7.3.7 Substance misuse (Adults)

Why is this issue important?

The misuse of drugs causes physical, psychological and social harm to the individuals concerned, as well as giving rise to significant disruption and cost to families and communities.[1] Reducing the supply and availability of drugs and promoting recovery from drug related harms are a national priority.

It is estimated that in 2011-12 there were approximately 293,879 heroin and/or crack cocaine users in England.[2] It its estimated that drug related crime costs £13.9billion per year and that offenders who use these drugs commit between a third and a half of all acquisitive crime.[3]

The use of 'legal highs' or 'Novel Psychoactive Substances' (NPS) has become a particular issue in recent years. In 2012 the National Treatment Agency published a report on the emerging use of these substances. The evidence for the health effects of these newer psychoactive substances is not clear however, there have been several isolated reports of death and heavy use can develop into a dependency.[4]

National data[5]continues to show that drug use amongst the general population continuing to fall with 4.7% of adults having taken an illicit drug in the last month. The proportion of those aged 16-24 years responding positively to this question was higher at 10.2%. Use of Ecstasy amongst the younger age group has also seen an increase, in contradiction to the overall fall in use.

In 2010 the Government published a new national drug strategy.[6] The 2010 strategy highlights the need to focus on building recovery in communities by creating a system that gets people into treatment, but also getting people into full 'recovery', and completely free from dependence on drugs or alcohol.

Key outcomes

National outcomes

- ***Increase successful completion of drug treatment (Public Health Outcomes Framework)[7]***
- ***Reduce the number of people entering prison with substance dependence issues who are previously not known to community treatment (Public Health Outcomes Framework)***

Local outcomes

- ***Increase percentage of people over 18 leaving treatment who do so in a planned way and do not re-present within 6 months***
- ***Increase successful completions as a proportion of all in treatment – opiate***
- ***Increase successful completions as a proportion of all in treatment – non-opiate***
- ***Reduce the percentage of people who have been in treatment for over four years***
- ***Reduce number of drug related deaths***
- **Increase the number of people from LGBT and BME communities accessing treatment**
- **Increase in those leaving treatment with no housing need reported**

Impact in Brighton & Hove

The impact of drug misuse on the city of Brighton & Hove is well documented.

It is estimated that in 2011-12 there were approximately 2,029 heroin and/or crack cocaine users in Brighton & Hove.[2]

A question on drugs was included for the first time in the 2012 Health Counts Survey. Most respondents, 60% had never taken drugs not prescribed to them or available at a chemist, 10% had taken in the last four weeks and an additional 7% in the last year (but longer ago than four weeks) and 23% more than one year ago.[8]

[1] Brighton & Hove Safe in the City Partnership. Community Safety, Crime Reduction and Drugs Strategy 2011-14.
[2] Public Health England, Prevalence Estimates 2011-12
[3] Home Office. The economic and social costs of Class A drug use in England and Wales, 2003-04 in Measuring different aspects of problem drug use: methodological developments. Online report 16/06; BCS 2007
[4] National Treatment Agency. Club drugs: Emerging Trends and Risks. 2012
[5] Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales. July 2015
[6] HM Government. Drug strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life.

[7] National Treatment Agency Quarterly Alcohol Summary Report.
[8] NHS Brighton and Hove and Brighton & Hove City Council. Health Counts Survey 1992-2012. 2013. Available at: http://www.bhconnected.org.uk/content/surveys [Accessed 03/09/2015]

7.3.7 Substance misuse (Adults)

At the end of the 2014-15 financial year there were 1,750[9] clients in drug treatment in the city. With 26% of this client group having been in treatment for over four years. Table 1 shows the main problem drugs of those in treatment during 2014 for Brighton & Hove, with almost two-thirds (65%) due to primary use of heroin. In 2014, 49 clients were supported for their use of NPS drugs (Novel Psychoactive Substances).

Table 1: Percentage of clients in drug treatment, by primary substance. Brighton & Hove, 2014

Heroin	65%
Cannabis	8%
Cocaine	4%
Crack	3%
Other	20%

Source: Brighton & Hove Public Health Directorate

The drug using population are considerably more at risk from blood born viruses. Data for 2014 indicates a local prevalence of hepatitis C of 60% for this population, compared with 49% for England, Wales and Northern Ireland.[10]

During 2013/14 and 2014/15 the outcomes for opiate users in treatment services decreased somewhat, with a reduction in the number of individuals successfully completing treatment.

The National Treatment Agency Cluster classification places Brighton & Hove in group E for opiate users, and group D for non-opiate users (with group A being the least complex and group E the most complex). For opiate users, this indicates a population of opiate users locally who present with the greatest complexity. Between April 2014-March 2015, 6.1% of opiate users (n= 75) left treatment successfully compared with 11.9% for comparator Local Authorities. 7% (n=87) left treatment and did not represent, compared with 7.6% for comparator Local Authorities.[11]

During 2014 there was an average of 14.3 attendances at the Royal Sussex County Hospital A&E department each month related to "drug addiction"[12] It is likely that this represents an under reporting of activity. The cost of A&E attendance and hospital admissions is high.

Drug misuse can have a major impact on young people's education, health, families and long-term life chances.[1] In Brighton & Hove, 15.5% of those in drug treatment live with a child.

The impact on the community is also documented.[5] There is often an impact on housing, and significant numbers of people within the integrated support pathway have substance misuse issues. Across the band two (24 hour hostel accommodation) and band three (supported accommodation) supported housing, high self reporting of a need to manage a substance misuse problem is seen in residents, with 87% reporting need in Glenwood Lodge Hostel, 85% in West Pier Project Hostel and 57% reporting need in band three (all supported housing provision for single homeless clients).[13]

Using National Programme on Substance Abuse Deaths (np-SAD) data, in 2013 Brighton & Hove had the second highest rate of drug-related deaths in the country.[14] There were 36 np-SAD drug-related deaths in residents aged 16 years or over, or 15.5 per 100,000 people, this is a fall from a peak of 32.6 per 100,000 in the year 2000, but an increase compared with 2012 when there were 22 recorded deaths (6.9 per 100,000). The area with the highest rate in 2013 was Blackpool (17.3 per 100,000 people).

Local Public Health audit data derived from City Coroners records indicates that during 2014 there were 27 deaths. The data sets do use different methodology, and this must be considered when comparing the year on year statistics. Programmes of work continue to reduce the number of drug related deaths e.g. naloxone mini jet provision and training and first aid/overdose prevention training and greater awareness of the intersection between mental health and risk taking behaviour that can lead to a drug related death.

[9] DOMES Quarter 4 sum of non-opiate and opiate clients in treatment.
[10] Public Health England, Unlinked Anonymous Monitoring Survey of People Who Inject Drugs 2014,2015
[11] DOMES Quarter 4 2014-15
[12] A&E Symphony Flat 2014 File Reason for Attendance Recorded as Drug Addiction
[13] Brighton & Hove City Council. Housing Commissioning Team Contract Monitoring.
[14] Drug-related deaths in the UK: January-December 2013, National Programme for Substance Misuse Deaths, 2015

7.3.7 Substance misuse (Adults)

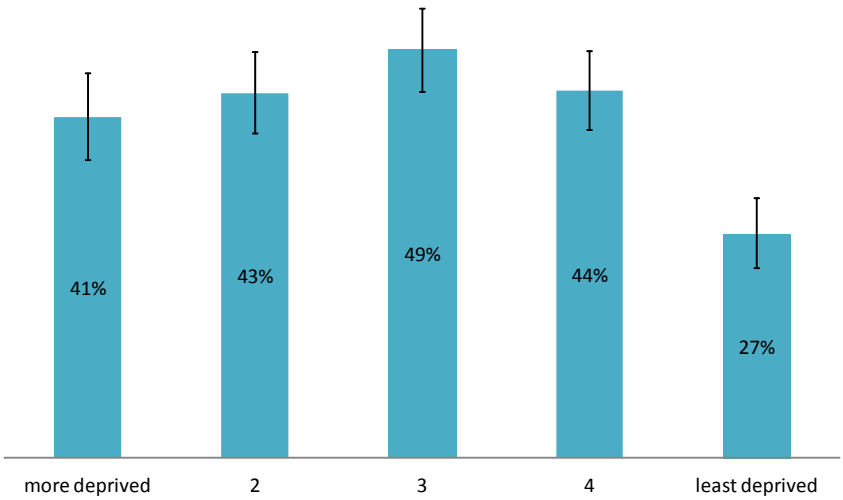
A service user involvement worker undertakes consultation with clients currently in the treatment system. The key priorities identified in 2013 were:

- Access to appropriate housing to support recovery and reintegration into the community
- A focus on those with a 'dual diagnosis' (usually substance misuse and mental health needs)
- Improved quality of care and support in hostels
- Improved access to counselling services and ongoing support
- Greater access to employment and training opportunities for service users

Local inequalities

According to the 2012 Health Counts survey having ever taken drugs is not associated with deprivation within the city. Whilst it is lowest in the least deprived areas it is highest in the middle three quintiles (Figure 1).[8]

Figure 1: Percentage of respondents ever having taken drugs by quintile of deprivation within Brighton & Hove, 2012



Source: Health Counts Survey 2012

The Health Counts 2012 Survey also showed that:

- Having ever taken drugs is higher for males than females (45% for males and 36% for females) and this is the case in all age groups. Having ever taken drugs is highest in those aged 25-34 years and falls in each age band after this age to just 5% of males and 0% of females aged 75 years or over.
- LGB and unsure respondents (63%) are statistically significantly more likely to have ever taken drugs than all respondents. The highest percentages were for lesbian/gay women (76%), bisexuals (74%), and those who are unsure of their sexual orientation (86%), however, it should be noticed that the sample sizes in those groups are very small.
- Drugs use is lower in BME respondents (34%) than White British respondents (42%), though the difference is not significantly significant.
- Those who are single are significantly more likely to have ever tried drugs (48%) and those who are widowed (9%) or separated or divorced (26%) significantly less likely.
- Carers (33%) were significantly less likely than all respondents to have ever tried drugs.
- Respondents with no religion (60%) were significantly more likely to have ever tried drugs than all respondents (though this could be related to age), Christians were significant less likely (21%) and 36% of those with another religion had ever tried drugs.
- Respondents who rent from a private landlord were significantly more likely to have ever tried drugs (54%).
- Employed respondents are significantly more likely to have ever taken drugs (49%). The figure was also higher for students (46%), though not significantly so. Retired respondents were significantly less likely (4%) to have ever taken drugs, though this is likely to be strongly age related.
- Respondents with degree level qualifications or higher were statistically significantly less likely to have ever tried drugs (22%).

The average age of those in drug treatment in the city is 36 years and 8 months for males and 34 years and 6 months for females. Women made up 28% of the treatment population in 2014.

There is an under-representation of the lesbian, gay, bisexual and transgender (LGBT) community within the treatment population (2014) (10.6%) in treatment compared with an estimate of 13%

within the City).[15] Use of substances within this community may not be problematic, however given evidence of higher levels of use and under-representation within treatment it is possible that a gap in provision exists. Of those in treatment for primary use of Novel Psychoactive Substances (NPS/Legal highs), 25% come from this community.

There is also under representation from the Black and Minority Ethnic (BME) groups. Anecdotally, feedback indicates that this may be due to cultural issues, and the preference to deal with these types of issues within communities, rather than approaching treatment services. There may also be some protective factors (for example abstinence from alcohol) associated with the culture of these communities that reduces use.

Substance-free accommodation can be very important for a person in the treatment system. However, there is a lack of this in the integrated support pathway for those who exit treatment into band 3 supported accommodation.[16]

A recent study looking at lesbian, gay and bisexual (LGB) people's alcohol and drug use in England found that LGB and unsure respondents (63%) are statistically significantly more likely to have ever taken drugs than all respondents. The highest percentages were for lesbian/gay women (76%), bisexuals (74%), and those who are unsure of their sexual orientation (86%), however, it should be noticed that the sample sizes in those groups are very small.[17]

Where we are doing well

Services for drug and alcohol community based treatment have recently been re-tendered, and a new partnership, 'Pavilions', has been operational since 1st April 2015. Drug and alcohol service provision is now integrated, and services should become more accessible in the future.

Pavilions will work in an integrated way with other service providers to ensure that service users receive the most effective intervention for their needs, at the most suitable time, in an appropriate setting and their care planning process will not be duplicated but transferable across settings. Service users will be engaged, involved, retained and reviewed to ensure progression through treatment and recovery and are supported to ensure positive, planned outcomes.

As part of the recovery journey, service users will be provided with support to gain and maintain recovery capital such as having positive relationships, having a sense of physical, mental and emotional wellbeing, meaningful occupation of their time, adequate housing, being a caring parent, strong sense of self within the community and financial resilience.

The strong partnership working that exists between providers and commissioners will continue under the new partnership.

The fall in drug-related deaths from 67 in 2000 to 27 in 2014 can, in part, be attributed to the extensive roll out of take home naloxone, and the provision of overdose and first aid training which has been instrumental in increasing service user and staff knowledge on how to support someone who may be overdosing.

Services put in place in 2013 and 2014 to support non-opiate users had a very positive impact, with more individuals successfully complete treatment. Performance declined slightly at the end of 2014/15, and the focus for Pavilions will be to continue to develop services and improve performance.

Predicted future need

Given the decline in performance standards for opiate users, it is vital that the new partnership of providers focuses on supporting individual to successfully complete treatment, and to sustain their recovery.

The services to support young people transitioning to adult services has been reviewed recently, and should provide the support required. However, it is likely that there is a group of people between the age of 18 and 25 not presenting to treatment service, particularly for alcohol and cannabis abuse.

It is possible that there are a number of different cohorts of people using novel psychoactive substances who could benefit from support. Evidence to date suggests these could include men

[15] NDTMS (Nebula) extract 2014 Drug Users in Treatment.
[16] Housing Commissioning Team.
[17] Part of the Picture: Lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011) Jez Buffin, Dr Alastair Roy, Heather Williams and Adam Winter.2012

who have sex with men, club drug users and people in employment who are unlikely to engage with 'traditional' treatment services. It is also possible that there are a cohort of individuals addicted to pain medication following a period of ill health. Supporting these individuals to successfully detox from the medication will be vital.

There will need to be a continued focus on the development of recovery-orientated services, ensuring that aftercare/post successful completion services are available to support people to stay in recovery. This will include a focus on health and wellbeing services, alongside employment, training and housing support.

What we don't know

The inequalities identified in the LGB and BME groups indicate that there may be a number of individuals who could benefit from treatment services, but do not present to treatment. We do not know the reason for this. It may be cultural, with more people from these community groups not considering themselves to have a problem with substances, or it could be because the communities are reluctant to present to treatment. It could be that these individuals do not actually have an issue with substance misuse. In the future, more detailed consultation work will be undertaken with these groups to identify barriers.

Key evidence and policy

The 2010 National Drug Strategy
http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010

Public Health England produces a number of key evidence and support documents.
https://www.gov.uk/search?q=substance+misuse

Locally an Independent Drug Commission was held in 2013. The recommendations are being taken forward.
http://www.safeinthecity.info/sites/safeinthecity.info/files/sitc/Drugs%20commission%20report%20final.pdf

Recommended future local priorities

Work will continue with Pavilions to ensure that the newly commissioned services better meet the needs of local residents. A key priority will be to ensure that services are accessible to all community groups. To do this, Pavilions will provide targeted accessibility which will involve, but not be limited to, the following:

- Targeted marketing e.g. focus on health and sexual health to meet the needs of Men who have Sex with Men (MSM)
- Visual representation of target group in publicity and around buildings e.g. BME and same sex couples
- Access points and sessions specific and exclusive to target group e.g. women-only with crèche facility, home visits for older persons, Lesbian, Gay, Bisexual and Transgender (LGBT), veterans , people with mental health needs
- Staff, volunteers and recovery mentors recruited from across target groups
- Setting up peer-led support initiatives specific to target group
- Targeted harm reduction messages and language
- Physical arrangements for those physically challenged
- Culturally sensitive points of entry and materials, which reflect local needs.
- Learning difficulties and cognitive impairment

The aim is to ensure that as many people as possible are supported to overcome their drug problems.

Key links to other sections

- Alcohol and substance misuse (Children and young people)
- Alcohol (Adults and older people)
- Dual diagnosis

Further information

Brighton & Hove Substance Misuse Needs Assessment 2013/14
http://www.bhlis.org/needsassessments

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