Drugs: Adult Needs Assessment 2014/15

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Executive Summary

The objectives of the needs assessment are to provide local epidemiological information on adult drug misuse: to highlight vulnerable groups and related needs; to analyse data from current services in order to identify unmet needs and gaps or inequities in access to services; and to present some evidence of the effectiveness of interventions.

Local and national context

In the past it could be said that we had a good understanding of drugs of misuse. This is no longer the case. The list of such drugs used to be short but it is now extensive and is constantly and rapidly changing due to substances being modified for use to counter legal challenges.

The drugs market has evolved and the emergence of internet-based access and supply is proving challenging to authorities with seizures in Europe steadily on the rise since 2006. Outside of London, the South East has the highest number of drug seizures in England.

The complexity and fast-changing nature of the drug market has exposed several areas of concern to address. In addition to known areas of concern, emerging and escalating areas of concern in Kent:

- The ageing population of those with drug (and alcohol) misuse issues who are more prone to co-existing poor health and premature death
- The spread of infections amongst people who inject drugs.
- Those who use new unregulated drugs (NUD)
- Individuals with both mental health and drug and alcohol misuse issues
- Drug use in prisons and the criminal justice system

There has been a long-term decline in the use of drugs and drug use is now at its lowest figure for ten years. Those aged 16-24 years are more likely to use drugs. The decline in the use of drugs has not been seen in older adults who have maintained their drug use into older age. This age group has the highest level of drug-related mortality. It would be reasonable to say this may be because of age-related co-existing and developing medical conditions.

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

Decreasing budgets across the public sector make it more important than ever to include service users in the design of services to ensure there is access to attractive, appropriate and high quality care. Local mutual aid organisations and community groups need to be involved in providing the necessary community support to promote and sustain recovery for individuals in our communities.

Demography

There is a strong relationship between deprivation and drug and alcohol misuse. Although Kent is one of the least deprived counties in England, it has areas of significant deprivation. Generally those living in deprived conditions are among the least likely to seek help for health-related issues although it should be remembered that fearing stigmatisation, those living in more affluent communities will also require help. Those living in urban areas are more likely to be misusing illicit drugs as are those frequenting night clubs and pubs.

Epidemiology

The complexity and fast-changing nature of the drug market has exposed several areas of concern to address in Kent. Chief amongst these are:

- The ageing population of those with drug and alcohol misuse issues who are more prone to co-existing poor health and premature death
- The spread of infections in people who inject drugs (PWIDs) including for MSM[1] and anabolic steroid users
- The rise of the use of new unregulated drugs (NUD)

Routine screening would benefit those individuals who partake in high risk activities such as 'chem sex'[2]. There is some evidence to suggest that whilst this group engage well with some services such as sexual health, they are less likely to engage with drug and alcohol misuse services. As well as improving health outcomes for this group, routine screening is important to address the spread of infections such as hepatitis.

Given the wide range of substances now been misused across a widening population base and which can go undetected, increased routine screening and vigilance amongst Health and Care professionals is required.

[1] MSM: 'men who have sexual contact with other men' is the term this document uses to identify most clearly the population of interest because it describes sexual behaviour, rather than sexual identity. We acknowledge that it is not a term appropriate to use more broadly when discussing issues of diversity relating to the male gay community or to the lesbian, bisexual and trans communities. However, we believe its use is helpful in this context in ensuring we are as inclusive as possible in covering the topic of chemsex. At times, other terminology, such as LGBT is used when discussing research or data issues, when appropriate.

[2] Intentional sex under the influence of psychoactive drugs (MSM)

Treatment services

Treatment services in Kent perform well overall and often exceed national performance benchmarks. As the profile of drugs of misuse is changing, services must be flexible to meet the needs and be attractive to different sections of the community. For example, the needs of those with dependency issues to opiates or prescription-only medication may well be markedly different to that of an individual with issues of misusing NUD.

Treatment services should ensure that they are attracting and meeting needs of individuals throughout the treatment journey. For example, service performance indicators for some sub-sets of substances such as amphetamine misuse are not as good as national comparators. Kent has more women in treatment services than the national average which should be borne in mind when considering and meeting women's needs in treatment services.

The return rate of those who have been in treatment services is also higher than national comparators. More follow-up information over time would be beneficial to identify areas for intervention and improvement e.g. links to holistic community and Mutual Aid[3] organisations, meeting the needs of those with multiple / complex need as well as housing and employment requirements to maintain recovery.

Summary recommendations

1. 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

2. Opportunities should be taken to align and integrate services to improve health promotion outcomes for individuals and ways to improve access to these services should be sought. For example, substance misuse intervention within sexual health services by non-traditional service providers to increase access to services especially for hard-to-reach groups

3. This needs assessment has been mainly quantitative. The findings from this needs assessment should be integrated with service users views with particular reference to service co-design and developing the Drug and alcohol Strategy 2017-22

4. When compiling housing and employment strategies writers should be mindful of accommodation needs of those with drug and alcohol misuse issues. There is a real risk of individuals becoming increasingly marginalised as an inadvertent result of housing legislation and welfare reform

[3] Mutual aid organisations provide community support, often peer-to-peer such as Alcoholics Anonymous.

5. Service commissioning should take into account the geographical spread of vulnerable and high-risk populations to ensure there are appropriate levels of service access for the full range of drug and alcohol misuse treatment and allied services such as needle exchange points

6. A review of primary care provision to manage long-term conditions to improve health outcomes and prevent premature death for those with drug and alcohol misuse problems should be undertaken

7. There should be an increase of systematic and routine screening for drug and alcohol misuse

8. Commissioners and Health professionals should follow recommended guidance, and best practice to prevent the spread of infection (e.g. hepatitis) and improve performance and outcomes for those people who inject drugs (e.g. steroids) to increase take up-rates and compliance for hepatitis vaccination

9. Improve the quality of services and for those with a dual diagnosis especially earlier intervention in primary and community care settings

10. Improve access and retention rates to treatment services for minority groups especially those in the LGBT community

11. Tailor service provision and follow-up to sub-groups of drugs e.g. amphetamine and NUD, to improve treatment outcomes, compliance rates and reduce return treatment journeys

12. 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

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1 Introduction

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 needs of adults (aged over 18 years) in Kent for drug and alcohol for the period 2014-2015.

This report examines the current level of adults' drug and alcohol misuse in Kent excluding alcohol which will be addressed in a separate need assessment. It includes prevalence estimates of drug and alcohol misuse, risk and protective factors. It also outlines the range of services available and explores how well services are meeting needs.

Separate needs assessments are available for:

- Adults Alcohol Misuse
- Children and Young People (drug and alcohol misuse)
- Offender Drug and alcohol misuse and Alcohol

1.1 Report structure

Drug and alcohol misuse is a varied and complex issue and there is an extensive evidence to support practice and commissioning. It is a fast-changing field and inevitably there are gaps in knowledge, evidence and prevalence data both nationally and locally. The lack of robust prevalence data around New Unregulated Drugs (NUDs) is an example[4].

Drug and substances of misuse are legally classified as either legal or illicit. This needs assessment primarily focuses upon illicit drug use that of non-medical use such as recreation or due to addiction that causes problems either to the individual, their family or the wider community.

This report makes reference to the wider evidence base as appropriate but features specifically upon key policy and guidance documents issued since the last drug and alcohol misuse needs assessment.

General information on highly-relevant areas e.g. housing, will be described both within the relevant section and featured again in the 'Treatment Services' section linked to individuals using treatment services in Kent.

1.2 Background

At one time it could be said that there was a good understanding of drugs of misuse. This is no longer the case. The list of such drugs used to be short but it is now extensive, constantly and rapidly changing due to such drugs being modified to counter legal challenges.

[4] Formerly referred to as 'new or novel psychoactive drugs'.

The emergence of internet ‘cryptomarkets’ and new methods of supplying illicit drugs in addition to more innovative and dynamic drug production are major challenges. Cannabis is the most commonly seized drug, accounting for about eight out of ten seizures in Europe and heroin is still the most common opioid. Overall the number of drug-supply offences in Europe has been increasing since 2006 (European Monitoring Centre for Drugs and Drug Addiction, 2015).

The emergence in recent years of novel or new psychoactive substances is a cause of concern. The prevalence overall of NPS use among is generally low compared with well-established drugs such as cannabis, powder cocaine and ecstasy (Crime Survey England and Wales, 2015).

For several reasons, it is recommended that going forwards the language and term used to describe substances categorised as NPS be referred to as “new unregulated drugs” (NUD) and the use of the generic term ‘substance misuse’ should be discouraged in favour of ‘drugs and alcohol’ (misuse).

The Patterns of use of NUD are similar to that of alcohol, ranging from infrequent use through to problematic dependency and severity of harms. Drug deaths involving NUD are low compared the number of deaths caused by opiates and cocaine but they have been on the increase; latest evidence suggests the rate is stabilising (Office for National Statistics 2015).

There has been a long-term decline in the use drugs and drug use is at its lowest figure for ten years. Those aged 16-24 years are more likely to use drugs. Cannabis is the most common drug of misuse; it is too early to tell if they increasing trend of cannabis use is an emerging issue (Crime Survey England and Wales, 2015).

The decline in the use of drugs has not been seen in older adults who have maintained their drug use into older age. This age group has the highest level of drug-related mortality. It would be reasonable to say this may be because of age-related co-existing and developing medical conditions (Office for National Statistics 2015).

Typically individuals using drugs are often involved in drug dealing and acquisitive crime and suffer a range of adverse effects to their health and wellbeing, including infection with blood borne viruses (hepatitis B and C and HIV), depression, unemployment, homelessness and custodial sentences. 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.

There are strong links between the prevalence of problem drug use and levels of deprivation, drug related hospital admissions and mortality (Shaw et al. 2009). Crack cocaine use is often associated with marginalised groups such as sex workers or the homeless and, due to the nature of crack cocaine use; these groups are not usually included in survey data.

These strong links between deprivation and increasing morbidity contribute significantly to the high level of need experienced by those with opiate dependence in particular. Consequently those individuals with opiate dependence make up the largest single group of those in treatment services. These individuals are often described as having 'complex' needs. The resources deployed in treatment provision are warranted to meet service need and to manage the associate relative harms presented by problematic opiate use.

1.3 Previous drug needs assessment

The previous Kent drug and alcohol misuse needs assessment (2012/13) highlighted a number of issues for review:

- improve the quality of treatment services
- dual diagnosis
- drug associated blood-borne virus transmission
- prescription medication misuse
- the links between drug and alcohol misuse and domestic violence and families

As we will see in this report, overall the quality of treatment services in Kent is good and there has been substantial progress in improving services for those with dual diagnosis. There is a revised joint working agreement between organisations; workforce training, new policy and a care pathway have been developed. There is also new data sharing arrangements in place and opportunity to share learning for continuous improvements in services.

The links between domestic violence and drug and alcohol misuse is well-established. Increased workforce training for earlier identification and referral to services has taken place and work continues. There is work underway across several areas in Primary Care in Kent to identify the prevalence of prescription medication misuse within General Practice settings and work is beginning to tackle the spread of blood borne virus (BBV).

2 Drug policy: legislation, strategy and economic review

This section contains information on the latest key policy developments related to drug and alcohol misuse since the last needs assessment. These are reviewed within three key areas:

- Legislation - introduced and pending
- Drug strategy – national and local
- Economic review

2.1 Legislation

The Misuse of Drugs Act (1971)

The Misuse of Drugs Act (Home Office, 1971) lists drugs that are dangerous or harmful if misused into three categories dependent upon their relative harm and associated criminal penalties for illicit production, possession or supply. The list is extensive and is regularly updated. Several substances have been recently added and upgraded to more controlled categories.

The Serious Crime Act (2015)

The Serious Crime Act (2015) introduced new legislation to tackle the problem of chemicals which can be used as 'cutting' agents. These are constituents added to make the 'pure' substance go further to maximise profits. Law enforcement powers are available under warrant to enter and search premises and seize and destroy suspect materials (SO, 2015).

Psychoactive Substance Bill

There is no legal definition of what constitutes a 'legal high' (NUD) but legislation to address the problem of psychoactive substances - the 'Psychoactive Substance Bill' came into force in May 2016.

The main constituents of the Bill make the production, supply, possession or import /export of psychoactive substances illegal. There will be exceptions for caffeine, alcohol, tobacco, medicines and food (scheduled products). There is no offence for personal use and this is expected to be enforced via prohibition and premise notices.

Anti-social Behaviour, Crime and Policing Act (2014) - Public Space Protection Orders

Public Space Protection Orders (PSPOs), are part of the Anti-social Behaviour, Crime and Policing Act 2014, allow for local authorities to designate restricted areas to curb antisocial activities in a geographical area where activities are taking place that are or may likely be detrimental to or have a negative impact on the local community's quality of life. The orders impose conditions or restrictions on people using that area, such as alcohol bans or putting up gates. Breach of a PSPO may be a criminal offence punishable by fixed penalty notice or prosecution (Home Office, 2014).

Drug driving

New limits for drugs included in the drug driving offence categories came into effect in 2015 (DT, 2014).

Naloxone administration

In October 2015 the law was changed in the United Kingdom to allow any worker in a commissioned drug service to supply Naloxone without prescription (Department of Health 2015). Naloxone is used in an emergency situation to treat opioid overdose as it blocks or reverses the effects of opioids.

Housing and Planning Bill

Legislation is pending of the Housing and Planning Bill which went to Second Reading in the House of Lords in January 2016. The Government's intention is to increase housing supply with councils playing a lead role in developing homes of mixed tenure including social housing and affordable homes, (House of Lords and House of Commons, 2016). The application of this legislation may have significant impacts on those with drug and alcohol misuse issues.

2.2 National and local strategies

Drug Strategy Review (2015)

The Government's previous *Drug Strategy 2010* (Home Office, 2010), emphasised the importance of a "whole-life" methodology to prevention covering early years, family support and drug education and targeted, specialist support. The key aim is to realise an environment where the majority of people have never tried drugs and are able to resist pressure to do so and to make it easier for people to stop misusing drugs.

Following its latest review of the national drug strategy the Home Office (HO, 2015), has maintained the focus upon all three strands of the strategy:

- Reducing demand
- Restricting supply
- Building recovery

It has also published a drug strategy evaluation framework (Home Office, 2013).

A joint Drug Strategy with partners and Kent Police will be developed for implementation in 2017 for drug and alcohol misuse.

Troubled Families Programme

The Troubled Families Programme in England (Department for Local Communities and Local Government, 2015) aims to help those families that are "that have problems and cause problems to the community around them, putting high costs on the public sector". Kent has an active programme.

The Family Nurse Partnership Trust

The Family Nurse Partnership Trust works with young families to support them until the child is two years old through home visits (Family Nurse Partnership Trust, 2015). The FNPT is available in Kent for clients living within the Gravesham, Swale, Thanet, Maidstone, and Tonbridge, Malling, Dover and Shepway districts.

*Campaign*s

National communication programmes commissioned by PHE are in place such as "Talk to Frank" (Talk to Frank, 2015). There are also a number of good websites offering information and resources such as the Angelus Foundation.[5] Kent specific campaigns will be developed in response to identified emergent issues.

2.3 Economic review

Evaluations of the economic impact of illicit drug use in the UK are limited. Following the decentralisation of public health spending, implemented in 2013, it is now more difficult to estimate drug-related expenditure in the United Kingdom. The economic impacts of drug and alcohol misuse in Kent are unknown.

The loss of productivity due to illicit drug use is considerable. Losses occur through incapacity of users or by whilst they engage in residential rehabilitation, be an in-patient in hospital or prison. The costs arising from the loss of productivity is thought to be between 4 – 8 times higher than associated health costs (United Nations Office on Drugs and Crime, 2012).

The estimated costs to society are described in Table 1 and include:

- Healthcare costs in relation to use of primary care and secondary care services, including emergency care and mental health services
- Costs related to crime, disorder and antisocial behaviour
- Economic impact of loss of productivity and profitability in the workplace – including impact of premature deaths due to drug use and absenteeism due to drug related illness
- Impact on family and social networks – including emotional impact due to breakdown of relationships, poverty, unemployment and domestic and child abuse.

[5] http://www.angelusfoundation.org.uk/

The recognition that the harms to children of drugs and alcohol misusing parents are significant and enduring was central to Kent's 'Hidden Harm' Strategy 2010-13 (Kent County Council, 2010).

Table 1 Estimated costs to society

Total annual costs		**£15.4bn**
Including	Crime	£13.9bn
	Deaths *(in 2011)*	£ 2.4bn
	Social Care[6]	£42.5m
	NHS costs	£488m
	Crime *(crack or heroin addictions; average annual crime costs of those not in treatment)*	£26, 074

Source: NDTA, (England and Wales), no date

Drug related expenditure

In the wake of the 2008 economic recession, many European governments imposed fiscal consolidation measures, often referred to as austerity measures. Data presented by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 2015 suggests that largely the biggest cuts were noted in the health sector rather than public order and safety or social protection.

Reductions in health funding are likely to have a negative impact on drug-related initiatives and EMCDDA reporting suggests that funding of drug-related research and prevention activities may have been particularly affected (European Monitoring Centre for Drugs and Drug Addiction, 2015)

Provisional expenditure on drug misuse services for adults in England in 2013/14 was £572.3m, with a further £75.6m being spent on services for young people (Gov.UK, 2014). These two elements of expenditure accounted for almost one quarter (24%) of public health spend by local authorities. It is important to note that the data collection is a new exercise and there may be differences with how local authorities report their public health spend. In September 2014, it was announced that public health allocations for local authorities will remain at £2.79 billion for 2015/16.

[6] 'Looked after children'; children of parents with substance misuse issues

3 Evidence base, social impacts and recovery

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

There is an extensive evidence base for the prevention and management of drug and alcohol misuse and it would not be practical to describe them all in this report. For this reason, the focus of information contained in this section will be from relevant, key organisations and sources information released since the last needs assessment.

A summary review of the evidence base of interventions for prevention, treatment, harm reduction, recovery and emerging topics are displayed in Tables 2-11 and taken from a report produced by the Advisory Council of the Misuse of Drugs (ACMD) (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406926/ACMD_RC_Prevention_briefing_250215.pdf.

Table 2 Evidence review: general population

Target Group	What works 	What's unclear ?	What doesn't work 
General population / communities	Computer-based programmes have the potential to reduce recreational drug use in universal drug prevention programmes, at least in the medium term.	It is not clear if programmes focused only on one component or mentoring programmes are helpful in reducing alcohol as well as drug use. More generally, it is not clear whether anti-alcohol and anti-cannabis community interventions reduce consumption	There are no known community interventions that cause harm
Partygoers			Information provision does not prevent drug and alcohol related problems
Families	Involving the whole family in prevention activities helps reduce the use of alcohol, tobacco and drugs		There are no known community interventions that cause harm

Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 3 Evidence review: treatment

Target Group	What works 	What's unclear ?	What doesn't work 
Family	Continuing care i.e. interventions following the initial period of more intensive care aimed at managing and sustaining recovery can help to improve treatment outcomes, irrespective of the duration and intensity of the programme	It is not clear if residential interventions can improve treatment outcomes	There are no known interventions that cause harm
Amphetamine	Some of the drugs used to treat depression (fluoxetine and imipramine) can help amphetamine users stay in treatment in the short and medium term For pregnant women, medications to assist detoxification from stimulants can be used but should be reserved when specific symptoms emerge	There are no data supporting a single treatment approach that can tackle the multidimensional facets of amphetamine addiction pattern	Pharmacotherapies based on psychostimulants are probably of little value in the treatment of amphetamine dependence Pharmacotherapy for routine treatment of dependent pregnant women is not recommended
Cannabis	Any behavioural intervention (including cognitive behavioural therapy (CBT), motivational interviewing (MI) and contingency management) can help to reduce use and improve psychosocial functioning, both in adults and adolescents, at least in the short-term Multidimensional family therapy helps reduce use and keep patients in treatment, especially in high-severity young patients	Medical preparations containing THC seem of potential value but given the limited evidence these applications should be considered still experimental	Pharmacotherapies based on antidepressants, anxiolytics and anticonvulsant are probably of little value in the treatment of cannabis dependence Pharmacotherapy for routine treatment of dependent pregnant women is not recommended

Cocaine	Psychosocial interventions can help to reduce cocaine use by influencing the mental processes and the behaviours related to the addiction Medicines used to treat other diseases (such as disulfiram for alcohol addiction, antidepressants and antiparkinsonians) can help cocaine users to reduce use Various psycho-social treatment (including contingency management) interventions for crack abuse/dependence show some positive yet also some limited/short-term efficacy For pregnant women, medications to assist detoxification from stimulants can be used but should be reserved when specific symptoms emerge. Psychosocial interventions alone or in addition to the usual care do not make a difference in both treatment and obstetrical outcomes, when standard comprehensive care options are in place, e.g. prenatal care, counselling	It is not clear whether antidepressants help reduce the craving for cocaine It is also not clear if either psycho-stimulants or anti-psychotics can help treat cocaine dependence	Pharmacotherapies based on dopamine agonists as well as anticonvulsants are probably of little value in the treatment of cocaine dependence Pharmacotherapy for routine treatment of dependent pregnant women is not recommended
Opiates	Opioid substitution treatment combined with psychosocial support, helps patients stay in treatment and reduces use and mortality. It also has a positive impact on the mental health of patients Methadone and buprenorphine are the recommended pharmacological treatments.	It not clear which option (methadone or buprenorphine) is the best choice in order to avoid drop-out when treating pregnant women It is not clear if the opioid antagonist naltrexone, normally used to prevent relapse to use, works for long-	Detoxification under heavy sedation does not work and can actually be harmful

	Taking into account clinical practice, methadone is superior to buprenorphine in retaining people in treatment – particularly in the first weeks - and equally suppresses illicit opioid use Heroin-assisted treatment is recommended in adult chronic opioid users who failed previous methadone treatment attempts Opioid substitution treatment is also strongly recommended for pregnant women dependent on opioids, even more than attempting detoxification. Psychosocial interventions alone or in addition to the usual care do not make a difference in both treatment and obstetrical outcomes, when standard comprehensive care options are in place, e.g. substitution treatment, prenatal care, counselling When detoxification is indicated, methadone or buprenorphine at tapered dosages are used in association with psychosocial interventions Relapse prevention is supported by naltrexone when relapse has major practical implications (for example professionals who risk losing their job or prisoners on probation)	term treatment For detoxification, it is unclear if detoxification under minimal sedation can help users to complete treatment and avoid relapse	

Dual Diagnosis	The therapeutic approach to tackle dual diagnosis, whether pharmacological, psychological or both, must take into account both disorders simultaneously and from the first point of contact in order to choose the best option for each individual Integrated treatment combining pharmacological and psychological interventions seems to help in cases of psychosis and substance use disorders as well as anxiety and opioid disorders The antipsychotic Clozapine helps to control both psychotic symptoms and reduce substance use in dual-diagnosis patients with schizophrenia	It is not clear if pharmacological and psychosocial treatments for depression can also help to reduce substance use Pharmacological treatment of attention deficit hyperactivity disorder helps reduce ADHD symptoms but has no effect on reducing substance use or improving retention in substance use treatment It is not clear if any specific pharmacotherapy is particularly beneficial in the treatment of personality disorders and substance use comorbidity disorders	So far no interventions which proved to cause harm have been identified Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 4 Evidence review: harm reduction

Group	What works 	What's unclear 	What doesn't work 
Opioid users	Infections caused by HIV and Hepatitis C among people who inject opioids can be prevented with opioid substitution treatment and the provision of clean needles and syringes People have less risky behaviours when they are in opioid substitution treatment, i.e. they inject less, and even when they continue to inject drugs they take less risks when participating in a needle and syringe programme, participate in outreach and education programmes as well as injecting in drug consumption rooms Death among drug users is reduced by keeping them in opioid substitution treatment. Hepatitis C treatment is effective in active drug users and opioid substitution treatment is not a contraindication to the treatment There is some evidence that education and training interventions with take-home naloxone provision decrease overdose-related deaths Intranasal administration of naloxone appears to be effective in treatment of opioid overdose when naloxone injection is not possible There is also some evidence that safer environment interventions (i.e. syringe exchange programmes, peer-based interventions and drug consumption rooms) help to reach, stay in contact and foster safer environments for highly marginalised target populations	Is not clear if being in opioid substitution treatment can help patients adhere better to Hepatitis C treatment or achieve better results It is also unclear whether drug consumption rooms can reduce HIV and Hepatitis C infections	No interventions for injecting opioid users that cause harm have been identified

stimulant injectors	Outreach treatment programmes help stimulant injectors to reduce medical problems, such as skin infections	It is not clear if provision of large volumes of sterile injection equipment (in general, stimulant injectors inject more often than opioid users, thus need more syringes), provision of condoms, outreach activities focusing on injecting and risky sexual behaviours can help stimulant injectors It is not clear if injection kits adapted to local drug use patterns, such as for people that inject home-made stimulants (e.g. distribution of specific paraphernalia for the production of drugs), can help to reduce harms It is not clear if dissemination of information on how to inject safely, basic hygiene (hand washing, short nails), vein care and simple wound care as well as distribution of antibacterial creams and ointments can help to reduce harms	No interventions for injecting opioid users that cause harm have been identified
Non-injectors	Interventions including, for example, the distribution of clean crack kits to prevent people sharing crack pipes, personal vaporisers for cannabis users, information, education and communication material and outreach activities may help these users, however more research is needed	Not applicable	No interventions for injecting opioid users that cause harm have been identified Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 5 Evidence review: new psychoactive substances

Target group	What works 	What's unclear ?	What doesn't work 
New unregulated Drugs (NUDs)	Generally, prevention interventions which stress skills and coping strategies are effective, independently of the substance concerned Harm reduction strategies in nightlife settings which have proved to be effective for alcohol may also be effective for new psychoactive substances	Research is ongoing in this area and we currently lack evidence on what works best	New psychoactive substances are an emerging topic. Research is ongoing in this area and we currently lack evidence on what works best Source: EMCDDA, 2015

Table 6 Evidence review: treatment and recovery

Target group	What works 	What's unclear ?	What doesn't work 
Individuals in drug treatment	Providing drug users with an incentive-based treatment (for example contingency management) together with some employment helps them to improve their social condition Residential treatment and therapeutic workplaces associated with contingency management improve work attendance and performance	It is not clear if both residential treatment and therapeutic workplaces can specifically help pregnant women improve their employability Moreover, it is also unclear whether therapeutic workplaces associated with training under simulated work conditions can help improve work attendance of drug users in treatment	No interventions that cause harm have been identified Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 7 Evidence review: employment

Group	What works 	What's unclear ?	What doesn't work 
Employment	Housing interventions to help the employability of drug users should be investigated further	It is not clear if psycho-social treatment interventions can help crack-cocaine users to improve their housing condition	No interventions that cause harm have been identified Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 8 Evidence review: education

Group	What works 	What's unclear ?	What doesn't work 
Education	Vocational training aimed at developing specific skills and job-seeking skills helps drug users to find employment Interventions based on motivational behavioural reinforcement can help methadone maintenance clients find employment	Several 'training and employment' programmes have been implemented in the United States yet it is not clear if they can really help improve drug users' employment motivation and outcomes Furthermore, it is unclear whether drug court vocational training programmes reduce reoffending	Employment counselling does not help drug users in treatment find a full-time job Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 9 Evidence review: criminal justice system

Group	What works 	What's unclear ?	What doesn't work 
Criminal Justice System	Drug court programmes (as assessed in the United States which is where most drug courts exist and where the vast majority of studies have been conducted) can help people be independent from financial assistance and find employment or enrol in education	It is not clear if drug court programmes have a more direct impact on the employability of drug users, namely by increasing their employment rate and individual annual income Furthermore, it is unclear whether drug court vocational training programmes reduce reoffending	No interventions that cause harm have been identified Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 10 Evidence review: prisons

Group	What works 	What's unclear ?	What doesn't work 
Prisons are one of the most important settings to provide interventions aimed at drug users, both in terms of treatment and harm reduction.	Opioid substitution treatment has a very strong protective factor against death in prison for opioid-dependent prisoners. This is also very important when drug users are released from prison and they need to find continuity of treatment in the community Substitution treatment is also particularly important in prison as it reduces injecting risk behaviours Psychosocial treatments reduce the re-incarceration rates in female drug-using offenders For drug-using offenders the use of naltrexone seems to help to reduce their re-incarceration rates	It is unclear if pharmacological treatment can help drug-using offenders to reduce use and criminal activity. Studies results are showing this also for the specific sub-group of female drug-using offenders, yet caution should be taken as the conclusions are based on a small number of trials. Moreover, it is unclear if the provision of needles and syringes in prison help prevent infections and reduce risky behaviours	No interventions that cause harm have been identified Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Table 11 Evidence review: prescribed medication

Group	What works 	What's unclear ?	What doesn't work 
Prescription medication	Cognitive behavioural therapy helps to reduce benzodiazepines use when added to tapering dosages in the short term as this is not sustained at 6 months follow-up Tailored letters sent by GPs to patients, standardised interview with GPs plus tapered doses and relaxation techniques are promising results of three small studies that deserve further investigation	It is not clear if motivational interviewing helps to reduce benzodiazepine use	No interventions that cause harm have been identified Source: Advisory Council of the Misuse of Drugs (ACMD), 2015

Key points: New Unregulated Drugs

- There is much evidence for the use of psychosocial interventions in drug treatment but less so for NUD specifically
- There are currently no screening tools for NUD specific use
- Patterns of NUD use are similar to alcohol

Key recommendations

- Opportunistic screening should be used – screening does not depend upon evidence of harm
- Stepped-care interventions of raising awareness, behaviour change and psychosocial interventions are recommended similar to the alcohol framework
- Individuals in treatment services should be offered advice on Mutual Aid organisations as routine for additional support
- Screenings and should be offered in:
    - Youth clubs
    - Adult clubs
    - Sexual Health Services
    - HIV services
- Systematic data capture including drugs and alcohol screening should be introduced to clinics such as Genito-Urinary Medicine (GUM) and as listed in point 4 above.
- NICE Quality Standards for substance misuse services should be implemented:
    - QS 23; QS 11; QS 52

National Drug Treatment Agency for Substance Misuse (NDTMS)

A four-step model of care and management for the treatment of adult drug misusers was first developed in 2006 and is still used today, Table 12 (National Treatment Agency for Drug and alcohol misuse, 2006). Kent drug and alcohol misuse commission services is currently based on this model.

Table 12 Model of Care for drug and alcohol misuse

Description	Setting
Tier 1 interventions include provision of drug-related information and advice, screening and referral to specialised drug treatment.	Interventions are provided in the context of general healthcare settings or social care, education or criminal justice settings (probation, courts, and prison reception) where the main focus is prevention / health promotion and not drug treatment.
Tier 2 interventions include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare.	Interventions may be delivered within and separately from Tier 3 settings. Other typical settings to increase access are in criminal justice settings (CJS), probation services, community, primary care and pharmacies.
Tier 3 interventions include provision of community-based specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison.	Tier 3 interventions are delivered in specialised drug treatment services, the community, GP settings, and hospital sites or domiciliary (home-based), pharmacies and prisons, probation and criminal justice settings. Specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care.
Tier 4 interventions include provision of residential specialised drug treatment, which is care planned and care coordinated to ensure continuity of care and aftercare.	Inpatient drug detoxification and stabilisation are provided for in specialised dedicated inpatient or residential drug and alcohol misuse settings.

Source: NDTMS, 2006

The National Institute of Clinical and Care Excellence (NICE)

NICE has produced many documents related to drug and alcohol misuse and drug misuse. These include information on general advice, Guidance, Clinical Guidelines, Technology appraisals, Care Pathways, Quality Standards and commissioning tools for both adults and children. It also has links to associated related topics and fields e.g. mental health. There are two drug-related Guidelines pending for 2016 Table 13. Available at: https://www.nice.org.uk/guidance/health-protection/drug-misuse

Table 13 NICE Clinical Guidelines in development

Clinical Guideline	Publication date
Severe mental illness and drug and alcohol misuse (dual diagnosis) – Community Health and Social Care Services	November 2016
Drug misuse Guidelines	February 2017

3.1 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 (Seddon, 2006) and are poorly educated and in receipt of benefits (National Drug Treatment Agency for Drug and Alcohol Misuse, 2015).

The effect of parental drug use on children is also a concern, frequently leading to problems in childhood and later life (Advisory Council on the Misuse of Drugs, 2011). A strategic review of health inequalities in England post 2010 showed that the poorest local authorities also tend to have the highest prevalence of problematic drug users (Marmott, 2010).

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 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 (Crisis 2011). It is likely that there are a significant number of homeless people in Kent who are misusing substances and are not receiving 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 to have a wider range of needs across Health, Social Care, drug and alcohol misuse and criminal justice (Crisis 2011).

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.

Homelessness prevention strategies will have to take into account the effects of the pending *Housing and Planning Bill* (House of Lords and House of Commons, 2016).

The Government's intention is to increase housing supply with councils playing a lead role in developing homes of mixed tenure including social housing and affordable homes.

Being able to access suitable and stable housing is a key recovery outcome in the governments Drug Strategy (Home Office, 2010). Despite this, housing needs of the treatment population remains an area of concern within the drug sector (Drugscope, 2013).

Concerns were raised by Crisis (2011) that budget cuts and competing demands upon local authorities who have an obligation to find accommodation for the statutory homeless, are a significant risk to raising the standard of accommodation for service users (Homeless Link, 2014).

In 2014 Homeless Link conducted a review on the nature of single homeless people in England; one-third of the single homeless people using accommodation projects included in the review had problems associated with drug use (33%), (Homeless Link, 2014).

Compared to the previous year, more accommodation projects reported refusing access to those with the highest needs or the most challenging behaviour 40% of projects had refused access to people who were intoxicated by drugs or alcohol, up from 22% in the previous year.

Key points

- Hidden homelessness is highly prevalent. In fact, to be single and homeless in England is, in the main, to be hidden
- Rough sleeping may be more prevalent, enduring and 'invisible' than we think
- An increasing in the number of long-term homeless people with intensifying support needs
- Vulnerable homeless people are being left without housing support and assistance

Hidden homelessness has detrimental consequences:

- Insecurity – no or few rights when relying on friends
- poor conditions leading to poor health
- criminalisation (to seek shelter, or obtain money for food and shelter)
- Exploitation – financially by friends offering shelter
- Personal safety –victimisation or subject to environmental dangers

Desperate measures:

- Engaging in sex work to get money for food and shelter
- 'Sex for a bed' (forming unwanted relationships)
- 'Safe haven institutions'- committing crime / visiting Accident and Emergency departments to gain safety and shelter
- Hidden homelessness and the consequences which flow from it can be traced to a significant degree to the lack of assistance single homeless people receive from local authorities.

Reeve et al, 2011

Homelessness in Kent

During 2014-15 there were 640 service users recorded in Kent County Council (KCC) commissioned Single Homeless and Rough Sleepers services.

Of the total number in receipt of services, 40% (*n=255)* reported a problem with drugs or alcohol:

- 149 had a Primary or Secondary client group of Alcohol (23.3%)
- 106 had a Primary or secondary client group of Drugs (16.6%)

The number and proportion of those with an identified need who received an intervention or further support are displayed in Table 16. Support interventions range from advice and self-management to referral to treatment services.

Table 14 Clients supported in Single Homeless/Rough Sleeper Service

	Identified with need	Given support
Rough Sleeper	107	94 (88%)
Single Homeless	227	156 (69%)

Source: KCC, 2016

Section seven contains the accommodation and employment profiles of individuals engaged with treatment services for the latest period.

3.3 Employment

Unemployment among drug users remains an area of concern within the UK (Drugscope, 2013). The unemployment rate among UK recipients of opioid substitution therapy was significantly higher than many European countries (Public Health England, 2014)

The *Work Programme*

The Work Programme (Department of Work and Pensions 2012) is part of 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 (House of Commons Work and Pensions Committee, 2015).

To promote more effective approaches to the education, training and employment (ETE) needs of people in drug treatment, the National Treatment Agency for Substance Misuse (NTSM) published a joint working protocol with Jobcentre Plus *'Employment and Recovery: a good practice guide'* (National Treatment Agency for Substance Misuse, 2012).

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.

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 included is a helpful directory. To further promote this, the work focus is directly on engaging and influencing London employers and educational establishments (London Drug and Alcohol Network, 2014).

Peer mentoring project in Wales

This project had the primary aim of assisting ex-drug and alcohol misusers across Wales to enter employment or further learning. The providers achieved almost all the four-year targets set for the project, which had been revised downwards in 2010 in the light of changed circumstances especially the economic recession and the advent of the Work Programme (Welsh Government Social Research, 2014).

Table 15 Peer mentoring project in Wales

Outcomes	Proportion
Entered employment	10%
Further learning	9%
Gained a qualification	14%
One other positive outcome e.g. course completion or volunteering	65%

(Welsh Government Social Research, 2014).

3.4 Multiple and complex needs

Individuals with multiple and complex needs especially those with opiate dependence comprise the largest group in treatment services. Such individuals tend to stay engaged with treatment services longer than other groups for several reasons.

These reasons include that they may not wish to be dependence-free preferring instead to maintain dependence at levels they feel they can cope with and is not problematic for them e.g. desire to be maintained on a morphine substitute such as methadone.

Another reason is that they value the range of support they receive from treatment services and cannot readily identify alternate elsewhere in the community. Indeed, these additional sources of support may not exist in their community. They may also feel more comfortable and have high levels of trust with the treatment service providers insofar that they ‘understand their problems’.

This presents an increasingly important challenge to treatment services especially with this ageing cohort of service users experiencing increasing levels of morbidity and multiple needs that they are not equipped or resourced to meet.

Some programmes are attempting to address more generally the needs of adults with multiple and complex needs.

Making Every Adult Matter (MEAM)

Making Every Adult Matter (MEAM) a coalition of four national charities published in 2014 the second annual evaluation of three pilot programmes designed to improve co-ordination of existing local services for people with multiple or 'complex' needs.

After a slight increase in the first year, the cost per client fell to below the baseline during year two. Both areas showed a significant reduction in costs associated with crime. The pilot services are continuing to operate and MEAM is working to expand the implementation of such programmes across the country[7].

In 2014, the MEAM coalition also developed a programme named *Voices from the Frontline (VFTF)* which aims to give a voice to people with multiple needs and to influence policy on their behalf.

Blue Light Project

The Blue Light project is a national initiative developed by Alcohol Concern to develop different approaches and care treatment pathways for 'resistant to change' drinkers. This was developed to address the burden on public services these individuals pose.

Key aims are to demonstrate there are a range of strategies that can be used to reduce harm, manage risk and promote change in resistant drinkers. This is of particular value to assist with the domestic and community violence initiatives.

North Kent participated in the project during the development of the initiative but to date no further areas in Kent have undertaken this work.

[7] http://meam.org.uk/

Social Impact Bonds

Social Impact Bonds (SIBs) are private / non-government investors who provide funding for interventions often not possible by conventional financing which are aimed to improve social outcomes. The full evaluation of those in place is pending. The advantages and risks identified to date are displayed in Table 18.

Table 16 Social Impact Bond Model

Advantages	Risks
Removal of upfront costs of service delivery from the government	Investors seeking to fund projects with easily measurable outcomes;
The shift of financial risk to private investors. Unlike other payment by results mechanisms, providers are paid upfront presenting the opportunity for providers including not-for-profit and third sectors organisations to embark on more risky projects or other kinds of service delivery which government might not prioritise for funding.	Investors having more influence on the project Reduced public responsibility

Source: Public Health England, 2014

Mutual Aid Organisations

Mutual Aid refers to the social, emotional and information-based support provided by, and to, members of a group at every stage of recovery. Mutual aid groups may include people who are abstinent and want help to remain so, as well as people who are thinking about stopping and/or actively trying to stop their alcohol or drug use.

The most common groups in England being 12-step fellowships like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and SMART Recovery, which apply cognitive behavioural techniques and therapeutic lifestyle change to its mutual aid groups to help people manage their recovery.

Over 300,000 adults were in treatment for alcohol and/or drug dependency in 2013/14 (Public Health Matters, 2015). Achieving the best possible recovery outcomes for those in recovery is a key public health concern in England. To support the development of quality and effective treatment and recovery services, PHE has produced a suite of resources to highlight the benefits of, and encourage local services to adopt, mutual aid and service user involvement, (Public Health Matters. 2015).

There are also mutual aid groups that exist to support families and friends of people with addictions to alcohol and drugs, such as Al-anon.

3.5 Crime and the Criminal Justice System

In the UK drug use is not a crime but the possession and production, dealing and trafficking of drugs are offences under the Misuse of Drugs Act (1971). It is not possible

to provide accurate data on the number of drug-related offences as police records to not contain this information. For the latest period in 2015, the CSEW reports that drug offences have decreased by 17% (Crime Survey England and Wales, 2015).

A Home Office programme called 'Drug Testing on Arrest' (DToA) is being extended across Kent (Home Office, 2011). 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. See Section Five for more information on the Kent programme.

3.6 Prison populations

The links between poor health and reoffending have been long understood (NHS England, 2015). 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.

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 prisoners 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 PHE to co-commission and deliver health care services in English prisons ((NHS England, 2015).

The Chief Inspector has stated that NUD use within prisons "are now the most serious threat to safety and security of jails" (HMIP, 2015).

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

The price for drugs such as opiates and cannabis in prisons is much greater than 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
- 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 use 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 (Prison Reform Trust, 2013). Other key findings from the report are described in Table 19.

Table 17 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 in 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.

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 commissioning community and 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).

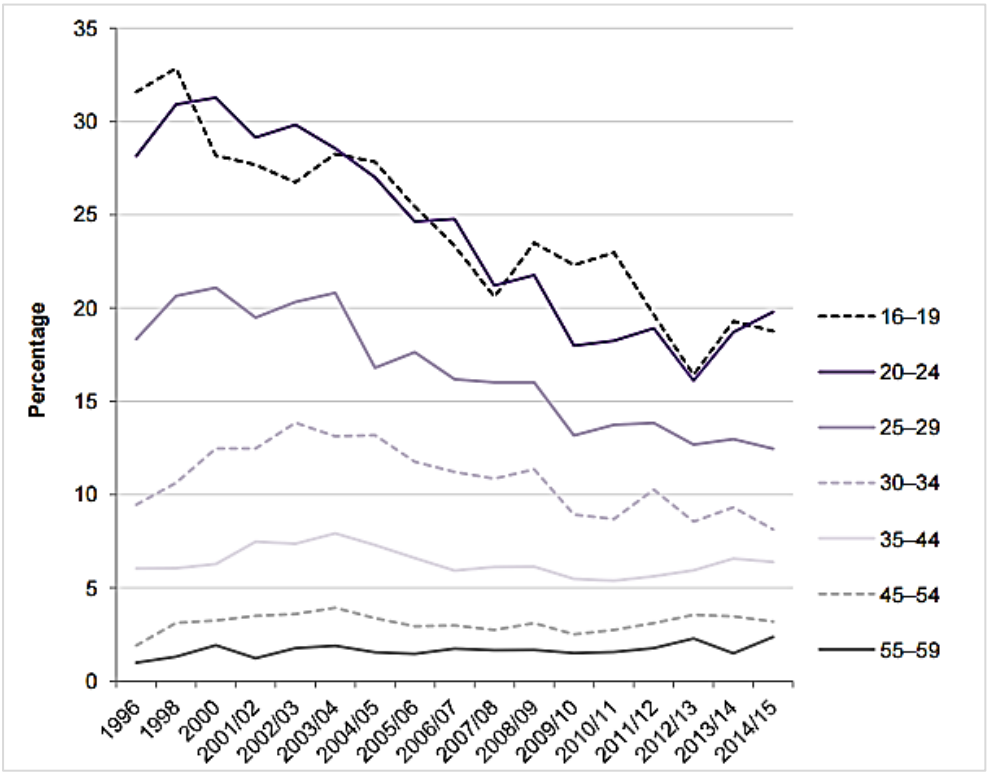
The health and wellbeing needs of offenders in Kent prisons are addressed in a separate Health Needs Assessment (Kent and Medway Public Health Observatory, 2014).

4 Demography and epidemiology of illicit drug use

There has been a long-term decline in the use of drugs and drug use is at its lowest figure for ten years. Those aged 16-24 are the most likely to take illicit drugs and there has been an increase in reported drug use by older adults as shown in Figure 1 (Crime Survey England and Wales, 2015).

It is likely that this is due to individuals continuing their drug misuse into older age. This age group also has the highest level of drug-related mortality. It would be reasonable to say this may be because of age-related co-existing and developing medical conditions.

Figure 1 Drug use trend



Source: CSEW, 2015

There has been a slight increase of those using a Class A drug but this is not statistically significant and use remains broadly stable. Cannabis is the most popular drug. It is too early to tell if they increasing trend of cannabis use is an emerging issue (Crime Survey England and Wales, 2015).

Nine per cent of those surveyed reported using two or more drugs at the same time which is significantly higher than previous years surveys (Crime Survey England and Wales, 2015). Cocaine use has significantly increased whilst the use of hallucinogens has decreased (Crime Survey England and Wales, 2015). Reported drug use ranked by reported popularity is shown in Table 20.

Table 18 Reported drug use ever

Drug	Proportion
cannabis	29.2%
class A drug use	15.5%
amphetamines	10.3%
powder cocaine	9.7%
ecstasy	9.2%
amyl nitrite	8.5%

CSEW, 2015

Key points:

- Drug use is at its lowest level for ten years
- Cannabis is by far the most commonly used drug
- Younger people are more likely to take drugs than older people
- Men are more likely to take drugs than women
- Around one in eight (11.9%) men aged 16 to 59 had taken an illicit drug in the last year, compared with around one in eighteen (5.4%) women
- People living in urban areas reported higher levels of drug use than those living in rural areas
- Around 9% of people living in urban areas had used any drug compared with 6.5 % of those living in rural areas
- Higher levels of drug use are associated with increased frequency of visits to pubs, bars and nightclubs
- The use of any Class A drug in the last year was around 10 times higher among those who had visited a nightclub at least four times in the past month
- A similar pattern was found for those visiting pubs and bars more frequently
- More people are using two or more drugs (poly drug use)

CSEW, 2015

- The Chief Inspector has stated that NUD use within prisons “are now the most serious threat to safety and security of jails”
- 55% of Kent prisoners were unknown to community treatment services
- 40% of people using KCC accommodation services reported a problem with drug or alcohol
- Patterns of NUD use are similar to alcohol
- Hidden homelessness is highly prevalent

4.1 Prevalence

Opiate and Crack Users (OCU) and People Who Inject Drugs (PWID)

Kent has lower than the national estimated prevalence rates for drug use as shown in Figure 2. To what extent is reflective of national data which estimates the number of people misusing drugs in Kent is low or to what extent there is a number of people in Kent who do not seek help or are being referred to services is unknown.

More men than women take drugs and enter treatment services. Women presenting to treatment often experience poor mental health, domestic violence and abuse, which may impact upon their recovery, and are more likely to be carers of children.

Kent has a more women in treatment services than the national average which should be borne in mind when considering and meeting women's needs in treatment services (Public Health England, 2015).

Figure 2 Kent drug prevalence estimates (2011-12); ages 15-64

Local prevalence estimates (2011-12)

(Aged from 15-64)	Local n	Lower confidence interval	Upper confidence interval	Rate per 1000	Lower confidence interval	Upper confidence interval	Treatment Penetration	Treatment Penetration by gender M	F
OCU	5,028	4,558	5,851	5.37	4.87	6.25	47%	42%	68%
Opiate	4,101	2,622	5,660	4.38	2.80	6.04	56%		
Crack	2,422	967	4,041	2.59	1.03	4.31	33%		
Injecting	1,692	958	2,480	1.81	1.02	2.65	48%		

National prevalence estimates (2011-12)

(Aged from 15-64)	National n	Lower confidence interval	Upper confidence interval	Rate per 1000	Lower confidence interval	Upper confidence interval	Treatment Penetration	Treatment Penetration by gender M	F
OCU	293,879	291,029	302,146	8.40	8.32	8.63	55%	51%	65%
Opiate	256,163	253,751	263,501	7.32	7.25	7.53	61%		
Crack	166,640	161,621	173,706	4.76	4.62	4.96	40%		
Injecting	87,302	85,307	90,353	2.49	2.44	2.58	56%		

Source: NDTMS, 2014

4.2 Health, deprivation and inequalities

Measures of health inequality are not primarily about health but of socio-economic status which has an impact on health and can lead to disease and disability. Relative deprivation impacts on a person's ability to participate in or have access to employment, occupation, education, recreation, family and social activities and relationships.

People in deprived circumstances often do not present with major health problems until too late. Barriers to presentation include structural issues such as poor access and transport, language and literacy problems, poor knowledge, low expectation of health

and health services, issues of condition denial, fear of service engagement and consequences and low self-esteem. However, it should be remembered that some of these barriers will apply to populations in more affluent communities and higher socio-economic groups who may be reluctant to visit alcohol and drug services because of perceived social stigma.

The Indices of Multiple Deprivation (IMD) measure relative deprivation for small geographical areas within England. The IMD combines information from seven domains (Income, Employment, Education, Skills and Training, Health Deprivation and Disability, Crime, Barriers to Housing and Services and Living Environment Deprivation) to produce an overall relative measure of deprivation. The use of drugs linked to deprivation is displayed in Table 21 (Crime Survey England and Wales 2015).

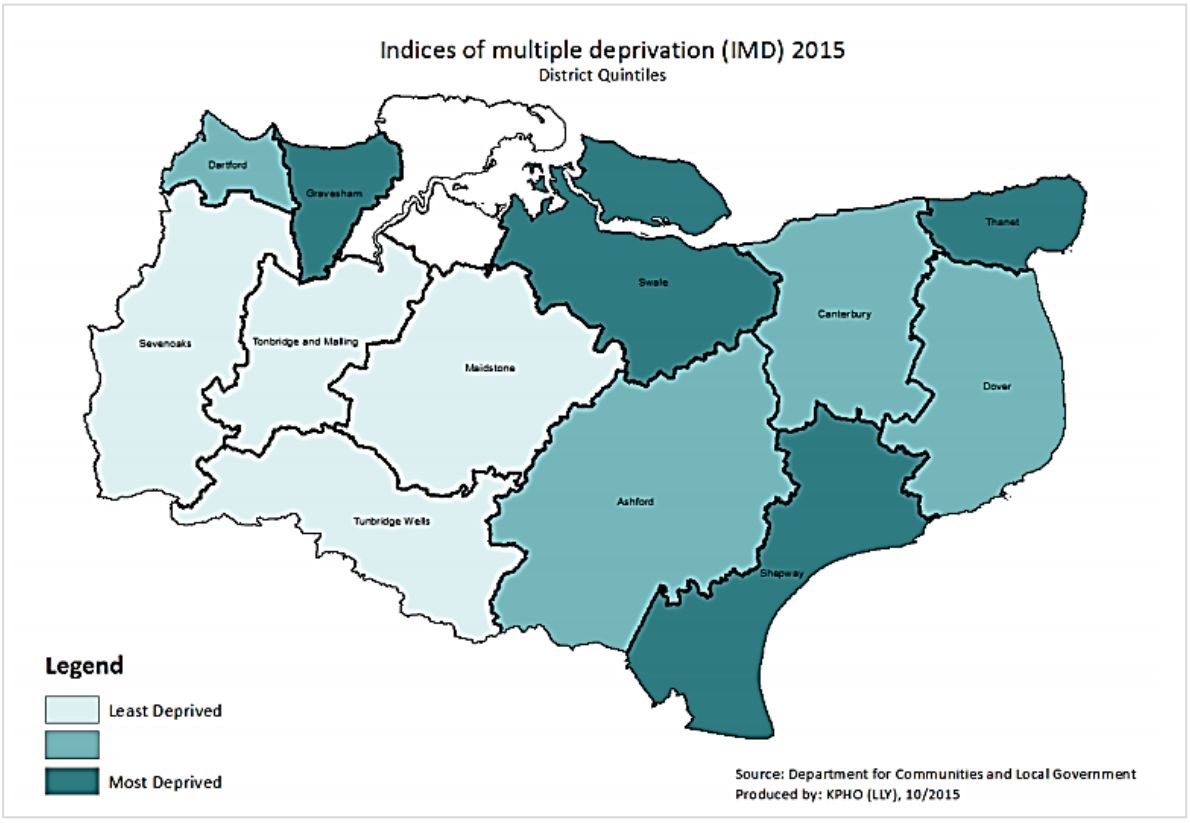
Table 19 Illicit drug use linked to deprivation

Area	Use of any drug	Class A - similar
Most deprived	10.2%	3.1%
Middle	Not recorded	3.3.%
Least deprived	6.9%	2.9%

Although Kent as a whole is amongst the least deprived of Local Authorities in England, there are very different levels of deprivation within the county and ward level. Kent's most deprived wards are in Thanet. In contrast Kent's least deprived district is Sevenoaks..

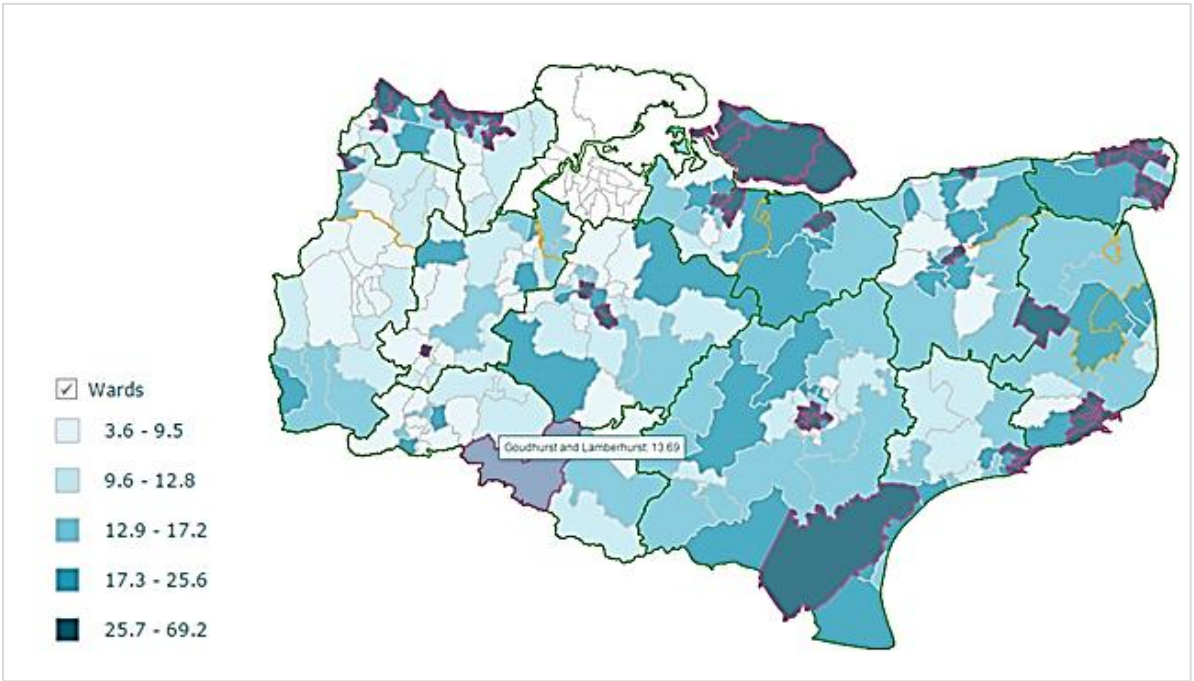
Kent areas of multiple deprivations are displayed at District and Ward level in Figures 3 and 4.

Figure 3 Areas of multiple deprivation: Kent level



Source: Kent Public Health Observatory, 2015

Figure 4 Areas of multiple deprivation: ward level



Source: Kent Public Health Observatory, 2015

4.3 Ethnicity

The prevalence of drug dependence varies with ethnicity. Black men were most likely, and South Asian men were least likely, to report symptoms of dependence. In women, reported dependence ranged from 4.8 per cent of Black women to 0.2 per cent of South Asian women (Health and Social Care Information Centre, 2014).

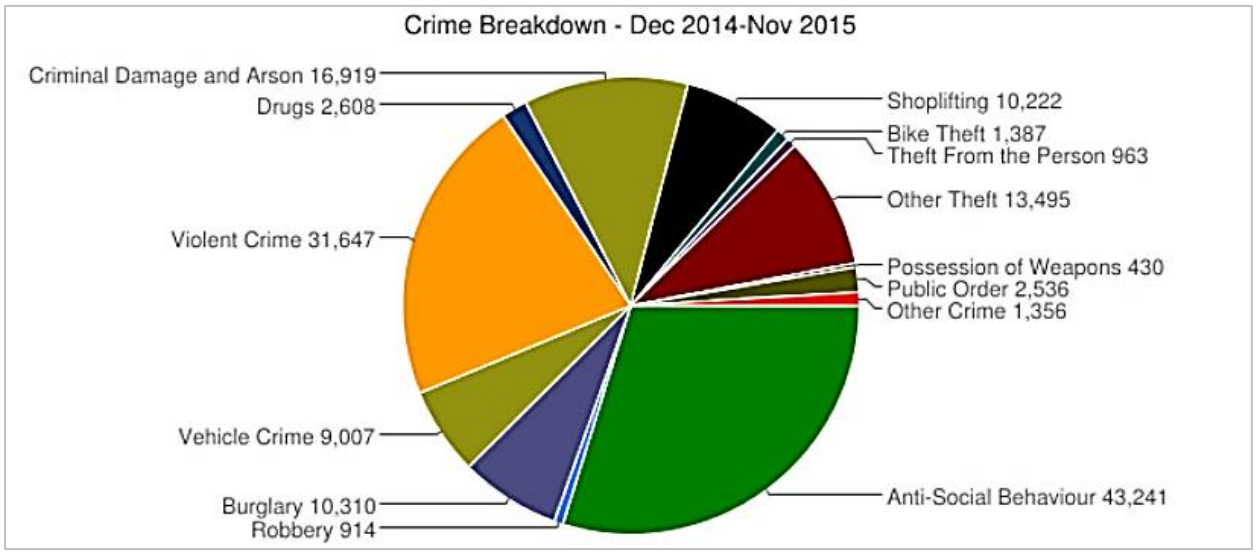
The Kent population is not significantly ethnically diverse with only 6% being of Black or Minority Ethnic (BME) origin. The vast majority of Kent's population are White, particularly within the older age bands. Of those aged 0-15, 9.4% of the population are of an ethnic background – mostly Asian or mixed ethnicity.

4.4 Crime

Drug related crime offences are fewer compared to other types of crime committed in Kent as displayed in Figure 5. However if the strong relationship between drug-related crime is considered such as theft to pay for a drug habit or violence connected to the drug-market, it would be reasonable to say that a proportion of these other crimes would be drug-related.

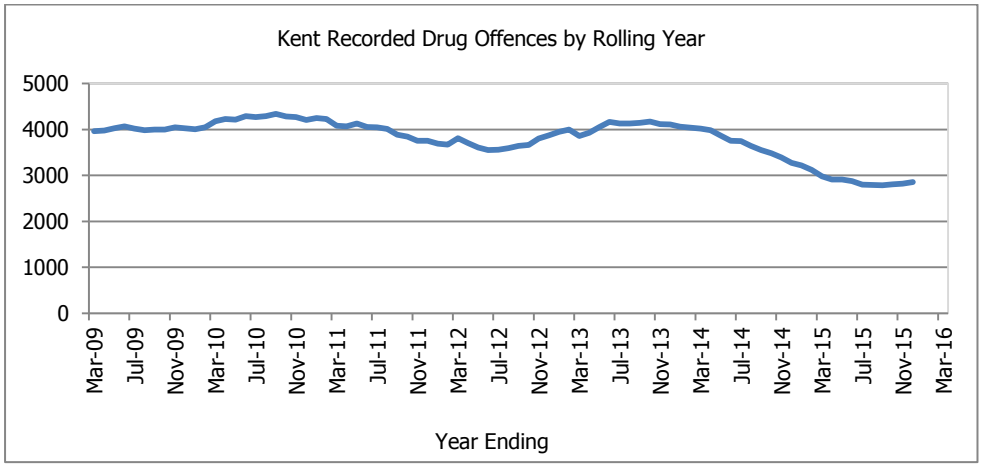
After a sustained period of reduction the rate of recorded drug offences in Kent stabilised in 2015, Figure 6.

Figure 5 Crime: drug-related offences



Source: Kent Police

Figure 6 Crime: drug-related offence trend



Source: Kent Police

Drug Testing on Arrest

A pilot scheme for Drug Testing on Arrest was introduced at Thanet Custody in April 2012 and has subsequently been extended to Maidstone Custody. DToA allows Police to request a drug test from adults arrested for a 'trigger' offence. These 'trigger' offences are largely acquisitive and are known to have a clear link to drug and alcohol misuse.

Offenders testing positive are required to engage with drug treatment services via formal assessment(s). Failure to take a drug test without good cause is a criminal offence and the Police can implement further enforcement where compliance with the drug treatment programme is not being achieved.

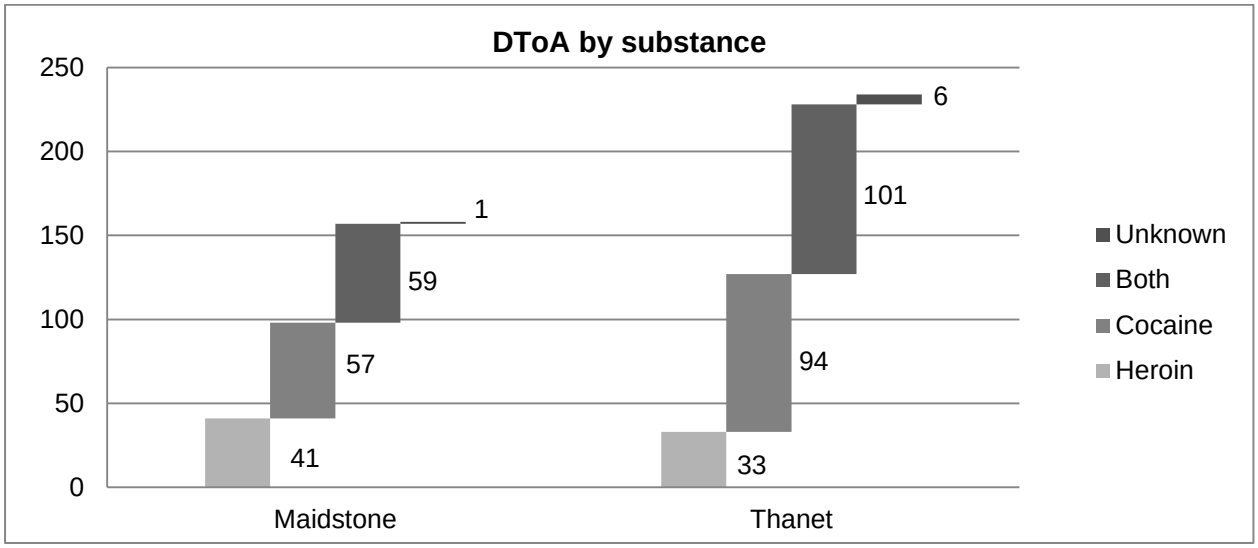
The numbers of people found to have a positive result when tested during April 2015 – January 2016 are displayed in Table 22. The proportion of arrests by substance is shown in Figure 7.

Table 20 Crime: drug tests on arrest

	Number of arrests	Positive result for cocaine, heroin or both	Cocaine	Heroin
Maidstone	340	46.5%	73%	63%
Thanet	525	44.6%	83%	57%

April 2015 – January 2016, Source: Kent Police

Figure 7 Crime: drug tests on arrest by substance



(April 2015 – January 2016), Source Kent Police

Drug driving

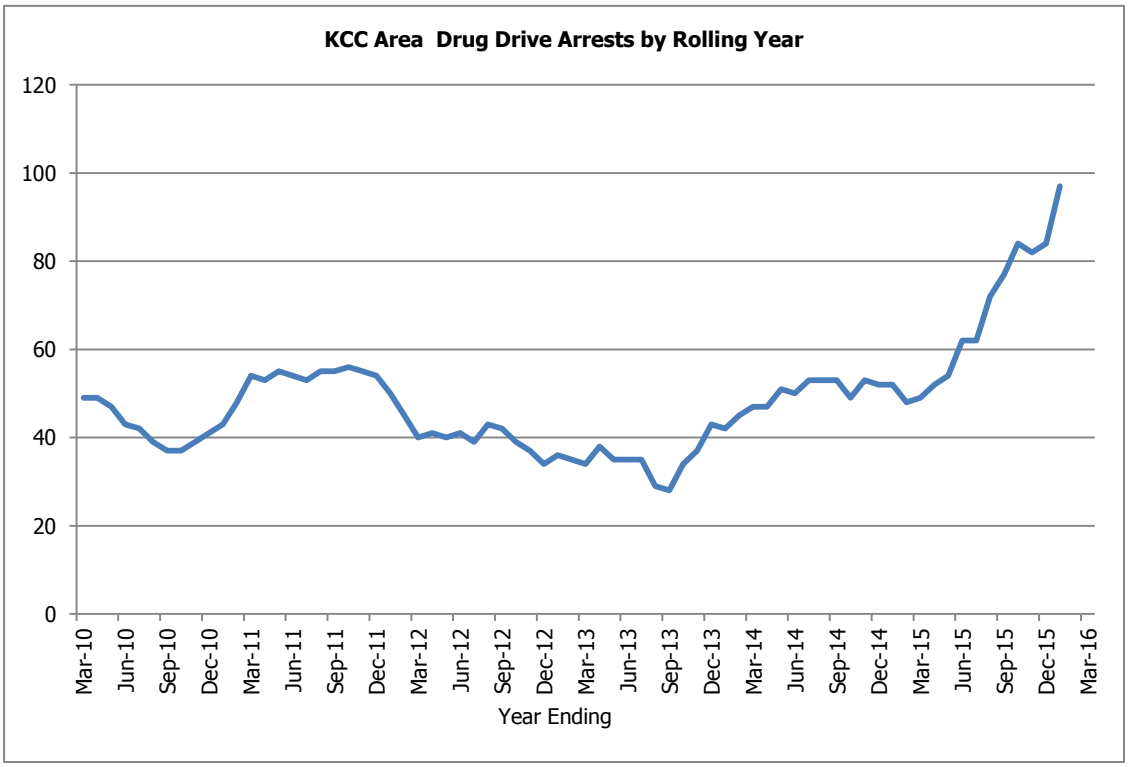
The number of individuals testing positive during the period 2015/16 is approaching double the numbers in the previous two years. The number and upward rolling trend of arrests for being unfit to drive due to drugs within Kent County Council area are displayed in Table 23 and Figure 8

Table 21 Drug driving arrests

Month	2013-14	2014-15	2015-16
Apr	7	7	10
May	1	5	7
Jun	2	1	9
Jul	2	5	5
Aug	1	1	11
Sep	2	2	7
Oct	7	3	10
Nov	5	9	7
Dec	7	6	8
Jan	3	3	16
Feb	6	2	
Mar	4	5	
Total	**47**	**49**	**90**

Source: Kent Police

Figure 8 Drug driving arrest trend



Source: Kent Police

4.5 Emergent drugs

4.5.1 New Unregulated Drugs (NUD)

In 2014/15 the CSEW measured NUD use in for the first time. NUDs refers to newly available drugs that mimic the effect of drugs such as cannabis, ecstasy and powder cocaine, and which may or may not be illegal to buy, but are sometimes referred to as 'legal highs'.

The term 'novel' is contested as many of the drugs are not novel or new but may be 'new' to being used in such a context i.e. 'old' drugs being used in new ways. The use of the term 'legal high' infers a level of 'safety' which is profoundly misleading. The use of this term is to be discouraged in favour of '*(new) unregulated drugs (NUDs)*.

It is possible that the CSEW underestimates the use of NUDs because it may be more concentrated in specific subgroups of the population, which are difficult to access using a household survey. Those most likely to be a frequent illicit drug user is white, young, male, single, a regular clubber and likely to be seen in the pub (Crime Survey England and Wales 2015).

However, it should be remembered that survey data is completed by residents in households and a large proportion of problematic drug users will be homeless or not in permanent residency. Those most likely to use NUD are displayed in Table 24.

Table 22 Groups using NUD (NPS)

Offenders	Aged 16 – 24 years	Subject to drug testing at work / Those in Professional roles
High proportion already using drugs / take at same time as other drugs	Using the night time economy – club, pubs etc.	Men who have sex with men (MSM)
Closely associated with alcohol consumption[8]	Predominantly men	'Psychonauts[9]' *(Neptune, 2014)*

(CSEW, 2014/15)

The NEPTUNE report reviewed global use of NUD and found they are largely used in the northern hemisphere and Europe with the UK accounting for 23% of the market. The most likely sources of supply to individuals in England and Wales are displayed in Table 25, (CSEW, 2015).

Table 23 Supply sources of novel psychoactive substances

Supply source	Proportion
neighbour or colleague	42%
known dealer	11%
shop	5%
internet	0%

Drugs may be classified in various ways either by their effect on the body, their chemical structure or psychological effects. A useful framework for clinical management is to define them in three main categories but these are not rigid.

- Depressant
- Stimulant
- Hallucinogenic

Synthetic cannabinoids are a separate category because they do not fit neatly into these categories but also because their clinical management is so different.

[8] People who had consumed alcohol once or more in the last month were significantly more likely to have used an NUD in the last year across all age groups

[9] Individuals that like to explore their own psyche especially by taking drugs with an emphasis on experiencing extremes of experience.

The United Nationals Office on Drugs and Crime identified six main groups; cannabinoids, ketamine, cathinones, phenethylamines, piperazines and plant-based substances and a seventh miscellaneous group. Some of the most common and their associated trends are displayed in Table 26.

Table 24 New unregulated drugs of concern

	NUDs	Trends	Comment
	Cathinones Mephadrone (most common)	Deaths have decreased since 2013 and appear to be stabilising.	This is consistent with reports by CSEW that the numbers of those using methadrone in the last 3 years remains fairly stable.
2.	Gamma-butyrolactone (GBL) The second most common NUD	GBL was involved in 20 deaths in 2014, which is in line with figures from the last 7 years.	Now controlled under the Drugs Act since 2009, some no longer consider it a new psychoactive substance
3.	Benzodiazepine analogues	Were involved in 9 deaths in 2014 (though around half occurred in 2013).	An emerging trend is the use of benzodiazepine analogues, such as etizolam, flubromazepam and pyrazolam
4.	Nitrous oxide	7.6% of people aged 16 - 24 used nitrous oxide in the last year, though this number had not increased significantly compared with the previous year (Crime Survey England and Wales). There is no evidence of an increase in deaths involving nitrous oxide (Office of National Statistics, 2015)	Only 3 deaths registered in both 2013 and 2014 and between 0 and 5 deaths each year prior to that" (Office of National Statistics, 2015)

NUD associated harms

The range of harms associated with NUD apart from those associated with drug-taking generally are those induced by the level of toxicity upon the body. These can be amplified by taking more than one substance together- either knowingly or a mixture of compounds in a NDU tablet for example or alcohol which is common. Mortality data for NDU deaths should be treated with caution as it is indicative but not robust.

The sources of supply which have been found to contain controlled drugs within NUD are headshops and internet had low levels whilst NUD substances found at festivals had very high levels of controlled substances contained in them (88%) (Home Office, 2014).

The most common pattern of NUD use is similar to that of alcohol; infrequent, non-dependent use with low-level risk of dependency through to a smaller group of those experiencing dependency and more severe harms. For this reason much of the evidence base of recommended interventions are drawn from alcohol approaches such as psychosocial interventions and behaviour change.

4.5.2 **Misuse of prescribed medication**

Data reported by CSEW in 2015 described the patterns of prescription medication (PM) misuse. The demographic features of those misusing prescribed medication are very different from those using illicit drugs although there are similarities.

- The use of prescription painkillers declines with age. The decline was shallower than the decline with age seen for illicit drugs. Higher levels of prescription-only painkiller misuse were seen in some older age groups such as 45 to 54 year olds.
- The misuse of did not vary by frequency of alcohol consumption, with similar levels across all categories
- Illicit drug use increased with the frequency of alcohol consumption
- People with a long-standing illness or disability were more likely to have misused PM and to have used an illicit drug in the last year
- Those with a longstanding illness are nearly twice as likely to misuse PM than those without and are more likely to use illicit drugs
- Cannabis use featured largely in this group. Around 9% of people a long-standing illness had used cannabis in the last year
- Misuse of painkillers was similar in both rural and urban areas
- Data suggests that the misuse of prescription painkillers is distributed more evenly across the general population than the use of illicit drugs

There are no prevalence data for dependency upon over-the-counter or prescribed medication in the general population in Kent.

4.6 High risk drug use

People who inject drugs (PWIDs) in the UK are considered to be at high risk. They are referred to as High Risk Drug Users (HRDUs) as they are at elevated risk of fatal and non-fatal overdose, contracting blood-borne virus (BBV) and are subject to poorer health-related quality of life. PWIDs and those who inject image-and-performance-enhancing drugs (IPED) are of also of increasing concern to Public Health (PHE, 2014).

Needle syringe programmes (NSP) are widely available to prevent the spread of blood-borne disease through the sharing of needles and syringes. The National Institute of Clinical Care and Excellence (NICE) has issued updated guidance (PH 52) for service providers (NICE, 2014). A NSP is active in Kent and is described in more detail in the Treatment Service section.

4.6.1 **Blood borne viruses and drug-related disease**

Injecting drug use is a well-established risk factor for blood borne virus (BBV) infection. The most common blood borne viruses associated with injecting drug use are HIV, Hepatitis B and Hepatitis C.

NICE has several Clinical Guidelines in relation to Hepatitis. Worth noting are the three new treatment options for the treatment of hepatitis C issued in 2015 and CG43 Hepatitis B and C testing: people at risk of infection (NICE, 2012).

The prevalence of blood borne viruses in injecting drug users in the United Kingdom is estimated using data from Public Health England's Unlinked Anonymous Monitoring (UAM) Survey of People Who Inject Drugs (PWID) (Public Health England, 2015).

Key points:

- The prevalence overall of NUD use among is generally low compared with well-established drugs such as cannabis, powder cocaine and ecstasy". (Crime Survey England and Wales, 2015).
- Patterns of use are similar to that of alcohol, ranging from infrequent use through to problematic dependency and severity of harms
- Drug deaths involving NUD are low compared the number of deaths caused by opiates and cocaine but they are on the increase; 67 in 2014 compared to 7 in 2013 (Office for National Statistics,2015)
- Survey evidence shows that NUD use is predominantly confined to existing drug users (Crime Survey England and Wales 2013/14)
- Anecdotal evidence suggests that those in prisons, young people aged below 16 years and those subject to drug testing at work, or in professional roles and MSM may be more likely to use NUD
- Use may be higher in some subgroups such as those frequenting night-time economy venues and men who have sex with men (Crime Survey England and Wales, 2014/15)

Data on the prevalence of BBV in PWID in Kent is not available but levels are likely to be similar to national levels. The prevalence of injecting drug use is lower in Kent than nationally.

There has been a significant increase in the proportion of PWID who report uptake of Hepatitis B vaccination nationally; 72% of participants in the UAM survey in 2014 reported HBV vaccine uptake compared to 56% in 2004. A stable prevalence of infections in recent initiates (to drug use), indicates ongoing new infections. This group should be a key target of health promotion and harm reduction strategies such as needle and syringe exchange, and increasing uptake of BBV testing.
It should be remembered that more vulnerable or chaotic individuals, who have less contact with drug services and needle exchange, are less likely to be included in the UAM survey (Public Health England, 2015). As such the survey may under-represent the burden of BBV in PWID who are harder to reach. Ongoing efforts must be made to increase coverage of harm reduction strategies to 'hard-to-reach' individuals.

The eligible numbers of those in Kent treatment services who accept a course for Hepatitis B vaccine (HBV) is lower than the national for 2014/15. However, when individuals do accept HBV, Kent has a better completion rate than nationally, Figure 9.

Figure 9 Hepatitis B vaccination rates

	Local				National			
	n	Proportion of eligible clients	Proportion by gender M	F	n	Proportion of eligible clients	Proportion by gender M	F
Adults new to treatment eligible for a HBV vaccination who accepted one	369	34%	33%	36%	21,726	40%	40%	41%
Of those:								
the proportion who started a course of vaccination	65	18%	18%	16%	4,746	22%	22%	23%
the proportion who completed a course of vaccination	101	27%	30%	20%	4,700	22%	22%	20%
Previous or current injectors eligible for a HCV test who received one	1,366	82%	82%	83%	80,447	81%	81%	83%

Source: NTDMS

4.6.2 **Image and Performance Enhancing Drugs (IPEDs)**

An emerging risk group for BBV associated with injecting drug use are users of anabolic steroids and IPEDs commonly referred to as "fat burning drugs". National data on users of IPEDs demonstrated similar rates of HIV to other PWID and low levels of Hepatitis B vaccine uptake and high levels of unprotected sexual intercourse and use of psychoactive drugs.

Up to 40% of clients visiting needle exchange services in Kent cite steroids as their primary substance of injection (40% in West Kent and 14% in East Kent). The reason for the difference in the two areas is unknown.

IPEDs include a number of substances such as steroids, hormones and metabolism altering substances. The main steroid group of misuse are those called 'anabolic' steroids. Many of these drugs were developed for therapeutic use and but have subsequently been marketed for their supposed 'image enhancing' properties.

The range of available IPEDs now includes new and emerging drugs, such as novel peptide hormones, for which there is little clinical evidence on efficacy or safety. The legal status of the IPED group varies between substances. Anabolic steroids are classified under the Misuse of Drugs Act (1971). For the purposes of this needs assessment they will be considered together with other IPED substances.

The use of IPEDs can have severe adverse outcomes. Nationally there have been a small number of reported fatalities linked to "fat burning" drugs. A review of national NPIS data showed a substantial increase in referred cases; an increase from 5 to 22 between 2012- 2013. Five cases were fatal (National Poisons Information Service, 2014).

National data indicate that the group most likely to use IPED are young men aged 18-25 who undertake regular exercise such as weight lifting. They can make some users feel paranoid, irritable, aggressive or even violent, and they can cause dramatic mood swings.

4.7 Morbidity and Mortality

Morbidity refers to the incidence (the occurrence, rate, or frequency of an event e.g. a disease) in a population. The term is used to describe ill-health related data in relation to a specific cause or disease e.g. alcohol related. Mortality (death) rate is a term to describe how many people die from a specific or general cause in a particular population e.g. due to alcohol or drugs.

4.7.1 **Hospital admissions**

There are two key indicators for drug related ill-health relating to hospital admission:

- Mental health and behavioural disorders
- Hospital admissions for acute poisoning

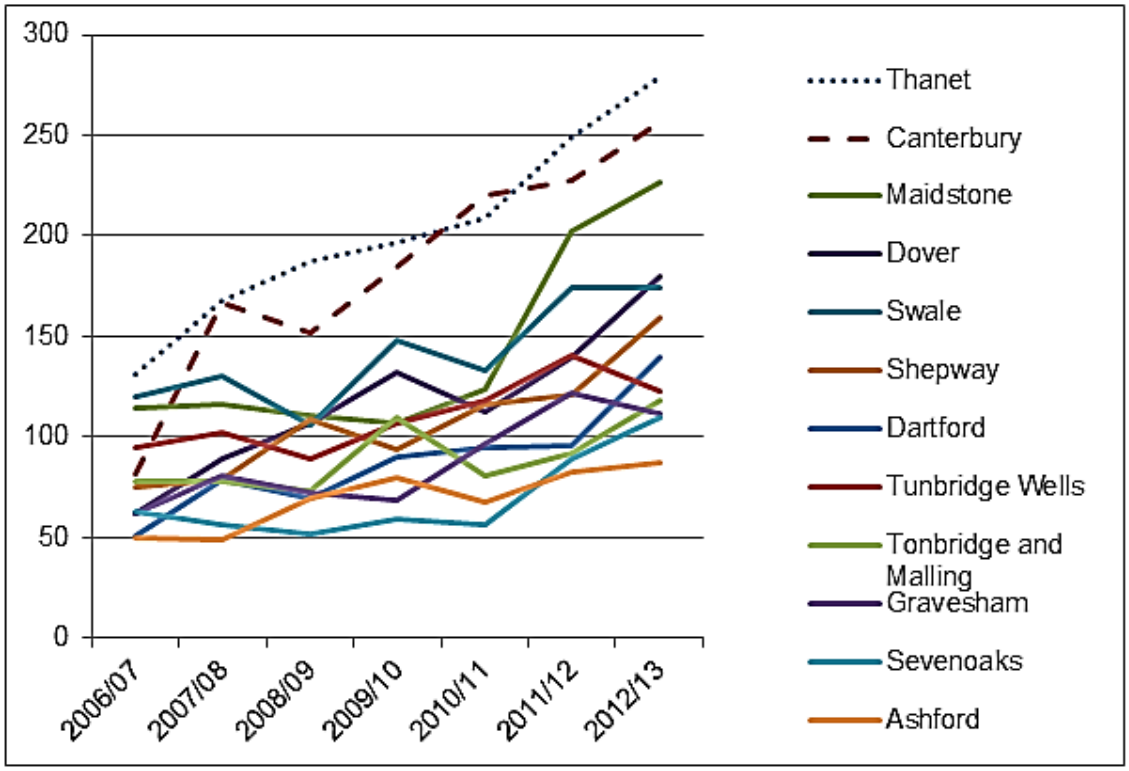
Mental health and behavioural disorders include effects that differ in severity and clinical form but are all attributable to the use of one or more psychoactive substances. Examples include intoxication and those individuals showing dependence and withdrawal symptoms.

Drug related hospital admissions (including poisoning and mental health disorder) have increased by 50% across Kent between 2006- 2013.

Drug related hospital admissions in Kent are displayed in Figure 10. Thanet has the largest number of admissions in Kent and admissions in Canterbury have increased significantly over time - 213% over the 6 year period.

All districts have increased admissions except Swale and Gravesham who have shown no change and Tunbridge Wells has seen a decrease (18 admissions).

Figure 10 Hospital admission: district trends



Source: KPHO, 2014

4.7.2 **Dual Diagnosis**

Dual diagnosis (DD) is a term applied to individuals with a mental health condition and a drug and alcohol misuse issue such as drug and / or alcohol addiction. Drug and alcohol misuse is the norm rather than the exception amongst individuals with (severe) mental health problems.

A large proportion of people in England with mental health problems have pre-existing or concurrent problems with drug or alcohol misuse. Likewise poor mental health is commonplace in people who are dependent upon or have problems with drugs and alcohol.

The 2012 Government's Alcohol Strategy reported that almost half of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the 12 months prior to treatment and 85% of users of alcohol treatment services were experiencing mental health problems. Kent treatment service data identify alcohol as the most commonly used substance among dual diagnosis clients in Kent.

The profile of those with a recorded mental health condition and a DD condition in Kent are described in Table 27.

Table 25 Dual Diagnosis: Kent profile

People with a MH condition + Drug and alcohol misuse Males Females	1 in 10 1.5 in 10 0.7 in 10 62% are male 38% are female
Commonest age range: 25-44	1 in 5
There is no ethnic pattern	
Highest rates of DD recorded in deprived areas	Maidstone, Gravesham and Thanet
Substance	Alcohol (47%) Psycho active substances (28%) Cannabis (23%)

Source: KPHO

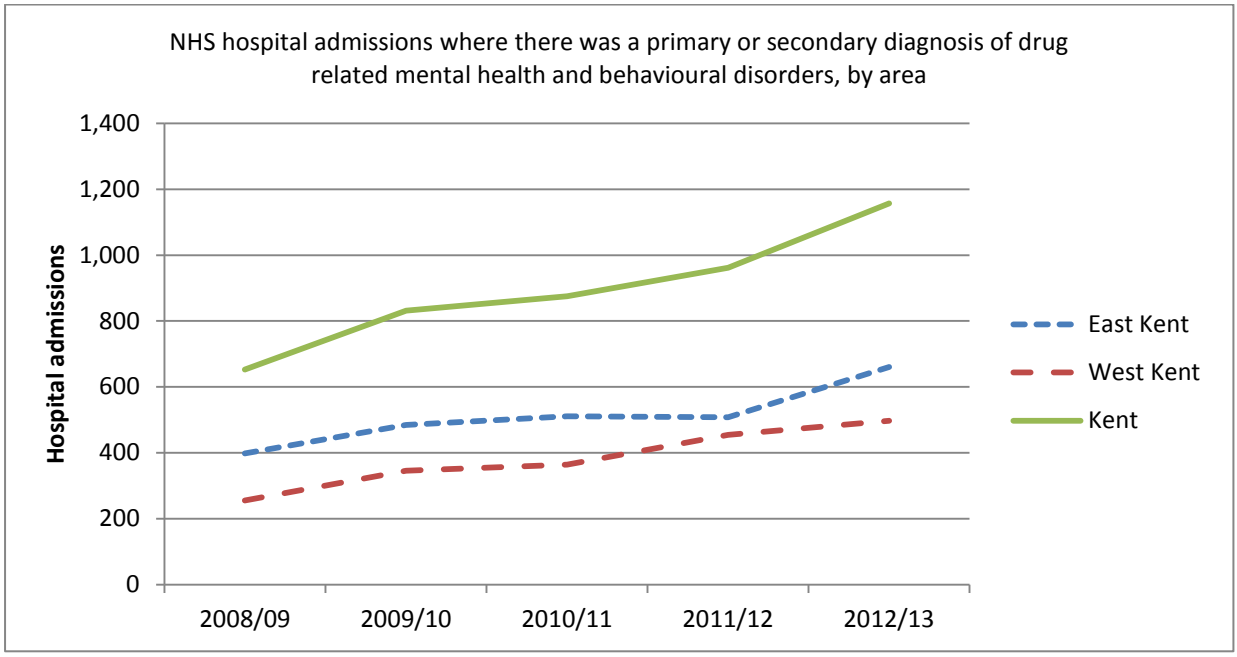
Hospital admissions: dual diagnosis

Hospital admissions are coded as 'Primary' or 'secondary'; primary being *the* (main) reason for admission and secondary meaning drug misuse/mental health (dual diagnosis) condition is a *contributory* factor. The numbers of hospital admissions for

drug related mental health and behavioural disorders in Kent have increased by 75% over 5 years to 337 in 2012/13.

The admission trend for those with a dual diagnosis in the period 2008-2013 is displayed in Figure 11. Adults aged 16 to 24 had the greatest number of admissions with a primary diagnosis of poisoning by illegal drugs.

Figure 11 Hospital admissions: dual diagnosis trend



Source: NHS Health and Social Care Information Centre (HSCIC) 2014

4.7.3 **Mortality**

The number of drug deaths reported in England and Wales in 2014 were the highest since records began; a 17% rise in 2014. In Wales the rate fell by16% the lowest rate for ten years. The majority (67%) of these involved illegal drugs. Over half of these deaths occurred in the years before 2014. Although the proportion of drug poisoning deaths involving illegal drugs has generally increased over the past 20 years, it has stabilised in recent years (Office for National Statistics, 2015).

Deaths from heroin and/or morphine increased by almost two-thirds and cocaine deaths rose sharply. Deaths from NUD are low compared to the numbers dying from heroin, morphine, other opiates, or cocaine but these are increasing. Latest data indicates that the upward trend in NUD mortality may have now stabilised. Men are over twice more likely to die than females and those aged 40-49 had the highest mortality rate (Office for National Statistics, 2015).

There are three key sources of information relating to drug related deaths. Depending on the purpose and definitions used will result in differing statistics. The organisations and the purpose of the reports produced are described in Table 28.

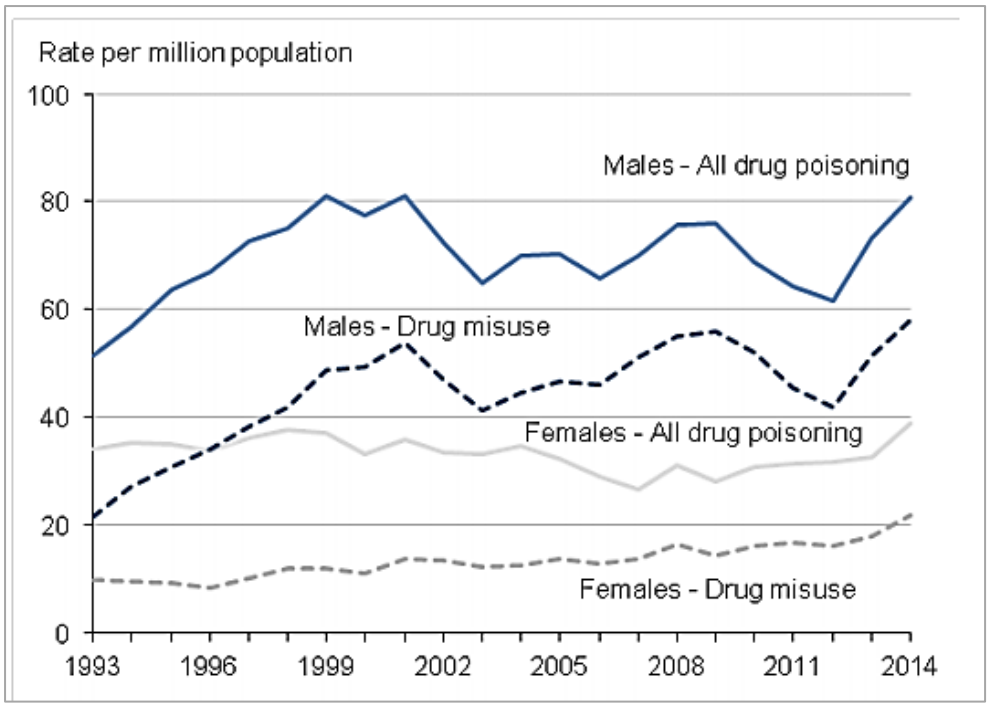
Table 26 Resources: drug-related deaths

Organisation/ Report	Definition	Reported trends for England and Wales
EMCDDA (European Monitoring Centre for Drugs and Drug Addiction, 2015). *Data is collated from across Europe. PHE contribute to this data collection via the UK Focal Point data.*	Death directly linked to the consumption of one illicit drug	1,946 deaths in 2013. This is a steep increase since 2012 - Three quarters of deaths were male; mean age 41.6 years. - Most deaths involved opioids (heroin, morphine and methadone). - In absolute numbers, heroin deaths in 2013 are higher than 2011 - Methadone deaths in absolute numbers have decreased since 2011. - Drug induced mortality in the UK is 44.6 per million, double that of the European average of 17.2 per million.
Drug Misuse statistics *Used in the Governments Drug Strategy*	Deaths where an underlying cause was drug abuse/dependence/ poisoning under Drugs Act 1971	
Office of National Statistics *Widely used*	Is much wider than other definitions and also includes death as a result of legal prescription drugs.	

Over time the *drug misuse* mortality rate for each sex has gradually become closer to the *all drugs* poisoning mortality rate which may mean that drug misuse has increased over time. It may also be explained by the ageing profile of drug-users who due to long-standing misuse are in poorer health and consequently suffering increased fatalities.

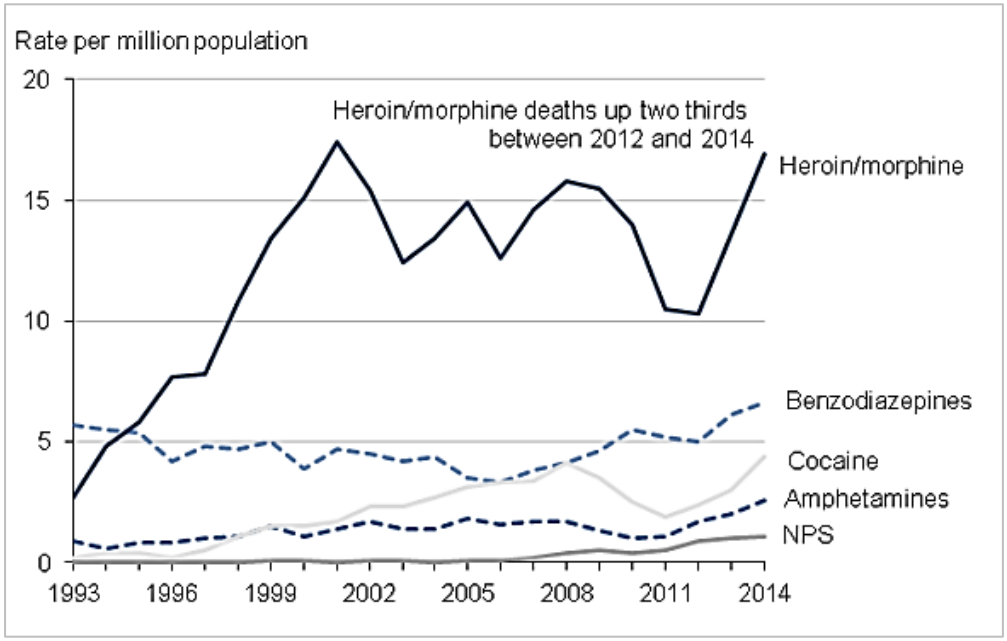
The Age-standardised mortality rates for deaths related to drug poisoning and drug misuse and those by selected drug by sex, deaths registered in 1993 to 2014 England and Wales is shown in Figures 12 and 13, (Office for National Statistics, 2015).

Figure 12 Mortality trend in England and Wales



Source : ONS

Figure 13 Mortality trend in England and Wales: selected substances

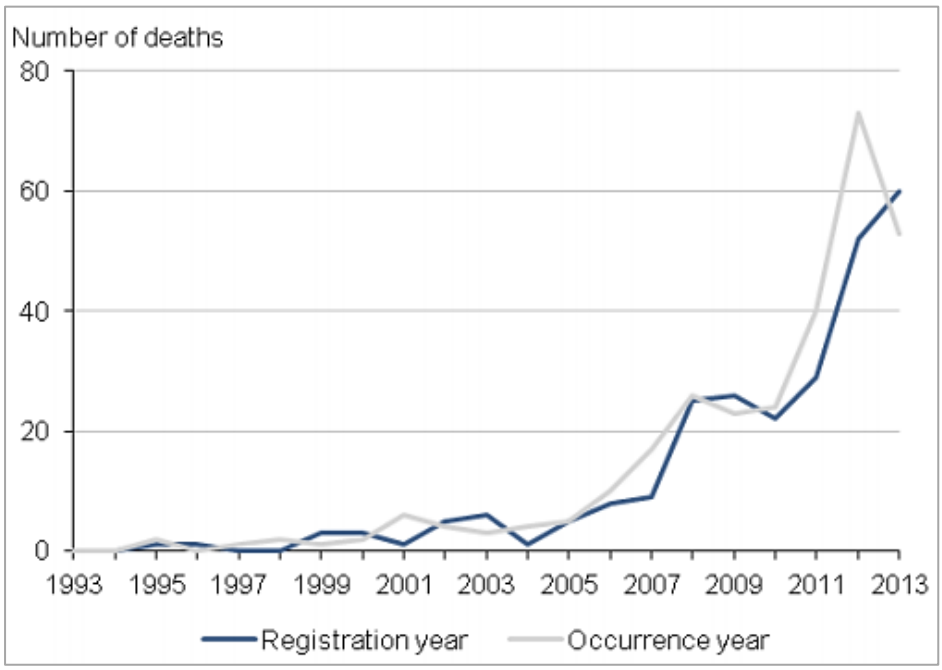


Source : ONS

When presenting data on the numbers of drug related deaths, it should be remembered that there are two dates to consider. The first will be the year a death occurred and a subsequent date or year when the death is registered. This is due to the interval for the Coroner to rule on cause of death.

The trend analysis based on the year when death occurred reveals a different pattern than that seen for registration year. Analysis of year of occurrence suggests that there were sharp increases in NUD deaths between 2011 and 2012, but then the number of deaths fell in 2013. Although figures for deaths occurring in 2014 are very incomplete and so are not shown in Figure 14., initial indications suggest that the upward trend in NUD deaths has now stabilised although this may be prone to change.

Figure 14 Mortality trend in England and Wales: NUD



Source: ONS, 2015

Drug-related deaths in Kent are highest in areas of high deprivation and areas with notable night time economies (NTE) such as clubs and pubs. Swale, Thanet and Canterbury have the greatest mortality rates in Kent as displayed in Table 14.

Systems are in place nationally and in Kent to review the circumstances surrounding a drug related death. This includes a system to review ‘near misses’ to inform quality assurance and system-wide learning and workforce learning.

The number of drug-related deaths and the crude mortality rates registered between the periods 2006 - 2014 by Kent districts are shown in Table 29,

Table 27 Kent mortality rates

Local authority	2006–08		2009–11		2012–14	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
England	*5,053*	*32.8*	*5,142*	*32.6*	*5,424*	*33.5*
Ashford	4	11.8	6	17.1	8	21.9
Canterbury	23	52.9	16	35.9	**19**	40.7
Dartford	5	18.0	6	20.7	5	16.6
Dover	14	42.8	15	45.1	7	20.8
Gravesham	6	20.3	11	36.3	12	38.5
Maidstone	11	24.8	6	13.0	**17**	35.5
Sevenoaks	3	8.9	3	8.7	7	19.9
Shepway	2	:	13	40.5	11	33.6
Swale	8	20.6	8	19.8	**20**	47.9
Thanet	21	53.6	20	50.0	**19**	46.2
Tonbridge and Malling	4	11.6	5	13.9	7	19.0
Tunbridge Wells	14	42.8	8	23.4	7	20.2
Totals	**115**		**117**		**139**	

Source: ONS

5 Treatment services

Introduction

This section contains information about the services provided for drug and alcohol misuse in Kent. It is important that services commissioned are flexible and responsive to the changing patterns of drug misuse. Although drug treatment services treat dependence for all drugs, heroin users remain the group with the most complex problems and the majority of those in treatment use opiates (heroin).

Overall, treatment services in Kent perform well, often exceeding national performance benchmarks. The current service providers of adult treatment are Turning Point in East Kent, and the *Change, Grow, Live* (CGL) in West Kent. The areas in Kent they provide services for are displayed in Table 30.

Table 28 Kent treatment services: locations

CGLI	*Dartford, Gravesham, Maidstone, Sevenoaks, Tonbridge and Malling, Tunbridge Wells*
Turning Point	*Ashford, Canterbury, Dover, Shepway, Swale, Thanet*

Services are commissioned to deliver or sub-contract a comprehensive range of services from advice, information and outreach through to intensive drug and alcohol misuse community treatment and residential rehabilitation.

Treatment demand indicators were altered in 2014 to report on a calendar year and not a financial year as previously. The data capture methodology has also been changed. This means data is not directly comparable to previous years.

Public Health England have introduced a new Public Health Outcome Framework measure (PHOF 2.16), recording the proportion of people entering prison with substance dependence issues who were not previously known to community treatment.

5.1 Service access and equity

Equity is the absence of avoidable or remedial differences among groups of people whether those groups are defined socially, economically, demographically or geographically. Health inequities therefore involve access to the services needed to improve and maintain health and wellbeing. Drug and alcohol misuse services should be designed and delivered to meet the needs of the sub-populations of the people of Kent regardless of their location or characteristics.
Adult drug and alcohol misuse services are provided across Kent in all districts both in the community and in custodial settings (prison and police custody). Services are delivered through fixed site hubs and satellite sites across Kent e.g. GP surgeries, Healthy Living Centres, Gateway Centres and mobile Recovery Vehicles.

In addition to receiving referrals from statutory organisations, drug and alcohol misuse treatment services have an 'open' referral system which means the public has direct access to request advice and support. Services provide telephone assistance 24 hours / seven days per week in addition to face-to-face sessions.

It is important that services are attractive to all groups and communities. This is particularly relevant for women and especially for the LGBT who are notably unrepresented in treatment services both nationally and locally.

5.2 Service user views

The importance of including service users, their families and the wider community, should not be overlooked when commissioning and designing services. PHE has produced guidance for commissioners on how to involve service users in designing treatment and recovery services. The NDTMS also provide commissioning toolkit and resources for this purpose[10]. The themes from the service user survey (2014/15) of Kent service users are displayed in Table 31.

[10] http://www.nta.nhs.uk/toolkits.aspx

Table 29 Treatment services user survey

Importance of easily accessible services was stressed	Extend availability of group sessions especially at weekends	Have more accessible services in more places or hubs
Provide a variety of types of services to cater for individual recovery experiences	Have more information about hubs – how they work and where they are	Improve understanding of what may be expected during the first months of recovery
Provide more outreach opportunities	Focus attention on the first few months of recovery to aid better attendance	High levels of service satisfaction were noted

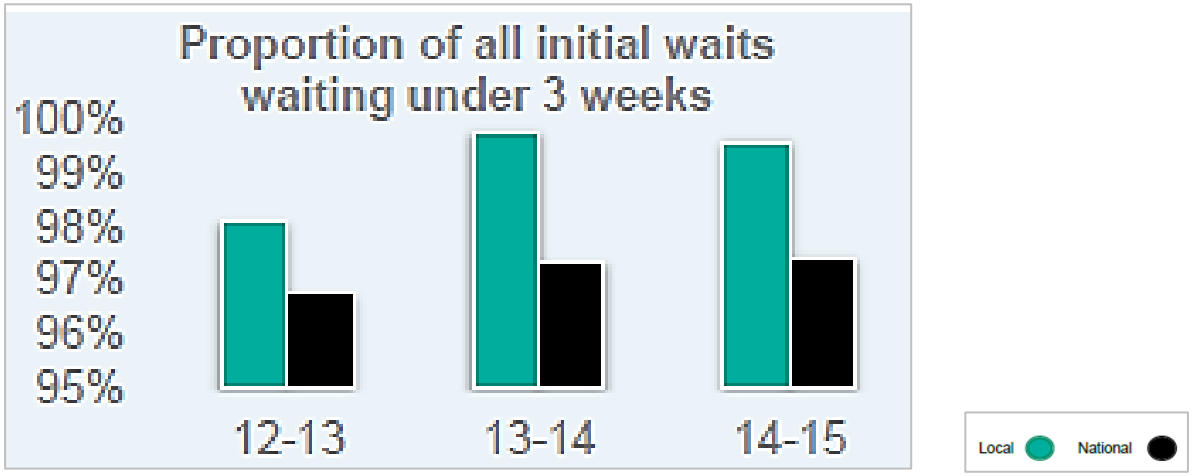
To enable direct comparisons between levels of service user satisfaction between different service providers and types of service provision, it is recommended that the tools and methods to gather client feedback are revised.

5.3 Waiting times

Drug users need prompt help if they are to recover from dependence. Keeping waiting times low will play a vital role in supporting recovery in local communities. In Kent, efforts to keep waiting times low mean that the national average waiting time is less than one week. The number of drug users who waited less than three or more than six weeks to start treatment is shown in Figure 15.

Figure 15 Treatment services: waiting times

	Local n	Local Proportion of all initial waits	National n	National Proportion of all initial waits
Adults waiting under three weeks to start treatment	1,663	100%	76,996	97%
Adults waiting over six weeks to start treatment	2	0%	582	1%



Source: NDTMS

5.4 Referrals into treatment services

It is important that effective referral pathways exist in order to ensure that individuals receive early-stage and appropriate treatment. There should be widespread and increased awareness amongst statutory workforces in particular on how to identify, refer and offer advice on self-referral to services and community support organisations.

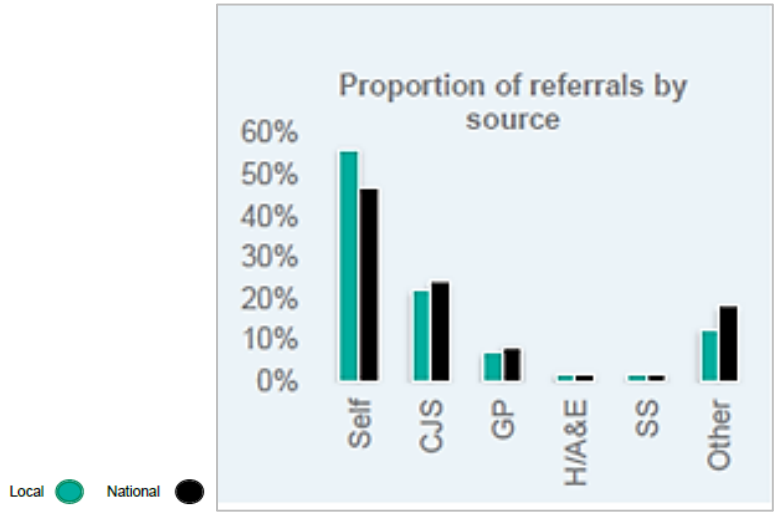
In the last period, there was a 3% decrease in new clients presenting to services.

The different ways people were referred into treatment services in 2014/15 are displayed in Figure 16, (NDTMS, 2015)[11] . The vast majority of people contact services themselves directly – self refer. Compared to national levels, more people in Kent refer themselves (42%).

This high proportion of self-referrals suggests effective communication and publicity of treatment services in Kent. It may further indicate that a proportion of individuals are not being offered a referral by professionals but advised to make a self-referral. Anecdotally this is a recognised practice amongst professionals and front-line workforces.

Figure 16 Treatment services: waiting times

Source of referral into treatment	Local	Proportion of referrals	Proportion by gender		National	Proportion of referrals	Proportion by gender	
	n		M	F	n		M	F
Self-referral	926	56%	54%	61%	37,285	47%	46%	49%
Referred through CJS	361	22%	26%	9%	19,070	24%	27%	14%
Referred by GP	110	7%	6%	8%	6,329	8%	7%	9%
Hospital/A&E	28	2%	1%	3%	1,249	2%	1%	2%
Social services	22	1%	0%	4%	1,121	1%	1%	3%
All other referral sources	205	12%	12%	14%	14,329	18%	17%	22%



Source:NDTMS

[11] To be 'referred through CJS' means referred through an arrest referral scheme or via a Drug Rehabilitation Requirement (DRR), prison or the probation service.

CJS referrals

The criminal justice system referred 22% of the total service referrals. The proportion of criminal justice referrals in Kent is lower than the national level. The need to ensure there is continuity of care for drug and alcohol misuse services when entering or leaving the criminal justice system is critical. This is especially important for those with mental health issues and drug and alcohol misuse problems (dual diagnosis).

In Kent the numbers of people entering prison who are treatment naïve (unknown to community treatment services) was 55% compared to 47% nationally (NDTMS, 2015).

Health referrals

GP referrals make up 7% of the total referrals. While this may appear low it is similar to national reported levels. An untested hypothesis for this low referral rate is that the GPs prefer to encourage self-referral as a rudimentary test of commitment to treatment services. This is not recommended practice.

Only 2% of referrals came from hospitals including Accident and Emergency (AE) units. Although similar to national levels, AE and hospital visits present a vital and timely opportunity to identify and refer individuals into treatment.

Given the increasing number of admissions and attendances for drug-related illness and general population 'foot fall' to hospitals, it would be reasonable to expect the number of referrals to increase if drug and alcohol misuse identification and referral to treatment services were given a higher priority.

Social Services

Referrals from Social Services should increase over time with the introduction of the new framework: *Alcohol and other Drug Use: The Roles and Capabilities of Social Workers* (Galvani, 2015) and the uptake of *Troubled Families* Programme.

5.5 Treatment participation

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing early service 'drop out' and keeping people in treatment long enough to benefit contributes to improved treatment outcomes.

As people progress through treatment, the benefits to them, their families and their community start to accrue. Remaining in treatment services for three months or longer is an effective measure of treatment engagement.

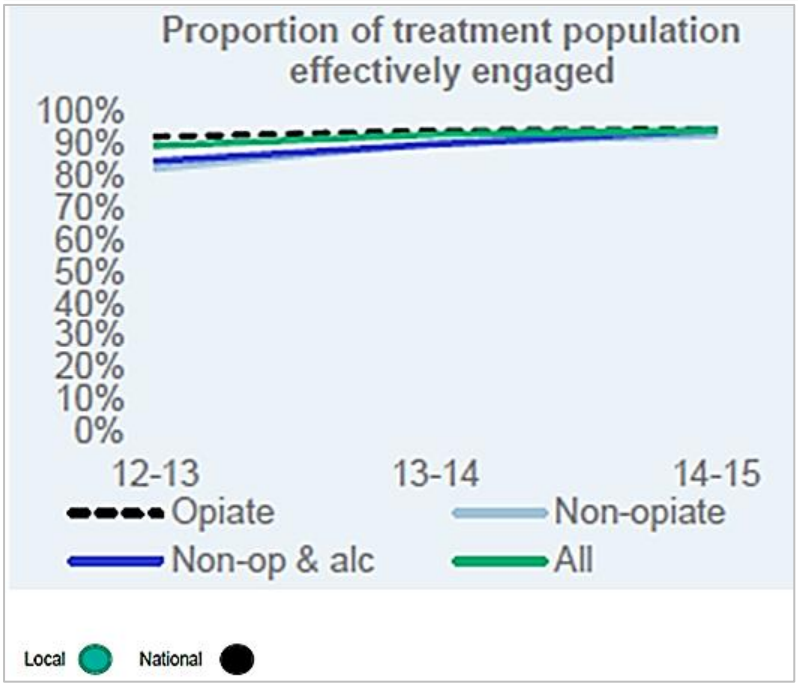
In 2014/15, Kent saw a 9% increase on the previous period for individuals engaging with services for opiates and non-opiates. This equates to 94% of the treatment

population effectively engaging with services. This compares favourably to the national performance which saw a 2% decrease, Figure 17 (NDTMS, 2015).

Figure 17 Treatment services: effectiveness of engagement

Adults effectively engaged in treatment 2014-15

	Local n	Growth in numbers from 13-14	Proportion of treatment population	National n	Growth in numbers from 13-14	Proportion of treatment population
Opiate	2,205	2%	95%	145,875	-2%	95%
Non-opiate	406	13%	93%	21,857	-2%	87%
Non-opiate and alcohol	668	33%	94%	24,686	-2%	88%
All	**3,279**	**9%**	**94%**	**192,418**	-2%	**93%**



A review of the primary drug of addiction within treatment services in Kent reflect the national pattern of drug misuse which is to say that heroin is amongst the most problematic substances for individuals seeking support. That cannabis is the second on the list is reflective of its popularity. No further information is available on 'other drugs'. It would be useful to have this information. The profile of substances reportedly used by those in treatment services in Kent are displayed in Table 32.

Table 30 Treatment services: use by substance

Drug	1st drug		2nd drug		3rd drug		Total
	n	%	n	%	n	%	n
Heroin	1813	68%	108	6%	18	2%	**1939**
Cannabis	308	12%	461	25%	238	29%	**1007**
Crack Cocaine	44	2%	534	29%	122	15%	**700**
Cocaine	111	4%	195	10%	58	7%	**364**
Other Opiates	144	5%	109	6%	52	6%	**305**
Methadone	69	3%	159	9%	69	8%	**297**
Benzodiazepines	28	1%	123	7%	113	14%	**264**
Amphetamines	66	2%	86	5%	53	6%	**205**
Prescription Drugs	37	1%	23	1%	26	3%	**86**
Other Drugs	14	1%	32	2%	28	3%	**74**
Ecstasy	7	0%	15	1%	21	3%	**43**
Hallucinogens	8	0%	14	1%	20	2%	**42**
NUD[12]	*Withheld due to small number*						
Solvents	*Withheld due to small number*						

Source: KDAAT/NDTMS, 2014

5.6 Service interventions

There are several treatment options available and which are delivered by a variety of *interventions (*settings). The type of intervention is based upon need. The 'setting' is the *type* of intervention and not the 'location' i.e. actual setting.

By far community-based pharmacological, psychological and recovery support is employed in Kent. The use of pharmacological intervention alone is not recommended. Kent has no service users solely receiving pharmacological support. The types of intervention used in Kent are displayed in Figure 18.

Figure 18 Treatment services: service interventions

	Local high level interventions								Proportion by gender	
	Pharmacological		Psychosocial		Recovery Support		Total individuals**			
Setting	n	%	n	%	n	%	n	%	M	F
Community	2,150	92%	3,437	99%	1,462	99%	3,440	99%	99%	100%
Inpatient unit	111	5%	109	3%	10	1%	112	3%	3%	3%
Primary care	286	12%	1	0%	0	0%	286	8%	8%	8%
Residential	12	1%	49	1%	15	1%	50	1%	1%	1%
Recovery house	0	0%	0	0%	3	0%	3	0%	0%	0%
Young person setting	0	0%	0	0%	0	0%	0	0%	0%	0%
Missing	0	0%	0	0%	0	0%	0	0%	0%	0%
Total individuals*	**2,347**		**3,460**		**1,475**		**3,464**			

	n	Proportion of pharmacological interventions
Number and % of individuals who were in treatment for the entire year and have only pharmacological interventions	0	0%
Of which received maintenance only interventions	0	

* This is the total number of individuals receiving each intervention type and not a summation of the setting the intervention was delivered in.
** This is the total number of individuals receiving any intervention type in each setting and not a summation of the pharmacological, psychosocial and recovery support columns.

[12] Formerly known as 'NPS'

5.7 Sexuality

Drug and alcohol misuse among the Lesbian, Gay, Bisexual, Transgender (LGB) community is estimated to be nearly four times greater than that of the overall population. In 2012, it was estimated that there are between 53,000 and 75,000 lesbian or gay adults in Kent (Kent County Council, 2012).

Treatment service data for 2012/13 shows that LGBT individuals were less likely to be in structured treatment in Kent than the population overall; 0.1% and 0.3% respectively, Table 34. This is reflective of national trends.

Table 31 Treatment services: sexual orientation

Sexual orientation	Proportion
Heterosexual	96%
Homosexual / Bisexual	2%
Unknown	2%

Source: KPHO, 2015

Men who have Sex with Men

This diverse group experiences significant inequalities relating to their health and wellbeing. Addressing the health problems affecting this group is a key part of improving public health nationally, as well as being a legal duty for all public bodies under the Equality Act (2010).

Although published data is limited, a small number of surveys along with PHE and Home Office data provide some insight into the level of substance use among MSM. Gay or bisexual adults were more likely to have taken any illicit drug in the last year than heterosexual adults, Table 34.

Table 32 Illicit drug use in last year by sexual orientation

Sexual orientation	Illicit drug in last year
Gay or bisexual men	33%
Gay or bisexual women	23%
Heterosexual men	11%

Source: UK Focal Point on Drugs, 2014

National NDTMS data shows that 959 self-reported gay or bisexual men started drug treatment in 2013-14, accounting for 3% of all men who started treatment in the year; 48% lived in London.

The drug-taking profile of the MSM group is markedly different to that of men who self-reported as heterosexual. Gay or bisexual men in treatment for *non-opiate* drugs were more likely to inject compared to heterosexual men. This may reflect the practice known as ‘slamming’ (injecting mephedrone or crystal methamphetamine). The rates for injecting *opiates* were practically the same for gay or bisexual men as for heterosexual men in the period 2013-14, Table 35.

Table 33 Treatment services: drug taking profile of Men, (England)

Substance	Gay or Bisexual Men	Heterosexual Men
Likelihood to inject non-opiates	16%	3%
Amphetamine use	32%	7%
GBL	16%	0.1%
Heroin	29%	Much less prevalent
Crack cocaine	19%	Much less prevalent

Source:NDTMS

'Chemsex'

Chemsex is a term for the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience. Chemsex commonly involves crystal methamphetamine, GHB/GBL and mephedrone, and sometimes injecting these drugs.

These practices can have an adverse impact on the health and wellbeing of MSM. It should be remembered that not all MSM who need treatment for other alcohol and drug problems participate in chemsex.

The extent of the Kent MSM population and associated patterns of drug use including rates of injecting and rates of club drug and NUD use is unknown. Some reasons for poor engagement of MSM with services are described in Table 36 (Public Health England, 2014).

Table 34 Treatment services: reasons for MSM non-engagement

Stigma	Services ill-equipped to help them	Concern that staff can be unsympathetic to their needs	Feel that sexual health services are more empathetic and knowledgeable than SMS
Some feel they 'don't have a drug problem' e.g. just party too hard	Increased risk of sexually transmitted infections and other diseases	Patterns of alcohol and drug misuse and Chemsex are often related to broader wellbeing issues or problems	MSM are a diverse group with men from minority ethnic groups having different needs
MSM are often in full-time employment, function well and use drugs intermittently	Individuals injecting drugs intermittently may be unaware of safer injecting practices and services	The needs of MSM using drugs for recreational purposes differ from those using in a sexual setting. Both groups may be reluctant to engage with traditional services and may need services relevant to their needs.	

It is clear that general health promotion for this group is required and that workforces should be knowledgeable and welcoming to attract this group into services. As well as improving service access, quality of services and health outcomes for this group, such steps are important to address the spread of infections and hepatitis.

Several reasons in particular should be of interest to commissioners. For instance the opportunities to further align and integrated sexual health services with drug and alcohol misuse services for this group.

5.8 Residential rehabilitation

Drug treatment mostly takes place in the community near to users' families and support networks. Sometimes, individuals need to undertake residential treatment which may be outside of Kent. The number of adult drug users in Kent who undertook residential rehabilitation based on need during their latest period of treatment is shown in Figure 19. The requirement for residential rehabilitation is based upon need and so no inferences can be drawn than Kent is lower than the national proportion.

Figure 19 Treatment services: residential rehabilitation

	Local		Numerical split by gender		National	
	n	Proportion of treatment population	M	F	n	Proportion of treatment population
Number of adults who attended residential rehabilitation	57	2%	41	16	5,693	3%

Source: NDTMS

5.9 Treatment journeys

In Kent during 2013-14, more opiate clients attended for several courses of treatment than nationally which is an increase of 6% on the previous period 2011/12. There has been a small increase overall of the number of people returning to services in those with opiate dependence, Table 37).

The reasons for this higher than average number of previous treatment 'journeys' are unknown. This may indicate that the shorter than average length of treatment journey are a result of higher client turnover rates i.e. clients dropping out and subsequently returning to treatment.

Table 35 Treatment services: previous treatment courses

	None	1	2	3	4+
Kent	24%	20%	17%	12%	27%
National	30%	21%	16%	11%	22%

Source: NDTMS

Services should make efforts to understand why this is occurring. More information from client follow-up would be useful to identify reasons. It is accepted that this can prove

difficult as clients may not wish to be reminded of their time spent in treatment services and so other methods should be employed.

These could include:

- More co-design input from service users
- Refining quality assurance measures including feed-back during treatment and on completion of treatment
- Service user survey

5.10 Treatment outcomes

In 2012/13 the number of successful completions in England remained stable at 15% of the total number of people in treatment (Public Health England, 2014). Individuals who stop using illicit opiates in the first six months of treatment are nearly five times more likely to complete successfully than those who continue to use.

During the period 2014/15, with the exception of amphetamines, Kent performed better than the national average with more successful completions across all substances including those who are no longer injecting substances. The reasons for the lower successful amphetamine outcomes are not recorded and would be useful, Figure 20.

Other notable outcomes include:

- More people in Kent reported working 10 or more days in the month before treatment was completed
- Less people than nationally report a housing need

Figure 20 Treatment services: outcomes at six months

Six month review outcomes	Abstinence					Significant reductions in use				
	Local	Proportion	Proportion by gender		National	Local	Proportion	Proportion by gender		National
	n		M	F	n	n		M	F	n
Opiate	251	49%	50%	48%	41%	116	23%	23%	23%	25%
Crack	128	66%	66%	68%	49%	18	9%	9%	11%	13%
Cocaine	117	76%	75%	81%	69%	9	6%	7%	3%	9%
Amphetamines	26	55%	61%	43%	58%	4	9%	9%	7%	8%
Cannabis	231	54%	54%	53%	45%	64	15%	15%	15%	14%
Alcohol (adjunctive)	216	37%	37%	37%	31%	99	17%	16%	20%	16%

Injecting use, housing need and employment	Local	Proportion	Proportion by gender		National	Proportion	Proportion by gender	
	n		M	F	n		M	F
Adults no longer injecting at six month review	119	50%	51%	42%	4,337	56%	56%	53%
Adults successfully completing treatment no longer reporting a housing need	70	77%	80%	69%	2,975	81%	82%	78%
Adults working ten or more days in the month before successfully completing treatment	249	34%	40%	18%	7,480	29%	33%	17%

Please note that all data is displayed here, regardless of TOP compliance in the local area

Source: NDTMS

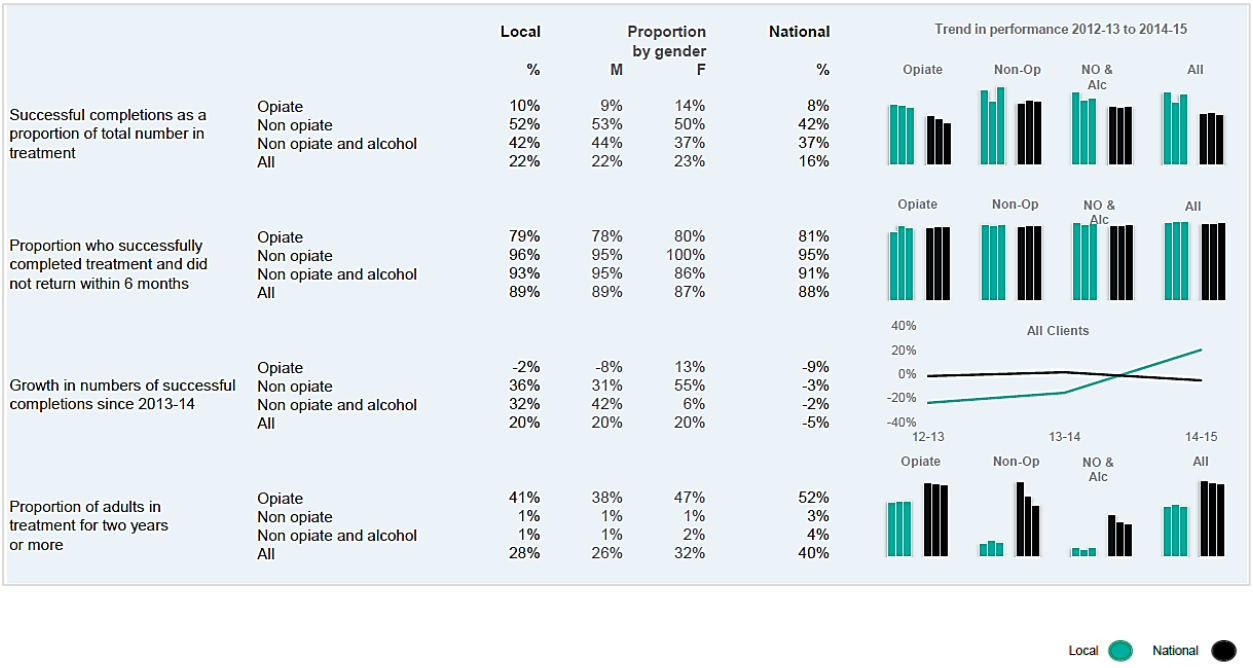
5.11 Successful completions

Assisting individuals to overcome dependence and sustain recovery is a central function of a drug treatment system. People may need several separate treatment courses over a number of years. Most people who overcome dependence do so within two years. Those that remain engaged with treatment services for longer than two years are less likely to complete their treatment or overcome their dependency.

In comparison to national benchmarks, Kent treatment services performed significantly better or similarly in assisting individuals to complete their treatment course in 2014/15 and not returning at six months or within two years. However, there has been a slight decrease (1%) on the previous year of the number of individuals with opiate dependence who have successful completed treatment, Figure 21.

Figure 21 Treatment services: successful treatments

		Local	Proportion by gender		National
		%	M	F	%
Successful completions as a proportion of total number in treatment	Opiate	10%	9%	14%	8%
	Non opiate	52%	53%	50%	42%
	Non opiate and alcohol	42%	44%	37%	37%
	All	22%	22%	23%	16%
Proportion who successfully completed treatment and did not return within 6 months	Opiate	79%	78%	80%	81%
	Non opiate	96%	95%	100%	95%
	Non opiate and alcohol	93%	95%	86%	91%
	All	89%	89%	87%	88%
Growth in numbers of successful completions since 2013-14	Opiate	-2%	-8%	13%	-9%
	Non opiate	36%	31%	55%	-3%
	Non opiate and alcohol	32%	42%	6%	-2%
	All	20%	20%	20%	-5%
Proportion of adults in treatment for two years or more	Opiate	41%	38%	47%	52%
	Non opiate	1%	1%	1%	3%
	Non opiate and alcohol	1%	1%	2%	4%
	All	28%	26%	32%	40%



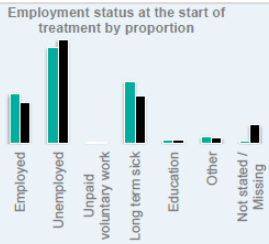
Source: NDTMS

5.12 Employment and benefits

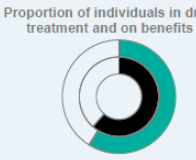
Improving job prospects is an important step to sustaining recovery and requires good multi-agency responses. Upon successful completion of treatment, more individuals in Kent were not on benefits compared to nationally. When they were in receipt of benefits, the median length of time was seven years. The employment status of those in Kent treatment services during 2012 are displayed in Figure 22.

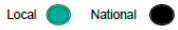
Figure 22 Treatment services: employment status

Employment status at the start of treatment	Local n	Local Proportion of new presentations	National n	National Proportion of new presentations
Regular employment	369	22%	15,080	19%
Unemployed/Economically inactive	721	44%	37,893	47%
Unpaid voluntary work	3	0%	197	0%
Long term sick or disabled	467	28%	17,135	21%
In education	23	1%	1,181	1%
Other	51	3%	2,062	3%
Not stated/Missing	18	1%	6,694	8%



Benefit profile of treatment population	Local n	Local Proportion of all in treatment on 31/03/2012	National n	National Proportion of all in treatment on 31/03/2012
Number of individuals in drug treatment on 31/03/2012	1,768		134,090	
Number of individuals in drug treatment on 31/03/2012 recorded as being on benefits (of any type) on the 31/03/2012	1,041	59%	82,347	61%





Source: NDTMS

Over the last three years most Kent districts have continued with a decreasing trend of unemployment for those using the treatment services. This includes Thanet which has the highest unemployment rate in Kent, Table 38.

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Table 36 Treatment services: employment trends

	Year in treatment			
	2008/09	2010/11	2012/13	2013/14
Regular employment				
Number	1073	921	917	612
Proportion	23%	19%	20%	21%
Unemployed				
Number	2541	2516	2116	1336
Proportion	54%	51%	46%	47%
Long term sick or disabled				
Number	91	745	1070	793
Proportion	2%	15%	23%	28%

Due to variances in data collection and analysis, there will be variance with the NDTMS treatment data in the 'employment and benefits' in the Kent Treatment Services Chapter. Source: KPHO

On review of the benefit profile of treatment service users, most benefit claimants are male which is consistent with the prevalence of drug use being higher amongst males than females.

There has been a significant increase in the proportion of clients being long-term sick or disabled.** This is consistent with trend with individuals maintaining their drug and alcohol misuse into older age and associated poor health from many years of drug and alcohol misuse, Figures 23 and 24.

Figure 23 Treatment services: benefit profile

Employment status at the start of treatment	Local n	Proportion of new presentations	National n	Proportion of new presentations
Regular employment	369	22%	15,080	19%
Unemployed/Economically inactive	721	44%	37,893	47%
Unpaid voluntary work	3	0%	197	0%
Long term sick or disabled	467	28%	17,135	21%
In education	23	1%	1,181	1%
Other	51	3%	2,062	3%
Not stated/Missing	18	1%	6,694	8%

Benefit profile of treatment population	Local n	Proportion of all in treatment on 31/03/2012	National n	Proportion of all in treatment on 31/03/2012
Number of individuals in drug treatment on 31/03/2012	1,768		134,090	
Number of individuals in drug treatment on 31/03/2012 recorded as being on benefits (of any type) on the 31/03/2012	1,041	59%	82,347	61%
Number of individuals in treatment recorded as being on benefits on the 31/03/2012 (by type)*:				
Jobseekers Allowance (JSA)	224	13%	19,178	14%
Employment Support Allowance (ESA)	386	22%	28,378	21%
Incapacity Benefit (IB)	297	17%	25,552	19%
Income Support (IS)	332	19%	26,315	20%
Disability Living Allowance (DLA)	279	16%	19,167	14%
Other	66	4%	4,308	3%
Median length of time (years) on benefits between the start of benefit claim and 31/03/2012 (by type)*,**:				
Jobseekers Allowance (JSA)	0.47		0.53	
Employment Support Allowance (ESA)	0.65		0.56	
Incapacity Benefit (IB)	7.10		8.02	
Income Support (IS)	5.15		6.48	
Disability Living Allowance (DLA)	4.00		5.03	
Other	3.24		3.73	

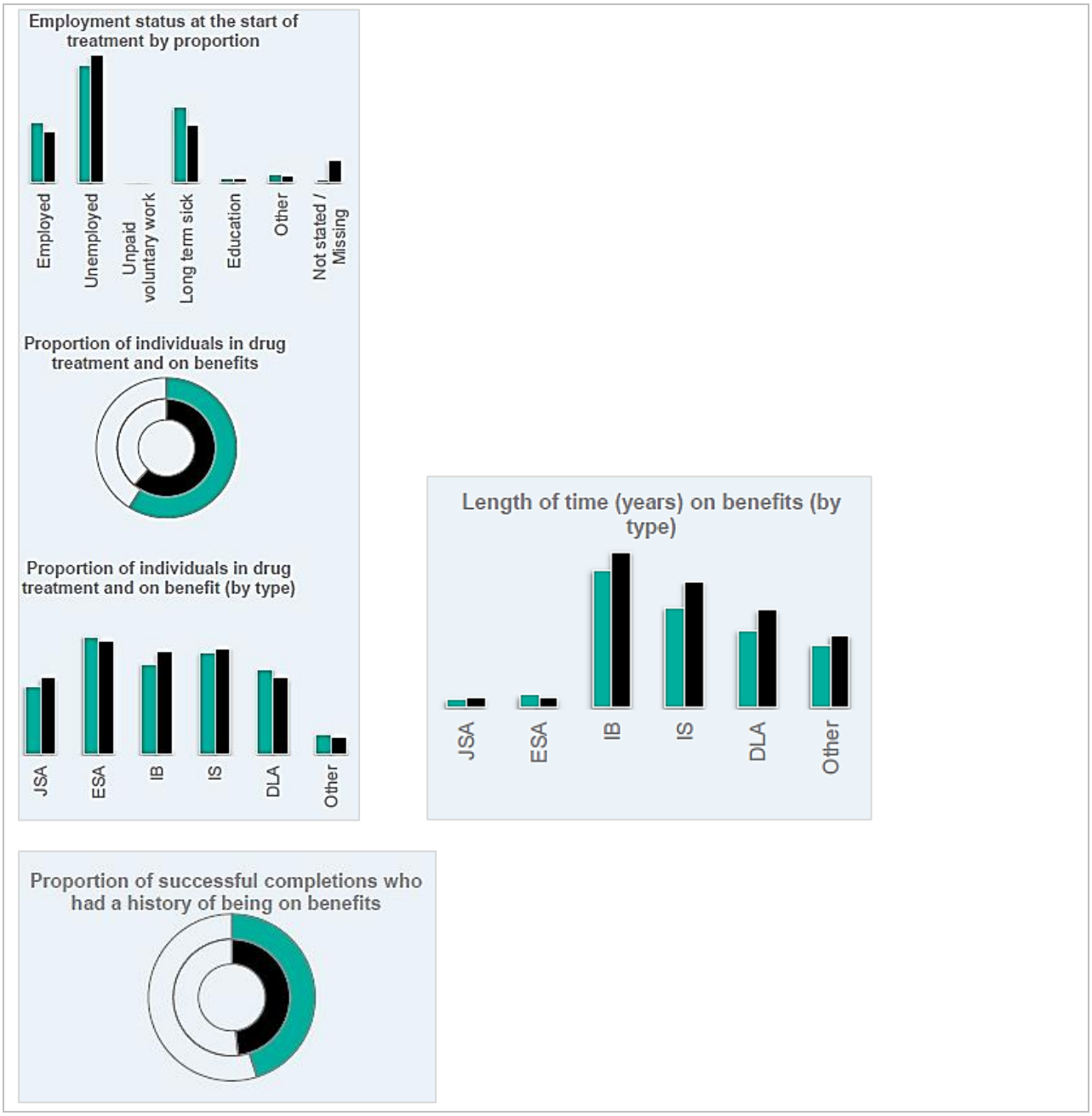
	Local n		National n	
Number of individuals in drug treatment who left successfully in 2011-12	873		29,858	

Of those successful completions, those who at the point of discharge:	Local n	% successful completions	National n	% successful completions
were on benefits	394	45%	14,416	48%
were not on benefits	479	55%	15,442	52%

Local National

Source: NDTMS

Figure 24 Treatment services: benefit profile graphs



Source: NDTMS

Notes:

** Individuals are counted once under each type of benefit they receive*

*** Length of time on benefits counted as the length of the benefits spell from the start until 31 March 2012, regardless of the length of time in treatment.*

5.13 Housing status of those in treatment services

In Kent the accommodation trends for those in treatment services have remained fairly stable since 2008/9, Table 39. The districts reporting the greatest urgent housing need for those in treatment services are Canterbury and Maidstone, Table 40.

Table 37 Treatment services: accommodation trends

	Year in treatment			
	2008/09	2010/11	2012/13	2013/14
No housing problem				
Number	4318 (83%)	4236 (85%)	3695 (81%)	3742 (83%)
Housing problem				
Number	550 (11%)	474 (9%)	544 (12%)	497 (11%)
NFA (No Fixed Abode) - Urgent housing problem				
Number	306 (6%)	296 (6%)	346 (8%)	256 (6%)

Source: Kent Public Health treatment data, 2015)

Table 38 Treatment services: accommodation trends by district

District	NFA - urgent housing problem	Housing problem	No housing problem	Unknown
Canterbury	**9%**	10%	81%	0%
Maidstone	8%	9%	82%	0%
Tonbridge & Malling	7%	9%	84%	0%
Tunbridge Wells	7%	10%	83%	0%
Gravesham	6%	11%	83%	1%
Thanet	6%	**13%**	81%	0%
Shepway	4%	12%	84%	0%
Swale	4%	10%	86%	0%
Ashford	4%	12%	84%	0%
Sevenoaks	3%	9%	87%	0%
Dover	3%	12%	84%	0%
Dartford	3%	14%	83%	0%
Totals	**6%**	**11%**	**83%**	**0%**

Source: Kent Public Health treatment data, 2015)

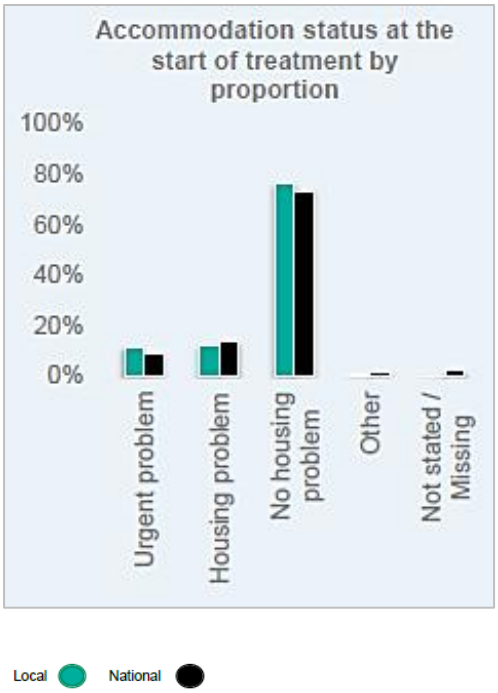
Compared to nationally, Kent has a higher proportion of new clients presenting to treatment services that reporting an urgent housing issue. More information on why this is the case and the nature of this need specific to those with drug and alcohol misuse

issues would be helpful. It is notable that the reverse is true on successful completion of treatment i.e. less people report having a housing problem on discharge, Figure 25

Figure 25 Treatment services: accommodation status at the start of treatment

Accommodation status at the start of treatment	Local n	Proportion of new presentations	Proportion by gender M	Proportion by gender F	National n
Urgent problem (NFA)	190	12%	13%	7%	7,188
Housing problem	198	12%	11%	14%	10,973
No housing problem	1,256	76%	75%	79%	58,801
Other	7	0%	0%	0%	1,467
Not stated/Missing	1	0%	0%	0%	1,813

	Local n	Rate per 1000	National n
Overall number of decisions taken by the local authority on homelessness applications	3,723	5.93	112,340



Source: NDTMS

5.14 Safeguarding

The detrimental impacts of children living with drug dependent parents or those with childcare responsibilities are well documented. The numbers of those not living with child/children or having no contact with them are much higher in Kent than nationally, Figure 26.

Figure 26 Treatment services: clients not living with their children

	Local	Proportion of treatment population	Proportion by gender		National	Proportion of treatment population	Proportion by gender	
	n		M	F	n		M	F
Living with children (own or other)	704	20%	15%	34%	61,331	30%	25%	43%
Parents not living with children	1,210	35%	37%	30%	53,184	26%	27%	23%
Not a parent/no child contact	1,540	44%	48%	35%	88,250	43%	47%	32%
Incomplete data	20	1%	1%	1%	3,352	2%	2%	2%

Source: NDTMS, 2015

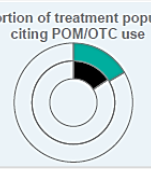
More information on this last point would be useful. The numbers of those having no parent/child contact at all, is similar to the national rate. It is highly likely that some of this group would be those eligible and benefit from early intervention and intensive support such as the *Troubled Families* programme.

5.15 Prescription and over-the-counter drugs and illicit drug use

Kent has a marginally higher number of service users who use Prescription Medication (PM) or Over-the-Counter (OTC) medications. The numbers reporting use of illicit PM and OTC medication is lower than nationally, Figure 27. The prevalence of PM and OTC misuse in the general population in Kent is unknown.

Figure 27 Treatment services: prescription medication and illicit drug use

		Local	Proportion of treatment population	Numerical split by gender		National	Proportion of treatment population
		n		M	F	n	
Number of adults citing POM/OTC use:	Illicit use	398	11%	281	117	26,266	13%
	No illicit use	176	5%	92	84	6,173	3%
	Total	574	17%	373	201	32,439	16%



Source: NDTMS, 2015

5.16 NUD (club drugs)

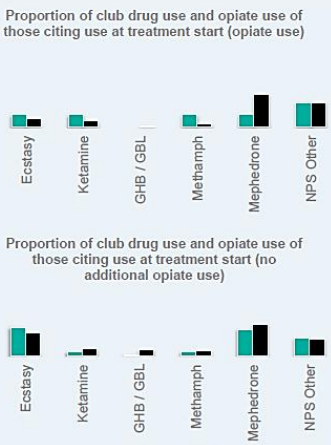
Opiate users still dominate adult treatment services and they generally face a more complex set of challenges and are much harder to treat. Those using non-opiate, 'club drugs' typically have good personal resources – jobs, relationships, accommodation – which means they are more likely to make the most of treatment.

New entrants to treatment who report the use of both NUD and opiates display a tendency to use a variety of club drugs which is different to national trends. The use of 'unclassified' NUD is almost double of identified NUD in Kent but is similar to the national reported number. For those citing club drug use only, this mirrors the national

trend with Mephadrone being the most popular. The use of ecstasy during 2014/15 in Kent is much higher than the national proportion, Figure 28.

Figure 28 Treatment services: NUD and Club drug use

		Local n	Proportion[1]	National n	Proportion[1]
Adults new to treatment citing club drug use and opiate use	Ecstasy	1	17%	96	12%
	Ketamine	1	17%	72	9%
	GHB/GBL	0	0%	15	2%
	Methamphetamine	1	17%	36	4%
	Mephedrone	1	17%	350	43%
	NPS Other	2	33%	265	33%
	Any club drug use[2]	6	1%	807	2%
Adults new to treatment citing club drug use (no additional opiate use)	Ecstasy	29	37%	1,188	29%
	Ketamine	4	5%	354	9%
	GHB/GBL	1	1%	306	8%
	Methamphetamine	4	5%	287	7%
	Mephedrone	27	35%	1,674	41%
	NPS Other	18	23%	889	22%
	Any club drug use[2]	78	9%	4,046	11%



[1] Proportions of ecstasy, ketamine, GHB/GBL, methamphetamine, mephedrone and NPS Other as a percentage of any club drug use. Clients' citing the use of multiple club drugs will be counted once under each drug they cite. Therefore figures may exceed the total (labelled any club drug use) and proportions may sum to more than 100%.

[2] Any club drug use is a percentage of all new treatment entrants.

Local National

Source: NDTMS, 2015

5.17 Needle syringe programme

Estimates suggest there were up to 2,480 people injecting crack cocaine or opiates in Kent in 2011/12 (Hay et al, 2012). Kent treatment service data showed that there had been over 14 000 visits to these sites in 2014/15 which averages about 1 200 visits per month. The Kent Needle and Syringe Programmes (NSP) provide harm reduction services from 43 locations across Kent, Table 41.

Table 39 Kent needle syringe exchange

NSP locations	Number
Permanent locations	9
Hospital	4
Pharmacy	30

Source: KPHO, 2015.

The levels of access to NSPs is generally good with the majority having a wide-range of opening hours across the week but there may be room for improvement. For example, hospital-based sites offer 24 hour, seven days per week facilities in Ashford, Folkestone and Margate but not in Gravesend. In Canterbury, there is limited weekend access only and is unavailable after 17:30 hours.

Given that urban areas with active night time economies and areas of deprivation are closely associated with drug and alcohol misuse, the service provision of NSPs in Kent should be reviewed. Another reason to review NSPs is the emergence of the misuse of steroids.

Kent service data also tells us that 40% of people using NSPs in Kent cite steroids as their primary injecting substance, Table 42. This highlights the growing use of performance and image enhancing drugs (IPED) in Kent. The prevalence of IPEDs use in the general population in Kent is unknown.

Table 40 Steroid use at needle exchange services

		Received harm reduction advice	
Total proportion who cited steroids as the primary injecting substance	40%	Kent	National
East Kent NSP	14%	**80%**	90%
West Kent NSP	40%	**66%**	

(Source: KPH, 2015)

It is a cause of concern that not all individuals using NSPs in Kent are receiving harm reduction advice. This data indicates that it is likely that some injecting users are using unsafe injecting practices.

6 Drug markets

As the drug market continues to evolve, the last decade has seen the emergence of a wide range of new psychoactive substances. The nature of the illicit drug market has also been changing as a result of globalisation, technology and the internet – both surface and deep web 'market places' also known as 'cryptomarkets'[13].

The NUD marketplace can be described as having three elements:

- Technological – the internet is an important marketplace for the sale of NUD
- Street markets
- Club markets

Additional challenges are presented by innovation in drug production and trafficking methods and the establishment of new trafficking routes. Cannabis is the most commonly seized drug, accounting for about eight out of ten seizures in Europe and heroin is still the most common opioid. Overall the number of drug-supply offences in Europe has been increasing since 2006 (European Monitoring Centre for Drugs and Drug Addiction, 2015). Drug seizures in England and Wales are displayed in Table 43.

[13] Crypto markets; (digital currency) in this context is the dealing and buying of drugs on the internet.

Table 41 Drug seizures in England & Wales

Number of drug seizures ***(Home Office, 2015)***	**Police recorded drug offences**	**Class A drug seizures**
Decreased by 14% ***N= 167,059***	Decreased by 14%	Decreased by 10% on previous year. Cocaine was the most commonly seized drug – over half of total amount seized There was a 72% increase in the amount of heroin seized

Source: Crime Survey England and Wales, 2015

There was little difference between the number of seizures across police regions and the Border Force in the period 2013 - 2015. Approximately one quarter of all seizures were made in London. London apart, the largest proportion of drug seizures was in the South East at 11 per cent (Home Office, 2015).

Key points:

Due to data limitations for some elements e.g. prevalence trends and the restricted nature of confidential treatment service data, where available data has been presented at district level. Efforts will be made in the future to improve the level of detail by at district level as far as useful and practicable.

Table 42 Key points by district

District	Ranked highest
Hospital admissions – drug related	Thanet, Canterbury, Maidstone
Hospital admissions – dual diagnosis	Maidstone, Gravesham, Thanet
Deaths - NUD (NPS)	Swale, Thanet, Canterbury
Housing problem[1]: Urgent Other	Canterbury Thanet

There are no prevalence data for dependency upon over-the-counter or prescribed medication in the general population in Kent.

The number of people accepting vaccination for hepatitis is lower in Kent than nationally.

Up to 40% of people using Kent needle exchange points cite steroids as their primary substance of misuse. Fewer people in Kent than nationally receive health promotion advice in needle exchange services.

Drug related hospital admissions (including poisoning and mental health disorder) have increase by 50% across Kent between 2006- 2013

1 in 10 people in Kent with a mental health condition have a substance misuse condition. Highest rates are recorded in deprived areas of Maidstone, Gravesham and Thanet.

Drug deaths are at record high levels; most involved illegal drugs. Swale, Thanet and Canterbury have the greatest mortality rates in Kent. Total Kent deaths; 139 (2012/14)

The ageing profile of drug-users who due to long-standing misuse are in poorer health and consequently suffering increased fatalities will be a contributory factor.

Deaths from NUD are low, have been increasing but appear to be stabilising. This is prone to change.

Kent treatment services perform well overall.

In the last period, there was a 3% decrease in new clients presenting to services

In Kent, the number of referrals to treatment services from several statutory organisations is lower than could be expected and national benchmarks. This is particularly true for NHS and Social Services.

LGBT individuals are underrepresented in Kent treatment services

There is poor engagement with MSM and treatment services. The extent of the Kent MSM population and associated patterns of drug use including rates of injecting and rates of club drug and NUD use is unknown

7 Conclusions and Recommendations

The aim of this needs assessment was to quantify the need for drug and alcohol misuse services in Kent and assess how well services are responding. To achieve this, the needs assessment considered demographic and epidemiological data; examined relevant national mental health policy and guidelines for services and interventions and analysed data from current service providers. The key messages and recommendations arising from findings are set out below.

Local and national context

Historically in the main, there has been a good level of partnership working in Kent to tackle issues of drug and alcohol misuse. With the pressures upon budgets in all public sector organisations and the increasing sophistication and technological challenges of the drug market to address, it is more vital than ever before to ensure that each partner organisation plays its part to the fullest going forwards.

Partners should make every effort to identify and make early and prompt referrals to treatment services. It is not the responsibility of treatment provider services or for individuals to self-refer.

The system-wide and well recognised problems with the commissioning and provision of mental health services in Kent and nationally, have a direct impact upon individuals with drug and alcohol misuse issues. Programmes in place to support parents, carers and vulnerable groups especially those living in deprived communities, should be vigilant to the opportunities afforded to them to prevent and alleviate drug-related harms in our communities.

The importance of suitable accommodation and employment continues to prove a key challenge for those with problems of drug and alcohol misuse. Changes to benefit and housing policy will have notable impacts upon these individuals and commissioners should seek ways to ensure they are adequately supported to sustain recovery.

Demography

There is a strong relationship between deprivation and drug and alcohol misuse. Although Kent is one of the least deprived counties in England, it has areas of significant deprivation. Generally, those living in deprived conditions are among the least likely to seek help for health-related issues although it should be remembered that fearing stigmatisation, those living in more affluent communities will also require help.

Those living in urban areas are more likely to be misusing illicit drugs as are those frequenting night clubs and pubs. The misuse of prescription and over-the-counter medications is an emerging issue. The prevalence of both is unknown in Kent.

Epidemiology

Drug related hospital admissions (including poisoning and mental health disorder) have increase by 50% across Kent between 2006- 2013. It is estimated that 1 in 10 people in Kent have both a mental health condition and an issue with drug and alcohol misuse. The age group most affected are those aged 25-44 with more men than women being affected. The areas with the highest hospital admission rates are Maidstone, Gravesham and Thanet.

Given that more adults are continuing to misuse drugs into older age, it is likely that more will have concurrent long-term illnesses either as a result of their drug and alcohol misuse or will have conditions which will be aggravated by their drug and alcohol misuse. The number of people in treatment services on long-term benefit or incapacity has steadily grown. The drug-related mortality rate is at the highest rate ever and given the aforementioned will most probably continue to rise.

Opiate dependence is predominant in treatment services being amongst the most problematic of substances whilst cannabis continues to be the most popular drug consumed. The overall prevalence of NUD is generally low compared with well-established drugs such as cannabis, powder cocaine and ecstasy. Patterns of use are similar to that of alcohol, ranging from infrequent use through to problematic dependency and severity of harms.

High risk drug users (HRDUs) including people who inject drugs (PWIDs) are at risk of death and illness particularly blood borne virus and disease such as hepatitis. The uptake of hepatitis vaccination is poor nationally but is improving. The rate of hepatitis uptake in treatment services Kent should be improved. The prevalence of hepatitis in the general Kent population is unknown. It is reported that 40% of people using needle exchange sites in West Kent are injecting steroids (performance / image enhancing and ‘fat burning’ drugs).

Vulnerable groups

The complexity and fast-changing nature of the drug market has exposed several areas of concern to address. In addition to known areas of concern, emerging and escalating areas of concern are:

- The ageing population of those with drug and alcohol misuse issues who are more prone to co-existing poor health and premature death
- Meeting the needs of those with multiple and complex needs with drug and alcohol issues
- The spread of infections in those who inject drugs. Targeted health promotion intervention is particularly recommended for MSM, PIEDs those engaging in ‘chem sex’
- Those who use novel and new psychoactive substances (NUD)
- Individuals with dual-diagnosis

Routine screening would benefit those individuals that partake in high risk activities such as ‘chem sex’. There is some evidence to suggest that whilst this group engage well with some services such as sexual health, they are less likely to engage with drug and alcohol misuse services. As well as improving service access, quality of services and health outcomes for this group, such steps are important to address the spread of infections and hepatitis.

In the past there has perhaps been a tendency amongst partner organisations to leave referrals to individuals to self-refer or to treatment services to recruit. Given the wide range of substances now been misused across a widening population base and which can go undetected, increased vigilance, routine screening and prompt intervention and referral amongst Health and Care professionals is required.

Service capacity and equity

Treatment services in Kent perform well overall often exceeding national comparators. As the profile of drugs of misuse is changing, services must be flexible to meet the needs and be attractive to a widening population. For example, the needs of those with dependency issues to opiates or prescription-only medication may well be markedly different to that of an individual with issues of misusing NUD. Kent has a more women in treatment services than the national average which should be borne in mind when considering and meeting women’s needs in treatment services.

Treatment services should ensure that they are attracting and meeting needs of individuals throughout the treatment journey. For example, service performance indicators for some sub-sets of substances such as amphetamine misuse and successful completions are not as good as national comparators. The LGBT community are underrepresented in treatment services which should be addressed as does the low uptake rate of hepatitis vaccination.

The return rate of those who have been in treatment services is also higher than national comparators. More follow-up information over time would be beneficial to identify areas for intervention and improvement e.g. more holistic community and Mutual Aid organisations, housing and employment to maintain recovery.

Summary recommendations

1. 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, health protection, treatment, implementation of evidenced cost effective interventions, quality assurance, housing, employment and the improvement and widening of whole family approaches

2. Opportunities should be taken to align and integrate services to improve health promotion outcomes for individuals and improve access to services should be sought. For example, substances misuse intervention within sexual health services and non-traditional service providers to increase access to services especially for hard-to-reach groups

3. This needs assessment has been mainly quantitative. The findings from this needs assessment should be integrated with service users views with particular reference to service co-design and developing the Drug and Alcohol Strategy 2017-22

4. Housing and employment strategies should be mindful of accommodation needs of those with drug and alcohol misuse issues. There is a real risk of individuals becoming increasingly marginalised as an inadvertent result of housing legislation and welfare reform

5. Service commissioning should take into account the geographical spread of vulnerable and high-risk populations to ensure there are appropriate levels of service access for the full range of drug and alcohol misuse treatment and allied services such as needle exchange points

6. A review of primary care provision to manage long-term conditions to improve health outcomes and prevent premature death for those with drug and alcohol misuse problems should be undertaken

7. There should be an increase of systematic and routine screening for drug and alcohol misuse

8. Commissioners and Health professionals should follow recommended guidance, and best practice to prevent the spread of infection and improve performance and outcomes for those people who inject drugs e.g. hepatitis and steroids and improve take up-rates and compliance for Hepatitis vaccination

9. Improve the quality of services and for those with a dual diagnosis especially earlier intervention in primary and community care settings

10. Improve access and retention rates to treatment services for minority groups especially those in the LGBT community

11. Tailor service provision and follow-up to sub-groups of drugs e.g. amphetamine and NUD, to improve treatment outcomes, compliance rates and reduce return treatment journeys

12. 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

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