Kent Drugs and Substance Misuse JSNA Chapter Update 2014

Introduction

An estimated 9% of adults used an illegal drug between 2011 and 2012; for those aged between 16 and 24 years the figure was 19%. Despite this being the lowest recorded level of drug use since records began in 1996, the adverse effect on the individual's health and quality of life and the significant crime, health and social costs is still too great. The cost of drug related crime in the United Kingdom alone is estimated to be around £13.3 billion every year (Home Office, 2015).

Evidence-based drug treatment reduces these costs and delivers real savings, particularly in crime costs, but also in savings to the NHS through health improvements, reduced drug-related deaths and lower levels of blood-borne disease.

The largely strong value for money case was endorsed by the National Audit Office (2010) and is the foundation of central government's significant ongoing investment. As well as being cost-effective, drug treatment has been shown to deliver significant benefits for society. Drug related deaths are at their lowest for three years and the numbers successfully drug-free at treatment completion are at record levels.

In conjunction with partners, Kent County Council Public Health produces an action plan which sets out how the Kent Drug and Alcohol Partnership will seek to deliver continual improvements to drug treatment service provision in order to contribute to the delivery of the wider Kent drug strategy.

The plan takes recommendations from the latest Substance Misuse Needs Assessment which identifies areas of service development to meet the needs of those likely to benefit from service provision and address emergent substance misuse issues. The plan supports the partnership's objectives to reduce the harm caused by substance misuse and facilitate real and lasting positive gains for individuals, families and local communities.

Emergent issues are concerned with the dynamic nature of drug trends; the rapid evolution of the production of 'new' or 'altered' substances such as novel psychoactive substances and the misuse of over-the-counter and prescription medications for example. Other key challenges include the availability and supply of substances with unknown constituent ingredients through the internet, both legal and illegal.

Many people use drugs at some stage in their lives and for some this leads to social, physical or mental health problems. This assessment focuses upon drug use for purposes of non-medical use such as recreation or due to addiction that causes problems either to the individual, their family or the wider community; drug use is widespread but addiction is concentrated.

These problems may be related to intoxication, regular excessive consumption or dependence. Where drug users are referred to as problem drug users (PDUs) this identifies them as users of heroin and/or crack cocaine. It should be remembered that drug use is widespread but addiction is concentrated.

There are other definitions but in essence the group consists of those people whose drug use causes substantial difficulties not only for themselves but also for their friends, families and the wider community.

Typically PDUs 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.

The aim of this needs assessment update is to describe the pattern of drug misuse in Kent and review current service provision in relation to need and make recommendations for service commissioning. For ease, adults and children / young people's services will be described separately.

Table 1 lists the key drugs of concern but it should be remembered that the list is extensive and changes frequently.

Table 1: Illegal or 'controlled' drugs listed in the Misuse of Drugs Act 1971

Classification	Drug	
Class A	Powder cocaine Crack cocaine Ecstasy LSD	Magic mushrooms Heroin Methadone Methamphetamine
Class A/B	Amphetamines	
Class B	Cannabis Mephedrone	
Class B/C	Tranquillisers	
Class C	Anabolic steroids Ketamine	
Not classified	Amyl nitrite Glues (including glues, solvents, gas or aerosols)	

Key Issues and Gaps

Service use

The estimated number of Opiate and Crack Users (OCUs) in Kent is 5,028 (NDTMS, 2014). In 2013-14 the total number of individuals engaged in structured treatment with an opiate or crack as their first problem substance was 2,070. This suggests that treatment is meeting 41% of potential need for the service.

- The estimated number of opiate users in Kent is 4,101; of these 2,026 (49%) were in structured treatment in 2013-14
- The estimated number of crack users in Kent is 2,422. Only 700 (29%) of these were in structured treatment in 2013-14. It should be remembered that not all OCUs will be willing to undergo treatment.

Dual diagnosis

Some of society's most vulnerable adults and young people are those with severe mental illness and substance misuse issues (dual diagnosis), yet they experience some of the worst health and wellbeing. They can also cost health and care services more than those severe mental illnesses who do not misuse substances (McCrone et al. 2000).

The UK prevalence of many people with dual diagnosis is unknown for several reasons:

- Differences in how 'dual diagnosis' is defined
- Unconfirmed diagnosis. For example, substance misuse may 'mask' an underlying mental illness or vice versa ('diagnostic overshadowing'); or people may come to acute services with unrelated health problems and their 'dual diagnosis' may be missed
- People in this group not using services or receiving appropriate care
- A lack of national data. UK studies have reported 'dual diagnosis' rates of 20–37% across all mental health settings and 6–15% in addiction settings. Rates may vary by gender, ethnicity and geography (Variations in rates of comorbid substance use in psychosis between mental health settings and geographical areas in the UK (Carrá and Johnson, 2009).

The proportion of dual diagnosis clients in Kent has increased significantly over recent years from 14% - 20% (2011-14) and these rates are lower than the estimated prevalence of dual diagnosis among the population who participate in substance misuse.

Criminal justice system

National research estimates that 55% of prisoners misuse drugs and prison is where many PDUs will first use or be exposed to heroin (Prison Reform Trust, 2014). In 2014, Public Health England (PHE) introduced a new Public Health Outcome Framework measure (PHOF 2.16), to record the proportion of people entering prison with substance dependence issues who were not previously known to community treatment. In Kent, 55% of prisoners were unknown to community treatment services compared with 47% nationally. The health and wellbeing needs of offenders in Kent prisons are addressed in a separate Health Needs Assessment (KMPHO, 2014).

Deprivation

There are strong links between levels of deprivation, prevalence of problem drug use, 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.

Dillon et al, (2007) identified a group of risk factors which may lead to drug use. These factors include parental discipline and monitoring, family cohesion, peer drug use, drug availability, genetic profile, self-esteem and hedonistic attitudes.

There is less consistent evidence linking drug use to mental health, parental substance use, Attention Deficit Hyperactivity Disorder (ADHD), religious involvement, sport, health educator-led interventions, school performance, early onset of drug use and socio-economic status. This review also recognised that there are certain groups of young people who are at a greater risk of drug use, in particular 17-24 year olds who:

- have anti-social behaviour
- begin early smoking
- are in trouble at school (including truanting and exclusion)
- are impulsive
- are un-sensitive
- belong to few or no groups.

They also show that the profile of the most likely frequent illicit drug user is white, young, male, single, a regular clubber and likely to be seen in the pub. However, it should be remembered that this survey is completed by residents in households and a large proportion of problematic drug users will be homeless or not in permanent residency.

The Level of Need in the Population

Prevalence estimates
The Crime Survey for England and Wales (Home Office, 2013) found that:

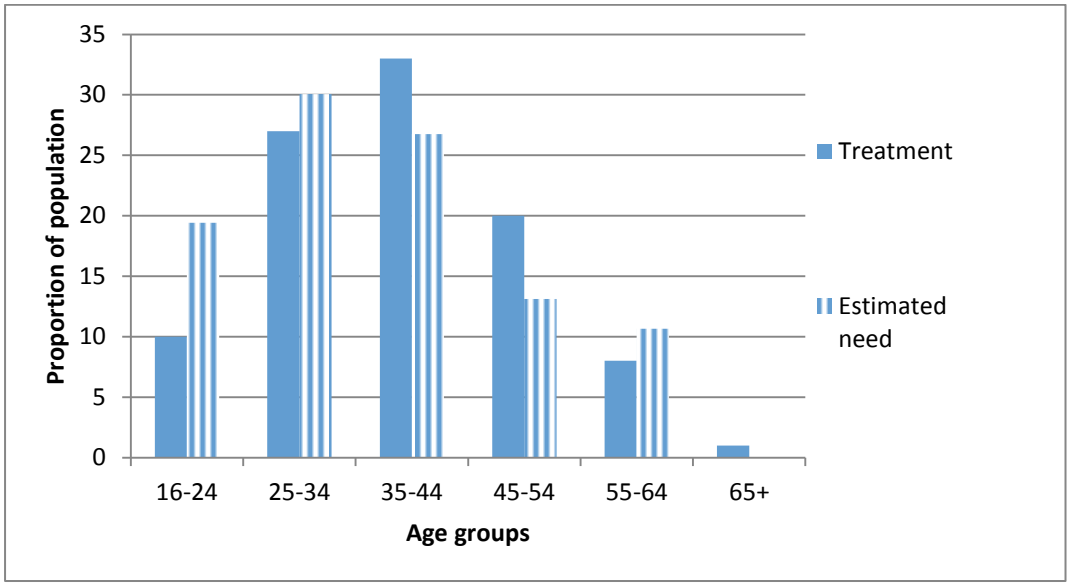
1. Around 1 in 12 (8%) adults had taken an illegal drug (excluding mephedrone) in 2012-13, a fall, when compared with 9% in 2011-12.

2. The proportion of adults taking any illicit drug in the last year has decreased to 8% in 2012-13 from 12% in 2003-04

3. Sixteen percent of 16 to 24 year olds reported taking any drug in the last year compared to 19% in 2011-12. Sixteen percent is nearly double those aged 16 to 59 taking any drug in the last year.

A limited estimate of the age profile of the Kent adult population of those requiring structured treatment (dependent drinkers and OCU) may be constructed from the available data. When compared to the age profile of the population in treatment, this gives an approximation of the equity of provision of the service by age. Figure 1 compares the age profile of those in treatment for all substances in 2013-14 with the age profile of the population of dependent drinkers and OCU.

Figure 1: Comparison of estimated need versus service provision by age profiles



The data indicates that the treatment need appears broadly similar to the estimated demand. The data on the estimated needs of the 35-64 age groups are limited and differences within these groups are prone to error. If the 35-64 age groups are considered as a whole they represent 60% of the treatment population in comparison to 50% of the estimated need.

The 16-24 age group appears to have a significantly lower than expected treatment rate in comparison to their expected need. This may indicate that adults' services are not set up for the needs of younger clients or be an indicator of a problem with continuity of care between young persons and adults' services. Early treatment for substance misuse is shown to provide better long term outcomes.

Opiate and crack users (OCUs)

The proportion of Kent OCUs remains low. However this is a key group of attention for substance misuse services as their use of drugs has a large impact on their health and society as a whole (NDTMS, 2014).

In 2011-12 there were between 4,558 and 5,851 OPUs. The mid-point estimate of 5,028 represents a 9% increase on the previous year's estimate and equates to 5.3 OCUs per 1,000 of the population. This is lower than the national rate of 9.5 per 1,000. The expected correlation between the prevalence of drug related poisoning, areas of high social deprivation and OCU use is likely to seen in Thanet, Swale and Gravesham.

There is notable variation between rates in districts within Kent. The highest rates are found in Thanet, Swale and Gravesham. The lowest rates are found in Ashford, Sevenoaks and Tonbridge & Malling. Dover has also had a very high rate over the period but this has reduced in recent years.

Mortality and morbidity

Mortality is another term for death and is the term used for the number of people who died within a population. Morbidity refers to the incidence (the occurrence, rate, or frequency of an event e.g. disease) in a population.

There are two key indicators for drug related morbidity: mental health / behavioural disorders and hospital admissions for acute poisoning. In their annual report, the National Poisons Information Service (NPIS) monitored reports related to 61 different drugs of misuse, including Novel Psychoactive Substances (NPS), (NPIS, 2014).

Nationally in 2012, drug-related poisoning accounted for nearly one in eight deaths among people aged between 20 and 30. The rates for drug use are higher in men and the annual number of male deaths from drug-related poisoning and misuse are more than double the number of female deaths. Nationally, opiate misuse is the largest cause of drug related deaths (ONS, 2012).

Performance and image enhancing drugs (PIEDs)

The use of PIEDs can have severe adverse outcomes. Nationally there have been a small number of reported fatalities linked to “fat burning” drugs. NPIS data showed a substantial increase in referred cases, from less than one annually to 22 in 2013. National data indicate that the group most likely to use PIED are young men aged 18-25 who undertake regular exercise such as weight lifting.

Novel psychoactive substances (NPS)

Nationally the number of deaths involving NPS increased by 15% to 60 in 2013 which is not as steep a rise as previous years but it is too early to say whether this trend is stabilising. The number of deaths from use of NPS is now higher than the number of deaths caused by use of MDMA/Ecstasy and is expected to rise (ONS, 2013).

It is difficult to provide detail on the mental health and behavioural morbidity caused by individual substances and NPS as no data is collected or available specific to NPS so it is hard to isolate the harm their use causes. However given that NPS are toxicologically similar to the illegal drugs they are designed to mimic, it is likely their use is contributing to the significant increases in drug related mental health and behavioural disorders.

Hospital admissions

Increased admissions have occurred in every district in Kent over the period 2006-07 to 2012-13. The data show a long-term increase in the numbers of hospital admissions for drug related conditions. Overall, Kent admissions have risen 82% and admissions for drug related mental health and behavioural disorders have increased by 75% over five years (2008-2013). Thanet had the largest number of admissions at 279 and Canterbury’s have increased from 82 to 257. This is an increase of 213% for Canterbury over the six year period.

There were a total of 337 admissions for acute drug poisoning in Kent in 2012-13. Adults in the 16 to 24 age group reported the highest number of admissions with a primary diagnosis of poisoning by illegal drugs in 2012-13. Those aged 65 to 74 had the lowest number of admissions (KMPHO, 2014).

Admissions for detoxification
Admissions for detoxification have fallen over the last period at a faster rate than the estimated numbers of users of drugs in Kent. This reduction could either indicate an actual lowering in the number of persons presenting to A&E with a drug or alcohol detoxification need or breakdown in the process of referral for treatment. It is not possible to isolate the cause from data available.

Dual diagnosis
The prevalence of clients entering substance misuse treatment with coexisting mental health issues varied according to the specific types of substance misused. Alcohol clients were significantly more likely to have a dual diagnosis when presenting to services (28%) than drug clients. Opiate clients were least likely to have a dual diagnosis (17%) while clients using other drugs (predominantly cannabis and cocaine users) were more likely (25%). This correlates with the documented links between heavy alcohol use, use of psycho-stimulants and use of cannabis with increased risk of psychosis.

Complexity
When compared nationally, Kent has a higher proportion of drug clients in treatment in the low complexity banding and a lower proportion of clients in the very high complexity banding. This suggests there is unmet need for this very high risk cohort in Kent. This group is likely to have very complex needs so it is particularly important to ensure that services are able to respond to them and support them through treatment and recovery.

Blood borne diseases
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 (PHE, 2014). An emerging risk group for BBV associated with injecting drug use are users of anabolic steroids and performance enhancing drugs. National data on users of IPED demonstrated similar levels of HIV to other PWID, low levels of Hepatitis B vaccine uptake, high levels of unprotected sexual intercourse and of psychoactive drugs.

Rates of HIV seen in users of injectable image and performance enhancing drugs are similar to the wider cohort of people who inject drugs (PWID). High levels of risky sexual activity and use of psychoactive substances have also been reported in users of injectable image and performance enhancing drugs (Hope et al, 2013). Data is derived from the PHE Unlinked Anonymous Monitoring (UAM) survey (PHE, 2015).

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

A stable prevalence of infections in recent initiates 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.

A 2001 pan-European study estimated that 0.4% of EU healthcare expenditure, €1.89BN was spent on BBV in PWID. Of this 59% was spent on HIV in PWID, 39%

on Hepatitis C and 2% in Hepatitis B (Postma, 2001). Of note, this evaluation was carried out prior to introduction of antiviral therapy for Hepatitis C. Owing to the availability of new treatment modalities the healthcare costs associated with Hepatitis C infection have doubled (Jager, 2004).

17.1% of PWID in structured drug treatment in Kent have completed a course of Hepatitis B vaccination, which is similar to the national level of 17.9%. Of note a completed course of HBV vaccine involves three vaccinations over 4-24 weeks and a follow-up test following completion to confirm response. This may account for the discrepancy in self-reported uptake of HBV vaccine in the UAM and levels of completed vaccination. In Kent approximately 71% of PWID have had a Hepatitis C test, which is similar to the national level of 70.3% (PHE, 2015).

Parents and families

Having a parent with substance misuse problems impacts hugely on children and can have serious consequences for children, including neglect, educational problems, emotional difficulties, abuse, and the possibility of becoming drug and alcohol misusers themselves. It can severely affect the ability of parents to provide practical and emotional support to children and it can also mean the children become carers of addicted parents.

In 2013-14, 21% of clients in treatment were reported to be living with children at the time of presenting to services. This highlights safeguarding issues and indicates a population of children who are at increased risk of substance misuse.

Sexuality

Despite prevalence statistics indicating that substance misuse among the LGB community is nearly four times greater than the that of the overall population; treatment data shows that LGB individuals in Kent were less likely to be in structured treatment in 2012-13 (0.1%) than the Kent population overall (0.3%) based on the estimation that there are between 53,000 and 75,000 lesbian or gay adults in Kent.

Ethnicity

More than 95% of clients identified themselves as white British or ‘other white’ with no other ethnicity accounting for more than 2% of the treatment population in Kent.

Accommodation

Although the proportion of clients in treatment with a housing problem is low, 753 clients in 2013-14 had a housing problem, of those with no fixed abode (NFA), 54% cited opiates, 28% alcohol and 18% non-opiates as their primary problem drug.

The highest proportion of clients with no fixed abode resided in Canterbury at the time of presentation to services (9%), closely followed by Maidstone (8%). Only nine individuals in total from Sevenoaks and Dartford presented to services with no fixed abode (KDAAT, 2013/14).

As it is known that substance misuse rates tend to be higher among homeless people and there is documented evidence of barriers to health care for rough sleepers, it is likely that there are a number of homeless people in Kent who are misusing substances and are not receiving treatment.

Employment

Employment is a critical factor in reintegrating into the community and increasing confidence, esteem and general wellbeing.

Twenty-one percent of service users were unemployed. Unemployment is particularly prevalent amongst drug clients with 50% unemployed compared with 44% of alcohol clients. There has been a significant increase in the proportion of clients being long-term sick or disabled from 2% in 2008-09 to 16% in 2013-14. (KDAAT, 2013/14).

Service outcomes – adults

Local service performance is compared to others nationally across multiple indicators such as numbers of clients in education, paid work, with housing problems, by health status and criminal activity. There were no significant differences in performance in Kent than nationally for all these indicators. Clients in all categories had exceeded their expected treatment outcome with the exception of amphetamine users; fewer than expected had managed to stop at six months.

Opiate clients

Fifty-three percent of opiate clients who were using opiates at the start of treatment reported abstinence of opiate use by their six month review. This outperforms the expected six month performance rate as stipulated by PHE. The proportion who achieved abstinence by 12 months increased further to 58%, also exceeding the PHE expected 12 month performance rate (NDTMS, 2014).

In line with national trends, mid-point estimates suggest that Kent has seen a decrease in the numbers of OCUs in those aged under 34 years with those aged over 35 largely static.

Non-opiate clients

Kent outperforms the national average across all substance types in achieving abstinence at the six month review, indicating good early progress whilst in treatment. The proportion of clients who stopped injecting was lower in Kent (50%) than nationally (55%). The number of non-opiate clients in treatment declined from 1,317 in 2011-12 to 951 in 2013-14. Increasing the number of non-opiate clients has been a priority for Kent in 2014-15 and a small increase has been noted, with 998 in treatment as of October 2014.

National and local data indicates that the rate of successful completion decreases when non-opiate clients have been in treatment for longer than three years. In 2013-14, 95% of non-opiate clients in treatment in Kent were in treatment for less than one year. No clients had been in treatment for longer than three years. For those in treatment for less than three years, the rate of successful completion was not impacted significantly by the length of time in treatment, although clients in treatment for one-two years were more likely to complete successfully.

Tier 3 services

These services are community-based drug assessment and structured treatment. Table three shows the number and proportion of individuals accessing structured treatment by substance in Kent in 2013-14.

Table 2: Number and proportion of individuals accessing structured treatment by substance, 2013/14

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

Source: NDTMS, 2014

Treatment journeys

In 2013-14, 27% of opiate clients had four or more previous treatment journeys (courses of treatment), compared to 21% in 2011-12. This higher than the 22% national rate.

The higher than average number of previous treatment 'journeys' 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 3.

Table 3: Treatment population by previous treatment journeys (2013-14)

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

**21% in 2011-12*

Waiting times
Alcohol misuse clients need prompt help if they are to recover from dependence and keeping waiting times short plays a vital role in supporting recovery in local communities. The proportion of clients receiving alcohol treatment within three weeks in Kent (100%) is greater than that nationally (93%).

Treatment engagement
The proportion for both opiate and non-opiate service users in Kent in 2012-13 who have been in treatment for three months or more is lower than the England average. There is a marked difference in the rates of people in treatment for crack and opiates between different parts of Kent.

Historically services have been overwhelmingly focused on opiate users, with little attention paid to the growing numbers of crack and poly-drug users (Audit Commission, 2002). Also the absence of a substitute drug for crack, the equivalent of methadone for heroin users, poses greater challenges in attracting users into services.

Prescription only medicine (POM) / Over the counter (OTC) medicine
Current information systems nationally cannot provide information regarding the prescribing patterns for opioid analgesics. The numbers issued in Kent is increasing but not outpacing those dispensed in England.

Guidance
NICE Clinical Guidance (CG120) emphasises that people with drug and/or alcohol misuse issues should not be excluded from mental health services or be excluded from substance misuse services. They should be given access to evidence-based treatment for both psychosis and drug and alcohol misuse. It further recommends that advance decisions and statements be made to indicate what treatment interventions and care they would like to receive if they become unwell in the future (NICE, 2011).

This builds upon the *Dual Diagnosis Good Practice* Guidance (DH, 2002) which urged professionals to provide “high quality, patient focused and integrated care… delivered within mental health services”. This integrated approach was aimed at stopping people being shunted between different sets of services or put at risk of dropping out of care completely.

Projected Service Use and Outcomes in Three-Five Years and Five-10 Years

Referrals to young person's services

Very few referrals came from health settings; only 3% came from mental health and other health settings compared to 4% nationally. Fifteen percent of the treatment population had an identified mental health problem and 20% suffered from self-harm (30% females).

Referrals from other settings:

- 7% via children's and family services (11% nationally)
- 10% via self, family & friend referrals - fewer than adult services. This is in line with national trends (11%)
- 29% via Youth Justice Services; none of these young people were picked up by a community service within three weeks of their release
- 33% via educational services

Tiers 1 & 2 services

In 2013-14 a number of brief interventions were provided by early interventions or specialist services to young people at risk of developing substance misuse. These are reported for all substances rather than separated into drugs and alcohol. This local data strongly supports the evidence that these groups of young people are at significantly increased risk of substance misuse problems.

Of the various 'at risk' categories, the following was reported:

- 1,538 (29%) of young people at risk of exclusion
- 400 (29%) looked after children
- 120 (16%) young refugees/asylum seekers
- 592 (60%) young people with parental substance as calculated on the reported number of adults in treatment who have a child
- 1,867 young people at risk of reoffending

Tier 3 specialist community services

The total number of those aged under 18 years in treatment has fallen from 416 (2011-12) to 316 (2013/4). The number in young people's secure estate services has increased from nil to 30.

Complexity
Ninety-three percent of the total number of young people who accessed specialist substance misuse services in the community had poly-drug use, 97% had started using their main problem substance under the age of 15 and 6% entered services aged 13 or younger. While these figures are comparable to national levels the data further indicates the need for primary substance misuse prevention in young teenagers.

In total 94% were in treatment for cannabis, 77% for alcohol and 43% for the use of stimulants (as a primary, secondary or tertiary substance of misuse). The pattern of use was similar across age groups. There are few users of crack and opiates in this cohort and very few users of NPS. The pattern of substance misuse is similar to national trends, Table 4.

Table 4: Young people accessing specialist substance misuse services in the community in 2013/14 by Age by substance

Age by substance	<=13	14-15	16-17	18-24	Total (n)	Total (%)
Heroin and/or crack	>5	>5	11	>5	15	5
Stimulants (cocaine, ecstasy amphetamine (not crack)	7	59	69	6	141	**43**
Cannabis	19	146	133	13	311	**94**
Alcohol	14	124	108	9	255	**77**
Novel psychoactive substances	>5	>5	>5	>5	>5	1
Tobacco	>5	7	>5	>5	10	3
Other drug	>5	25	16	>5	45	14
Total (n)	19	151	146	14	330	

Source: NDTMS, 2014

Waiting times
The proportion of young people receiving treatment within three weeks in Kent (100%) is greater than that nationally (98%).

Outcomes of treatment
Overall young person's services appear successful; 86% of those treated exiting treatment in a planned way and only 6% of young people who left specialist substance misuse interventions in a planned way re-presented to young people's or adult specialist services within six months.

Dual diagnosis and other vulnerabilities
Young people accessing misuse services often have wider vulnerabilities including concurrent mental health needs. Each of these vulnerabilities was more prevalent in Kent than in the national treatment population. This again highlights that substance misuse is a social issue.

Of those in treatment in 2013-14:

- 19% were looked after children
- 15% had an identified mental health problem
- 31% were involved in offending
- 31% were affected by others' substance misuse
- 20% suffered from self-harm (30% of females)
- 22% of females were affected by domestic abuse

Projected Service Use and Outcomes in Three-Five Years and Five-10 Years

Short term
Drug use prevalence is at its lowest since 2001 (NHS Information Centre, 2013) but with the continuous emergence of new drugs and trends in drug use especially amongst the young, it is difficult to predict long term service needs. Improved prevalence data is also needed to produce accurate local projections.

Latest figures for England describe around 1 in 11 adults aged 16 to 59 (9%) had taken an illicit drug in the last year.

Medium term
In the medium term (five-10 years), in a redesigned treatment system with a focus upon recovery and integration, a fall in numbers may be anticipated. However, we know that we are still not sufficiently engaging with those who may benefit from treatment services and that Kent treatment services are not receiving expected levels of referrals compared to national rates. The model revision will consider the use of:

- assertive outreach
- harm minimisation interventions (e.g. BBV testing and vaccinations)
- needle and syringe programmes
- pharmacological interventions
- structured psycho-social Interventions
- intensive key working
- structured group work programmes
- community detoxification
- access to in-patient stabilisation and detoxification
- access to residential rehabilitation
- criminal justice interventions (Arrest Referral Scheme and Cannabis Diversion Scheme
- tailored interventions to improved social functioning and enhance life skills
- family focused interventions (including support to carers/significant others)
- initiatives to promote general physical improvement.

Evidence of What Works

There is an expectation that the number of PDUs exiting structured treatment successfully will increase with more people achieving sustained recovery and freedom from dependence on drugs.

Drug treatment is effective – The Drug Treatment Outcomes Research Study (DTORS): Baseline Report (Jones *et al.* 2007) highlights the positive outcomes which include a reduction in illicit drug use, abstinence, reduction in criminal activity, lower risk of overdose and the spread of blood borne viruses, and better health, which benefit the individual, their family and society.

Gossop (2006) also reviewed the evidence of the effectiveness of drug treatment from the last 30 years; pharmacological interventions are shown to have better outcomes in terms of reduced illicit drug use, reduced criminal behaviour and lower levels of HIV risk and better retention rates have been linked to methadone clients.

Psychological interventions help in terms of greater treatment retention and fewer relapses, and a reduction in drug use. Residential rehabilitation has shown positive outcomes in terms of improved rates of abstinence, drug injection and needle sharing. Needle exchange schemes reduce injecting risk behaviours, reduced public order problems and reduced HIV prevalence. Complementary therapies have been linked to better attrition.

Drug users in treatment commit fewer crimes, offences halved when drug users went into treatment, particularly acquisitive crime. For those that triggered test on arrest, there was a reduction of 61% in follow up offences. They also found a link between positive outcomes and treatment duration (Millar et al, 2008).

Kent drug treatment services reference the following guidance:

Drug Misuse and Dependence: UK Guidelines on Clinical Management
Models of Care for Treatment of Adult Drug Users (MOCAM)
Nice Guidelines on Drug Misuse: Psychosocial Interventions
Nice Guidance on the use of methadone and buprenorphine for opioid dependence
Nice Guidance on the use of Naltrexone for the management of opioid dependence
Reducing Drug-Related Harm: An Action Plan

Information, Policies and Strategies

Local

Kent Drug and Alcohol Action Team (Kent DAAT)
KDAAT Adult Treatment Plan 2010 - 2011
KDAAT Young people's specialist substance misuse treatment plan 2010/11
KDAAT Adult Needs Assessment 2011
KDAAT Young People's Needs Assessment 2010 (PDF 232kb)

Kent Hidden Harm Strategy 2010-2013 (PDF 3.4) Hidden Harm refers to children and young people whose particular needs are often overlooked; where their parental substance misuse has serious negative effects on their childhood.

National

Drug strategy 2010: annual review May 2012
https://www.gov.uk/government/publications/drug-strategy-2010-annual-review-may-2012

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118345/drug-strategy2010-review-may2012.pdf

Department of Health (2002) *Dual Diagnosis: Best Practice Guidance.* http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4009058

National Treatment Agency (now part of Public Health England) Falling drug use: the impact of treatment http://www.nta.nhs.uk/uploads/prevalence-commentary.pdf

Commissioning treatment for dependence on prescription and over-the-counter medicines: a guide for NHS and local authority commissioners PDF (780kb) 28 June 2013

Routes to recovery via the community: mapping user manual PDF (2mb) 29 July 2013

NICE Guidelines

CMG27 Needle and syringe programmes Published 08/06/2011
QS23 Drug use disorders quality standard: NICE support for commissioners and others Published 19/11/2012
Needle and syringe programmes Pathway Published 06/12/2011
Drug misuse Pathway Published 10/01/2013
PH37 Tuberculosis - hard-to-reach groups: guidance Published 16/01/2013
Reducing substance misuse among vulnerable children and young people Published 06/12/2011
CG120 Psychosis with coexisting substance misuse: full guideline Published 23/03/2011

Social *Care Online; Public Health England*

Supporting information for the development of joint local protocols between drug and alcohol partnerships, children and family services Published 01/01/2011
A fresh approach to drugs : the final report of the UK Drug Policy Commission Published 30/09/2012
Practice standards for young people with substance misuse problems Published 01/01/2012

Public Health England

Medications in recovery: re-orientating drug dependence treatment Published 28/08/2012
Substance misuse interventions within the young people's secure estate: guiding principles for transferring commissioning responsibility from the YJB to local partnership areas Published 04/04/2012

European Centre for Disease Prevention and Control Prevention and control of infectious diseases among people who inject drugs Published 12/10/2011

British Association for Psychopharmacology BAP updated guidelines: evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAPPublished 30/04/2012

Systematic reviews

Cochrane Database of Systematic Reviews
Mentoring adolescents to prevent drug and alcohol use Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users Published 14/11/2012

Databa*se of Abstracts of Reviews of Effects*
Community reinforcement and family training: an effective option to engage treatment-resistant substance-abusing individuals in treatment Published 21/09/2011
Alcohol and drug prevention in nightlife settings: a review of experimental studies Published 12/02/2013

Social Care Online
Economic evaluation of drug abuse treatment and HIV prevention programs in pregnant women: a systematic review Published 01/01/2012
Mortality among people who inject drugs : a systematic review and meta-analysis Published 01/02/2013
What data are available on the extent of illicit drug use and dependence globally? Results of four systematic reviews. Published 31/08/2011

Service User Views

Service Users informed the commissioning and development of substance misuse services throughout 2010-11 through the monthly Service User Expert Panel and other consultation and communication channels, and continue to do this on an ongoing basis.

User research has been conducted specifically in relation to:

- what service users value about current services
- what could be improved
- what helped and what hindered an individual's recovery.

Areas highlighted for the consideration of commissioners were:

- the need for aftercare, especially when moving on from structured treatment services
- help for peer support programmes and activities, especially for those focused on keeping those engaged with services busy when not attending treatment
- a strong feeling that all services needed to concentrate on giving people back a purpose in life

- the need for treatment agencies to work in a more integrated way with welfare and social agencies such as Job Centre Plus.

Unmet Needs and Gaps

- increase the uptake and completion rates for Hep B vaccinations
- develop new treatment approaches for non-opiate clients (eg stimulant users, novel psychoactive substance users, steroid users) with a view to increasing the treatment uptake among this client group
- increase the number of criminal justice clients successfully complete treatment
- improve co-ordination of service delivery for service users presenting with dual diagnosis/multiple needs
- further work is required to understand the lower proportion of clients in the very high complexity banding; the current low levels suggests there is unmet need for this very high risk cohort
- vulnerable groups: relative levels of need for different groups needs to be assessed
- OTC/POM: work is required to assess levels of dependency and possible treatment approaches
- novel psychoactive substances and PIEDS – there is a considerable challenge around quantitative data
- youth community services need to improve engagement rates with Criminal Justice Services; no young people were picked up by a community service within three weeks of their release.

Recommendations for Commissioning

1. Raise awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of substance misuse. Give consideration to wider distribution of culturally appropriate resources for new communities.
2. Develop pathways for generic young people's risk reduction services, from brief advice to referrals for specialist services to be jointly carried out by commissioners across child health, KDAAT and KCC Education.
3. The integrated drug and alcohol services as envisaged in the new treatment specifications will need to link into mental health services at all levels, including signposting and referral to IAPT and Primary Care Services to improve general health outcomes.
4. Dual diagnosis, co-morbidity, mental health disorders and social problems are common in people who misuse drugs. It is vital to link into mental health services at all levels, including signposting and referral to primary care psychological services.
5. Commissioned services need to be responsive in meeting the needs of changing ethnic and minority profiles across Kent, including new communities.
6. Commissioners of acute hepatology services should ensure that referral mechanisms to drug or alcohol services are explicit within their commissioning treatment pathways and give consideration to the financial benefit of contributing to additional treatment service provision which will be needed as a result.
7. Develop links with the IAPT programme.

8. Raise awareness through campaigns in the press, radio and through partner newsletters including workforce initiatives about the risks of drug misuse. Give consideration to wider distribution of culturally appropriate resources for new communities.

Recommendations for Needs Assessment Work

- Relative levels of need for different ethnic minority groups, which are specific to Kent, need to be assessed
- Use of novel psychoactive substances – there is a considerable challenge around quantitative data and work may need to be focused around qualitative data and development of specific surveys
- Dual Diagnosis Needs Assessment

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