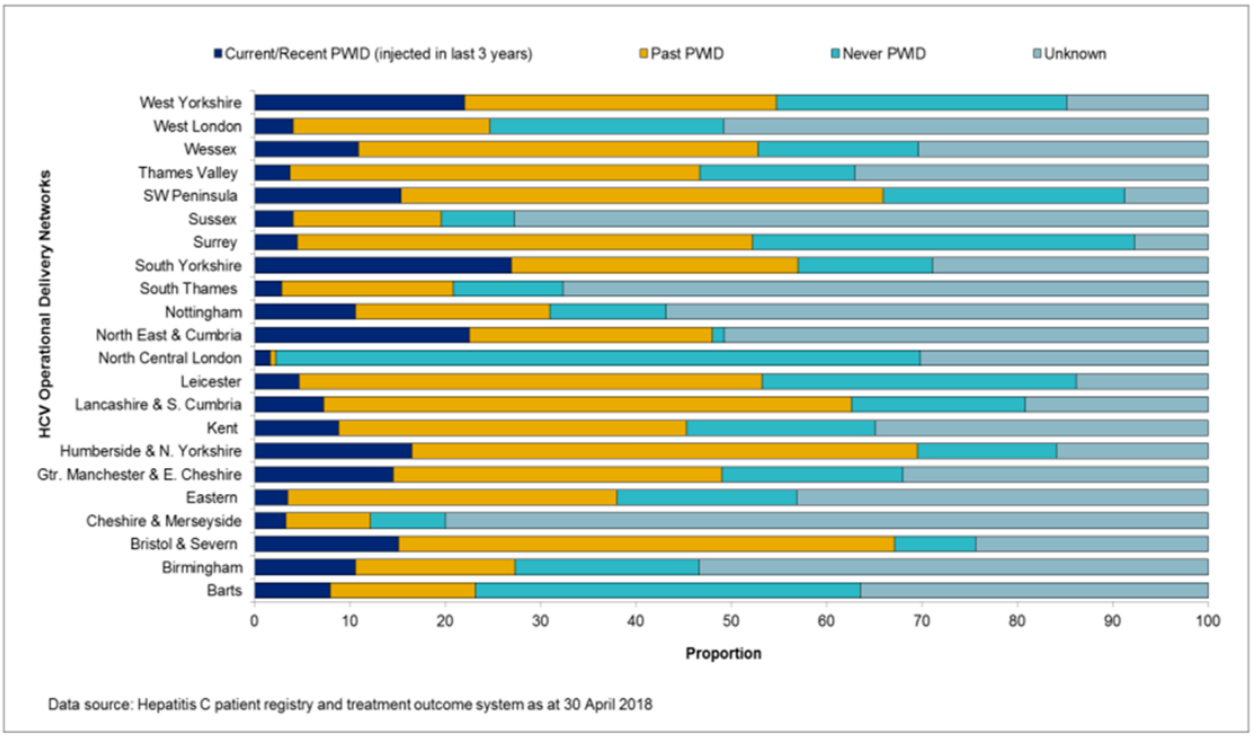
Hepatitis B	Kent total	Proportion of eligible clients - Kent	Kent - Males	Kent - Females	England	Proportion of eligible clients - England
Adults new to treatment in 2018-19 eligible for HBV vaccination who accepted one	152	17%	17%	17%	21,871	40%
Of those: The proportion who started a course of vaccination	17	11%	9%	16%	1,819	8%
The proportion who completed a course of vaccination	26	17%	17%	18%	2,320	11%
Hepatitis C	**Kent total**	**Proportion of eligible clients - Kent**	**Kent - Males**	**Kent - Females**	**England**	**Proportion of eligible clients - England**
Previous or current injectors new to treatment in 2018-19 eligible for a HCV test who received one	389	82%	80%	85%	18,633	76%
Clients who have positive hep C antibody test*	89	30%	26%	40%	3,723	33%
Clients who have a positive hep C PCR (RNA) test*	64	24%	21%	32%	2,216	25%
Clients referred to Hep C treatment	32	8%	7%	10%	762	4%

Drug treatment service users in Kent who have received vaccination/treatment for Hepatitis B and C infections are routinely monitored. In 2018/2019, only 17% (n=152) of adults new to

drug treatment services who were eligible for Hepatitis B vaccinations accepted the offer, which is lower than the national rate of 40%. There was no gender discrepancy in likelihood to accept testing (17% of eligible males and 17% eligible females). However, only 11% (n=17) of those who accepted Hepatitis B vaccinations were reported to have commenced a vaccination course and only 17% (n=26) completed a vaccination course.

Further, 82% (n=389) of current or previous injectors new to drug treatment in 2018/2019 who were eligible for a Hepatitis C test received one, compared to 76% nationally. There were 153 service users who had a positive Hepatitis C (n=89) antibody test or a positive Hepatitis C (PCR) RNA test (n=64). There were 32 service users recorded as having been referred for treatment.

Figure 27 Injecting route of transmission for patients in the Hepatitis C patient registry and treatment outcome system, by ODN (n=24,592).



As reported by PHE, 304 (21% in England) of eligible new clients in Kent drug treatment services received a Hepatitis C test. 57 (5%) and 47 (4%) of clients tested positive for an antibody and PCR test respectively, higher than 4% and 2% in England.

Recommendation: Blood-borne viruses are a significant public health concern among drug users but recording of Hepatitis B and C testing and/or vaccination rates are however not well captured in standardised recording practices. It is therefore vital to amend recording practices to ensure that there is good understanding and monitoring of testing and vaccination uptake rates in Kent. Ensuring high uptake rates of viral testing, antiviral treatments, opioid substitution therapy and sterile injecting equipment are important

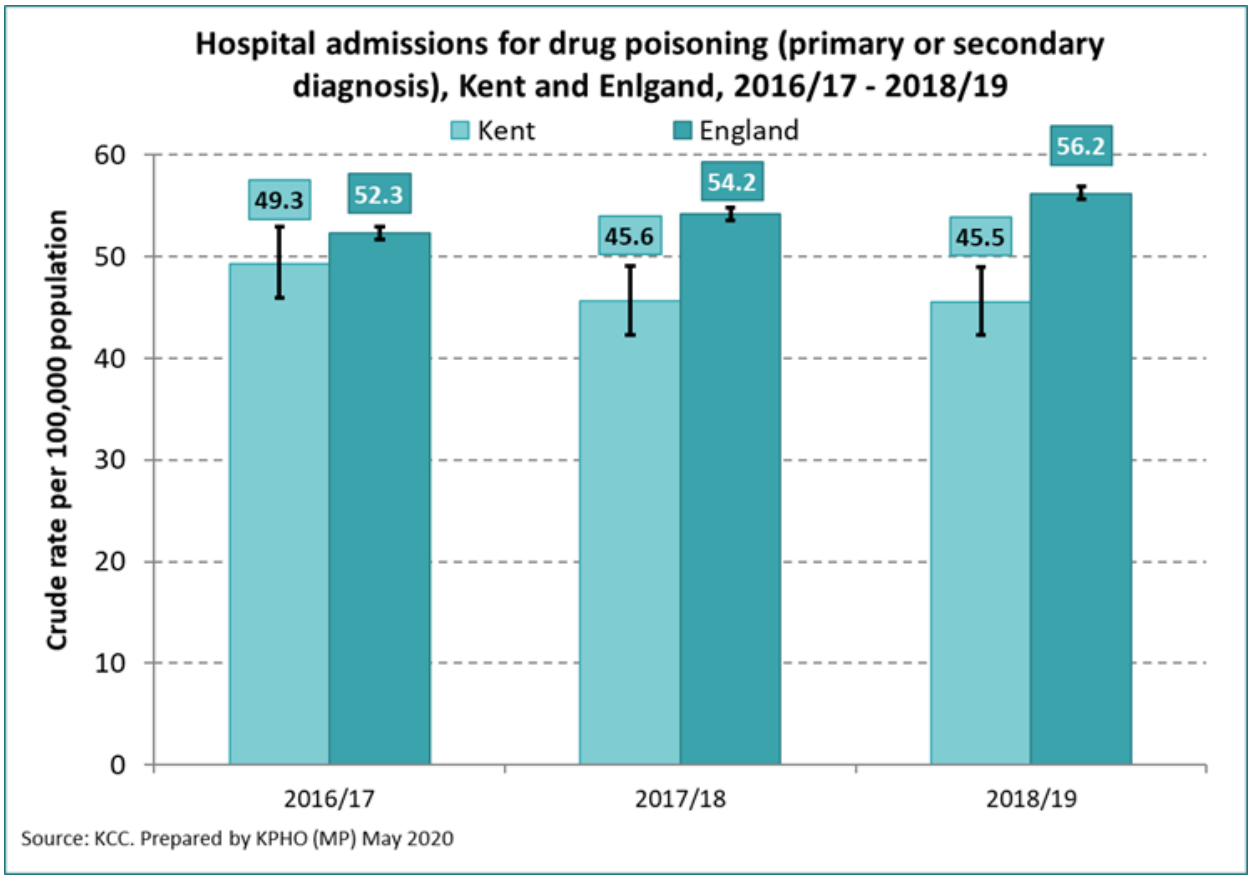
strategies to protect drug users and the broader community, reduce drug use-associated health inequalities, and provide long-term cost-savings.

Recommendation: Public Health professionals working in Local Authorities and Clinical Commissioning Groups to consider including HCV in Joint Strategic Needs Assessments and subsequent Health and Wellbeing strategies.

7.6 Drug-related inpatient hospital admissions

Hospital admissions from non-fatal overdoses can be an important indicator of likely future drug misuse-related deaths.[124] Drug treatment services should be assessing and managing overdose (including suicide) risks. The crude rate of hospital admissions per 100,000 population in which drug poisoning was coded as either the primary or secondary reason for admission in 2018-19 was 45.5 per 100,000 population in Kent. This is lower in comparison to the national rate of 56.2 per 100,000 population.

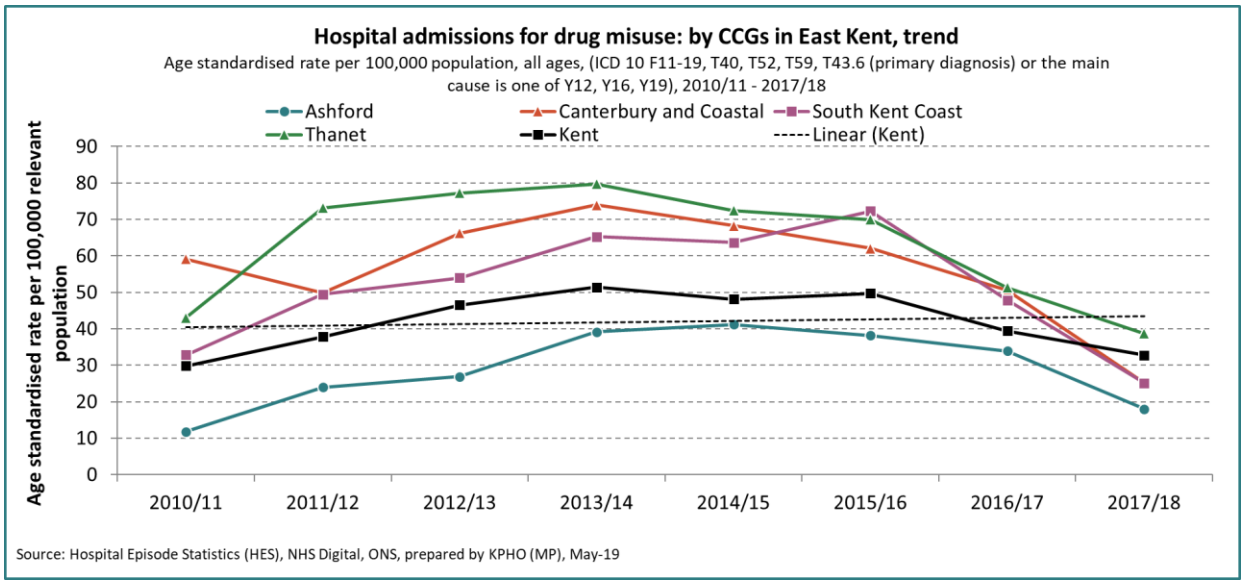
Figure 28: hospital admissions for drug poisoning, Kent and England



[124] Hwang LY, Ross MW, Zack C, et al. Prevalence of sexually transmitted infections and associated risk factors among populations of drug abusers. Clin Infect Dis 2000;31:920–926

Figure 29 below shows the trend of hospital admissions for drug poisoning for all ages over time by CCGs in East Kent. The importance of this graph is comparing different CCGs in East Kent for hospital admissions for drug misuse.

Figure 29 - Trend of hospital admissions for drug misuse by CCG in East Kent for all ages between 2010/11 – 2017/18:

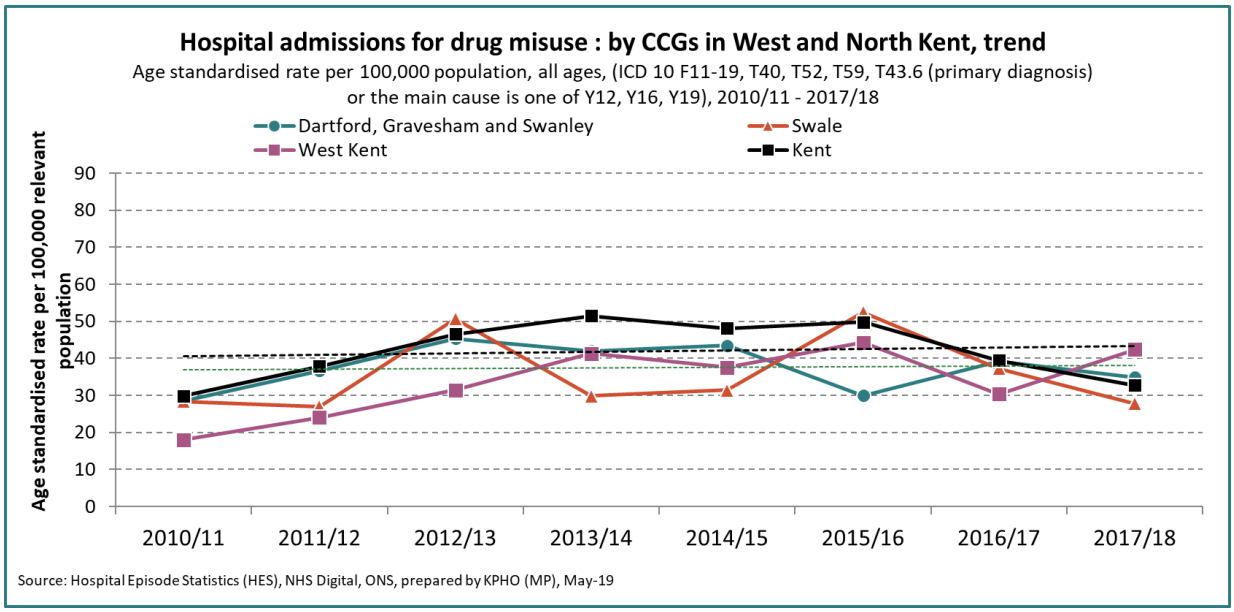


Key finding of this figure:

- Hospital admissions for substance misuse (illicit drug use) have fallen across Kent for the past two years, which is in line with national trends, but have remained stable since 2010/11.
- The East Kent CCGs have all seen significant reductions in 2017/18, although Thanet still remains having the highest rate among CCGs in East Kent.

Figure 30 below shows the trend of hospital admissions for drug for all ages over time by CCG in West and North Kent. The importance of this graph is comparing different CCGs in West and North Kent for hospital admissions for drug misuse.

Figure 30– Trend of hospital admissions for drug misuse by CCGs in West and North Kent for all ages between 2010/11 – 2017/18:

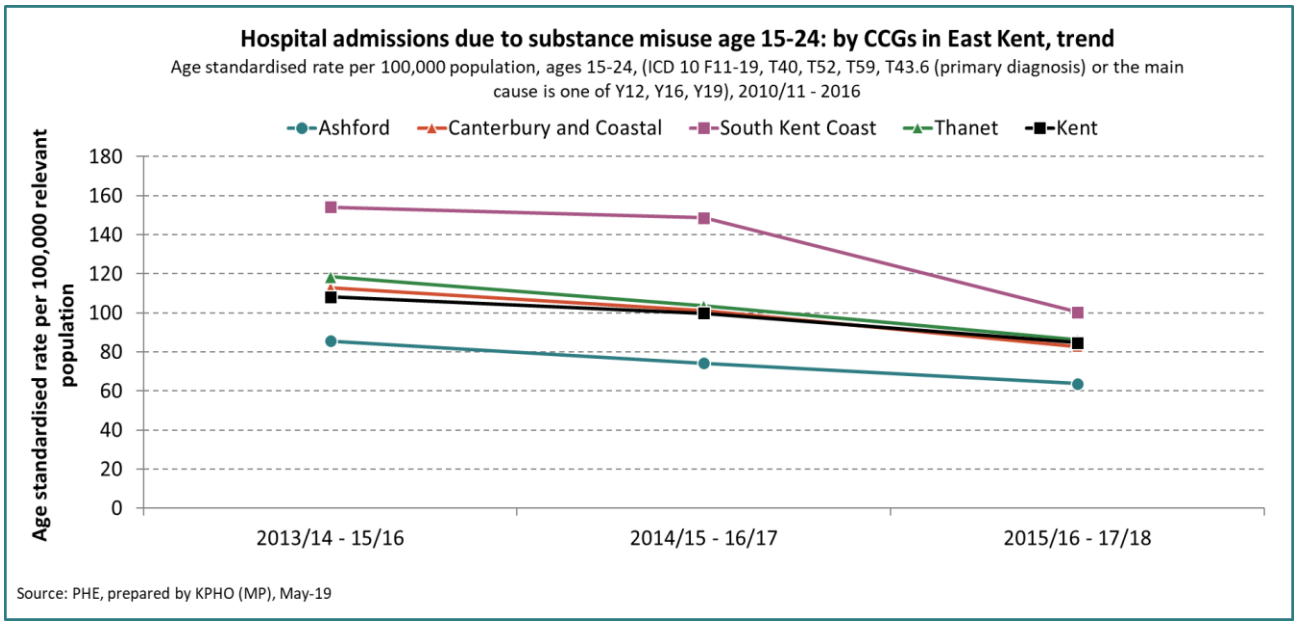


Key finding of this figure:

- Trend of hospital admissions for drug misuse in DGS and Swale CCGs has remained largely stable since 2010/11, but West Kent CCG has seen increases.

Figure 31 below shows the trend of hospital admissions for drug misuse in young people who are aged 15-24 years old over time by CCG in East Kent. The importance of this graph is comparing different CCGs in East Kent for hospital admissions for drug misuse in young people who are aged 15-24 years old.

Figure 31 – Trend of hospital admissions for drug misuse in young people who are aged 15-24 years old, by CCG in East Kent, between 2013/14-15/16 and 2015/16-2017/18:

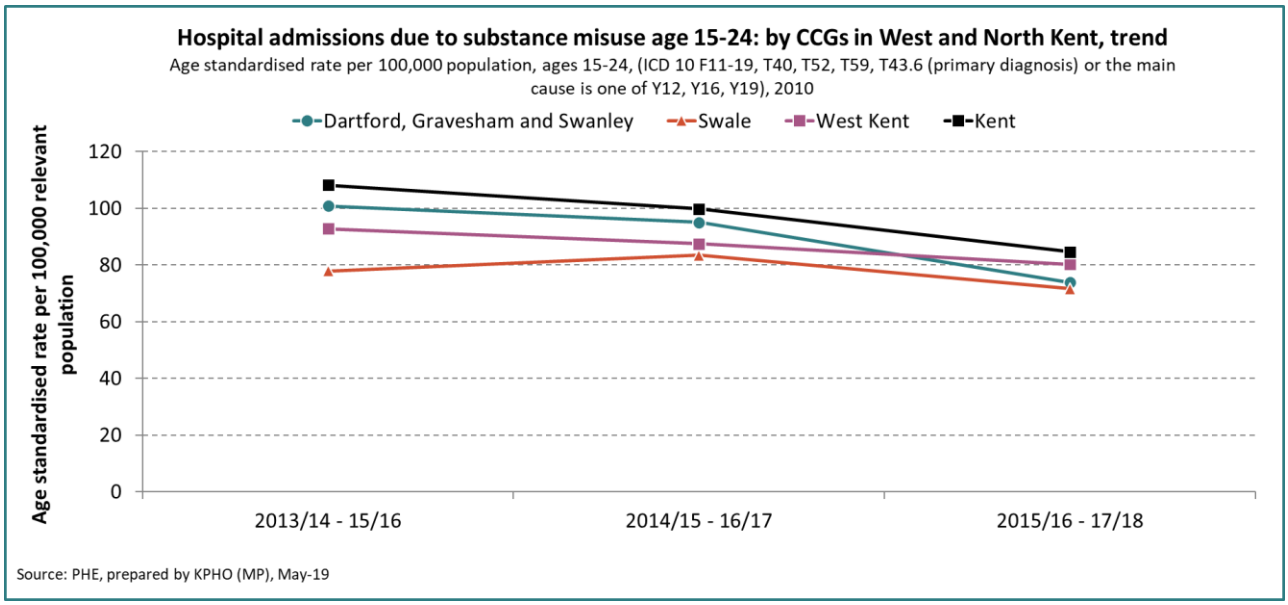


Key finding of this figure:

- Hospital admissions in the 15 to 24-year-old age group have shown a more modest decline than the 'all age' group. South Kent Coast CCG remains the CCG with the highest rate of admissions in this age group.

Figure 32 below shows the trend of hospital admissions for drug misuse in young people who are aged 15-24 years old over time by CCG in West and North Kent. The importance of this graph is comparing different CCGs in West and North Kent for hospital admissions for drug misuse in young people who are aged 15-24 years old.

Figure 32 – Trend of hospital admissions for drug misuse in young people who are aged 15-24 years old, by CCG in West and North Kent, between 2013/14-15/16 and 2015/16-2017/18:



Key finding of this figure:

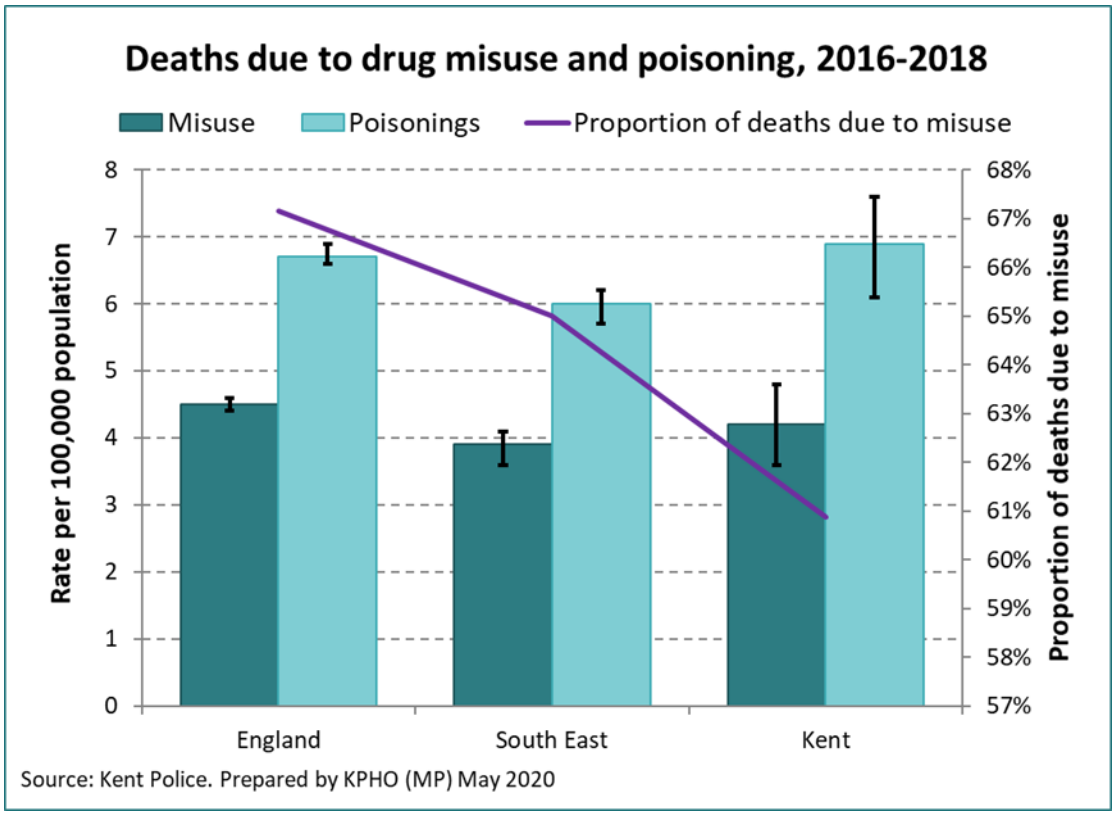
- The West and North Kent CCGs have all seen significant reductions in 2015/16-17/18, and the rate in lower than Kent average in the same year.

| 8. Mortality from misuse and poisoning

8.1 National trend

Nationally, the ONS reports[125] that there were 4,359 deaths in England and Wales in 2018 due to drug poisonings – an increase of 16% in 2017 and the highest since records began. This includes poisonings from both legal medicinal drugs (accidents and suicides) as well as deaths from all illicit drug misuse, which saw an increase to 2,917. Two thirds of these are from drug misuse, which is where drug abuse or dependence is involved, or an illegal substance has been detected.

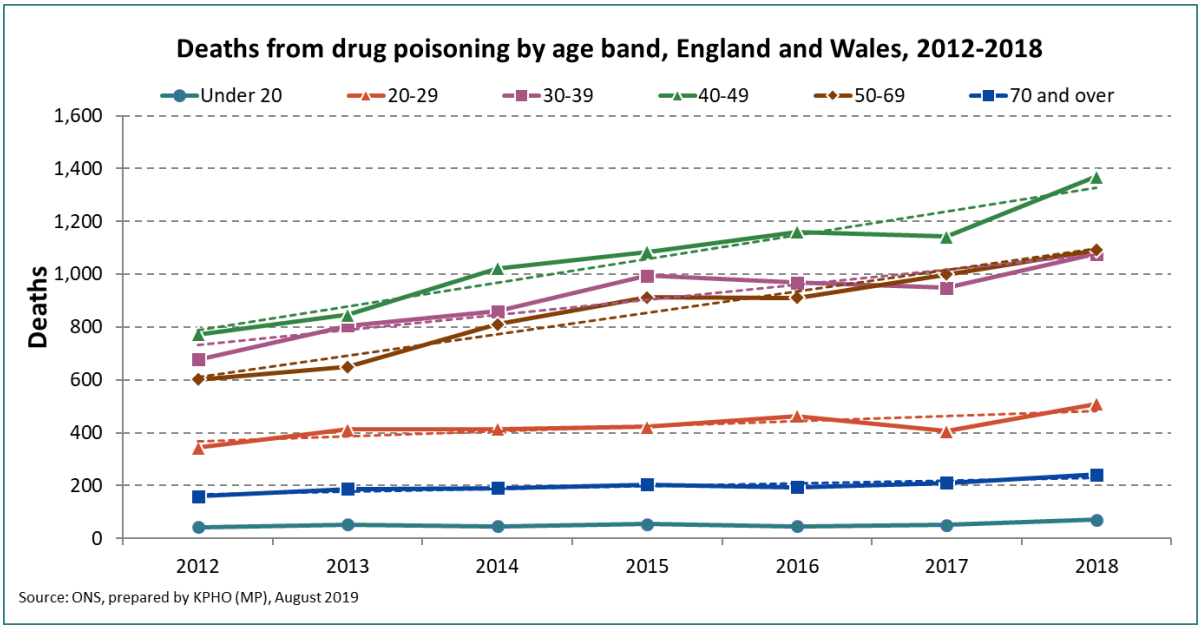
Figure 33 Comparison of drug deaths from poisoning and misuse, Kent and England



Kent sees a similar rate of deaths from both drug poisoning and drug misuse to England but is close to having a statistically significantly higher rate of drug poisoning deaths than the South-East average. In Kent, 61% of deaths from poisoning are due to misuse, lower than England which has 67% of drug poisoning deaths from misuse.

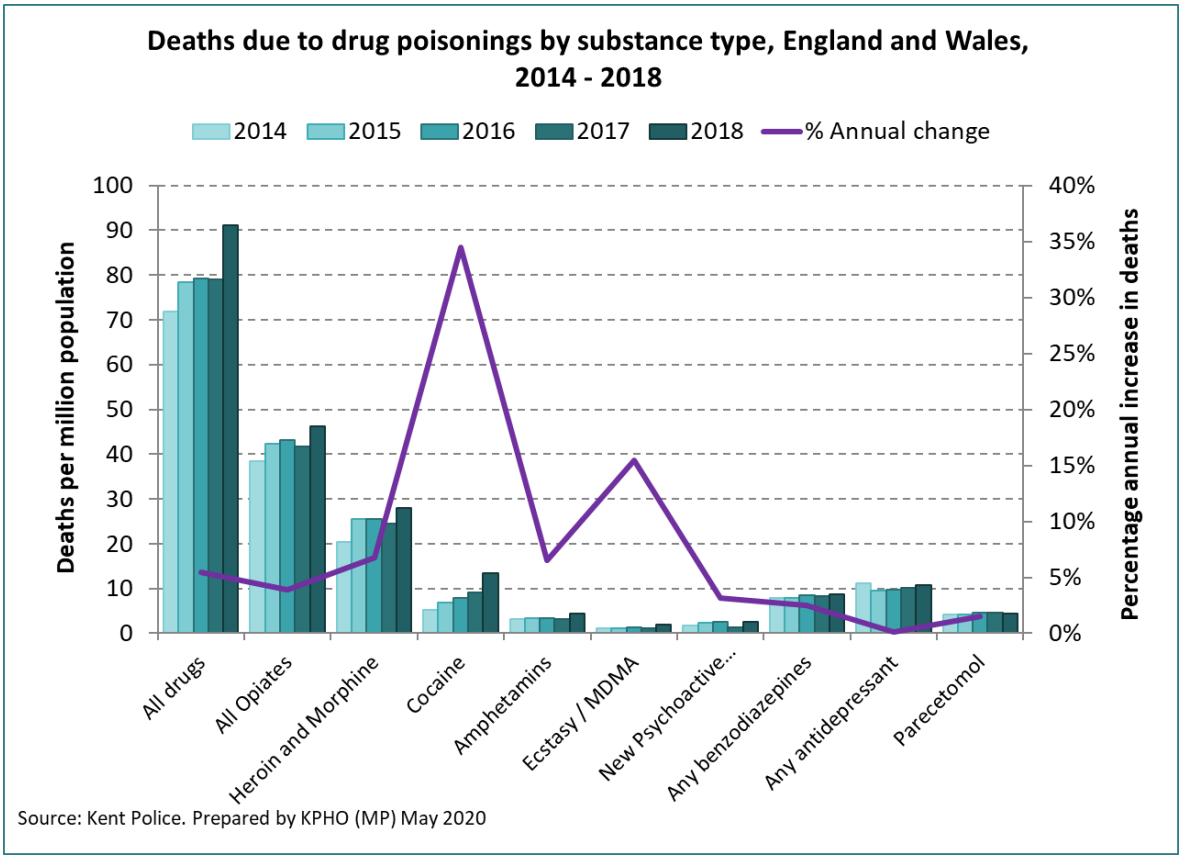
[125] drug-related deaths in England and Wales

Figure 34 – Deaths from drug poisoning by age, England & Wales:



40-49-year-olds have the highest rate of drug poisoning deaths. Rates have increased across all age groups, but in particular, the 40 – 69-years-old have been experiencing higher increases, perhaps further supporting the idea of an ageing cohort at greatest risk of opioid overdose death. However, in the past year, the under 20's and 20-29's saw the largest proportional increases with 39% and 25% between 2017 and 2018 respectively.

Figure 35: Drug poisoning deaths by substance type



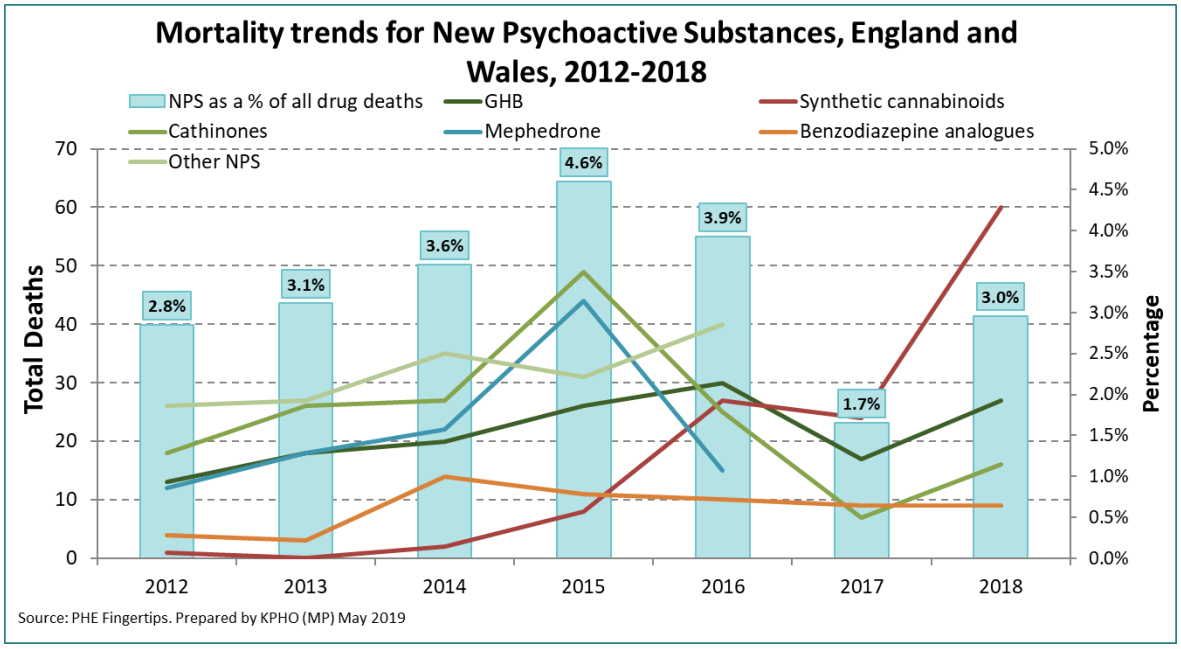
Key findings from deaths by substance type:

- The most significant, and continuing, rise is in cocaine deaths.
- There was a 47% (637 deaths) increase between 2017 and 2018.
- Although deaths from heroin and/or morphine have fallen a little, from over half (51%) of all deaths related to drug poisoning still involve an opiate. This is likely due to an older generation of long-term heroin users with failing health and higher overdose risks.

Nationally, drug deaths from poisoning have been increasing at a rate of 5.5% annually between 2014 and 2018. Opiates remain the drug family responsible for most deaths from drug poisoning, with just over half of all deaths involving an opiate. Proportionally, deaths involving cocaine have risen sharply, with a 35% annual increase between 2014 and 2018. Deaths involving other drugs have also been increasing each year, with ecstasy/MDMA (16%), heroin/morphine (7%) and amphetamines (6.5%) showing the largest annual increases from 2014 to 2018. The largest overall increases in deaths were between 2017 and 2018, which increased by 47%.

New Psychoactive Substances (NPSs) or New Unclassified Drugs (NUDs) were banned under the Psychoactive Substances Act 2016. Since then, deaths from poisoning due to NUD use has fallen dramatically.

Figure 36 Trends in deaths from drug misuse (new psychoactive substances) in England & Wales between 2012 and 2018

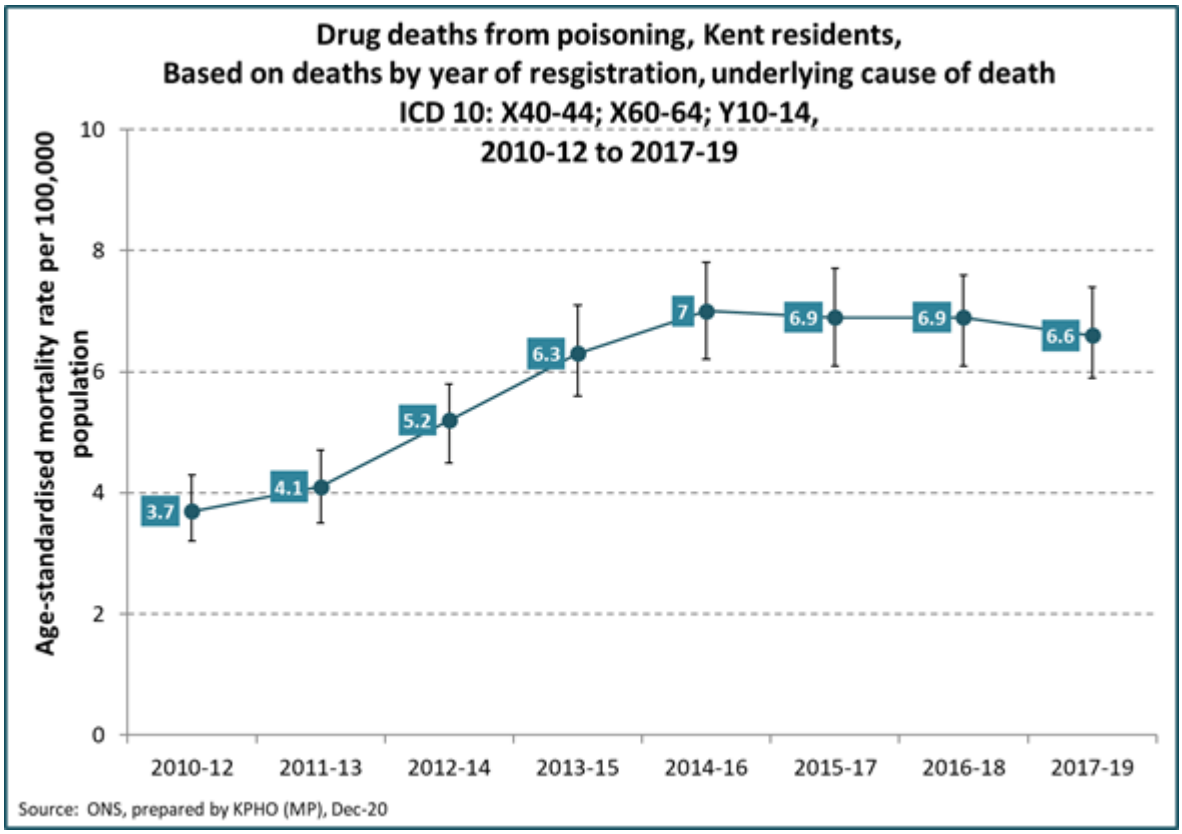


Overall deaths from poisoning due to NPS have been increasing modestly at around 3% per year but make up a relatively small proportion of all drug deaths. The largest increases have been seen in synthetic cannabinoids (e.g. spice), which is a drug commonly associated with use in prisons.

8.2 Local trend

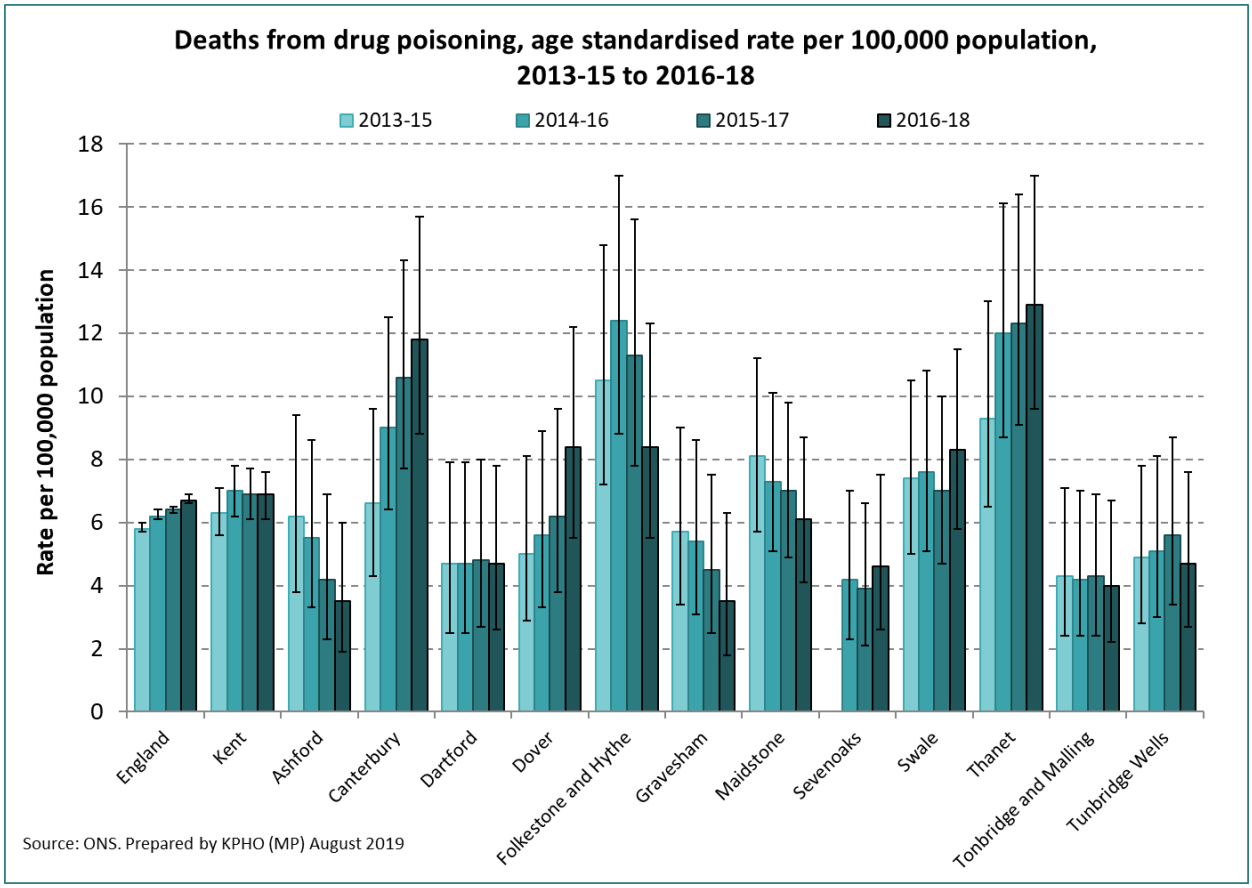
Understanding and preventing Drug-Related Deaths (DRDs) is an important function of a recovery-orientated drug treatment system. This is even more pressing in the light of recent increases in such deaths. Concerns about this has led to drug misuse deaths to be included in the Public Health Outcomes Framework (PHOF 2.15iv).

Figure 37: deaths from drug poisoning, Kent trend



In Kent, deaths from drug poisoning for the period 2017-19 was lower than the previous 3 years, although significantly higher than rates seen in 2013-15 and before. Rates are also similar to England and Wales.

Figure 38: deaths from drug poisoning, Kent districts



Once deaths are examined at district authority level, small numbers involved mean wider statistical confidence intervals and consequently it is harder to confer significant differences. Thanet, Dover and Canterbury districts appear to have increased deaths over the past 4 time periods, but the wide confidence intervals make them not statistically significant. Canterbury and Thanet districts are significantly higher than Kent in the 2016 -2018 time period.

9. Conclusions & recommendations

In conclusion of this needs assessment the following recommendations are made, which include recognition of the need for future work to uncover the drivers of our substance misuse-related outcomes and workable actions for the wider partnership. In terms of who specifically should take these recommendations forward, this report is drafted primarily for service commissioners. It is drafted to inform their planning and commissioning decisions, therefore lead commissioners for substance misuse services, within Kent County Council, and mental health commissioners within Kent and Medway CCG are tasked with addressing or overseeing them, but clearly with the support of the wider system.

The key messages and recommendations arising from findings are set out below:

Recommendation: Increasing drug misuse among older ages, alongside an aging general population, highlights a need to ensure treatment services are accessible to older service users, and tailored to their needs. For example, older service users may be more resistant to attend drug treatment services alongside younger people, and may benefit from dedicated treatment times and/or locations, and awareness campaigns of services should be available at locations that may be more visible to older service users, such as health-care centres or pubs. Given that most older drug users commence drug use before the age of 40, preventive strategies should be particularly mindful of initiation of drug use in younger age groups, and target preventive strategies at the under 40 population. (Please see section 5.8 - Older service users - ageing substance misuse population)

Recommendation: Facilitate close input from mental health services during substance misuse treatment and as part of follow-up care to maximise potential for recovery and reduce substance-misuse associated health inequalities. To reach individuals in the community for whom untreated mental health issues are a barrier to seeking substance misuse treatment there should be shared intelligence between mental health services and substance misuse treatment services (for example through inclusion of mental health services in any substance misuse strategic working group), streamlined referral pathways, and joint outreach work to shared high-risk groups (such as the homeless). (Please see section 7.1)

Recommendation: Consider close cooperation with children's support services and charities during provision of substance misuse treatment to mitigate the impact on children who have a parent in structured treatment, and to support the identification of high-risk groups such as children living in toxic-trio households, i.e. domestic risk factors including domestic

abuse, substance misuse and mental health illness. Further, explore if there is a need and/or adequate provision of child-care support for parents for whom child-caring responsibilities may be a barrier to fully engaging with treatment services. (Please see section 5.3)

Recommendation: Outreach and awareness efforts of substance misuse treatment services should target the most deprived districts in Kent, particularly east Kent, notably Canterbury, Dover and Thanet, where current levels of need from drug-associated harm are higher. Prioritise Thanet. (Please see figures 27 & 38)

Recommendation: Establish close ties and joined up pathways between local criminal justice and prison systems and community treatment services, with specific regard to individuals who enter or leave prison services, or who are given community substance misuse treatment orders. This may help address a large area of need in increasing successful and timely pick-up rates by community substance misuse treatment services of service users released from prison. This is likely to not only support recovery of service users, but also benefit the broader community and criminal justice system by acting to prevent criminal reoffending associated with substance misuse. (Please see table 5)

Recommendation: There are substantial overlapping communities of need across several public health services, such as relatively high rates of substance misuse alongside sexual health issues. Close collaborative working and streamlined referral pathways between different public health services could therefore ensure a more holistic approach to care management, by for example offering needle exchange services in sexual health centres and by utilising client contact with substance misuse treatment services as a vital opportunity to offer testing for sexually transmitted infections. Further, the data suggest a particular missed opportunity to incorporate HIV testing into other points of contact with services, or to offer novel self-testing opportunities for clients. (Please see section 7.3 – sexual health and HIV)

Recommendation: Close partnership working with agencies that support sex workers from the private, public and voluntary sector. It would be helpful for partnership work to also facilitate monitoring of uptake of substance misuse treatment support in this high-risk group. Further, it is vital that close communication is maintained with Children's Social Services as part of partnership working. Reducing substance dependency among sex workers would likely not only affect sex workers themselves, but also affected children given that the majority of sex workers have reported that a need to support their children is a driver of sex work. (Please see section 5.9)

Recommendation: Parents who misuse drugs or alcohol have reported fear of engagement from social services as an important barrier to accessing treatment services. This particularly relates to concerns with regard to whether their children would be taken into care if it was found that the parents misuse drugs or alcohol. A component of partnership working with Children's Social Services should therefore include to consider how the negative perception of the role of social services can be improved among this community.

Recommendation: Close partnership working with relevant organisations in the public, private and voluntary sector, such as Kent Police, local fire services, adult and children social care services, and charities focused on issues such as county lines, child drug exploitation and modern slavery. Partnership working facilitates a holistic approach to substance misuse treatment and the development of services which are responsive to a changing social environment. Moreover, it is important to enhance data quality, accessibility to data and data sharing pathways across partnership work to combine intelligence.

Recommendation: This needs assessment highlights the gap between service demand and the unmet needs of drug misuse treatment and recovery services in Kent. In order to address these there must be strengthened preventative pathways, a better access to services, and increased equity. An increased focus on vulnerable people entering and staying engaged in treatment, particularly those with long-term co-occurring conditions, both physical and mental health, complex social needs is a key recommendation of this report.

Recommendations for Kent Substance Misuse Alliance (All Partners):

- For all partners - Whilst developing any strategy and related delivery plans, continued priority should be given to a strategic approach that makes explicit goals for early help/intervention, prevention approaches, mental health promotion, meeting the needs of those with multiple / complex needs, health protection, treatment, implementation of evidenced cost-effective interventions, quality assurance, housing, employment and the improvement and widening of whole family approaches.
- For all partners: There should be increased opportunities of routine screening for drug misuse in key areas such as police custody, prison.
- Any strategies and delivery plans should be mindful of recommendations of the Prisons Needs Assessment and national guidance to maintain the health and wellbeing needs of offenders and those in the criminal justice system.
- Continue to work alongside and support the police in raising awareness of and reducing the impact of County Lines, particularly supporting vulnerable people.

- 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.

Recommendations for Prevention to Treatment pathways

- For Kent Public Health: Prioritise deep dive needs assessment for inpatient detox and rehab.
- For all services: align and co-ordinate social prescribing, recovery and social support so that those recovering from addictions have access to all community resources.
- Public Health & All partners: Each partner agency to have clearly defined links and action for the Kent and Medway Drug and Alcohol Strategy.
- Highlight the vulnerability, social care needs and safeguarding and frailty needs of vulnerable people who are drug misusers in line with Care Act responsibilities. This should be clearly assessed and care planned via multi agency meetings.
- For Public Health: A review of primary care provision to manage long-term conditions to improve health outcomes and prevent premature death for those with drug misuse problems should be undertaken.
- For Providers: To facilitate regular awareness and educational GP training to further their knowledge on substance misuse issues.

| 10. Appendix

10.1 Appendix 1

10.1.1 Opioids use and dependence[126]

10.1.1.1 Effect of methadone or buprenorphine treatment on outcomes

Opioids Agonist Treatment (OAT) is the most effective treatment for opioid dependence and a WHO essential medicine.[127] Evidence shows that OAT affects multiple outcomes in people who are opioid dependent. OAT reduces injecting risk behaviour[128] and the risk of HIV and HCV infection[129,130], increases engagement in the HIV services [131] and HCV cascade of care. OAT also reduces criminal activity,[132] and reduces all-cause[133] and overdose[134] mortality. Evidence that OAT might reduce suicide and accidental injuries is weaker.[135] OAT is highly cost-effective and is cost saving when costs of crime (i.e. costs of incarceration and direct costs to the economy of crimes such as theft) are considered.[136] Evidence for alternative treatments other than OAT are as yet inconclusive.

The protective effect of OAT on mortality is marked in people who have been incarcerated, especially during the highest risk periods in the first weeks after incarceration.[137,138] This

[126] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32229-9/fulltext

[127] WHO: WHO model list of essential medicines. World Health Organization, Geneva 2017

[128] Gowing L, Farrell MF, Bornemann R, Sullivan LE, Ali R. Oral substitution treatment of injecting opioid users for prevention of HIV infection. Cochrane Database Syst Rev 2011; 8: CD004145.

[129] MacArthur GJ, Minozzi S, Martin N, et al. Opiate substitution treatment and HIV transmission in people who inject drugs: systematic review and meta-analysis. BMJ 2012; 345: e5945

[130] Platt L, Minozzi S, Reed J, et al. Needle syringe programmes and opioid substitution therapy for preventing hepatitis C transmission in people who inject drugs. Cochrane Database Syst Rev 2017; 9: CD012021.

[131] Low AJ, Mburu G, Welton NJ, et al. Impact of opioid substitution therapy on antiretroviral therapy outcomes: a systematic review and meta-analysis. Clin Infect Dis 2016; 63: 1094–104.

[132] Maglione MA, Raaen L, Chen C, et al. Effects of medication assisted treatment (MAT) for opioid use disorder on functional outcomes: a systematic review. J Subst Abuse Treat 2018; 89: 28–51.

[133] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ 2017; 357: j1550.

[134] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ 2017; 357: j1550.

[135] Degenhardt L, Randall D, Hall W, Law M, Butler T, Burns L. Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: risk factors and lives saved. Drug Alcohol Depend 2009; 105: 9–15.

[136] Chetty M, Kenworthy JJ, Langham S, Walker A, Dunlop WC. A systematic review of health economic models of opioid agonist therapies in maintenance treatment of non-prescription opioid dependence. Addict Sci Clin Pract 2017; 12: 6.

[137] Degenhardt L, Larney S, Kimber J, et al. The impact of opioid substitution therapy on mortality post-release from prison: retrospective data linkage study. Addiction 2014; 109: 1306–17

[138] Marsden J, Stillwell G, Jones H, et al. Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. Addiction 2017; 112: 1408–18

protective effect could reduce the transmission of HIV and HCV, which is also elevated at this time.[139]

10.1.1.2 Differences between Methodone and Buprenorphene

Methadone and buprenorphine differ on some outcomes. Retention is higher in patients on high doses of methadone (>80 mg daily) than for buprenorphine and lower methadone doses (<60 mg daily).[140] Two studies have found a lower risk of mortality during induction onto methadone versus buprenorphine, but evidence is unclear on differences at other points in or out of treatment.[141,142] Among women who are opioid dependent and pregnant, neonatal outcomes might be superior for women maintained on buprenorphine compared with methadone.[143]

Higher doses of methadone and buprenorphine increase retention in treatment.[144] Low-quality evidence suggests that supervised dosing (i.e.: directly observed doses provided by a pharmacist or other clinical worker) does not improve retention.[145] Evidence to assess the effect of urine drug screening during OAT on retention is insufficient.[146]

10.1.2 Cannabis[147]

10.1.1.3 This needs assessment will not cover the medicinal use of cannabis: But will focus on evidence for treatments of cannabis misuse

Cannabis is the most frequently used illegal psychoactive substance in the world. There is a significant increase in the number of treatment admissions for cannabis use disorders in the past few years, and the majority of cannabis-dependent individuals who enter treatment have difficulty in achieving and maintaining abstinence. There is poor quality of evidence for treatment options. The most severe effects of Cannabis intoxication syndrome (anxiety, panic, psychosis) are best treated symptomatically with a benzodiazepine or second-

[139] Stone J, Fraser H, Lim AG, et al. Incarceration history and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis. Lancet Infect Dis 2018; 18: 1397–409.

[140] Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev 2014; 2: CD002207

[141] Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ 2017; 357: j1550

[142] Hickman M, Steer C, Tilling K, et al. The impact of buprenorphine and methadone on mortality: a primary care cohort study in the United Kingdom. Addiction 2018; 113: 1461–76.

[143] Zedler BK, Mann AL, Kim MM, et al. Buprenorphine compared with methadone to treat pregnant women with opioid use disorder: a systematic review and meta-analysis of safety in the mother, fetus and child. Addiction 2016; 111: 2115–28.

[144] Faggiano F, Vigna-Taglianti F, Versino E, Lemma P. Methadone maintenance at different dosages for opioid dependence. Cochrane Database Syst Rev 2003; 3: CD002208.

[145] Saulle R, Vecchi S, Gowing L. Supervised dosing with a long-acting opioid medication in the management of opioid dependence. Cochrane Database Syst Rev 2017; 4: CD011983

[146] McEachern J, Adye-White L, Priest KC, et al. Lacking evidence for the association between frequent urine drug screening and health outcomes of persons on opioid agonist therapy. Int J Drug Policy 2018; 64: 30–33.

[147] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31789-1/fulltext

generation (atypical) anti-psychotic medication. No medication is approved specifically for treatment of cannabis intoxication. Behavioural and cognitive approaches are available with limited studies and data. There have been some successful trials with Naltrexone and the best evidence for pharmacology is available here. Understanding the co-morbidities with depression and anxiety are key to getting better treatment outcomes.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3171994/

10.1.3 Stimulant misuse (nicotine, amphetamines and cocaine)

10.1.1.4 Psychosocial treatment to reduce stimulant use

The current standard of care for stimulant dependence is primarily psychosocial interventions combined with case management.

Meta-analytic reviews indicate that contingency management leads to a statistically significant reduction in stimulant use.[148] Contingency management involves providing non-financial or financial incentives in exchange for evidence (e.g. clean urine tests) of abstinence from stimulant use. Nonetheless, contingency management has not been applied in routine care because of substantial opposition from service planners, clinicians and communities to contingency management. Some evidence suggests that adding a community reinforcement approach or cognitive behavioural therapy to contingency management is more effective than contingency management alone. [149] No Pharmacotherapy and medication to reduce stimulant use have been approved to treat either cocaine or amphetamine (or methamphetamine) dependence, whether in managing withdrawal, maintaining abstinence, or preventing relapse. Other psychostimulants (e.g. bupropion, modafinil, dexamphetamine, lisdexamfetamine, methylphenidate, mazindol, methamphetamine, mixed amphetamine salts, and selegiline) can produce a small temporary increase in abstinence from cocaine use, but the quality of evidence was classified as very low.[150]

10.1.1.5 Prison, compulsory detention, and law enforcement responses

Imprisonment is an added risk for people who use stimulants in most countries. No evidence exists to suggest that compulsory drug detention centres reduce drug use,[151] drug risk behaviours,[152,153,154] or related harms. Major infringements of human rights occur within

[148] De Crescenzo F, Ciabattini M, Loreto G, et al. Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: a systematic review and meta-analysis. *PLoS Med.* 2018; 15e1002715.
[149] Colfax G, Santos G-M, Chu P, et al. Amphetamine-group substances and HIV. *Lancet.* 2010; 376: 458-474.
[150] Castells X, Cunill R, Perez-Mana C, Vidal X, Capella D. Psychostimulant drugs for cocaine dependence. *Cochrane Database of Syst Rev.* 2016; 9CD007380.
[151] Werb D, Kamarulzaman A, Meacham MC, et al. The effectiveness of compulsory drug treatment: a systematic review. *Int J Drug Policy.* 2016; 28: 1-9.
[152] WHO. Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: an application of selected human rights principles. Manila: World Health Organization, 2009.

these settings; the number of relapses and reincarcerations are very high after release. Prisons and jails increase risky injecting behaviours and blood borne virus exposure in people who use stimulants.[155] People with a history of incarceration face major challenges in social and vocational integration.

Drug courts are often seen as an alternative to prison and a bridge between the criminal justice and the health-care systems. Drug court evaluations might reduce the number of reimprisonments, but studies are often confounded by participant selection bias. Initial enthusiasm for so-called Swift and Certain Justice Courts (Project HOPE) has been tempered by trials reporting less compelling evidence for effects.[156,157,158] Police diversion before court has been suggested to avert substantial criminal justice costs and reduce drug use and reoffending, but the evidence supporting this theory is weak.[159] Pathways from the criminal justice system to treatment need to be better evaluated.

10.1.1.6 Prevention and treatment of blood borne viruses and sexually transmitted infections

Well established, effective interventions exist to reduce blood borne viruses and sexually transmitted infections in people who use drugs generally rather than in people who use stimulants specifically (although globally a third of people who use stimulants primarily administer the drugs through an injection).[160]

Effective approaches include the provision of sterile injecting equipment through needle and syringe programmes, which reduces injecting risk,[161, 162] HIV,[163] and potentially HCV transmission;[164] provision of materials for safer inhalation of drugs, which might reduce injecting risk behaviour;[165, 166] and professionally supervised drug consumption rooms.[167]

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[153] Pearshouse R. Compulsory drug treatment in Thailand: observations on the Narcotic Addict Rehabilitation act B.E. 2545 (2002). Toronto: Canadian HIV/AIDS Legal Network, 2009.
[154] Open Society Institute International Harm Reduction Development Program. Public health fact sheet. Human rights abuses in the name of drug treatment: reports from the field. 2009. https://www. opensocietyfoundations.org/uploads/78894bdf-3e8e-4e0f-97e773a9667067fa/treatmentabuse_20090309.pdf (accessed January 15, 2021).
[155] DeBeck K, Cheng T, Montaner JS, et al. HIV and the criminalisation of drug use among people who inject drugs: a systematic review. Lancet HIV 2017; 4: e357–74.
[156] Cullen FT, Pratt TC, Turanovic JJ, Butler L. When bad news arrives: project HOPE in a post-factual world. J Contemp Crim Justice 2018; 34: 13–34.
[157] Schaefer L, Beriman M. Problem-solving courts in Australia: a review of problems and solutions. Vict Offender 2019; 14: 344–59.
[158] Kornhauser R. The effectiveness of Australia's drug courts. Aust NZ J Criminol 2018; 51: 76–98.
[159] Mazerolle L, Soole D, Rombouts S. Drug law enforcement: a review of the evaluation literature. Police Q 2007; 10: 115–53.
[160] Degenhardt L, Peacock A, Colledge S, et al. Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review. Lancet Glob Health 2017; 5: e1192–207.
[161] Tilson H, Aramrattana A, Bozzette S. Preventing HIV infection among injecting drug users in high-risk countries: an assessment of the evidence. Washington, DC: Institute of Medicine, 2007
[162] Palmateer N, Kimber J, Hickman M, Hutchinson S, Rhodes T, Goldberg D. Evidence for the effectiveness of sterile injecting equipment provision in preventing hepatitis C and human immunodeficiency virus transmission among injecting drug users: a review of reviews. Addiction 2010; 105: 844–59.
[163] Aspinall EJ, Nambiar D, Goldberg DJ, et al. Are needle and syringe programmes associated with a reduction in HIV transmission among people who inject drugs: a systematic review and meta-analysis. Int J Epidemiol 2014; 43: 235–48.
[164] Sutcliffe CG, Aramrattana A, Sherman SG, et al. Incidence of HIV and sexually transmitted infections and risk factors for acquisition among young methamphetamine users in northern Thailand. Sex Transm Dis 2009; 36: 284–89.
[165] UN Office on Drugs and Crime. Systematic literature review on HIV and stimulant drugs use (B). Part 5/5. Treatment and prevention of HIV, HCV and HBV among stimulant drugs users. Vienna: UNODC, 2017.
[166] Leonard L, DeRubeis E, Pelude L, Medd E, Birkett N, Seto J. "I inject less as I have easier access to pipes": injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed. Int J Drug Policy 2008; 19: 255–64

Testing and treatment of HIV and HCV infections might reduce injecting risk and incidence in people who inject drugs.[168, 169]

Evidence suggested that the potential effect of needle and syringe programmes on HIV and HCV infection in people who inject stimulants, could ameliorate, but not eliminate, excess injecting-related HIV and HCV transmission in this group. Results were consistent with empirical findings of insufficient needle and syringe programme coverage for people who inject drugs transitioning to stimulant (methamphetamine) injection.[170] The findings reinforce the urgent need to scale-up needle and syringe programmes for people who inject stimulants and to develop effective novel interventions to reduce risk in this group.

Provision of condoms[171] and pre-exposure prophylaxis (PrEP) for both HIV[172] and sexually transmitted infections[173] reduce sexual risk behaviours, and the transmission of HIV, HCV, and sexually transmitted infections in people who inject drugs and MSM, rather than specifically in people who use stimulants. Condoms and treatment for infectious diseases will probably prevent blood borne viruses and sexually transmitted infections in people who use stimulants, but who do not inject them as these interventions do in the general population. However, there is a poor understanding of blood borne viruses and sexually transmitted infection risk in this context (e.g. via pipe sharing and sexual risk behaviour), and of the effectiveness of interventions to mitigate these risks.

10.1.1.7 Interventions to improve the mental health of people who use stimulants

Developing effective responses around comorbid mental health issues is essential because of the high prevalence of the comorbidity and the strong associations between stimulant use and mental health problems. The use of the interventions is complicated in people who use stimulants because mental health problems can be both premorbid and induced or exacerbated by stimulant use. The implementation and evaluation of the interventions is an essential area for further research because very few mental health interventions have been evaluated in people with stimulant dependence.

Acute psychoses can be treated effectively with antipsychotics, but there is only a small amount of evidence regarding the effectiveness of antipsychotics in managing acute

[167] MacArthur GJ, van Velzen E, Palmateer N, et al. Interventions to prevent HIV and hepatitis C in people who inject drugs: a review of reviews to assess evidence of effectiveness. Int J Drug Policy 2014; 25: 34–52.
[168] Caven M, Malaguti A, Robinson E, Fletcher E, Dillon JF. Impact of hepatitis C treatment on behavioural change in relation to drug use in people who inject drugs: a systematic review. Int J Drug Policy 2019; published online May 18. DOI:10.1016/j.drugpo.2019.05.011.
[169] Reddon H, Marshall BDL, Milloy MJ. Elimination of HIV transmission through novel and established prevention strategies among people who inject drugs. Lancet HIV 2019; 6: e128–36.
[170] O'Keefe D, Scott N, Aitken C, Dietze P. Longitudinal analysis of change in individual-level needle and syringe coverage amongst a cohort of people who inject drugs in Melbourne, Australia. Drug Alcohol Depend 2017; 176: 7–13.
[171] Giannou FK, Tsiara CG, Nikolopoulos GK, et al. Condom effectiveness in reducing heterosexual HIV transmission: a systematic review and meta-analysis of studies on HIV serodiscordant couples. Expert Rev Pharmacoecon Outcomes Res 2016; 16: 489–99
[172] Martin M, Vanichseni S, Suntharasamai P, et al. The impact of adherence to preexposure prophylaxis on the risk of HIV infection among people who inject drugs. AIDS 2015; 29: 819–24
[173] Bolan RK, Beymer MR, Weiss RE, Flynn RP, Leibowitz AA, Klausner JD. Doxycycline prophylaxis to reduce incident syphilis among HIV-infected men who have sex with men who continue to engage in high-risk sex: a randomized, controlled pilot study. Sex Transm Dis 2015; 42: 98–103

stimulant psychosis.[174] No evidence is available regarding whether antipsychotic prophylaxis is safe and effective in people who use stimulants who have recurrent episodes of psychosis. These patients are often excluded from mainstream services for psychotic disorders because of their comorbid stimulant dependence.

Managing agitation and violence in stimulant-induced psychoses is a substantial challenge for frontline emergency medical and police services. This risk of violent behaviour has an immediate, but unquantified adverse effect on family and peers. More research is needed on the effectiveness of protocols to reduce agitation related to stimulant intoxication and to manage violence risk more generally.[175] Punitive responses to aggressive or violent behaviour within clinical services can exclude people who use stimulants from treatment and perpetuate their engagement with the criminal justice system. Therefore, treatment needs to be delivered in ways to reduce the risk of violent behaviour.

Evidence-based strategies to reduce depression include psychological therapies (cognitive behavioural therapy, contingency management, acceptance and commitment therapy, and meditation-based therapies). Cognitive behavioural therapy can also reduce suicide risk in people who use drugs[176] and it is effective for depression.[177] Antidepressant drug therapy reduces depression in people who use cocaine,[178] but it does not reduce stimulant use and some antidepressants are contraindicated for methamphetamine dependence.[179] Substitution therapies (including dopamine agonists) do not relieve depression in people who are dependent on stimulants.[180,181,182]

10.1.1.8 Interventions to prevent and treat overdose, injuries and other harms

Harm reduction approaches to reducing risky stimulant use and the harms of acute intoxication are not well evaluated.[183] Common strategies include providing information and education about avoiding rapid-onset routes of administration (such as smoking and injecting), limiting the quantity and frequency of stimulant use, identifying early signs of stimulant psychosis (e.g. illusions and persecutory ideation), general advice on risk assessment (e.g. drug driving), and tips on general health (e.g. sleep hygiene, diet, and

[174] Shoptaw SJ, Kao U, Ling W. Treatment for amphetamine psychosis. Cochrane Database Syst Rev 2009; 1: CD003026.
[175] Bunting PJ, Fulde GW, Forster SL. Comparison of crystalline methamphetamine ("ice") users and other patients with toxicology-related problems presenting to a hospital emergency department. Medical J Aust 2007; 187: 564–66
[176] Calear AL, Christensen H, Freeman A, et al. A systematic review of psychosocial suicide prevention interventions for youth. Eur Child Adolesc Psychiatry 2016; 25: 467–82.
[177] Churchill R, Moore TH, Furukawa TA, et al. 'Third wave' cognitive and behavioural therapies versus treatment as usual for depression. Cochrane Database Syst Rev 2013; 10: CD008705
[178] Pani PP, Trogu E, Vecchi S, Amato L. Antidepressants for cocaine dependence and problematic cocaine use. Cochrane Database Syst Rev 2011; 12: CD002950.
[179] Shoptaw S, Huber A, Peck J, et al. Randomized, placebo-controlled trial of sertraline and contingency management for the treatment of methamphetamine dependence. Drug Alcohol Depend 2006; 85: 12–18.
[180] Castells X, Cunill R, Perez-Mana C, Vidal X, Capella D. Psychostimulant drugs for cocaine dependence. Cochrane Database of Syst Rev 2016; 9: CD007380
[181] Minozzi S, Amato L, Pani PP, et al. Dopamine agonists for the treatment of cocaine dependence. Cochrane Database of Syst Rev 2015; 5: CD003352.
[182] Indave BI, Minozzi S, Pani PP, Amato L. Antipsychotic medications for cocaine dependence. Cochrane Database Syst Revs 2016; 3: CD006306.
[183] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32230-5/fulltext

dental health). Overdose prevention approaches to stimulants emphasise awareness of drug strength and avoiding high-dose toxicity complications, such as seizures, by reducing dose. No substantial attention has been given to reducing accidents and injuries, nor to reducing cardiovascular risk in this population.[184]

10.2 Appendix 2: Economic review - Crime & Economic Costs to Society

In Kent, 17% of referrals into treatment were made through the Criminal Justice System (CJS), higher than the 14% reported nationally in the Kent Police Force Area (KPFA).

Of those, 50% were referred in through the prison service, and 24% through alcohol treatment or drug rehabilitation requirements.

Figure 1: Referral source for CJS referred treatment clients

CJS Referrals	Kent PFA	England
Arrest referral / CJIT	6%	15%
CRC	10%	3%
Prison	50%	46%
Probation	6%	13%
DRR	9%	6%
ATR	15%	6%
Other	4%	12%

Of the clients in treatment in 2017/18, it is estimated the numbers of the following crimes were committed in their time before treatment entry:

Figure 2: Estimated number of crimes committed before treatment entry, Kent clients:

	Estimated number of crimes committed before treatment entry	
Offence Type	Drug Clients	Alcohol Clients
Shoplifting	141,294	4,992
Theft of a vehicle	1,904	14
Theft from a vehicle	5,713	23

[184] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)32230-5/fulltext

Domestic burglary	1,143	72
Non-domestic burglary	7,236	40
Robbery	2,285	26
Fraud	3,047	14
Criminal damage and arson	130	33
Violence against the person	336	118
Sexual offences	52	28
Begging	17,900	1
Drink/Drug Driving	28	40
Other theft	14,472	76
Drug Offences	81,120	12
Prostitution	3,487	0
Breach offences	340	48
Public Order	50	17
Other	213	36
Total	280,749	5,590

Alcohol clients have shown the larger reduction in re-offending rates upon starting treatment, however those drug clients that do reduce offending rates have a much higher impact on average and higher return on investment.

Figure 3: Estimated social and economic costs of treatment of Kent clients in 2017/18:

Estimated % reduction in offending after starting treatment	Drug Clients	-28%
	Alcohol Clients	-53%
Estimated crimes prevented per year after starting treatment for Kent	Drug Clients	78,230 (280,749 before treatment)
	Alcohol Clients	2,956 (5,590 before treatment)

Average crime related cost per client in Kent	Drug clients - Before starting treatment	Drug clints - After starting treatment	Alcohol clients Before starting treatment	Alcohol clients After starting treatment
Social costs	£ 3,403	£ 2,454	£ 604	£ 285
Economic costs	£ 28,337	£ 20,441	£ 1,744	£ 822
Social and Economic costs	£ 31,739	£ 22,895	£ 2,349	£ 1,107

Gross Benefits for Kent	**Drug clients**	**Alcohol clients**	**Total**
Social costs	£ 2,909	£ 980,697	£ 3,890,488
Economic costs	£ 24,232,524	£ 2,831,052	£ 27,063,575
Social and Economic costs	£ 27,142,315	£ 3,811,749	£ 30,954,063

Substances Misuse Services	64%	KCC Commissioned
Mental Health Services	60%	NHS Commissioned
Employed in Social Care	16%	KCC
Homeless People	55%	KCC & District

Source: Public Health England. Adults - alcohol commissioning support pack 2017/18: key data

A similar amount of money is spent per client in both drug and alcohol treatment services currently. Alcohol only clients are more likely to have successful treatment, have lower crime rates prior to treatment and more likely than drug clients to not re-offend once treatment has started.

Drug clients have considerably higher crime rates and are more likely to re-offend after treatment has started, however for those that engage well with treatment the crime and societal economic benefits are unequivocal.

Figure 4: Crimes and costs in Kent

Crimes and Costs in Kent	**Drug treatment**	**Alcohol treatment**
Clients 2017/18	3,055	1,515
Estimated crimes per client before treatment	91.9	3.7
Service spend 2017/18	£5,074,000	£2,633,000
Service spend / number of clients	£1,661	£1,738
Estimated crime reduction after starting treatment	-28%	-53%
Average reduction in social and economic costs per pt after starting treatment	£8,844	£1,242

10.3 Appendix 3 – Working Protocol

WORKING PROTOCOL

Kent and Medway Joint Working Protocol

for

Co-occurring Mental Health and Substance Misuse Disorders

Version Date:	October 2021
Ratified by:	Dual Diagnosis Strategy Group
Date ratified:	
Title of Author:	Prosper Mafu – Head of Service KMPT & Representatives from Kent & Medway Substance Misuse Services
Title of responsible Officer	Jess Mookherjee
Governance Committee	Dual Diagnosis Strategy Group
Date issued:	November 2021
Review date:	May 2022
Target audience:	All staff of agencies providing mental health and substance misuse services in Kent & Medway
Disclosure Status	Can be disclosed to patients and the public

Summary

This operational protocol is designed to give a clear framework within which all Kent and Medway Substance Misuse Services and Mental Health providers can operate with regard to providing comprehensive service user focused services to those with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis).

This Working Protocol describes locally agreed assessment and joint-working criteria and is an update on the *Dual Diagnosis Joint Working Protocol Kent and Medway for Co-existing Mental Health and Substance Misuse Disorders* produced in April 2016.

This protocol is to be used working in conjunction with the best guidance via PHE and NHS to tackle barriers in care and support for people who have both mental illness and substance misuse addictions/ problems.

The Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) Protocol must be shared with and understood by all staff working with service users with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) as defined in this Protocol in:

- CGL (West Kent Substance Misuse Services) provided by CGL (change, grow, live)
- KMPT
- IAPT Providers (via NHS CCG Commissioners)
- Live Well Kent providers
- Forward Trust (East Kent Substance Misuse Services)
- Prison and Probation Trust Providers
- Police Mental health Teams
- Social Services KCC
- Public Health providers (One You) KCHFT
- Primary Care Mental Health Teams
- Any Multi-disciplinary team formed as part of care co-ordination.
- Inpatient detox and rehab facilities commissioned by Kent providers

Purpose

The purpose of this Protocol is to support effective and well-co-ordinated services for people with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) within Kent.

To ensure that all individuals with co-existing mental health and substance use issues receive a service fit for their varying needs, irrespective of where and how they present.

The protocol is intended to foster joint working between services and maintain and build on each organisation's specialist role within the mental health and substance misuse system.

Responsibilities of Participating Agencies

In Kent, The Director of Public Health (and via his consultant PH deputies) is responsible for commissioning treatment services for those with drug and/or alcohol problems through the Public Health Commissioning Team.

Services are commissioned from a range of providers in both the statutory and voluntary sectors. The Public Health Commissioning Team have commissioned Kent and Medway Adult Substance Misuse Treatment Services to be the primary providers of substance misuse services within Kent with specification to support a Joint Dual Diagnosis Pathway with the mental health providers - in the main KMPT.

The Kent and Medway Adult Substance Misuse Treatment Services are commissioned to provide specialist multi-disciplinary care and treatment for those with complex substance misuse problems. The Medical Directors are ultimately responsible for the provision of substance misuse services to those with Dual Diagnosis in Kent and Medway.

The Integrated Health and Commissioning Team commissions services for those with the more severe mental health problems from KMPT. The Trust provides services to those with severe mental illness, a significant proportion of whom also have substance misuse problems, through a range of services including Community Mental Health Teams (CMHTs), Early Intervention in Psychosis Service, Acute Inpatient Units, Crisis Resolution and Home Treatment Team (CRHT) and Mental Health Liaison (A&E Liaison) Teams.

Effective joint working between all agencies is key to meeting the needs of those with co-existing mental health and substance misuse disorders (Dual Diagnosis).

Managers in these services have a responsibility to make their teams aware of this Protocol and related operational policies, and staff are expected to comply with these policies.

In some situations, there may be service users who do not wish to engage with any or specific services even though it may appear counter-intuitive to the providers. In these cases, involved organisations will try and contact the service user if they believe that the service that they can provide will be of benefit to him/her. If KMPT strongly believe that not engaging with them places the Service User at risk, either to self or public, then KMPT will make a judgement on whether a more assertive approach is needed in order to prevent harm to the service user or other individuals. KMPT will use collateral information provided by carers, GP's and other organisations to assist KMPT with this judgement. KMPT will work within the guidance of the Mental Health Act, where appropriate. It is ultimately the service user's personal choice whether to engage Forward Trust/CGL's [Kent Adult Substance Misuse Treatment Services] or not. (for issues around Capacity – please refer to Appendix 1-point 3).

There are rare occasions when any provider is unable to offer a service to a client and in these circumstances the reasons need to be fully explained to the client in writing. The clients and carers have the right to challenge the provider (refer to complaints section).

Target Service User Group

- Is aged 18 years and over
- Has a significant history or shows symptoms of serious mental health harm/illness?
- Is resident in Kent and Medway either permanently or temporarily
- Requires mental health services in respect of a mental health problem
- Requires specialist drug and alcohol services provided by CGL/Turning Point/Forward Trust
- May have identified eligible social care needs in respect of their mental health disorder/substance misuse
- Requires joint care involving more than one of the following agencies; primary care, substance misuse services, mental health services (not all service users with mental illness will be receiving specialist mental health services. For example, some will be self-managing and others may be supported by their GP.)
- May be involved with the criminal justice system, and related service providers

The protocol does not cover individuals with Dual Diagnosis needs who are under 18 years old. Services for this client group are provided by Child and Adolescent Mental Health Services (CAMHS).

Cooccurring Conditions

The locally agreed term for ‘Dual Diagnosis/ Co-occurring condition’ in respect of this Protocol refers to any individual who requires treatment and/or support for co-existing mental health and substance misuse disorders.

There is no gain in debating which causes what – as it has been agreed clinical presentation and care is more important as per national guidance. Mental health problems in this guideline can range between clinical diagnoses of:

- schizophrenia, schizotypal and delusional disorders
- bipolar affective disorder
- severe depressive episode(s) with or without psychotic episodes
- personality disorder / adult attachment disorder
- Complex Post Traumatic Stress Disorder.

and common mental health problems of mild to moderate severity including:

- phobias

- generalised anxiety
- obsessive compulsive disorder
- social anxiety
- single event trauma
- depression

Substance misuse refers to the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage." - (NICE guideline: Severe mental illness and substance misuse (dual diagnosis): community health and social care services)

The nature of the relationship between these two conditions is complex.

Possibilities include:

1. A primary mental health condition precipitating or leading to substance misuse.

2. Substance misuse worsening or altering the course of a mental health condition.

3. Intoxication of substance dependence leading to psychological symptoms.

4. Substance misuse and/or withdrawal leading to mental health symptoms or illness.

The decision as to which service has the primary responsibility for providing a lead role in the care for these service users depends on the severity of the mental health condition experienced. A significant majority of those with a Dual Diagnosis who have mental health issues which are not severe will be cared for predominantly within Substance Misuse Services, while those with Severe Mental Health conditions will be cared for predominantly by statutory Mental Health Services. A number of primary care (IAPT) or non-statutory mental health services may also provide significant support and care for service users experiencing mental health problems.

The underlying principle of this protocol is JOINED UP CARE PLANNING – particularly in the most vulnerable patients (*See Appendix 1 Expected Elements of Joint Working - Essential Guidance*). Also noting – that the history of vulnerability may mean that people need to be stepped up and down over time.

The Service Users' Carers, subject to issues of consent on a case by case basis, will be given the opportunity to express their point of view with regard to which service needs to be involved. While this opportunity will be provided, decisions will ultimately be based on clinical judgement.

Referral to Services

Referral to Substance Misuse Services:

All agencies can refer to substance misuse services for an assessment. Whilst substance misuse services will accept self-referrals from patients, professional referrals are very helpful as these may help identify the need for joint working at the earliest opportunity.

For some complex cases, it might be preferable for a Mental Health clinician to present the referral in person at the substance misuse service MDT meeting. We encourage substance misuse services to offer a slot to the referrer to enable them to present the referral via video link. This is seen as a positive step to encourage joint working.

Referral to Secondary Care Mental Health Services:

Secondary Mental health services will accept referrals from substance misuse services.

- Referral by a consultant psychiatrist in substance misuse or other qualified mental health practitioner are preferable and will be accepted for assessment.
- Referral from the local care co-occurring conditions MDT will be accepted for assessment.
- Referrals from non-qualified Mental Health professional will be accepted but may have to go through a triage process.

For some complex cases, it might be preferable for a Substance Misuse Practitioner to present the referral in person at the Mental Health service MDT meeting. We encourage Mental Health to offer a slot to the referrer to enable them to present the referral via video link. This is seen as a positive step to encourage joint working.

For the *Referral Flowchart: Substance Misuse Services to Mental Health Services* see Appendix 2.

Referral to Improving Access to Psychological Therapies (IAPT) and Primary Care Mental Health Services:

Substance Misuse Services can refer directly to IAPT and Primary Care Mental Health Services. IAPT and Primary Care Services can also refer directly to Substance Misuse Services.

In all cases, referrals from Kent and Medway Adult Substance Misuse Treatment Services will outline the following: –

a) What is the mental disorder that the Kent Adult Substance Misuse Treatment Services practitioner thinks that the service user is experiencing?
b) How will the service user's substance misuse problem obstruct the treatment provided by mental health services?
c) What the service user subjectively hopes to gain from accessing mental health services?

Referral to third sector organisations such as live well Kent and One you Kent:

These services will accept referrals from Kent and Medway Adult Substance Misuse Treatment and Mental Health Services and other agencies.

It is important to acknowledge that referral of people with co-occurring conditions can come from other sources such as GPs, Acute hospitals Local Care multidisciplinary team (MDT) meetings. Where the agency receiving the referral decides that there is need for another agency to be involved they will take responsibility for onward referral or signposting to either Mental Health services or Mental health services without returning the referral to the GPs, Acute hospital or local care MDT meeting.

Assessment

An initial Assessment will help practitioners to establish immediate risks and support needs. Service user experience and planning of care is improved if this is completed jointly between agencies involved, service user and carers.

The key factors to assess at this stage are:

a. Severity of Mental Health: mild / moderate / severe & enduring condition. Brief Mental Health Questionnaire, GAD7 & PHQ9 screening tools may be used to aid this process, available at: PHQ 9 and GAD 7: https://talk2gether.nhs.uk/quick-self-assessment/
b. Substance use patterns: current use, dependence, perceptions & readiness Assess motivation to change: AUDIT and ASSIST screening tools may be used to aid this process, available at:

- PHE AUDIT: https://www.gmmh.nhs.uk/download.cfm?doc=docm93jijm4n639.pdf&ver=1017
- WHO ASSIST: http://apps.who.int/iris/bitstream/handle/10665/44320/9789241599382_eng.pdf;jsessionid=CAC16D2BFDC3657A9395F0337FA7F56A?sequence=1
- NIDA DAST 10: https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69

c. Housing & support networks: e.g. homelessness, engagement with supported housing, social networks.

d. Risks: to self, to others, in relation to all of the above.

Key Question: can your service alone support the person's overall needs and manage any associated risks?

Practitioners must use clinical indicators and experience to consider if the mental health symptoms identified at initial assessment can be explained by alcohol or substance misuse. If the alcohol or substance use was addressed would it be likely to address the mental health symptoms; could the situation change; or get worse? Support and advice should be sought from partner agencies and co-occurring conditions Champions.

If post-assessment, your service cannot support the care needs of the individual and / or manage the associated risks consider:

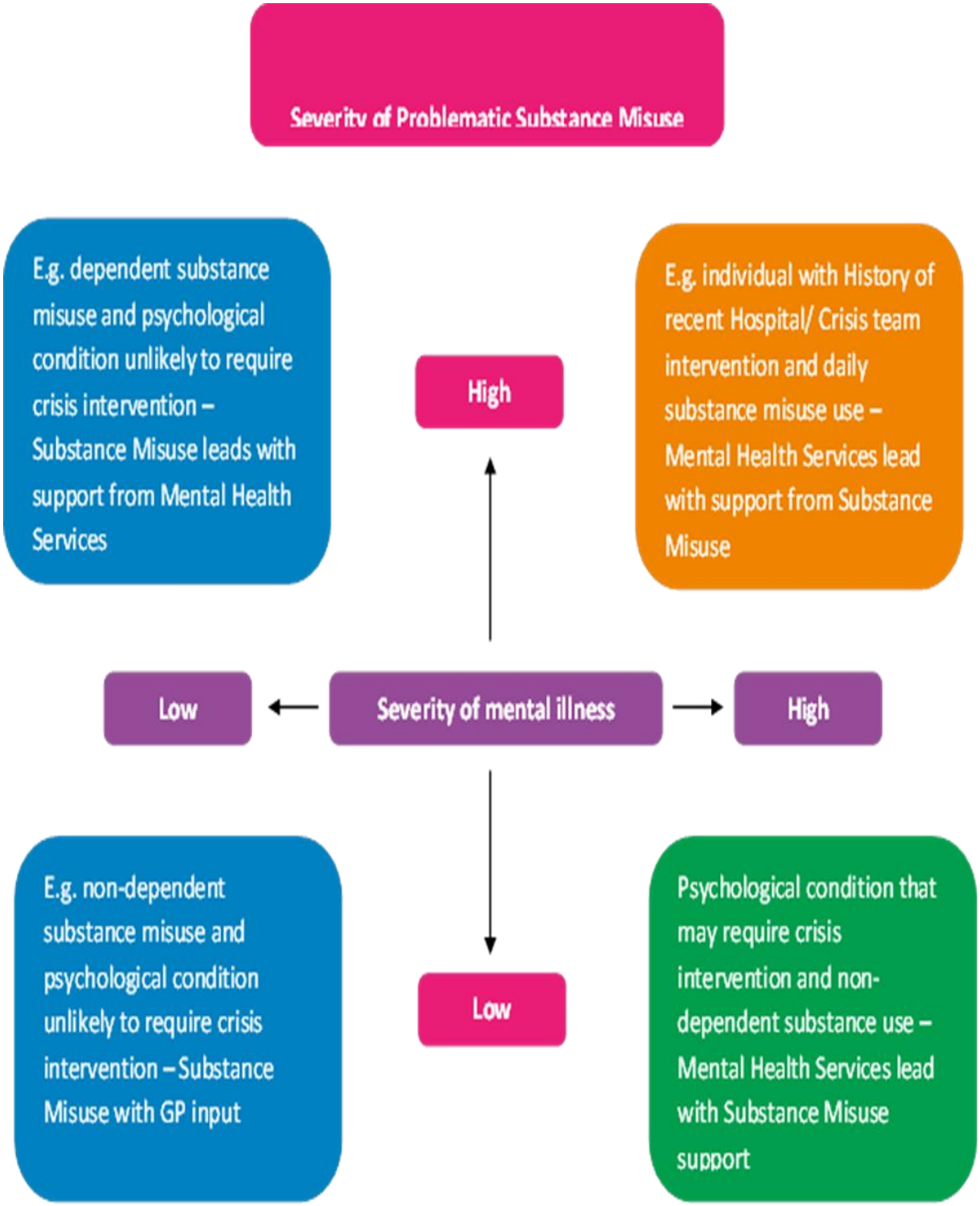
- Consulting with another service
- Offering collaborative/joint care with another service
- Assertively referring on to another service

The co-occurring conditions guide and locally agreed protocols are to assist practitioners to make decisions based on assessed need matched to service provision.

Model of Co-Occurring Conditions (Quadrant Model)

Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis): exists along two axes.

The vertical axis describes the severity of problematic substances misuse while the horizontal axis describes the complexity of mental health issues, giving four "quadrants", or situations where people may find themselves, as depicted in the diagram below.



Model of Co-Occurring Conditions (Quadrant Model)

Service users with co-existing mental health and substance misuse disorders can be broadly described as presenting in four categories –

1) Severe Mental illness with substance dependence-high mental illness and high substance misuse.

2) Severe & persistent mental illness with substance misuse-high mental illness and low substance misuse.

3) Non-severe mental health problems and substance dependence-high substance misuse and low mental illness.

4) Non-severe mental health problems and non-dependent-low mental illness and low substance misuse.

The quadrant model above serves as a guide however, in practice, the service user's mental health and drug misuse can be very changeable and dynamic. People dynamically move between these quadrants and care should follow the patient in a safe and high-quality fashion. Service user life events impact significantly upon both elements and the service user may move between quadrants. A person-centred approach is needed so that the most appropriate service is accessed.

Therefore, it is important that vulnerability is assessed and identified, a key worker is assigned, a care plan is in place and that any change in quadrant is handed over appropriately with an adjusted care and safety plan, clearly communicated to patient (and if appropriate carer/family).

The care pathway gives clear direction as to which service leads and which service supports. This protocol ensures that there will be clear agreements about how to meet the needs of those with co-existing mental health and substance misuse disorders (Dual Diagnosis), as defined in this Protocol, under their care. These are based on the principle of working jointly to provide individualised packages of care that are most suited to individual service users, rather than allowing the ways services are organised to dictate how care is provided.

Management and lead responsibility for delivery of care will be dictated in line with aforementioned categories. Noting at all stages that people can change 'quadrant' and that for the most vulnerable patients an annual review of a care plan is good practice.

Lead Agency in joint working depending on Severity of Mental illness and Substance dependency.

A) Severe Mental illness with substance dependence-high mental illness and high substance misuse.

Lead Agency: Secondary mental health services local or forensic mental health services in consultation and collaboration with Substance Misuse Services as appropriate.

Case management responsibility for individuals with severe and enduring mental illness will remain the responsibility of the Mental Health Service. These clients will have severe and enduring mental illness and high levels of substance misuse or dependence e.g. an individual with schizophrenia who has alcohol dependence.

B) Severe & persistent mental illness with substance misuse-high mental illness and low substance misuse

Lead Agency: Secondary Mental Health Services or forensic MHS mental health services in consultation and collaboration with Substance Misuse Services as appropriate.

Case management responsibility for individuals with severe and enduring mental illness will remain the responsibility of Mental Health Services.

The service user can either be newly referred to the Specialist mental health services or previously known to services. In either case Specialist mental health services can refer to Kent and Medway Adult Substance Misuse Treatment Services for assessment to identify the most appropriate intervention.

If there is no dependency – then a risk assessment and treatment plan will be made. If the substance misuse is complex and problematic and cannot be managed via any other agency – the Kent Substance Misuse Treatment Services can provide support if needed.

If dependence is also diagnosed in addition to the Severe Mental Illness, then this service user will need the joint working protocol where the Kent Adult Substance Misuse Treatment Services Recovery Coordinator involvement in the CPA process. Other services such as ONE YOU KENT should not deny a patient a service due to mental illness.

C) Non-severe mental health problems and substance dependence-high substance misuse and low mental illness

Lead Agency: Substance Misuse Services (SMS).

This will be in accordance with National Training Agency Models of Care case management framework. These will be clients with primary substance misuse disorder with secondary low-level mental illness e.g. a dependent drinker who experiences symptoms of anxiety or depression, a dependent opiate user or regular stimulant user with symptoms of anxiety. This care will primarily be provided by SMS partner agencies.

Kent and Medway Adult Substance Misuse Treatment Services will initially be responsible for the assessment of mental health needs of service users and the necessity for onward referral to (IAPT).

As part of this assessment process, service users are offered a Health Care assessment, carried out by a Health and Wellbeing Nurse. The assessment may

involve use of screening tools such as GAD-7, PHQ-9 and Mini Mental State as well as assessment by their Clinician.

If the assessment process identifies the need for onward referral the Kent and Medway Adult Substance Misuse Treatment Services clinicians will support referral to IAPT or primary care mental health if needed.

D) Non-severe mental health problems and non-dependent low mental illness and low substance misuse.

Lead Agency: Primary care with support from partner agencies.

These clients will be individuals who have low-level mental health and low-level substance use. This will include a recreational misuser of ecstasy who struggles with low mood after using the drug or a non-dependent drinker who feels they are not coping well with anxiety. This care will primarily be provided in Primary care settings in collaboration with Community Psychiatric link workers, SMS services and mutual aid organisations and support agencies as required.

The Kent and Medway Adult Substance Misuse Treatment Services will initially be responsible for the assessment of mental health needs of service users and the necessity for onward referral to LIVE WELL/ ONE YOU. As part of this assessment process, service users are offered a Health Care assessment, carried out by a Health and Wellbeing Nurse. The assessment may involve use of screening tools such as GAD-7, PHQ-9 and Mini Mental State as well as assessment by their Clinician.

If the assessment process identifies the need for onward referral the clinicians will support referral to services such as Live Well Kent, IAPT and Primary Care Mental Health Nurses.

Service users with non-severe mental health conditions, whether dependent on either illicit drugs or alcohol, may be referred for consideration for the Live Well or One You Kent.

Dependent drinkers

Once the service user has completed an alcohol detoxification and is abstinent then Kent and Medway Adult Substance Misuse Treatment Services will make the referral to Mental health services at this critical period where a person needs support.

Kent and Medway Adult Substance Misuse Treatment Services can make informal enquiries to the Specialist Mental Health services clinicians on the viability of the referrals and can state in the referral that the case has been informally discussed with the Mental Health Service clinician which will guide the service on how these referrals are progressed.

The joined-up care plan will take note of the mental health risk and the support needed and a plan will be made and shared with the patient (and if appropriate – cares and family).

Non-dependent drinkers

The clinician can make a referral as above on a case by case basis.

Dependent Opiate users in receipt of substitute medication

Service Users assessed as stable enough to be on interim collection from the pharmacy can be deemed to have made sufficient progress in their recovery journey to make optimum use of the primary care mental health services and IAPT are capable of working with a service user only if the opiate use is not a barrier to treatment.

Kent and Medway Adult Substance Misuse Treatment Services can make informal enquiries to the IAPT clinicians on the viability of the referrals and can state in the referral that the case has been informally discussed with the IAPT clinicians which will guide the assessor on how these referrals are progressed. The IAPT team will aim to assess the service user within two-weeks of receiving the referral.

Other Drugs (Cocaine, Cannabis, NPS)

There are no objective methods to assess the impact of these drugs on the effectiveness of IAPT therapies. Therefore, the Kent and Medway Adult Substance Misuse Treatment Services needs to make a referral on a case by case basis.

Involvement of Carers / Significant Others

Carers are important partners in service user care and can play a vital role in recovery and preventing relapse but caring takes its toll and can have an impact on the carer's own health. It is essential to listen and respond to the voice and needs of carers and ensuring, where consent is given, that carers are invited to attend, exchange ideas with the treating team so that they can have an active role in joint reviews.

Transfer from Inpatient Mental Health Services

When Service Users with co-occurring conditions are transferred to the community from inpatient mental health services, they will have:

- An identified Lead Health Care Professional from mental health services
- An allocated recovery coordinator from Kent and Medway Adult Substance Misuse Treatment Services who will have been invited to the transfer planning meeting
- A care plan that includes consideration of needs associated with both their severe mental illness and their substance misuse, and;
- Will have been informed of the risks of overdose if they start reusing substances, especially opioids that have been reduced or discontinued during their inpatient stay.

Patients with co-occurring conditions presenting to Kent and Medway Emergency Department and/or admitted to Acute General Hospitals

For all Mental Health patients referred to the Liaison Psychiatric Services (LPS) by the acute hospitals, the LPS staff will discuss substance misuse as part of the assessment and review process.

The outcome could be a referral to the local Substance Misuse service and if already open to substance misuse services LPS will notify the Substance Misuse service of the presentation to the emergency department and subsequent admission where appropriate. ***In all cases the patient will need to be asked for their consent to this sharing of information*.**

Where there is also a referral to community and/or inpatient mental health services LPS will alert these mental health services of the involvement of substance misuse services.

The LPS discharge letter to the G.P will also notify the G.P of referral and signposting to substance misuse services.

Where joint working is identified substance misuse will be involved in the acute hospital discharge planning in the same way as the transfers from inpatient mental health wards as above.

Transition

In order to ensure that young people with co-occurring conditions who continue to need treatment for Dual Diagnosis are transferred smoothly to services for adults, refer to NELFTs & KMPTs Trust policy on Transition arrangements to Adult Mental Health Services.

Dispute Resolution

Disputes over case responsibility will be rare if full information is shared and if all services are willing to operate with some flexibility in the interests of the service user. In the cases where a dispute does arise, it will be referred to the respective service managers for resolution. Clinician to clinician discussion are encouraged.

If no resolution is achieved through this meeting, cases will be referred to relevant provider organisations Clinical Directors/Senior Management for resolution, with commissioner input as necessary.

Sharing of Information & Monitoring

Information should only be shared on a ‘need to know’ basis and strictly in compliance with duty of care.

There is an expectation that consent to share information is sought from the service user although this may differ in exceptional circumstances such as crisis/high risk scenarios.

Consent to share information should be re-considered/updated at regular review meetings.

Staff Training

Provider organisations will work with commissioners to carry out a training needs analysis for mental health and substance misuse services.

Clinical learning forums facilitated by public health are a good resource for both Substance Misuse and Mental Health Services.

Appendix 1 Expected Elements of Joint Working - Essential Guidance:

In all cases it is vital that a service user does not fall between services, and service users must be given every opportunity to engage with services.

- Assertive referral between care providers which demonstrates an understanding of the partner agencies information need, including where possible completed tools (e.g. regarding alcohol consumption). This should involve enhanced actions to support engagement e.g. attending along with the service user for an appointment with substance misuse service or mental health service. *It is unacceptable to refer on to another service without following-up to ensure that suitable care/intervention has been offered.*

- Jointly conducted, formal comprehensive assessment of a service user's needs and risks, leading to the drawing up of a joint care plan with the service user.

- Joint approach to supporting and motivating engagement of dual diagnosis service users, to ensure every opportunity for services to be accessed.

- Wherever possible partner agencies must have a presence on each other's sites. Whether this be informally or with formal arrangements e.g. clinic sessions, attendance at clinical forum, risk forums, engagement sessions etc.

- Comprehensive & proactive handover, where a case is being closed by one service but picked up by the other.

- A clear agreement with the service user, within care planning, as to which person/service will, where necessary, liaise with non-statutory agencies.

- Robust discussions and documented decision making shared between both services regarding any safeguarding work (adult & child), even at alert level.

- Within information governance and risk parameters, both services will share patient history. This will be with signed consent but can be without consent where risk issues dictate a need to know situation.

- Joint investigations of SI, with sharing of learning actions (see joint investigation of SI protocol – currently in draft).

- Assertive links with primary care.

- Where appropriate, contacts will be recorded on partners' clinical record.

- Working together to share understanding of the needs of dual diagnosis service users with partner services e.g. A&E Liaison, A&E staff training.

- Work together to provide advice for GPs on when to request joint assessment by mental health and substance misuse service providers.

- Joint home visits for the purpose of assessment, intervention, and monitoring.

- Clearly designated roles and actions within the care plan, reflecting recovery actions and interventions, relapse indicators, and risk issues.

- Proactive information sharing between service providers, in line with information governance, service users' wishes and risks. Ensuring signed consent to share is completed where possible.

- Collaborative working with the service user's carers, family members or advocates, as expressly agreed with the service user.

- Also, where appropriate a carer's assessment will be carried out jointly.

- The Care Act 2014 provides that where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment.

- Rethink Dual Diagnosis leaflet for families, friends and carers.

- What it means to make a difference - Caring for people with mental illness who use alcohol and drugs.

- Joint reviews and clinical meetings e.g. CPA review meetings, clinical risk forums, safeguarding meetings. Again, in line with information governance, service user wishes and identified levels of risks.

- Use of mutually accessible venues and times to see the service users/carers to facilitate good engagement.

- Joint staff training and sharing of best practice across agencies and localities.

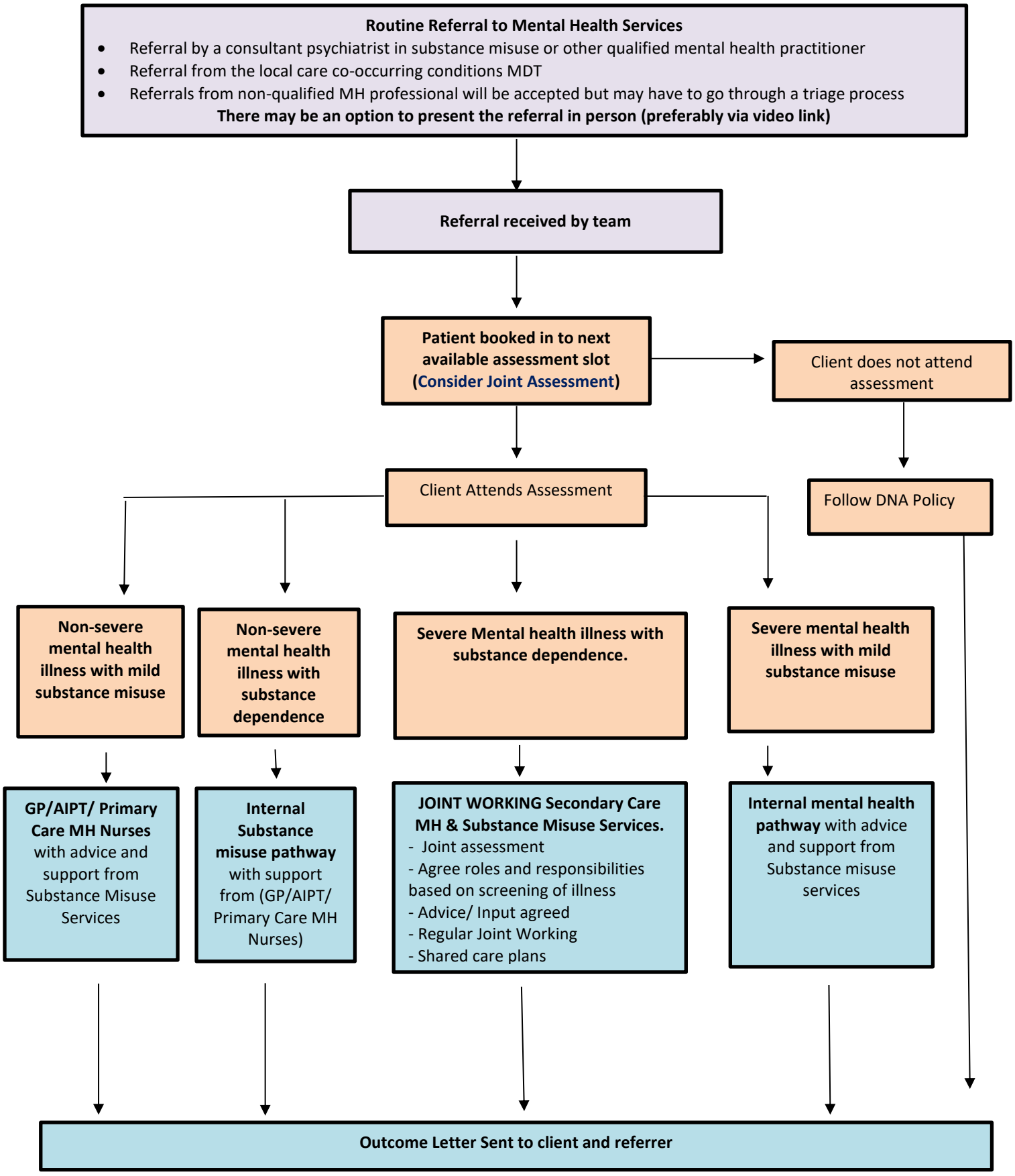
- Staff mutually and proactively, seeking and sharing information about the partner agency. Fostering a clear understanding of the remit, resources, interventions provided and tools used by a partner service, and developing good working relationships.

- Full consideration given to inter-agency referrals, where necessary seeking more information to enable a decision about the need for joint assessment. Where this is not the case, a written recommendation should be provided for the referrer.

- Each agency/service to identify Dual Diagnosis Champions for each team, who will liaise regularly with other Champions in the locality, they will attend agreed Dual Diagnosis training and Champion

- Locality Dual Diagnosis Forums held regularly and owned by local service providers, dual diagnosis champs, service user & carer representatives, with other stakeholders in attendance. There will be an agreed term of reference for each group.

Appendix 2: Referral Flowchart SMS to MHS Services



Appendix 3 REFERRAL EMAIL ADDRESSED AND CONTACT NUMBERS

Kent & Medway NHS & Social Care Partnership Trust Services		
Area/ Team	**Email/ Pager**	**Phone Number**
Early Intervention for Psychosis		
West Kent	Kmpt.eipwest@nhs.net	0300 303 3189
East Kent	Kmpt.eipeast@nhs.net	01227 812390
Anyone calling the West Kent 0300 number needs to press option 3 for EIP		
Liaison Psychiatry Service		
Medway Hospital Windmill Road Gillingham Kent ME7 5NY	Pager: 07623 382 686	01634 833826
Maidstone Hospital Hermitage Lane Maidstone ME16 9QQ	Pager: 07623 381735	01622 220265 01622 228834
Tunbridge Wells Hospital Tonbridge Road Royal Tunbridge Wells Tunbridge Wells TN2 4QJ	Pager: 07623 381734	01892 634958
William Harvey Hospital	Pager: 07623 382 685	01233 633331 (ext:

Kennington Road Willesborough Ashford TN24 0LZ		723 8705)
Queen Elizabeth the Queen Mother Hospital (QEQM) Ramsgate Road Margate CT9 4AN	Pager: 07623 381 746	01843 267072
Darent Valley Hospital Darenth Wood Road Dartford DA2 8DA	Pager: 07623 382 292	01322 927465
Kent & Canterbury Hospital Ethelbert Road Canterbury CT1 3NG	Pager: 07623 914 652	01227 868727
The Liaison Psychiatry Service only accept referrals Via their pager system, all teams have half an hour to respond to a pager.		
Community Mental Health Teams		
Ashford CMHT Eureka Place Eureka Business Park Trinity Road Ashford	KAMNASCPT.adminas@nhs.net	01233 658100

Kent TN25 4BY		
Canterbury CMHT Laurel House 41 Old Dover Road Canterbury Kent CT1 3HH	kmpt.cccmht.spoareferrals@nhs.net	01227 597111
DGS CMHT Arndale House 18-20 Spital Street Dartford Kent DA1 2DL	KAMNASCPT.dgscmht@nhs.net	01322 622230
Dover & Deal CMHT Coleman House Brookfield Ave Dover Kent CT16 2AH	kmpt.doveranddealduty@nhs.net	01304 216666
Maidstone CMHT Albion Place Medical Centre 23-29 Albion Place Maidstone Kent ME14 5TS	KAMNASCPT.maidstonecmht@nhs.net	01622 766900
Medway CMHT Britton House Britton Farm High Street	kmpt.crsladmin.mit@nhs.net	0300 303 3189

Gillingham Kent ME7 1AL		
Shepway CMHT Ash Eton Radnor Park West Folkstone Kent CT19 5HL	kmpt.shepwaycmhtadmin@nhs.net	01303 227510
Swale CMHT Sittingbourne Memorial Hospital Bell Road Sittingbourne Kent ME10 4DT	KAMNASCPT.swalecmht@nhs.net	01795 418350
SWK CMHT Highlands House 10-12 Calverly Park Gardens Tunbridge Wells Kent TN1 2JN	kmpt.swkadminteam@nhs.net	01892 709211
Thanet CMHT The Beacon Centre Manston Road Ramsgate Kent CT12 6NT	kmpt.clinicaldutybeacon@nhs.net	01843 855200
Older Adults		
Medway	KAMNASCPT.MedwayCMHSOP@nhs.net	0300 3033189

		Option 2
Swale		
Dover/ Deal	KMPT.DoverCMHSOPadmin@nhs.net	01304 216664
Shepway	KMPT.ShepwayCMHSOPadmin@nhs.net	01303 228838
DGS	KAMNASCPT.dgscmhsopadmin@nhs.net	01322 622202/07
SWK	Darent House: KAMNASCPT.sevenoakscmhsopadmin@nhs.net Highlands House: KAMNASCPT.TunbridgeWellsCMHSOP@nhs.net	Darent House: 01732 228242 Highlands House: – 01892 709200
Maidstone	kamnascpt.maidstonecmhsop@nhs.net	01622726899 01622723981
Ashford	KAMNASCPT.ashfordOPMH@nhs.net	01233 658 125
Canterbury		
Thanet	KAMNASCPT.ThanetCMHTOP@nhs.net	01843 267071
East Kent Rapid Transfer Dementia Service	kmpt.eastkentrtds@nhs.net	07554225815
Single Point of Access (SPOA)		
Whole of Kent	KAMNASCPT.spoa@nhs.net	0800 783 9111
West Kent Primary Care Mental Health Service (PCMHS)		
Medway PCMHS	kmpt.medwaypcmhs@nhs.net	0300 303 3189
SW Kent PCMHS	kmpt.pctmentalhealth.swkkmpt@nhs.net	01622 766 939
Maidstone PCMHS	kmpt.maidstonepcmhs@nhs.net	01622 766 939
Primary Care Admin	kmpt.primarycareadmin@nhs.net	01622 766 939

WK RSI Team	kmpt.westkentrsi@nhs.net	01622 766 939
Medway RSI Team	kmpt.medwayrsi@nhs.net	0300 303 3189
Please note that KMPT only provides West Kent PCMHS. The other PCMHN teams in the North and East are provided by Invicta.		
Kent Community Health NHS Foundation Trust		
Area/ Team	**Email/ Pager**	**Phone Number**
One You Kent		
Dartford BC	Kashmir.powar@dartford.gov.uk	N/a
Gravesham BC	Ravinder.Marwaha@thegrand.org.uk	N/a
Ton & Malling BC	Sarah.Wright@tmbc.gov.uk	N/a
Tun Wells BC	Rebecca.Bowers@TunbridgeWells.gov.uk	N/a
Maidstone BC	JolandaGjoni@Maidstone.gov.uk	N/a
Sevenoaks DC	Daniel.McDermott@sevenoaks.gov.uk	N/a
East Kent for Tier 2 Weight loss	markcummings@nhs.net	N/a
The diabetes services would need to refer to the service and the best way is through the One You Kent website referral form https://www.kent.gov.uk/social-care-and-health/health/one-you-kent which is found on the Strip halfway down the first page (Get Support from One You Kent) the referral form can also be found on other pages specifically for Adult Tier 2 weight loss services, to talk to a One You Kent advisor, and smoke free services page. KCHFT also deliver the smoke free and NHS Health Checks programme across the county.		

The Forward Trust		
Area/ Team	**Email/ Pager**	**Phone Number**
East Kent		
Ashford	Theforwardtrust.ashford@nhs.net	
Canterbury	Theforwardtrust.canterbury@nhs.net	
Dover	Theforwardtrust.dover@nhs.net	
Margate	Theforwardtrust.margate@nhs.net	
Sittingbourne	Theforwardtrust.sittingbourne@nhs.net	
Turning Point		
Area/ Team	**Email/ Pager**	**Phone Number**
Medway	medwayreferrals@turning-point.co.uk.cjsm.net	
	turning.point@nhs.net	
Change Grow Live (CGL)		
Area/ Team	**Email/ Pager**	**Phone Number**
	cgl.gravesend@nhs.net cgl.maidstone@nhs.net cgl.tunbridgewells@nhs.net	

Appendix 4 MEDWAY ACTIVE RECOVERY SERVICE - REFERRAL FORM (TURNING POINT)

Please note that Turning Point will also accept just a name, address and phone number.

Medway Active Recovery Service - Referral form								TURNING POINT Inspired by possibility
Date of referral:			**Time of referral:**				**Referral Taken by:**	
Forename: **Surname:** *(Previous Surname insert here_____)* **Address:** **Postcode:**_____ Please tick ☐ For **No Fixed Abode**			**Home phone Number:** **Mobile number:** Can we leave a message on number/s provided? Yes ☐ No☐				**Preferred method of contact:** Home phone ☐ Mobile Phone ☐ Text ☐ Letter ☐ No Preference ☐ **Date of Birth**: **Age**: **Gender:** Male ☐ Female ☐ Transgender ☐	
Local authority of Residence: Medway ☐ Other ☐ (please state) _____			**Nationality:**				**Religion:** Baha'i ☐ Buddhist ☐ Christian ☐ Hindu ☐ Jain ☐ Jewish ☐ Muslim ☐ Pagan ☐ Sikh ☐ Zoroastrian ☐ Declines to disclose ☐ Religion Unknown ☐ None ☐	
Sexuality *(Please tick)*	**Bisexual ☐**		**Heterosexual ☐**	**Homosexual ☐**			**Not disclosed ☐** **Other ☐**	
Sex worker *(please tick as appropriate)*	**Not a sex worker ☐**		**Selling sex from premises ☐**				**Selling sex on the streets ☐**	
Ethnic group: (Circle one)								
A	**White British**	**E**	**White & Black African**	**K**	**Bangladeshi**	**R**	**Chinese**	**Interested in Phone interventions:** **Yes ☐** **No ☐** **It may be possible for us to offer telephone support instead of attending regular sessions at our locations. A care coordinator will call at an agreed time to offer advice and brief interventions to control, reduce or stop their substance use.** *(Subject to being seen in the service at least once*
B	**White Irish**	**F**	**White & Asian**	**L**	**Other Asian**	**S**	**Other**	
C	**Other White**	**G**	**Other Mixed**	**M**	**Caribbean**	**Z**	**Not stated**	
D	**White & Black Caribbean**	**H**	**Indian**	**N**	**African**	**Insert code here:**		
		J	**Pakistani**	**P**	**Other black**			

							per month and individual circumstances).

Referral Details:		
Name Of Referrer:	How did you hear about the service?	
	Referral Organization:	
Contact details of referrer:	*Referral Organization Further Details: (please tick)*	
	ATR – Community Rehabilitation Company	
	ATR – National Probation Service	
	DRR – Community Rehabilitation Company	
	DRR – National Probation Service	
	Voluntary (Self) – Community Rehab. Company	
	Voluntary (Self) – National Probation Service	
	Family Drug & Alcohol Court	
Email Address of referrer:	Please tickto confirm consent has been given to make referral ☐	
Reason for referral and other information please add any background you think may be useful (additional sheets if necessary):		

Drug and/or Alcohol use (Please state substances used in the last three months):

		Frequency	Amount
First drug:			
Second drug:			
Third drug:			

Please add any relevant details:

Alcohol units per day-days in last 4 **Drinking weeks-**

Injecting status-

Injected in last 28 days ☐ Currently sharing ☐

Ever shared (not now) ☐ ☐ Previously injected

Never injected ☐ ☐ Declined to answer

Helpful Links

Coexisting severe mental illness and substance misuse: community health and social care services

NICE guideline [NG58] Published: 30 November 20

https://www.nice.org.uk/guidance/ng58

Coexisting severe mental illness and substance misuse Quality standard [QS188] Published: 20 August 2019

https://www.nice.org.uk/guidance/qs188

Dual Diagnosis Good Practice Guide 2002 / 2006 update - archived

Mental Health Policy Implementation Guide 'Dual Diagnosis Good Practice Guide' (DH, 2002)

A guide for the management of dual diagnosis for prisons

https://lx.iriss.org.uk/content/guide-management-dual-diagnosis-prisons

The Bradley Report 2009

https://lx.iriss.org.uk/content/bradley-report-lord-bradleys-review-people-mental-health-problems-or-learning-disabilities-c

Rethink Mental Illness

https://www.mentalhealthatwork.org.uk/organisation/rethink-mental-illness/

Dual Diagnosis toolkit: A practical guide for professionals and practitioners

Association of Mental Health Providers

Published: August 17, 2017

https://amhp.org.uk/dual-diagnosis-toolkit-a-practical-guide-for-professionals-and-practitioners/

https://amhp.org.uk/app/uploads/2017/08/dualdiagnosistoolkit.pdf

Dual Diagnosis - Turning Point

https://www.turning-point.co.uk/_cache_ec2f/content/dualdiagnosisgoodpracticehandbook-5090910000025794.pdf

Care Programme Approach NHS England and NHS Improvement position statement 1 July 2021 Version 1.0

https://www.england.nhs.uk/wp-content/uploads/2021/07/Care-Programme-Approach-Position-Statement_FINAL_2021.pdf

Dual Diagnosis toolkit: A practical guide for professionals and practitioners

Association of Mental Health Providers

Published: August 17, 2017

https://amhp.org.uk/dual-diagnosis-toolkit-a-practical-guide-for-professionals-and-practitioners/

Dual diagnosis toolkit - Association of Mental Health Providers

https://amhp.org.uk/app/uploads/2017/08/dualdiagnosistoolkit.pdf

toolkit for families affected by co-occurring conditions - Adfam

https://adfam.org.uk/files/Toolkit-co-occurring-conditions.pdf

Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit

Jack, Joseph and Morton Mandel School of Applied Social Sciences 2011

https://case.edu/socialwork/centerforebp/resources/dual-diagnosis-capability-addiction-treatment-ddcat-toolkit

Capability Framework toolkit for co-occurring mental health and drug/alcohol released. Alcohol Policy UK 2019

https://www.alcoholpolicy.net/2019/06/capability-framework-toolkit-for-co-occurring-mental-health-and-drugalcohol-released.html

Better care for people with co-occurring mental health and alcohol/drug use conditions A guide for commissioners and service providers

Public Health England, 2017

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

The Bradley Report five years on an independent review of progress to date and priorities for further development. Centre for Mental Health.

http://www.mentalhealthchallenge.org.uk/library-files/MHC151-Bradley_report_five_years_on.pdf

The Bradley Report and the Government's Response: The implications for mental health services for offenders. Sainsbury Centre for Mental Health.

http://www.ohrn.nhs.uk/resource/policy/SCHMBradleyReport.pdf