LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT 2018-2021

Substance Misuse in Adults

MARCH 2019

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FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, CCGs and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCGs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with CCG and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester, District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group supports the JSNA work across the Health and Wellbeing Board. To examine the detail of the chapters, Task and Finish groups have been established to bring together local professionals, where they can share their expert knowledge on the work area being examined. The outputs of the JSNA will include:

1. Subject-specific chapters of an assessment of current and future health and social care needs

2. An online infographic summary of each chapter available on the internet

3. An online data dashboard that is updated on a quarterly basis to allow users to self-serve high level data requests

The JSNA has reviewed the population health needs of the people of Leicestershire in relation to

Substance Misuse. This has involved looking at the determinants of the Substance Misuse, the health needs of the population in Leicestershire, the impact of the Substance Misuse, the policy and guidance supporting Substance Misuse, existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

Please note, the majority of indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. The term significance is used throughout the report and refers to statistical significance. This examines if the result presented is different to the national result, due to something other than chance. Most often, this is calculated using 95% confidence intervals.

EXECUTIVE SUMMARY

The Crime Survey for England and Wales identified that 1 in 11 adults aged 16-59 had taken an illicit drug in the previous year with 2% reporting frequent drug use in the past year and a third of adults reporting having taken drugs at some point in their lifetime. The survey also identified that the 16-24 age group report higher drug use than any other age group. Cannabis is reported as the most commonly used drug, with a prevalence of 7.2%, followed by powder cocaine with 2.6% reporting using it. Although this focuses on recreational use, there is a risk to ongoing usage and a risk of dependency resulting in harm to the individual. Aside from illicit drug use, there have been reports of a rise in addiction to some prescription and over-the-counter medicines and misuse of anabolic steroids. Further work is required to explore these issues.

In 2017/18, there were 1,434 individuals engaged in drug treatment services in Leicestershire with almost 8 out of 10 of these individuals receiving treatment for opiate use. This is higher than the national average of 66%. Furthermore, it is estimated that half of all opiate users in Leicestershire are not in receipt of treatment. While this is similar to the national average, it accounts for an unmet need for an estimated 1,139 individuals. National evidence also suggests that 2 in every 5 people who inject drugs are living with hepatitis C and that approximately half of those with the infection who inject drugs, remain undiagnosed. For many drug users, engaging in treatment can be the catalyst for getting the help they need to address other issues such as their physical and mental health, housing and financial issues which can have a significant impact on the individual and wider society.

When engaged in treatment, people use less illicit drugs, commit less crime, improve their health, and manage their lives better. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these outcomes. For those leaving treatment in an unplanned way, the benefits are reduced. Although the proportion of unplanned exits from treatment is lower (better) locally compared to the national average (12% vs 18%), this equates to 59 people in who did not successfully complete treatment in the last year.

Drug misuse is often concurrent with alcohol misuse, tobacco use, and mental health and wellbeing problems. In Leicestershire:

- 13% of individuals in treatment for drug misuse also report alcohol misuse
- 60% of individuals accessing substance misuse treatment services report smoking tobacco compared with 12% of the general population
- Out of those who started treatment in 2017-18, almost half were identified as having a mental health treatment need for reasons other than their alcohol misuse. This is higher

than the national average of 41%.

Drug misuse can lead to ill-health, early mortality and disability. In Leicestershire (over a 2 year period), there were 176 hospital admissions and 18 deaths due to substance misuse. Although these are significantly better than the national average, these are avoidable events. In addition to ill health; drug misuse and dependency can lead to or be caused by an array of factors including unemployment, homelessness, family breakdown and criminal activity.

The consequences of drug misuse impacts on the individual, the family, the community, the economy, and on public sector resources. Furthermore, the relationship between drug misuse and deprivation is evident with the rate of deaths from drug misuse being almost 60% higher in the most deprived areas compared with the least deprived areas in England. Consequently, preventing and reducing the harms caused by drug misuse will contribute to reducing health inequalities and contribute to improving the health and wellbeing of the population.

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1. Introduction

A wide range of terminology is used when talking about substance misuse, but throughout this chapter, substance misuse and drug misuse has been used interchangeably. This chapter focuses on substance misuse in adults aged 18 and over. Substance misuse in those aged under 18 will be covered in the Physical Health of Children JSNA which is due to published in Spring 2020.

The majority of substance misuse data in this report is reported from the National Drug Treatment Monitoring System (NDTMS). This represents adults who are aged 18 and over who live in Leicestershire and are receiving help for their substance misuse through accessing a service for drugs and/or alcohol. The substance misuse service delivered in Leicestershire is called Turning Point. Due to differences in users, NDTMS reporting divides people in treatment into four substance groups:

- **Opiates:** people who are dependent on, or have problems with opiates, mainly heroin. Opiate users still dominate adult treatment and generally face a more complex set of challenges and are harder to treat than non-opiate users.

- **Non opiate:** people who have problems with non-opiate drugs, such as cannabis, crack and ecstasy

- **Non-opiate and alcohol:** people who have problems with both non-opiate drugs and alcohol

- **Alcohol only:** people who are dependent on alcohol but don't have problems with any other substances

This needs assessment follows the terminology and groupings as used in NDTMS. Please note that while reference may be made to the alcohol only group, this user group is analysed in detail separately in the Alcohol JSNA available here: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

This chapter is based on illicit drug use only, unless otherwise stated. The surveys referenced throughout include the Crime Survey for England and Wales (CSEW). The CSEW is a household survey and is recognised as a good measure of recreational drug use for the drug types and population it covers. However, it may not provide as good coverage of problematic drug use, as many such users may not be part of the household resident population which is covered by the survey, or they may lead such chaotic lifestyles that they are unlikely to take part in the survey. 'Any drug' excludes new psychoactive substances

(NPS) and comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone, amphetamines, cannabis, tranquillisers, anabolic steroids and any other pills/powders/drugs smoked plus ketamine since 2006/07 interviews, methamphetamine since 2008/09 interviews and mephedrone since 2012/13 interviews. 'Any Class A drug' comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin and methadone, plus methamphetamine since 2008/09 interviews.

2. Who is at risk?

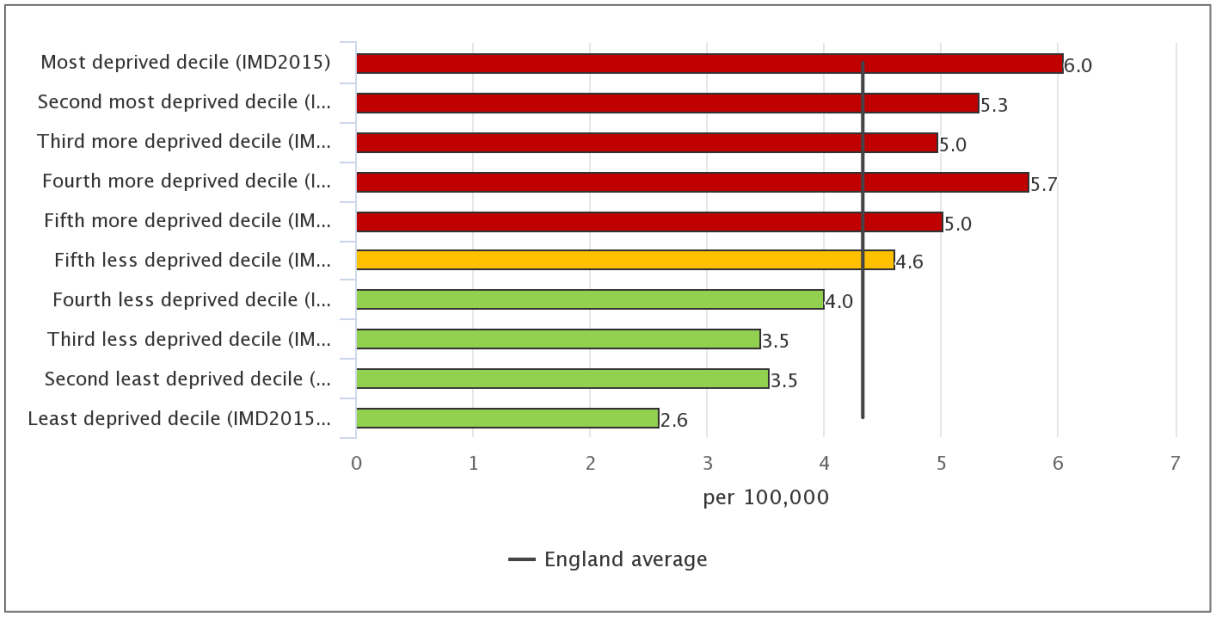
Several groups are identified in literature as being at high risk of misusing substances. These include those mentioned in this 'who's at risk' section. It is important to note that identification of the risk factors below does not mean an individual will inevitably misuse drugs. Rather, evidence suggests these are some of the risk factors that increase the likelihood of this happening. These groups are not exclusive and individuals may have a range of interlinked vulnerabilities which increase their overall risk of drug misuse.

2.1. Socioeconomic status

> Although drug misuse exists in most areas in the UK, it is more prevalent in areas characterised by social deprivation.[1]

Figure 1 shows there is a significantly higher rate of deaths from drug misuse in the counties categorised in the most deprived decile in England, compared to the least deprived decile in England. In 2015-17, the rate of deaths from drug misuse was 57% higher in the most deprived decile areas of England (6.0 per 100,000), compared to the least deprived decile (2.6 per 100,000).[2]

Figure 1: Deaths from drug misuse – England, 2015-17 – Data partitioned by County & UA deprivation deciles in England (IMD2015)



Source: Public Health Outcomes Framework, Public Health England

Just over 90,000 people (13.2%) in Leicestershire live in neighbourhoods falling in the four most deprived deciles nationally (out of a total population of over 680,000). Four neighbourhoods (LSOAs) in the county fall within the most derived decile in England. These areas can be found in Loughborough (Loughborough Bell Foundry and Loughborough Warwick Way LSOAs) and two in the Greenhill area of Coalville.[3]

For further information on the population and deprivation that exists throughout Leicestershire, please visit the Demographics JSNA chapter: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

2.2. Age

The 2017/18 Crime Survey for England and Wales (CSEW) found the use of any drug was highest among the youngest age groups; 16.9% of 16 to 19 year olds and 21.8% of 20 to 24 year olds reported any drug use in the last year. Levels of drug use then decreased as age increased, from 13.9% of 25 to 29 year olds to 2.0% of 55 to 59 year olds. It is important to note that the CSEW is a household survey and is regarded as a good measure of recreational drug use, but may not provide as good coverage of problematic drug use.[4]

The effect of drug use in younger age groups is likely to affect Leicestershire at a lesser extent than average as the population of Leicestershire is older than the population of England as a whole. In Leicestershire in 2016, 16.8% of the population were aged under 15 and 29.6% were aged 15-39 years, lower than the national percentages of 18.1% and 32.1% respectively. [3]

2.3. Sex

The 2017/18 CSEW found levels of drug use in the last year were significantly higher among men than women with 11.8% of men reporting taking any drug in the last year, compared with 6.3% of women. This pattern has existed since the 1996 survey, even though levels of use have fallen for both sexes (13.6% of men and 8.6% of women in 1996).[4]

In Leicestershire's population in 2017, there were approximately 7,000 more females (348,694) than males (341,518).[3]

2.4. Ethnicity

The evidence on drug use by ethnicity is mixed. The Crime Survey for England and Wales 2017/18 suggests higher use in the past year in mixed ethnicity groups (19.0%) compared to white and non-white groups (9.8% and 4.8% respectively). This survey is recognised as a good measure for recreational drug use.[4] The Adult Psychiatric Morbidity Survey 2014 also

found the proportion showing signs of drug dependence was highest among adults in the Black/Black British group (7.5%) compared to any other ethnic group. This may be explained by higher rates of cannabis use in this group, and could reflect reporting of daily use.[5]

However, other research suggests the prevalence of substance misuse amongst BME groups may be lower due to social stigma. For South Asian and Chinese communities for example, stigma surrounds not only drug users, but also their families, all of whom could be alienated from the community. It is also possible that individuals from minority backgrounds do use, but conceal use from family members, and are further reluctant to access services to seek support. Language and cultural barriers, concerns surrounding confidentiality and anonymity, and the unfamiliarity of treatment (in particular talking therapies) may also act as obstacles towards treatment.[6]

The vast majority of the county population belong to White ethnic groups. The Annual Population Survey (APS) via NOMIS in 2016 found that over 42,000 people (7.8% of the population) in Leicestershire were from ethnic minorities. This percentage is significantly lower than the national and regional percentage of 13.6% and 10.6% respectively.[3]

2.5. Sexual orientation and gender identity

Drug use among LGBT groups is higher than among their heterosexual counterparts, irrespective of gender or different age distributions in the populations.[7] Data from the Crime Survey for England and Wales for the three-year period from 2011-12 to 2013-14 showed that reported drug use was around three times higher among gay and bisexual men than among heterosexual men.[8]

The Part of the Picture research project is a five year study exploring drug and alcohol use among LGB people in England. The report of the project was published at the end of the third year of the study based on a sample of more than 4000 responses collected between January 2009 and December 2011; it found that just over one quarter of lesbian, gay or bisexual people in the study met the criteria for substance dependence. The report further found significant barriers exist to seeking information, advice or help among LGB people with only 1/3 of respondents to their questionnaire had sought information, advice or help about their substance use.[9]

Public Health England has delved further into substance misuse in men who have sex with men, with particular emphasis on 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 (also known as slamming). These practices can have an

adverse impact on the health and wellbeing of MSM. As well as the effects of problematic alcohol and drug use, chemsex can pose additional hazards both to the individual involved and public health. Where drug use takes place in a sexual context the risk of transmission of HIV, hepatitis B and C and other sexually transmitted infections (STIs) increases. Surveys indicate that compared to the average for the adult population as a whole, a higher proportion of MSM use drugs.[8]

In the East Midlands in 2016, there was an estimated 92,000 residents who identified as gay, lesbian, bisexual, or 'other', which equated to 2.5% of the regional population, compared to 2.4% of the national population.[10] There is no available data on gender identity.

2.6. Childhood

Guidance from Public Health England notes family history of addiction is a recognised risk factor for drug misuse.[11] There is a cyclical relationship between childhood experiences of, and exposure to, adult substance misuse, and subsequent misuse of substances in adulthood. The study of adverse childhood events (ACE's) in England found that children who experience four or more adversities are 11 times more likely to go on to use crack cocaine or heroin. Parents or carers affected by ACE's are at increased risk of exposing their own children to ACE's, resulting in an intergenerational cycle.[12] With this, substance misusing can be a sign that young people are dealing with adversity, trauma and/or experimenting with their identities. Drug misuse hence overlaps with a range of other vulnerabilities which can also exacerbate their risk of abuse and exploitation.[13] In England, 1 in 25 adults lived at some point during their childhood with someone misusing, or dependent on, drugs.[12]

The Smoking, Drinking and Drug Use among Young People in England survey questions secondary school pupils, aged 11 to 15 on certain health behaviours in exam conditions. Due to the difference in methodologies, the results of the SDD and WAY surveys should not be directly compared. The survey shows that substance misuse (including alcohol) amongst young people has been broadly in decline since 2001. The most recent survey in 2016 showed 24% reporting they had ever taken drugs, an increase from the 15% reported in 2014. It is however noted that an estimate from the 2018 survey is required before confidently being able to conclude that these survey results reflect a genuine trend in the wider population. In the meantime, the results for drug taking from this survey should be treated with caution. The likelihood of having ever taken drugs increased with age, from 11% of 11 year olds to 37% of 15 year olds. Similar proportions of girls and boys said they had ever taken drugs at 24% and 25% respectively. Although cannabis was the most commonly used drug among 11 to 15 year olds, with 8% reporting that they had used it in the last year, there was also an increase in the proportion reporting Class A drug use, from

2.0% in 2014 to 3.2% in 2016.[14]

The 2014/15 What About Youth (WAY) survey is a home postal survey which questioned 15 year olds on various health behaviours, including whether they had ever tried cannabis. In Leicestershire, 9.5% of 15 year olds reported having tried cannabis, similar to the national percentage of 10.7%. When examining results nationally, there was no significant difference between males and females (10.6% and 10.8% respectively). However, gay, lesbian and bisexual 15 year olds were significantly more likely to have tried cannabis than their heterosexual peers. Those from white or mixed ethnic backgrounds were significantly more likely to have ever tried cannabis than those from Asian, Black or other backgrounds.[15]

2.7. Rural urban classification

The 2017/18 CSEW found people living in urban areas reported higher levels of drug use than those living in rural areas. Around 1 in 11 (9.4%) people living in urban areas had used any drug in the last year, compared with around 1 in 14 (7.0%) of those living in rural areas.[4]

While the county is rural in terms of area, the population is concentrated within urban areas. Overall, 70% of the population of Leicestershire live in areas classed as Urban City and Town, while 18% live in area classed as Rural Town and Fringe and the remaining 13% live in areas classed as Rural Village and Dispersed.[3]

2.8. Population groups

2.8.1. *Homeless*

The association between homelessness and drug misuse is complex. Problems with drugs can be part of a person's spiral into homelessness, but homelessness can also result in drug misuse. As such, homelessness can be both a cause and consequence of drug misuse, although not everyone who has problems with drugs becomes homeless, and not every homeless person has problems with drug misuse.

Homelessness can be defined in many ways: from statutorily homeless, single homeless people, rough sleepers and those at risk of homelessness. Many people who become homeless do not show up in official figures. This is known as hidden homelessness. This includes people who become homeless but find a temporary solution by staying with family members or friends, living in squats or other insecure accommodation. Research by the charity Crisis indicates that about 62% of single homeless people are hidden and may not show up in official figures.[16] In Leicestershire, the number of rough sleepers has increased from 121 in 2010, to 313 in 2017.

The charity Crisis reports that nationally levels of drug abuse are relatively high amongst the homeless compared to the general population. During 2013-15, 27% of their clients reported problematic drug/alcohol, with two thirds of homeless people citing drug or alcohol use as a reason for first becoming homeless. They found that those who use drugs are seven times more likely to be homeless[16]. It is recognised that a safe, stable home can further enable people to sustain drug misuse recovery.

The 2017/18 NDTMS data shows that of the 509 individuals who had an accommodation status recorded at the start of treatment, 107 individuals reported a housing problem or urgent no fixed abode problem. This is just over a fifth (21%) of those with an accommodation status at start of treatment. In the same time period, there were 700 decisions taken by the local authority on homelessness applications, at a rate of 2.5 per 1,000 households. Please note this includes both positive and negative decisions in order to capture the demand on local authority housing provision.[17] When presenting to treatment, opiate clients tended to report the highest percentage of an urgent housing problem, usually No Fixed Abode (NFA), or some form of current housing problem (such as staying with friends or family as a short term guest or residing at a short-term hostel).Nationally, the proportion of clients presenting to treatment with a housing problem has remained relatively stable for most substance groups since 2009-10, although there has been an increase in the proportion of opiate clients with an urgent housing problem from 10% in 2009-10 to 16% in 2017-18. In Leicestershire, the increase has been from 8% to 16% in the same period of time.[18]

Experimental statistics by the Office for National Statistics (ONS) show information on the deaths of homeless people in England and Wales 2013 to 2017. They found that there were an estimated 597 deaths of homeless people in England and Wales in 2017, a figure that has increased by 24% over the last five years. Just under a third (32%) of all homeless deaths in 2017 were due to drug poisoning; this accounts for 190 deaths. This means homeless people account for 0.7% of all deaths in the general population in 2017, and 5.0% of all drug poisoning deaths. Overall, the proportion of deaths of homeless people that are due to drug poisoning has increased by 52% percentage over the last five years.[19]

2.8.2. *Military Personnel and Veterans*

The Ministry of Defence has a 'zero tolerance' approach to use of 'drugs' or controlled substances. It is likely that prevalence of drug misuse within this population is low as people who test positive for drugs will face disciplinary proceedings. There are no military bases in Leicestershire so quantifying the number of serving military personnel attached to the county, who have tested positive for drugs misuse, is not possible.[20]

As with civilian members of the community, veterans can be vulnerable to substance misuse. Veterans sometimes use alcohol, and/or, drugs to cope with the physical and psychological effects of military service. These risks can be increased if their physical, and/or, mental health reduces their ability to find and hold long-term, fulfilling employment and secure accommodation.[13] However, it is not possible to quantify how many veterans are misusing drugs within local authority areas.

2.8.3. *Prisoners*

People in prison or those in the criminal justice system have a higher prevalence of substance misuse than the general population, and prisoners with addiction issues are at an increased risk of self-harm and suicide. The level of drug misuse in prisons is measured by the Random Mandatory Drug Testing programme (RMDT). The aim of RMDT is to test a random sample of 5% or 10% of prisoners each month (depending on prison capacity) and to monitor and deter drug-misuse. Between 1998/99 and 2014/15, in the UK, the share of prisoners testing positive for drug use from all randomly tested prisoners decreased from 18.3% to just below 7% respectively. The level has increased in recent years to 9.3% in 2016/17.[21]

Substance misuse can further be a problem for those released from prison. Nationally in 2017/18, 32.1% of individuals who were transferred to a community treatment provider for structured treatment interventions for substance misuse (either drugs or alcohol) post-release, started treatment intervention within 3 weeks of release. Leicestershire and Rutland (combined) performed significantly better with 63.7% doing so, accounting for 179 individuals.[2]

There are two prisons within Leicester and Leicestershire for males; Leicester prison and the Gartree prison in Market Harborough, Leicestershire. Female prisoners are most commonly sent to Peterborough prison.

3. Level of need in Leicestershire

“An estimated 300,000 people in England are dependent on heroin and crack. Increasing numbers of people are reportedly having problems with other drugs such as cannabis, new psychoactive substances and image and performance-enhancing drugs. Concern is also growing about misuse of, and dependence on, prescribed and over-the-counter medicines. A person’s drug use or dependence can significantly affect their families, friends, communities and society.[22]”

3.1. Prevalence

Prevalence is a measure of all individuals with a disease, illness or characteristic at a given time or time period. For the purposes of this chapter, prevalence is defined through the proportion of the Leicestershire population misusing drugs, or using drugs illicitly, unless otherwise stated. A compilation of survey data, secondary care data and specialised treatment service data is used to provide an insight into, and estimates for, the population.

Survey data, notably the CSEW 2017/18 provides estimates for recreational drug use; specialised treatment data provides insights into largely problematic drug users who are trying to recover from their addiction; while secondary care data looks at hospital admissions for those who may or may not be in contact with a specialised treatment service. It is noted that certain populations, such as the homeless, who are at higher risk of misusing drugs, may not be accounted for in some of these figures, and hence the data is likely to present an underestimate of the true prevalence of illicit drug use in the population.

3.1.1. *Overall prevalence estimates*

The CSEW estimates the prevalence of recreational drug use by taking a representative sample and applying the results to the whole population in England and Wales. This survey is used here to provide national estimates where local information is not available. Results from the 2017/18 survey show that approximately 1 in 11 adults aged 16–59 years had taken an illicit drug (excluding New Psychoactive Substances, NPS) in the previous year. While this is significantly lower than a decade ago, a stable trend of illicit drug use between 8% to 9% of the population is evident for the last nine years.[4] Approximately one third (34.6%) of adults report having taken drugs at some point during their lifetime. While there has been a decrease in levels of lifetime use estimated by the 2017/18 survey compared with a decade ago (36% in the 2007/08 survey), this remains higher than the 1996 survey (30.4%). When considering frequent use, where frequent use is defined as taking an illicit drug more than once a month on average, 2.1% of 16-59 year olds reported frequent drug use in the past year. This is not statistically different to the 2016/17 survey. Due to a change in formulation of the question, long term trend information is not available on frequent use.[4]

The National Drug Treatment Monitoring System (NDTMS) collects regular activity and performance data from all drug treatment services in England and reports information on individuals receiving structured drug or alcohol treatment in each local area. The data includes all individuals who cited an illicit substance misuse problem upon entering treatment. In 2017/18, there were 2,074 individuals in drug and alcohol misuse treatment services in Leicestershire. These individuals are segmented by the four substance groups in

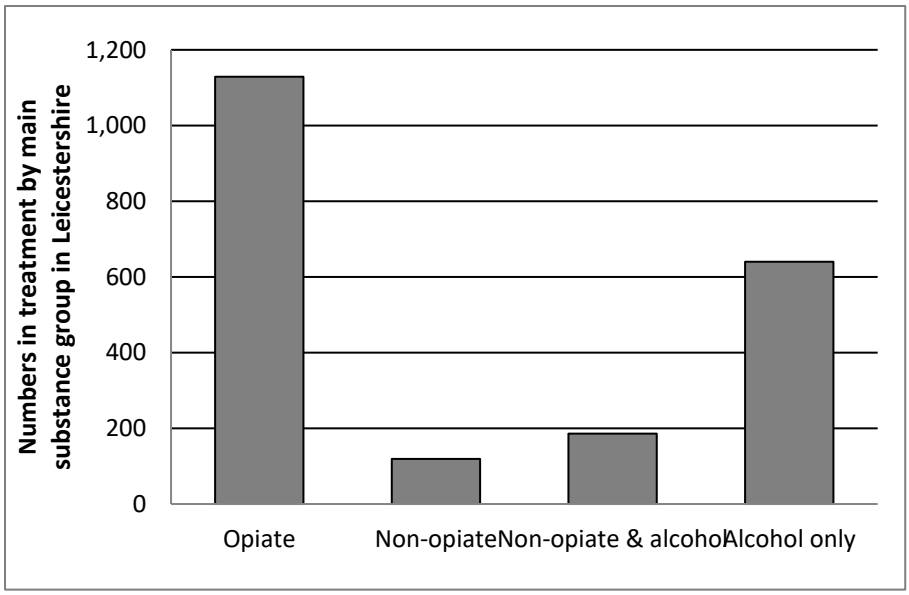
Table 1. Nationally, just over half the clients in contact with treatment during the year (144,189, 53%) had presented with problematic use of opiates, a further 19% had presented with problems with other drugs and just under a third (75,787, 28%) had presented with alcohol as the only problematic substance. The comparative proportions in Leicestershire are 54%, 15% and 28% respectively. As visible in Figure 2, the most common reason for being in treatment was opiate misuse.[18]

Table 1: Numbers in treatment by main substance group 2017/18[18]

	Leicestershire		England
	Numbers	**% of total**	**% of total**
Opiate	1,129	54%	53%
Non-opiate	119	6%	9%
Non-opiate & alcohol	186	9%	10%
Alcohol only	640	31%	28%
Total	2,074	100%	100%

Source: NDTMS, Local area trend report, 2017-18

Figure 2: Numbers in treatment by main substance group, in Leicestershire, 2017/18[18]



Source: NDTMS, Local area trend report, 2017-18

For the purposes of this report, the 'alcohol only' substance group is excluded unless otherwise stated. This leaves 1,434 adults in drug treatment in Leicestershire in 2017/18, with 79% in treatment for opiate use, and 21% in treatment for non-opiate use. Nationally, there is a lower proportion in treatment for opiate use when compared to Leicestershire (66%) and a higher proportion in treatment for either form of non-opiate use compared to

Leicestershire (34%).[18]

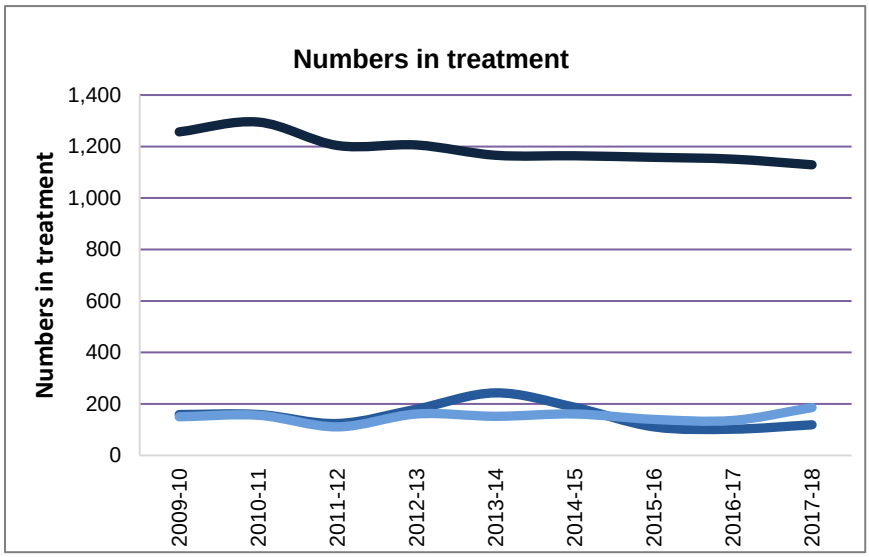
Table 2 presents the numbers in substance misuse treatment in 2017-18, the number of new presentations to treatment in 2017-18 and the respective percentage changes when comparing to 2016-17. The number of new presentations to treatment for opiate use in 2017-18 had decreased by 12% when compared to the previous year. Analysing this data alongside Table 1, shows that while opiate users continue to make up the majority of those in treatment, this percentage has decreased. In the same time period, there was a 48% increase in new presentations for non-opiate and alcohol use, and a 37% increase in the numbers in treatment compared to the previous year. This reflects an absolute increase of 41 and 50 individuals respectively. The increase in numbers in treatment may be partly attributed to the increase in new presentations. For non-opiate use there was no change in new presentations to treatment when compared to 2016-17, although there was a 17% increase in the number in treatment. This could suggest that a higher proportion of those entering treatment prior to 2017-18 have stayed in treatment.[18]

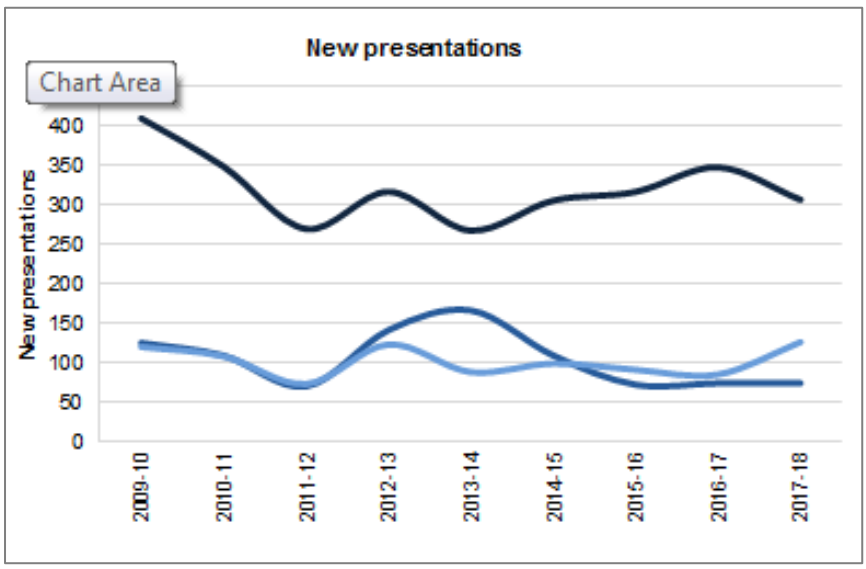
Table 2: Numbers in treatment, numbers of new presentations and % changes compared to previous year, Leicestershire 2017/18[17]

	No. in treatment in 2016/17	**No. in treatment in 2017/18**	**% change compared to previous year**	**No. of new presentations to treatment 2016/17**	**No. of new presentations to treatment 2017/18**	**% change compared to previous year**
Opiate	1,151	1,129	2% decrease	348	307	12% decrease
Non-opiate	102	119	17% increase	75	75	no change
Non-opiate and alcohol	136	186	37% increase	86	127	48% increase
All	1,389	1,434	3% increase	509	509	no change

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

Figure 3: Trends in numbers presenting to treatment and new presentations to treatment by main substance group, Leicestershire





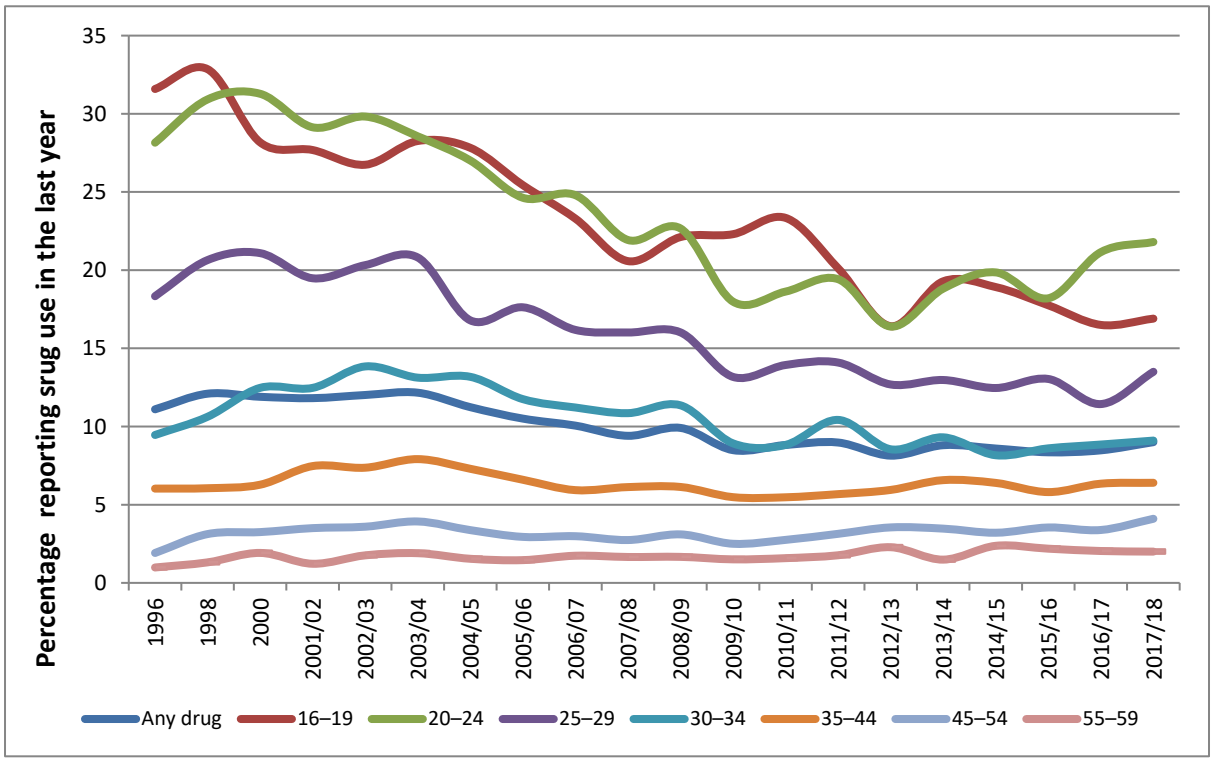
3.1.2. *Prevalence by age*

The 2017/18 CSEW found the youngest age groups, 16-19 and 20-24 years reported higher drug use than any other age group in the last year at 16.9% and 21.8% respectively. The prevalence in these groups is more than double the wider age group (16-59 years) where 9.0% had taken an illicit drug in the past year. Other than the 16-24 age band, drug use decreases as age increases all the way to 2.0% in 55-59 year olds.[4] It is important to note that the CSEW is a household survey and is regarded as a good measure of recreational drug use, but may not provide as good coverage of problematic drug use.

Between the 1996 and 2017/18 surveys, there was a fall in use of any drug in the last year among 16 to 59 year olds as shown in Figure 4. This was largely due to declines in drug use among 16 to 24 year olds, and to a lesser extent, 25 to 29 year olds. The last three years however have shown a gradual increase in use for 20-24 year olds, from 18.2% in 2016/17 to 21.8% in 2017/18. Drug use in those aged 29 and under has shown a long term significant decline since 1996, although there have been no significant changes in trend since 2007/08. Over the same period, there have been increases in last year drug use among older ages. Those aged 45-59 have seen a statistically significant increase in prevalence since 1996, and for 45-54 year olds, this has also been seen since 2007/08. Last year use of any drug among 55 to 59 year olds has significantly increased from 1.0 per cent in the 1996 survey to 2.0 per cent in the 2016/17 survey. This has mainly been driven by increases in the use of cannabis. No age group has shown a statistically significant increase in drug use compared to the 2016/17 survey.

The survey also suggested that frequent use in 16 to 24 year olds was almost double that in the wider age group (16-59) year olds, with 4.1% of 16 to 24 year olds classed as frequent users, compared to 2.1% in the wider age group. There has been no statistically significant change in either group since the previous year, and long term trend data is not available due to a change in formulation of the question in the survey.

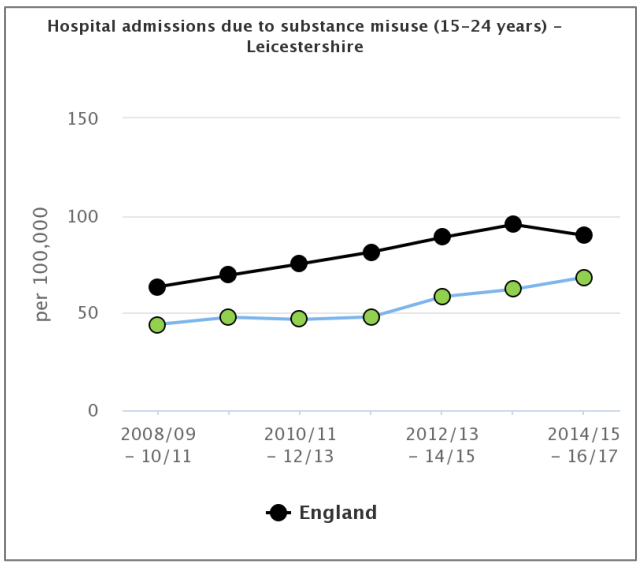
Figure 4: Proportion of 16-59 year olds using any drug by age range by year 1996-2017/18



Source: Crime Survey for England and Wales, 2017/18

Public Health England also reports on hospital admissions due to substance misuse. This data is only available for 15-24 year olds, and is combined over three years due to low counts in some areas. Hospital admissions for substance misuse are categorised as those with a primary diagnosis of mental and behavioural disorders due to drugs, poisoning due to drugs or toxic effects of drugs. Figure 5 shows the rate of hospital admissions due to substance misuse for people aged 15-24 years was 68.4 per 100,000 in the period between 2014/15-16/17 in Leicestershire. This accounts for 176 admissions during this time. Leicestershire performs significantly better than England and has done so since data was first reported in 2008/09-10/11. The most recent figure demonstrates a statistically significant increase compared to 2011/12-13/14 although the gradual year-on-year increases loosely follow the national pattern. It is worth noting that this data refers to episodes of admission, not number of persons admitted.[15]

Figure 5: Trends in hospital admissions due to substance misuse (15-24 years) in Leicestershire

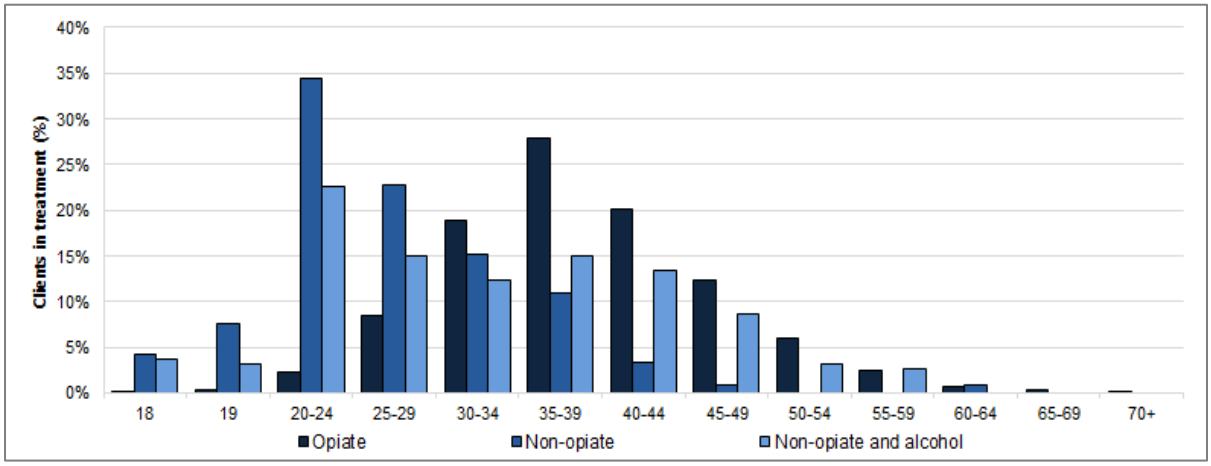


Source: Child and Maternal Health Profiles, Fingertips, Public Health England

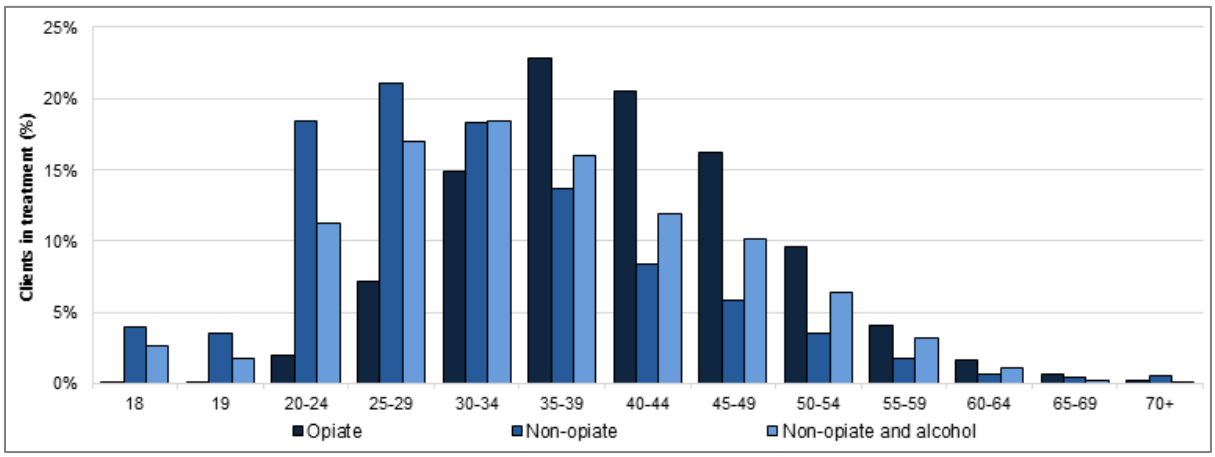
Treatment data from NDTMS shows that both locally and nationally, the highest proportion of those in treatment were aged 30-39, compared to any other age group (42% and 37% respectively).[17] Both locally and nationally, the lowest proportion of those in treatment were those in age bands 60 and above. Please note these figures also include those who are in treatment for alcohol misuse. Both nationally and locally, non-opiate clients presenting without problematic alcohol use have the youngest age distribution, while opiate clients have the oldest age distribution as shown in Figure 6. The majority of opiate clients both locally and nationally were aged 35-39 years old. Meanwhile the highest proportion of non-opiate clients were aged 25-29 nationally, but 20-24 in Leicestershire.

Figure 6: Age distribution of all clients in treatment in Leicestershire, 2017-18[18]

Leicestershire:



National:



Source: NDTMS, Local Area Trend Report 2017-18

Nationally, the number of under-25s accessing treatment has fallen by 50% since 2005-2006. This reflects changes in the patterns of drinking and drug use in this age group over the last 12 years.[23] Locally the number of under-25s presenting to treatment has fallen from 200 in 2009-10 to 103 in 2017-18; a 48.5% decrease.

3.1.3. *Prevalence by sex*

In line with previous years, the CSEW showed drug use is significantly higher in men than women with 11.8% of men compared to 6.3% of women reporting illicit drug use in the previous year. This pattern has existed since the 1996 survey, even though levels of use have fallen for both sexes (13.6% of men and 8.6% of women in 1996). This pattern continues when looking at individual drug types. Drug use in the last year is highest in

young men aged between 16 and 24 years and lowest in women aged 55-59 years.[4]

NDTMS data shows that 75% of those in treatment in Leicestershire in 2017/18 were males, and 25% females, compared to national percentages of 73% and 27% respectively. For both males and females, the highest proportion of those in treatment were aged 30-39.[17] Please note these figures, also presented in Table 3 include those who are in treatment for alcohol.

Table 3: Age of all male and female adults in drug and alcohol treatment in 2017-18[17]

	Leicestershire				England		
	n	Proportion of all clients	Males	Females	Proportion of all clients	Males	Females
18-29	291	20%	18%	28%	17%	16%	20%
30-39	609	42%	42%	43%	37%	36%	39%
40-49	412	29%	30%	24%	32%	33%	28%
50-59	107	7%	*	*	12%	13%	10%
60-69	13	*	*	*	*	*	*
70-79	*	*	*	*	*	*	*
80+	*	*	*	*	*	*	*

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

3.1.4. *Prevalence by ethnicity and sexual orientation*

Of all people in treatment in Leicestershire in 2017/18 for either alcohol or drugs, 509 were new presentations who were starting treatment within that year. This equates to 35% of all clients, compared to 40% nationally. When splitting by ethnicity, 92% of new presentations identified as White British, accounting for 466 individuals. The second most common ethnic group was Indian, with 9 individuals accounting for 2% of new presentations, followed by 8 individuals who identified as 'Other White'. All other ethnic group had counts of under 5. 93% of new presentations identified as heterosexual, accounting for 473 individuals, with 2% identifying as bisexual, accounting for 11 individuals.

3.1.5. *Prevalence by drug type*

The CSEW 2017/18 found 1 in 11 adults aged 16-59 had used an illicit drug in the last year. Cannabis is reported as the most commonly used drug over the past year, with a prevalence of 7.2%. While there have been fluctuations in its reported use over the past 10 years, this was the highest estimate during that time. The increase from 2016/17 (6.6%) is not statistically significant. Of those who'd taken it, 34% reported being frequent users, where a frequent user is defined as someone who has taken an illicit drug more than once in the last

year. Cannabis use is most prevalent in the 20-24 age group, with 18.2% reporting its use in the last year, although the only age group with a statistically significant increase compared to the previous year is 25-29 year olds (8.4% to 10.6%). A gradual increase over time is however evident in 20-24 year olds since 2012/13, while use in 45-54 year olds is statistically significantly higher than 10 years ago (2.2% to 3.1%).[4]

The next most common drug was powder cocaine with 2.6% reporting using it. There have been fluctuations in its reported use over the last 10 years although the increase from the 2007/08 survey is not statically significant. The increase from 2016/17 to 2017/18 (2.3% to 2.6% respectively) is also not statistically significant. However, both the 35-44 age group and 45-54 age groups have seen a statistically significant increase since 2007/08 with reporting use increasing from 1.3% to 1.9% and from 0.3% to 0.8% respectively. Cocaine, in either form, is categorised as a Class A drug.

Class A drugs include powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, heroin, methadone and methamphetamine. These are grouped together because they are considered the most harmful and carry the maximum penalties for possession, supply or production. Some of these drugs are also grouped as 'club drugs' in section 2.1.7. The CSEW found around 1 in 29 (3.5%) adults aged 16 to 59 had taken a Class A drug in the last year. This has increased compared with the previous year and a decade ago when reported prevalence was 3.0%. While there have been no statistically significant increases compared to 2016/17 for any age group, Class A drug use has significantly increased in 20-24 year olds, 35-44 year olds and 45-54 year olds when compared to 10 years ago. Highest use of class A drugs was in the 20-24 year age group, which is also the age group that saw the largest increase since 2007/08, from 8.0% to 10.6% reporting its use. Reported use in 35-44 year olds in the same period of time increased from 1.7% to 2.4% while for 45-54 year olds it increased from 0.5% to 1.1%. The proportion reporting opiate use (either heroin or methadone) remains at 0.1%, as it has for the past 4 years. This is also the case for crack cocaine.[4]

LSD and magic mushrooms are both types of hallucinogens, categorised under Class A drugs. Both of these drugs saw a statistically significant increase on last year drug use in the CSEW; both increasing from 0.3% to 0.4%. When considering hallucinogens as a whole, 0.7% reported their use in the past year in the 2017/18 CSEW, an increase from the 2016/17 prevalence of 0.4%. The age group with the highest prevalence in 2017/18 was 20-24 year olds, at 3.1%. This age group also saw the largest increase on the previous year (1.8%), although the only age group with a statistically significant increase on the previous year was 25-29 year olds, where prevalence increased from 0.3% in 2016/17 to 1.0% in 2017/18.[4]

The way drugs are grouped in treatment data differs to categories in the CSEW. Therefore a

direct comparison is not always possible, and any comparisons that are made should take into account the different populations and methodologies within each data source. While the CSEW is recognised as a good measure for recreational drug use, treatment data, particularly new presentations to treatment, can provide an insight into problematic drug use in the population. Reporting of new presentations to treatment is split by under 25's and over 40s for different drug types. The substances cited as problematic among new presentations to treatment from 2009-10 to 2017-18 are presented in Figure 7 for those aged under 25 and 40 and over.

Cannabis was the most commonly cited drug when presenting to treatment both locally and nationally for under 25's in 2017/18. This is followed by cocaine and then opiates. Nationally presentations for cannabis use in this age group have declined year on year since 2010-11. Locally, presentations have fluctuated over the same period of time. Although there has been an overall decline, presentations have started to rise again since the all-time low of 25 individuals in 2015-16. By 2017-18, this figure had approximately doubled to 51 (of 112 citations). Please note the number of citations may not add up to the number of individuals accessing treatment, as an individual may cite the use of more than one drug. For over 40s, cannabis was the second most commonly cited drug when presenting to treatment with 28 (of 151) citations of its use in Leicestershire in 2017/18. The number citing its use has remained lower than its peak of 49 in 2013-14.

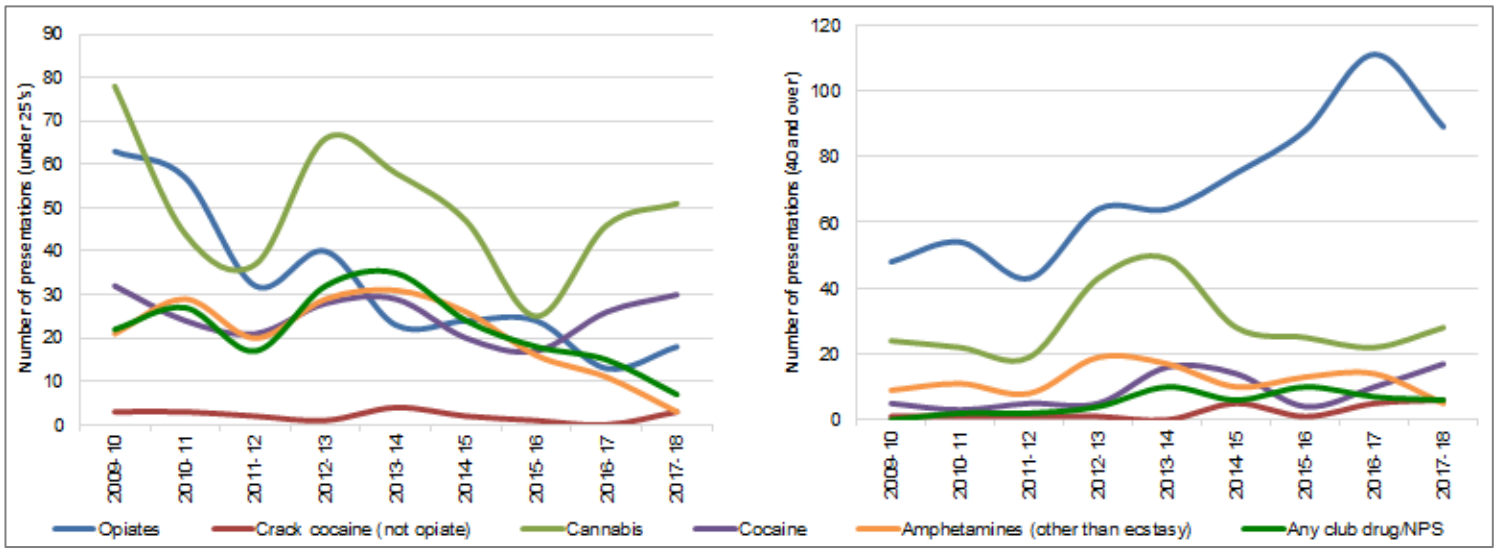
Opiates were the most commonly cited drug group for over 40s when presenting to treatment nationally and locally, followed by cannabis, and then cocaine. Nationally there has been a 34% increase in the number aged 40 and over citing opiate use from 2009-10 to 2017-18. This compares to an 85.4% increase locally with presentations increasing from 48 to 89 during this time. Presentation peaked in 2016-17 for this group at 111 individuals citing opiate use, meaning there has been a 19.8% decrease on the previous year. For under 25's opiate use was a lot lower, cited by 18 individuals (of 112 citations). Nationally, the number of under 25 year olds citing any opiate use has fallen by 70% from 2009-10 to 2017-18. In Leicestershire, numbers have decreased from 63 in 2009-10 to 18 in 2017-18, accounting for a 71.4% decrease during this time.

Nationally, there has been an increase in the number of under 25s stating the use of crack cocaine in treatment from 281 in 2015-16 to 417 in 2017-18. However this was still 44% less in comparison to 2009-10. Local presentation for crack cocaine use has remained low since recording began, with figures for all years remaining under 5 for under 25's. There has also been an overall increase nationally for the number of those aged 40 and over citing and crack cocaine use between 2009-10 and 2017-18. Although figures have fluctuated during this time, there is a year-on-year increase evident for the past 4 years. In 2017-18 the

number of presentations for crack cocaine was highest since reporting began. In Leicestershire, numbers presenting for treatment for crack cocaine remained 5 or under prior to 2016-17, with the 2017-18 figure increasing to 6.

Nationally, numbers of under 25s citing cocaine use has shown a year on year decline between 2009-10 and 2016-17, with a slight increase in 2017/18. Locally, figures have fluctuated during this time, although there has been a year on year increase from 17 in 2015/16 to 30 in 2017/18. Presentations with cocaine use in over 40s have shown a year on year increase between 2010/11 and 2017/18 nationally. In Leicestershire, there has been an increase from 5 citations in 2009-10 to 17 in 2017-18.

Figure 7: Trends in presenting substances of under 25s and over 40s in Leicestershire[18]



Source: NDTMS, Local Area Trend Report 2017-18

In an evidence review of the outcomes that can be expected of drug misuse treatment in England, Public Health England noted that the proportion of people in treatment with entrenched dependence and complex needs, particularly surrounding heroin use, is likely to increase. Further, the proportion of heroin users aged 40 and over, in treatment with poor health has been increasing, and is likely to continue to rise nationally. This is likely due to the aging cohort of heroin users, many of whom started to use heroin in the 1980's and 1990's, needing support for an increasing number of cumulative physical and mental health conditions.[24]

3.1.6. *Unmet need in opiate and/or crack cocaine users*

For 2014/15, Public Health England estimated the number of opiate and/or crack cocaine users by local authority. These figures were produced through compiling statistics from local and national data sources, including drug treatment services, probation, police and prisons, to calculate estimates of drug misuse prevalence. The estimated prevalence of opiate and/or crack/cocaine use among 15-64 year olds was 6.3 per 1000 population in Leicestershire, accounting for an estimated 2,700 people. This is similar to the national estimate of 8.6 per 1,000 population.[25]

Public Health England further calculate the proportion of opiate users not in treatment, in attempts to estimate the unmet need among the opiate using population. This is calculated by subtracting the number of people aged 15-64 in contact with drug treatment services, citing problematic opiate use, from the estimated number of opiate users within each local authority. In 2016/17, it is estimated that 49.8% of Leicestershire's opiate users were not in receipt of treatment for their opiate use in that year, accounting for an approximated 1,139 individuals. While Leicestershire has performed similar to national for the past three years, this means approximately half of the local opiate using population has consistently not being treated for their use or addiction.[26]

Table 4 presents NDTMS estimations for the prevalence of and unmet need for opiate and/or crack users (OCUs) in Leicestershire and nationally combined and individually. It is estimated that locally OCU prevalence is 6.3 per 1000 population aged 15-64, lower than the national rate of 8.6 per 1,000 population. The prevalence of OCUs is estimated to be higher than opiate or crack use individually. Opiate use alone is estimated to be higher than crack use, both locally and nationally, and while all local estimates are lower than national, the Leicestershire opiate rate of 5.35 is significantly lower than the national rate of 7.33 per 1,000 population.

Despite lower prevalence estimates locally than nationally, Table 4 shows that the unmet need for Leicestershire is estimated to be higher than the unmet need in England across all use types. The largest unmet need is estimated to be in the crack using population at 68%, indicating over two-thirds of this group are not currently in treatment locally. Over half of opiate and OCU users are estimated not to be in treatment locally according to the 2014-15 estimates.[17]

Table 4: Local and national prevalence and unmet need estimates, 2014-15

	Leicestershire			National[17]		
	n	Rate per 1000	Unmet Need	n	Rate per 1000	Unmet Need
OCU	2,700	6.32	57%	300,783	8.57	51%
Opiate	2,285	5.35	51%	257,476	7.33	46%
Crack	1,478	3.46	68%	182,828	5.21	62%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

When examining unmet need by gender, it is evident that it is higher in males compared to females both locally and nationally, with 56% of local male users not being in treatment compared to 25% of local female users. This compares to 48% and 38% in England, respectively. This shows that while the unmet need in Leicestershire OCU, opiate and crack users is higher than national, this is being driven by males rather than females.

3.1.7. *Club Drugs and New Psychoactive Substances (NPS)*

Socialising in the night-time economy, for example attending pubs and clubs, is associated with increased drug taking behaviour. The CSEW notes that 'Club drugs and new psychoactive substances (NPS)' brings together a number of different substances typically used by people in bars, nightclubs, concerts and/or parties, before and/or after a night out. Club drugs, as categorised by the CSEW include ecstasy, ketamine, GHB/GBL, methamphetamine and mephedrone. The 2017/18 survey found increased levels of drug use were associated with a higher frequency of visits to pubs, bars and nightclubs. For example, use of any Class A drug in the last year was around 11 times higher among those who had visited a nightclub at least four times in the past month (22.4%) compared with those who had not visited a nightclub (2.1%).[4] It is important to note that demographic factors are not necessarily independently associated with higher drug use. For example, while visiting nightclubs and bars is associated with higher drug use, some of this association may be driven by age, as younger people are more likely to visit nightclubs or bars.

Treatment data from NDTMS also considers club drug use, although with a slightly different grouping. Here, club drugs include ecstasy, GHB/GBL, methamphetamine, mephedrone, and NPS other. NDTMS reports note that non-opiate using, adult club drug users typically have good personal resources – jobs, relationships, accommodation and are hence more likely to make the most of treatment compared to opiate users who often face a more complex set of challenges. In 2017-18 in Leicestershire, 8% of new treatment entrants cited club drug use, with no additional opiate use, compared to 7% nationally. This equates to 17 individuals. In the same time period, 4% of new entrants cited club drug use alongside

opiate use compared to 2% nationally. Locally, this equates to 12 individuals. When examining trends in presenting substances in over 40's, figures have fluctuated between 6 to 10 individuals citing any club drug use between 2013/14 and 2017/18. For under 25's, there has been a gradual year-on year decline of the number stating any club drug on presentation to treatment, from 35 in 2013-14 to 7 in 2017-18.

The CSEW found 1.7% of 15-69 year olds reported having taken ecstasy in the last year. This represents a significant increase on the previous year's prevalence of 1.3%, although fluctuations have been apparent since data was first reported in 1996. Ecstasy use is highest in 20-24 year olds, with 5.9% of this age group reporting its use in the last year, although the largest increase compared to the 2016/17 survey was seen in the 20-25 age group, from 1.9% to 2.9%. If the 16-19 age group is excluded, ecstasy use decreases as age increases. Of all 'club drugs', ecstasy was found to be the second most commonly reported nationally with 939 citations in 2017/18. This follows a year on year decline for the past 3 years, while prior to that citations had fluctuated. In Leicestershire, ecstasy was the most commonly cited club drug when presenting to treatment in 2017-18, with 11 citations, the same as in 2016/17.

The CSEW found 0.8% of 15-69 year olds reported having taken ketamine in the last year. This represents a significant increase on the previous year's prevalence of 0.4%, and a significant increase from the 2007/08 survey value of 0.3% although fluctuations have been apparent during this time.[4] National treatment data shows presentations citing ketamine use have increased year on year for the past 4 years, with 426 citations in 2014/15, increasing to 752 in 2017/18. The numbers presenting to treatment locally, citing ketamine use have remained under 5 since 2014/15.

When compared to other drugs in the CSEW, methamphetamine and mephedrone use was comparatively low with 0.1% and 0.2% reporting their use in the last year, respectively. Methamphetamine use in the past year has varied between 0% and 0.2% since reporting began in 2008/09. Mephedrone use has seen a declining trend since 2010/11 when 4.4% reporting its use in the past year. When considering NDTMS data, nationally there has been a large decline in the number of individuals in treatment citing the use of mephedrone from 2,024 in 2014-15 to 236 in 2017-18. In Leicestershire mephedrone use peaked in 2013-14 with 84 of new presentations citing its use. Since then, numbers have dropped year on year with 5 new presentations reporting its use in 2017-18.

An evidence review of the outcomes that can be expected of drug misuse in England by Public Health England found the use of NPS is increasing, and is a particular problem in prisons and the homeless.[24] The CSEW 2017/18 found 0.4% of 16-59 year olds had taken NPS in the last year. This rose to 1.2% of 16-24 year olds in the last year. The majority of

people who had taken a NPS in the previous year had also taken another drug. Both prison settings and the homeless are not included in the CSEW survey. As a result, NPS use is likely to higher. NPS was found to be the most common cited club drug when presenting to treatment in 2017/18 nationally (with 1,223 citations). This follows decline in presentations[23] stating NPS use, from its peak of 2,042 in 2015-16 to 1,223 in 2017-18; equating to a 16% decrease. This is largely driven by a 36% reduction in under 25 year-olds (321 in 2016/17 to 206 in 2017/18). Local numbers have remained low and stable, changing from 7 to 9 in those respective years.

3.1.8. *Anabolic steroids*

There is little data available around the use of anabolic steroids in the population. However, the 2017/18 CSEW found that 0.2% of the population reported its use in the previous year, a significant increase from 2007/08. In adults aged 16 to 24, 0.3% reported its use. The substance misuse service in Leicestershire, Turning Point, has recently begun collecting data on this cohort. From July to September 2018, 92 steroid users accessed the needle exchange service at Turning Point in Leicestershire. Please note these individuals may not necessarily reside in Leicestershire.

3.1.9. *Prescription only medicine/over-the-counter medicine (POM/OTC)*

In an evidence review of the outcomes that can be expected of drug misuse treatment in England, Public Health England noted "there are reports of increasing problems of misuse and dependence associated with some prescription and over-the counter medicines.[27]" There is currently limited data on this outside treatment data. In 2017/18, there were 112 individuals who cited a prescription only medicine or an over the counter medicine in their latest treatment journey in Leicestershire. This accounts for 8% of those in treatment, lower than the national average of 14%, as shown in Table 5.[17] Within this, illicit use is defined through clients who cite the use of a POM/OTC alongside another drug(s), while no illicit use refers to those in treatment for only their POM/OTC.

Table 5: Number of adults citing prescription only medicine/ over-the-counter medicine use[17]

	Leicestershire		National
	n	Proportion of treatment population	Proportion of treatment population
Illicit use	80	6%	11%
No illicit use	32	2%	3%
Total	112	8%	14%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

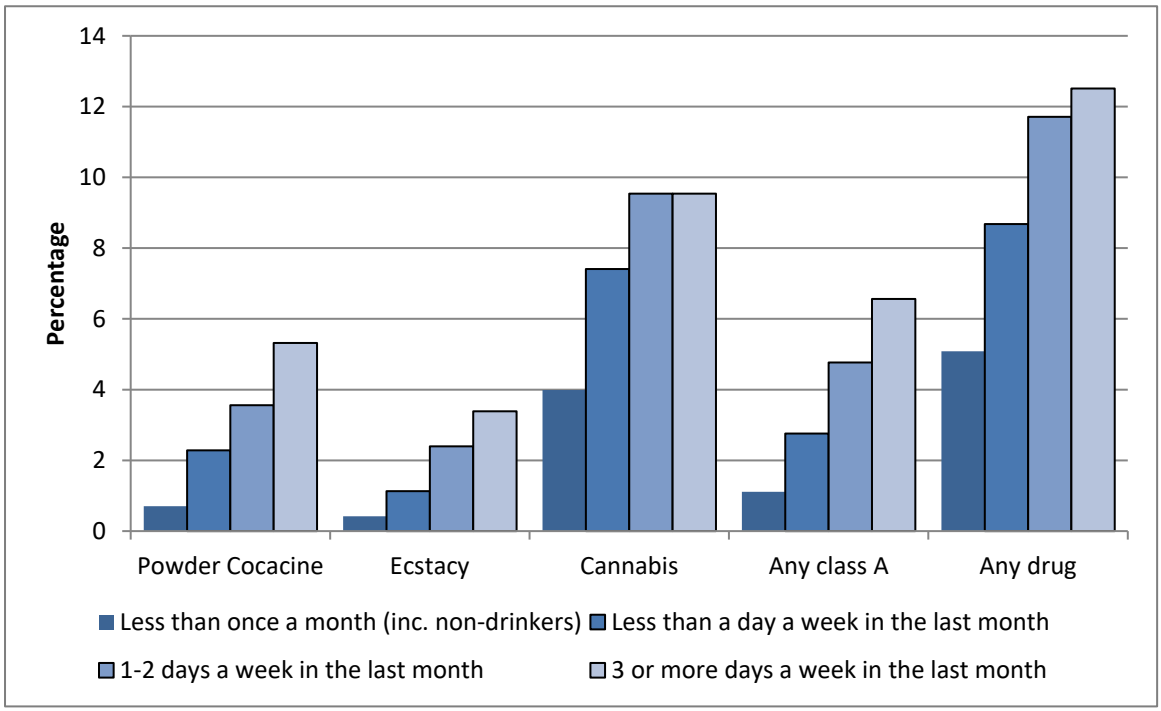
3.2. Comorbidities

Comorbidity is the presence of one or more additional diseases or disorders co-occurring with a primary disease or disorder. Data shows that drugs misuse is often concurrent with alcohol misuse, tobacco use, and mental health and wellbeing problems.

3.2.1. *Alcohol*

The 2017/18 CSEW provides information on last year drug use by frequency of alcohol consumption. Figure 8 shows that as frequency of alcohol consumption increased, so did levels of last year drug use. Adults aged 16 to 59 who reported drinking alcohol three or more days per week in the last month were more than twice as likely to have used any drug (12.5% compared with 5.1%) and six times as likely to have used a Class A drug (6.6% compared with 1.1%) in the last year than those who reported drinking less than once a month (including non-drinkers).

Figure 8: Frequency of alcohol consumption and drug use, adults aged 16 to 59 years, England 2017/18



Further analysis by PHE found that alcohol is mentioned in around a third of drug misuse deaths annually in England.[28]

In 2017/18 in Leicestershire, there were 196 individuals in treatment for non-opiate and alcohol use, accounting for 9% of all those in treatment. While this is a small proportion of

the total, this group saw the largest increase for numbers in treatment compared to the previous year (37%) and the largest increase of new presentations compared to the previous year (48%). Please see Table 2 in 3.1.1 for more detail. Over a third (38.2%) of those in treatment for non-opiate and alcohol successfully completed treatment. (See Table 13 in 2.4.6 for more detail)

For further information on alcohol misuse, please refer to the alcohol jsna chapter available here: http://www.lsr-online.org/leicestershire-2018-2021-jsna.html

3.2.2. *Tobacco*

Smoking in people who use drugs and alcohol is highly prevalent and a major cause of illness and death. The 2017 Annual population survey showed that 12.1% of Leicestershire's population were self-reported smokers, significantly better than the England average of 14.9%. Table 6 shows that 60% of Leicestershire residents accessing substance misuse services were smoking tobacco at the start of treatment. This suggests that smoking prevalence is higher for those in treatment for substance misuse compared to the general population.

People in treatment for opiates had the highest reported rates of smoking when starting treatment both nationally and in Leicestershire (68% and 64% respectively). This was closely followed by people in treatment for non-opiates and alcohol (61% both nationally and locally). The proportion of those in treatment for non-opiates who smoke locally was 43%, lower than the national average of 57%.[17]

Table 6: Clients identified as smoking tobacco at the start of treatment, 2017/18[17]

	Leicestershire		National
	n	Proportion of all in treatment	Proportion of all in treatment
Opiate	124/194	64%	68%
Non-opiate	23/53	43%	57%
Non-opiate and alcohol	54/89	61%	61%
All	201/336	60%	64%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

3.2.3. *Mental Health and wellbeing*

Mental wellbeing can be defined through psychological attributes such as confidence and optimism or through affective or emotional states such as happiness and life satisfaction. The 2017/18 Crime Survey for England and Wales reported that people with self-reported

higher levels of happiness, life satisfaction, feeling worthwhile and low anxiety were less likely to have taken drugs. Among those who were classified as having very high levels of happiness, around 1 in 16 (6.4%) had used a drug in the last year. Among those who were classified as having low levels of happiness, around 1 in 6 (16.1%) had used any drug in the last year. Similar patterns are evident for life satisfaction and feeling worthwhile, with the opposite being true for anxiety.[4] It is important to note that these findings only report associations between personal well-being and drug use, not causal links. It is not possible to infer a causal link between these variables. Further, it is not possible to identify the direction of any association; it is equally possible that low life satisfaction could lead to drug use, or that drug use could lead to low life satisfaction. It is also possible that an unknown third variable could cause both low life satisfaction and drug use.

Direct indicators of dual diagnosis are currently largely unavailable. However, mental health problems are common in those in treatment for drug use. In Leicestershire and Rutland, 15.2% of those entering substance misuse treatment services were also receiving mental health support services for a reason other than their substance misuse in 2016/17. This accounts for 72 service users, and is significantly lower than the England average of 24.3%.[29] This measure is indicative of levels of co-existing mental health problems in the drug treatment population but should not be regarded as a comprehensive measure of dual diagnosis as it only captures whether a person is receiving mental health treatment at a given point in time rather than at any point in time.

In 2017-18 in Leicestershire, 51% of adults who entered treatment said they had a mental health treatment need, for reasons other than substance misuse. This is higher than the 41% national average and accounts for 258 individuals. The majority of these were opiate using clients locally (52%), although nationally this group had the lowest mental health need when compared to other groups (39%). Although a lower number of females entered treatment compared to males, a higher proportion of them were identified as having a mental health need, with 64% identified as having a mental health need, compared to 51% nationally. For males, figures were 48% and 38% respectively.

While there was a lower proportion of new clients entering treatment in Leicestershire in 2017-18 compared to national, a higher proportion of those entering in Leicestershire had a mental health need. The difference is highest for females taking opiates, with 67% of Leicestershire females entering treatment in the 2017-18 being identified as having a mental health need compared to 47% nationally.[17]

Table 7: Adults who entered treatment in 2017-18 who were identified as having a mental health treatment need[17]

	Leicestershire				National		
	n	Proportion of new presentations	Males	Females	Proportion of new presentations	Males	Females
Opiate	159	52%	47%	67%	39%	36%	47%
Non-opiate	36	48%	42%	60%	41%	38%	52%
Non-opiate and alcohol	63	50%	47%	59%	47%	43%	58%
All	258	51%	46%	64%	41%	38%	51%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

In 2017-18, 216 individuals in treatment for their substance misuse problem were also receiving mental health treatment in Leicestershire. This accounts for 84% of those with a mental health need within that year. The majority of clients (64%) identified with a mental health need were receiving mental health treatment from their GP.

Table 8: Clients identified as having a mental health need and receiving treatment for their mental health[17]

	Leicestershire		National
	n	Proportion of clients identified	Proportion of clients identified
Already engaged with the Community Mental Health Team/other mental health services	42	16%	23%
Engaged with IAPT	7	3%	2%
Receiving mental health treatment from GP	165	64%	43%
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	*	*	2%
Has an identified space in a health based place of safety for mental health crises	*	*	1%
Total individuals receiving mental health treatment	216	84%	71%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

The data in Table 9 shows NHS finished hospital episode admissions where any of the primary or secondary diagnoses included a drug related mental or behavioural disorder. The data shows the rate of hospital admissions locally have remained lower than the national average for the past 5 years. In 2017/18, there were 87 admissions per 100,000 population

in Leicestershire, compared to 157 per 100,000 population nationally. Leicestershire also performs lowest amongst its top 5 CIPFA similar neighbours. Nationally, there has been a year-on-year increase in the rate of admissions from 2014/14 to 2017/18. In Leicestershire, there had been a year on year increase in admission rates from 2013/14 to 2016/17, with the latest value being a decrease on the previous year.

Table 9: NHS finished hospital admission episodes where any of the primary or secondary diagnoses included a drug related mental or behavioural disorder

	2013/14		2014/15		2015/16		2016/17		2017/18	
	Admissions		Admissions		Admissions		Admissions		Admissions	
	All (n)	Per 100,000	All (n)	Per 100,000	All (n)	Per 100,000	All (n)	Per 100,000	All (n)	Per 100,000
England	68,597	125	74,801	136	81,904	148	82,135	149	86,966	157
Leicestershire	336	53	396	62	455	71	579	89	575	87
Warwickshire	481	91	431	81	500	95	484	91	525	99
Gloucestershire	521	91	719	125	847	147	738	127	875	151
Staffordshire	546	68	728	91	845	106	831	104	865	107
North Yorkshire	520	96	535	103	646	126	571	109	475	90
Worcestershire	436	84	453	87	508	97	449	86	515	97

For further information on the Mental Health of Adults in Leicestershire, please visit the Adults Mental Health chapter: http://www.lsr-online.org/uploads/mental-health-of-adults.pdf

3.3. Harm reduction interventions

3.3.1. *Identification and brief advice*

The commissioned substance misuse service in Leicestershire is called Turning Point. The NDTMS figures which are presented in this report are based on those individuals who need treatment. However others may come in for identification and brief advice but not necessarily go on to the treatment pathway hence get missed out of NDTMS figures. In July-September 2018, there were 682 individual substance users receiving information and guidance (without going onto the treatment pathway and excluding needle exchange). Please note this figure is for Leicester City and Leicestershire County combined.

3.3.2. *Needle and Syringe Programmes*

There is long standing recognition of the importance of encouraging people who inject illicit drugs to inject more safely and to use clean injecting equipment. Harm reduction policies

have been instituted to provide needle and syringe programmes (NSP) to assist users in reducing the risk of acquiring and transmitting bloodborne viruses. Specialist agencies and community pharmacists are seen as serving an important role in helping people to reduce the extent of drug injecting-related harm, by promoting improved hygiene during intravenous drug use and encouraging the use of new needles and syringes and the safe disposal of used equipment.[24] In Leicestershire, the substance misuse service Turning Point liaises with pharmacies to provide access to sterile equipment including needles and syringes, and sharps containers for return of used equipment. Where agreed locally, associated materials, for example condoms, citric acid and swabs, will be provided to promote safe injecting practice and reduce transmission of infections by those misusing substances. As of July-September 2018, there are 37 pharmacies participating in the needle and syringe programme

For more information on NSP in pharmacy settings, please visit the Leicestershire Pharmaceutical Needs Assessment, available here: http://www.lsr-online.org/uploads/leicestershire-pna-2018.pdf

3.3.3. *Supervised consumption*

Supervised consumption is another service based in pharmacies. This service requires the pharmacist to supervise the consumption of methadone or other prescribed drugs at the point of dispensing in the pharmacy ensuring that the dose has been administered to the patient. Pharmacies offer a user-friendly, non-judgmental, client centred and confidential service. The pharmacy will provide support and advise the patient including referral to primary care or specialist centres where appropriate. As of July-September 2018, there are 138 pharmacies participating in the supervised consumption service.

For more information on supervised consumption, please visit the Leicestershire Pharmaceutical Needs Assessment, available here: http://www.lsr-online.org/uploads/leicestershire-pna-2018.pdf

3.4. Treatment pathway measures

3.4.1. *Routes into treatment*

Routes into treatment are also known as source of referral i.e. the routes by which people accessed treatment. There are many possible sources of referral an individual can provide, these have been grouped by self, family and friends; health services and social care; criminal justice system (CJS); substance misuse service and other. The CJS is mainly made up of prison referrals, probation and arrest referrals, or court based referral scheme.

Table 10 shows the number of clients who were referred into treatment broken down by their referral source in 2017/18. The most common route of referral locally and nationally was self-referral, accounting for 49% and 55% of all referrals respectively.[17]

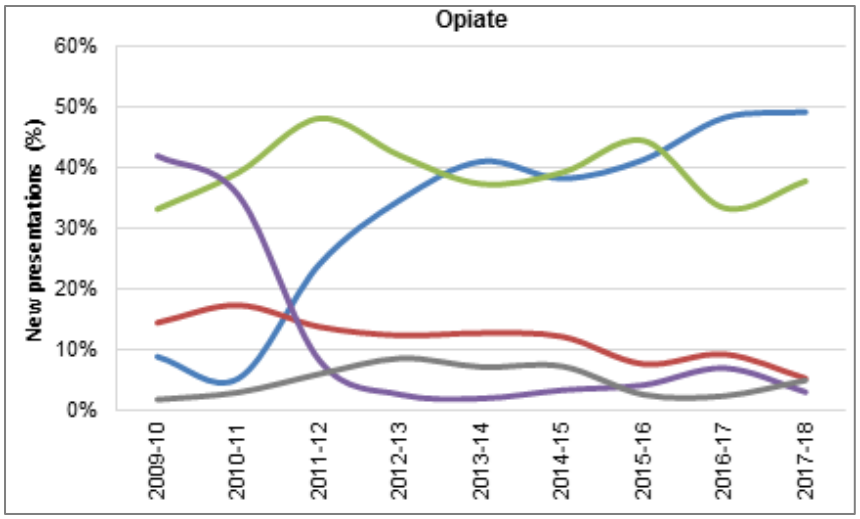
Table 10: Routes into treatment, 2017/18[17]

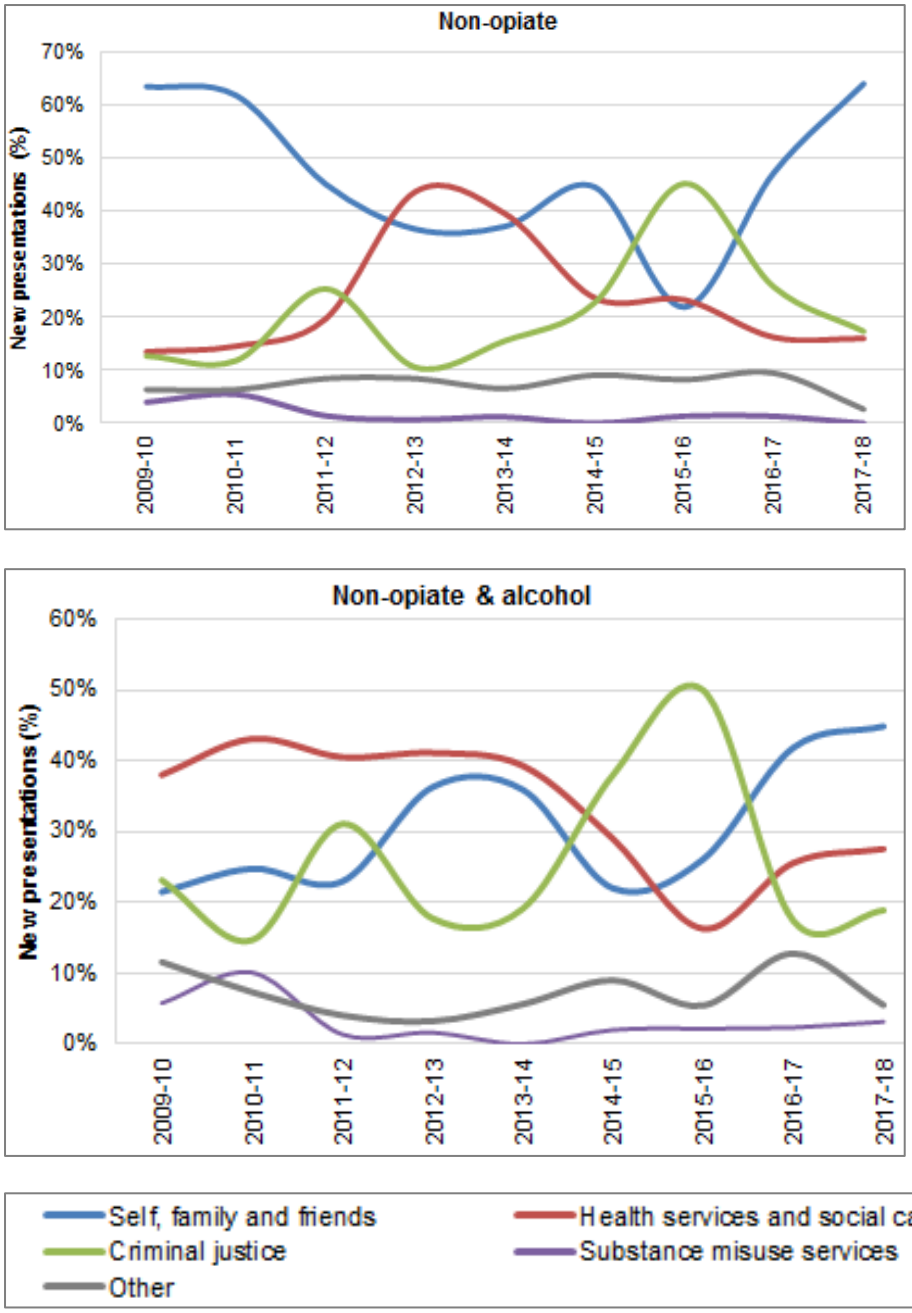
	Leicestershire		National
	n	Proportion of referrals	Proportion of referrals
Self-referral	248	49%	55%
Referred through CJS	153	30%	19%
Referred by GP	48	9%	7%
Hospital/A&E	*	*	2%
Social Services	*	*	2%
All other referral sources	47	9%	15%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

Figure 9 shows that when examining source of referral by drug use type, the most common route is self, family and friends; numbers have increased gradually across all three drug types since 2015-16. For non-opiate clients and opiate clients, the next most common route of referral was the criminal justice system, although the proportion of referrals from this source has been decreasing for non-opiate drug users since 2015-16.[18]

Figure 9: Trends in source of referral into treatment, new presentations proportions in Leicestershire





Source: NDTMS, Local Area Trend Report 2017-18

3.4.2. *Waiting times*

Drug users need prompt help if they are to reduce the harms of drug use and the impacts on the individual and community, and recover from dependence. Waiting times refer to the number of first interventions that took less than 3 weeks from referral to first offered appointment. Nationally, 99% of initial waits to start treatment were under three weeks in 2017/18. In Leicestershire 100% of all initial waits for the start of treatment were less than three weeks, a 2% improvement on last year. For the past three years, 95% or more[17] of those waiting for their first treatment intervention were seen in less than three weeks.[18]

3.4.3. *Treatment engagement*

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. For those leaving treatment in an unplanned way/dropping out, those benefits are reduced.

The information in Table 11 shows the proportion of adults entering treatment in Leicestershire in 2017-18 who left treatment in an unplanned way, without being discharged as completed treatment, before 12 weeks. Overall, 12% of new presentations had an early unplanned exit in Leicestershire in 2017/18 accounting for 59 individuals, lower than the national average of 18%. Leicestershire's early unplanned exits were lower than England averages across all drug user types.[17]

Table 11: Proportion of new presentations who left treatment in an unplanned way, 2017/18[17]

	Leicestershire		National
	n	**Proportion of new presentations**	**Proportion of new presentations**
Opiate	42	14%	16%
Non-opiate	6	8%	20%
Non-opiate and alcohol	11	9%	19%
All	59	12%	18%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

3.4.4. *Length of time in treatment*

Clients that have been in treatment for long periods of time (six years or over for opiate clients and over two years for non-opiate clients) are most likely to be entrenched users who will find it harder to successfully complete treatment. Opiate clients who successfully complete within two years of first starting treatment have a higher likelihood of achieving sustained recovery. Time in treatment is calculated from the first triage of the latest treatment journey to the latest discharge of the same journey.

The proportion of opiate clients whose latest treatment journey lasted less than two years as of 31st March 2017 was 50% in Leicestershire compared to 48% nationally. The proportion of opiate clients whose latest treatment journey lasted for 6 years or more in

Leicestershire is 26%, compared to 27% nationally. The proportion of non-opiate clients whose latest treatment journey lasted for more than two years is 1% in Leicestershire, compared to 3% nationally, while the proportions for non-opiate and alcohol clients were 4% and 3% respectively.

3.4.5. *Residential rehabilitation*

Drug treatment mostly takes place in the community, near to the individual's family and support networks. Residential rehabilitation may be cost effective for someone who is ready for active change and a higher intensity treatment. In 2017/18 in Leicestershire, 18 individuals attended residential rehabilitation. This makes up 1% of the treatment population; nationally 2% of the treatment population attended residential rehabilitation.

3.4.6. *In-treatment outcomes*

Data from NDTMS suggests that clients who stop using illicit opiates in the first sixth months of treatment are almost five times more likely to complete successfully than those who continue to use. In 2017-18 in Leicestershire there were 22 clients who were injecting at the start of their treatment who reported no longer injecting on their six month review treatment outcome profile. This accounts for almost half (48%) of those who had reported injecting at the start of their treatment. In the same time period, there were variations by drug type in the proportions reporting abstinence from drug use in the previous 28 days of their sixth month review treatment outcome profile, who had initially reported using drugs at treatment start, as in Table 12. The table also shows numbers and proportions reporting significant reductions in use where significant reduction is defined through a reliable change index calculation which varies per drug type.

Table 12: In-treatment outcomes by drug, 2017/18[17]

	Abstinence			Significant reductions in use		
	Leicestershire		National	Leicestershire		National
	n	Proportion	Proportion	n	Proportion	Proportion
Opiate	59	39%	40%	38	25%	25%
Crack	41	45%	40%	10	11%	17%
Cocaine	*	59%	66%	*	*	10%
Amphetamines	*	60%	57%	*	*	7%
Cannabis	34	42%	44%	14	17%	13%
Alcohol (adjunctive)	33	26%	32%	24	19%	17%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

3.4.7. *Completion of treatment*

The percentage of successful completions of drug treatment varies depending on drug of dependence. Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do within two years of entry. The proportion of clients whose latest treatment journey ended during 2017-18 and whose reason for discharge was 'treatment completed', as a proportion of all clients in treatment during 2017-18 was 13.7%, lower than the national proportion of 14.8%. The non-opiate user group had the highest proportion of clients who completed treatment locally and nationally at 40.3% and 39.4% respectively as shown in Table 13. This equated to 44.7% of non-opiate male clients, although only 29.4% of female non-opiate clients.

A large proportion of the opiate users in treatment have entrenched long-term drug use, are often in ill health and less likely to have access to the personal and social resources that can aid recovery, such as employment and stable housing. This often results in opiate users being less likely to complete treatment successfully or sustain their recovery, when compared to people who use other drugs, or only alcohol.[23] Due to these factors, opiate treatment clients had the lowest successful completions, locally and nationally (6.8% and 6.6%).

More recent local data from Turning Point shows for Q2 and Q3 2018, the percentage of successful completion of opiate treatment was 8.2% for both quarters respectively. The percentage of successful completion of non-opiate treatment was 43.0% and 41.4% in the same time periods. This is encouraging for both indicators as it infers the successful completion percentages for 2018 are likely to be much higher than the published figures for 2017.

Table 13: Successful completions as a proportion of total number in treatment, 2017/18[17]

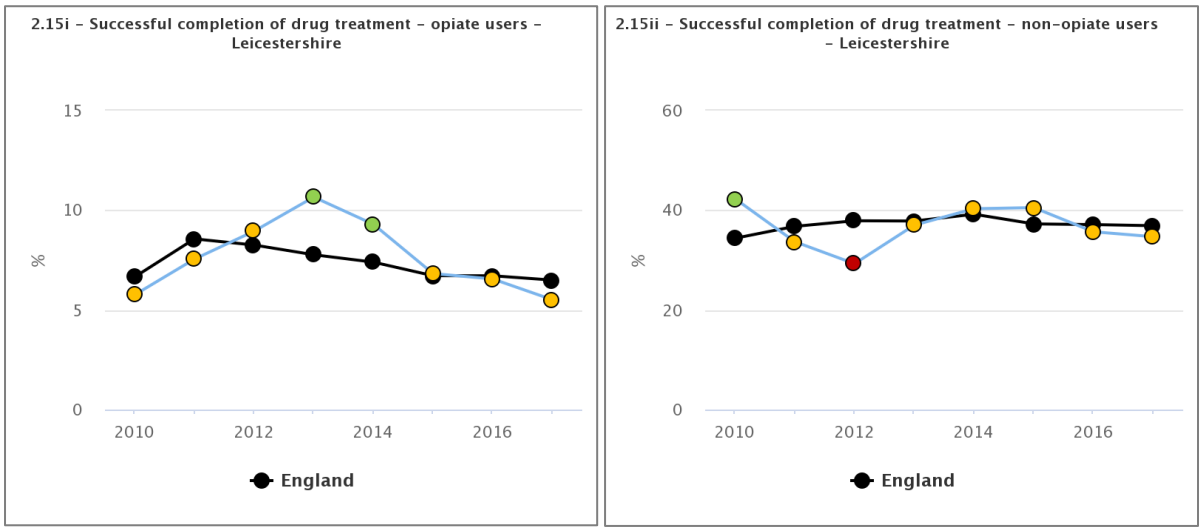
	Number of successful completions	Numbers in treatment	Percentage of successful completions			
	Leicestershire		Leicestershire			National
	Persons		Persons	Males	Females	Persons
Opiate	77	1,129	6.8%	6.9%	6.6%	6.6%
Non-opiate	48	119	40.3%	44.7%	29.4%	39.4%
Non-opiate and alcohol	71	186	38.2%	35.3%	50.0%	35.5%
All	196	1,434	13.7%	13.9%	13.1%	14.8%

Source: NDTMS, Drugs commissioning support pack, key data 2019-20

Another definition of successful treatment is those who leave treatment free of drug(s) dependence and do not re-present to treatment within six months. Since 2013, this proportion has been declining, contributing to a significantly worsening trend over the past five years, resulting in Leicestershire changing from being significantly better than England to similar to England. In 2017, in Leicestershire and Rutland, 5.5% of opiate users successfully completed drug treatment, similar to the national average of 6.5%. For Leicestershire, this equates to 5.5% of all males in treatment, and 5.6% of all females in treatment.[2]

When considering the successful completion of drug treatment, (who do not represent) of non-opiate users, the trend over the past eight years has remained stable, with Leicestershire and Rutland's proportions for the past five years being similar to the national average. In 2017, 34.7% of non-opiate users in treatment completed treatment successfully.[2] This equates to 102 people; 35.7% of all males in treatment and 30.8% of all females in treatment.[17]

Figure 10: Trend in successful completion of drug treatment of opiate users and non-opiate users, Leicestershire[2]



3.5. Drug related illnesses

3.5.1. *Hepatitis B & Hepatitis C/ Liver Disease*

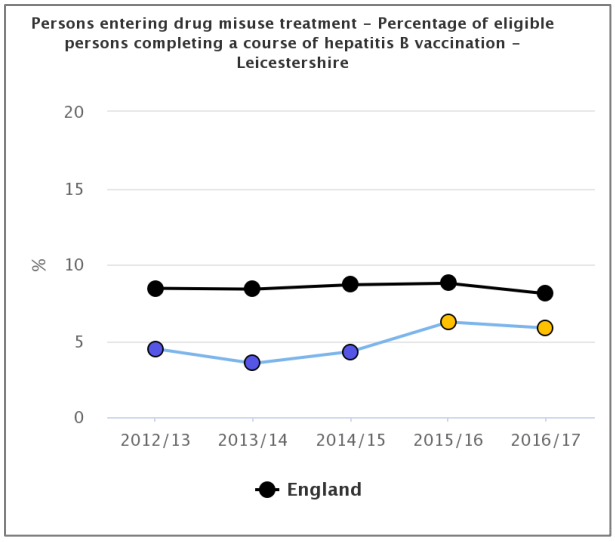
Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by the prevalence of hepatitis B and hepatitis C infections, which are both amenable to public health interventions. Persons who inject drugs are at higher risk of contracting hepatitis B and C infections.

The majority of clients entering treatment have never injected, although there is variation amongst substance groups with the proportion of opiate clients injecting being significantly higher than other substance groups. The majority of non-opiate clients who inject are likely to be individuals using methamphetamine and mephedrone. Sharing of injecting equipment is the single biggest factor in blood-borne virus transmission among individuals who use and inject drugs. It also elevates mortality risk and those who inject have a more complex profile, and are therefore harder to treat.[18]

The 'Shooting up: Infections among people who inject drugs in the UK' report by Public Health England noted that 2 in every 5 people who inject drugs are living with hepatitis C. Approximately half of those with the infection, who inject drugs, remain undiagnosed. Published data from Public Health England shows that in 2016/17 in Leicestershire, 5.8% of persons entering drug misuse treatment who were eligible for hepatitis B vaccinations, were offered and completed the course. This is similar to the national average of 8.1%. The trend has remained stable for the past five years as visible in Figure 11, with numbers increasing from 19 in 2012/13 to 22 in 2016/17.[30]

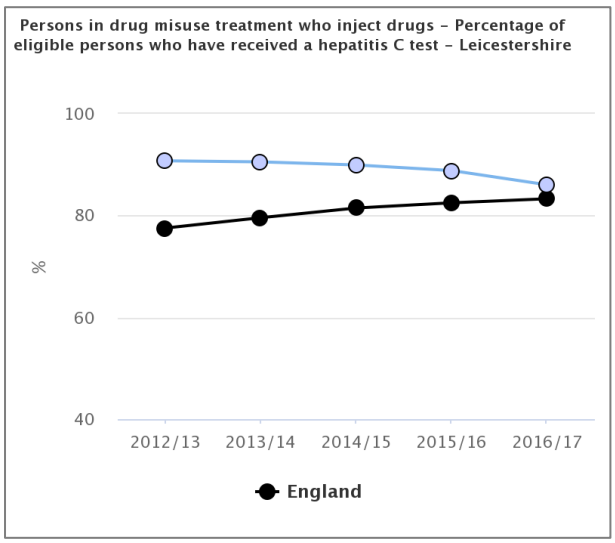
Local data from NDTMS reporting further provides a more up to date picture. This shows that in Leicestershire in 2017-18, 35% (142 individuals) of those adults new to treatment who were eligible for a HBV (Hep B) vaccination accepted one at any episode during their latest treatment journey. Of those accepting the vaccination, 13% (19 individuals) started a course of vaccination and 8% (11 individuals) completed a course of vaccination. All new presentations are eligible unless the client had acquired immunity or had been immunised already, or the clinician had assessed that it was not appropriate to offer them the vaccinations.

Figure 11: Persons entering drug misuse treatment – percentage of eligible persons completing a course of hepatitis B vaccinations[30]



The 'Shooting up: Infections among people who inject drugs in the UK' report by Public Health England noted hepatitis C remains the most common blood borne infection among people who inject drugs in the UK. One quarter of this population is currently infected with hepatitis C and approximately one half of those infected are unaware of their HCV infection.[31] Of those in drug misuse treatment who were eligible for receiving a hepatitis C test i.e. those who currently or have previously injected drugs, published PHE data shows 86.0% received the hepatitis C test in Leicestershire in 2016/17. While this is significantly higher than the England average of 83.3%, the trend has been significantly declining over the past five years as shown in Figure 12. The 2016/17 uptake is significantly lower in Leicestershire than when data was first reported in 2012/13 when uptake was 90.8%.[30]

Figure 12: Persons in drug misuse treatment who inject drugs: Percentage of eligible persons who have received a hepatitis C test, Leicestershire[30]



Local data from NDTMS reporting shows that in 2017-18, 121 clients who were a current or previous injector at triage, received a HCV test (for Hepatitis C). This equates to 16% of those eligible receiving the test, compared to 20% nationally. All previous or current injectors are eligible unless the clinician has assessed that it was not appropriate to offer them a test.

3.5.2. *Drug poisoning*

In 2016, 80% of drug misuse deaths in England and Wales were due to accidental poisoning.[32] As well as being a key issue to be addressed in themselves, poisoning admissions can be an indicator of future deaths. People who experience non-fatal overdoses are more likely to suffer a future fatal overdose. In 2017-18 in Leicestershire there were 34.3 hospital admissions for drug poisoning (with a primary or secondary diagnosis) per 100,000 population. This is significantly lower than the national rate of 54.2 per 100,000

population. It should be noted that this indicator includes poisonings by 'other opioids, which may include poisonings by non-illicit or prescribed opioids.[17]

3.5.3. *Deaths*

3.5.3.1. Deaths in treatment

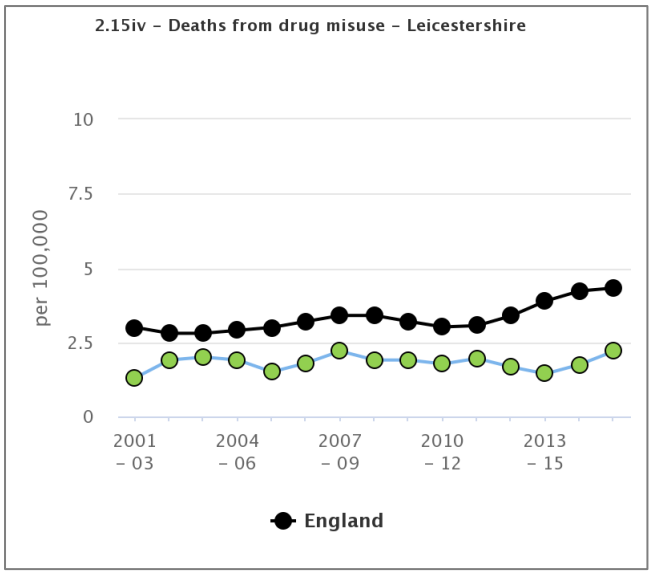
Deaths can occur while people are in contact with treatment services. This is measured by a standardised mortality ratio which considers the number of deaths occurred against the number of expected deaths. The ratio is indicative of the safety, effectiveness and protection offered by drug treatment services. The standardised mortality ratio for those in drug treatment in Leicestershire in 2014/15-16/17 was 0.54, meaning there was a significantly lower number of deaths in treatment than expected (around half the expected amount). This equalled 18 deaths during this time.[26] This supports PHE guidance which highlights that it is important to get drug users into treatment. The majority of drug misuse deaths occur among people who are not in treatment. Evidence shows that being in treatment is protective against the risk of mortality.[32]

3.5.3.2. Deaths from drug misuse

Drug misuse is a significant cause of premature mortality in the UK. Analysis of the Global Burden of Disease Survey 2013 shows that drug use disorders are now the third ranked cause of death in the 15–49 age group in England. Nearly one in nine deaths registered among people in their 20s and 30s in England and Wales in 2014 were related to drug misuse. Deaths from drug misuse substantially increased in England in 2013 and 2014, with a 42% total increase in these two years

The Office for National Statistics reported in 2015-17, the rate of deaths from drug misuse in Leicestershire is 2.2 per 100,000 population, significantly better than the national rate of 4.3 per 100,000 population. Leicestershire performs best out of all its nearest CIPFA neighbours. The rate has remained significantly better than the national average since data was first reported in 2001-03. The rate has gradually increased over the past three time periods, in line with national trends.[2] Please note these figures are based on deaths of all individuals, regardless of whether or not they were in treatment. Nationally, PHE estimates that there will be an increase in the proportion of people in treatment for opiate dependence who die from long term health conditions and overdose.[24]

Figure 13: Trend of deaths from drug misuse in Leicestershire[2]



When partitioning data by sex, Leicestershire males continue to perform significantly better (lower) than the England average, with 3.5 per 100,000 deaths from drug misuse. However, they perform significantly worse than the local average of 2.2 per 100,000 population (when males and females are combined). Due to low counts, it is not possible to reliably calculate a directly standardised mortality rate for females; although data shows from 2015-17 there were 9 female deaths from drug misuse, compared to 33 male deaths from drug misuse.

It is noted that these figures are based on registered deaths i.e. those certified by a coroner following an inquest. Therefore, all caveats regarding time delays in recording due to the length of time it may take to hold an inquest should be noted. It is also recognised that registration delays may vary considerably across England, which may affect comparisons to other areas. Drug related deaths include both accidental and intentional poisoning by drugs or medicaments. Figures are for registration of deaths which may not equate with year of death given the time delay in time of death and inquest proceedings.

3.6. Data Summary

The data in the above intelligence sections highlights that several groups are identified in the literature as being at increased risk of misusing substances. This includes, although is not limited to, those living in the most deprived deciles compared to those in living in the least deprived deciles, young adults compared to their older counterparts, males compared to females, LGBT+ groups compared to their heterosexual counterparts, those who have had childhood experiences of and exposure to substance misuse, and the homeless.

National and local coverage of problematic drug use is available through the NDTMS data

which represents adults who are aged 18 and over who are receiving help for their substance misuse through accessing a service for drugs and/or alcohol. Data is split into four main substance groups: opiate users, non-opiate users, non-opiate and alcohol users and alcohol only users. Treatment pathway measures show the most common route of referral to treatment is self-referral locally and nationally, with and local self-referrals have increasing gradually across all three drug type users since 2015/16.

Excluding the alcohol only substance group, 79% of those in treatment in 2017/18 in Leicestershire were there for opiate use and 21% in treatment for non-opiate use. Nationally, there is a lower proportion in treatment for opiate use when compared to Leicestershire (66%) and a higher proportion in treatment for either form of non-opiate use compared to Leicestershire (34%). While opiate users continue to make up the majority of those in treatment, this percentage has decreased compared to previous years. The number of new presentations to treatment for opiate use in 2017-18 had decreased by 12% when compared to the previous year. For non-opiate use there was no change in new presentations to treatment when compared to 2016-17, although there was a 17% increase in the number in treatment. This could suggest that a higher proportion of those entering treatment prior to 2017-18 have stayed in treatment.

The age distribution of all clients in treatment in Leicestershire generally follows national patterns. Both locally and nationally, the highest proportion of those in treatment were aged 30-39, compared to any other age group. The lowest proportion of those in treatment were those in age bands 60 and above. Both nationally and locally, non-opiate clients presenting without problematic alcohol use have the youngest age distribution, while opiate clients have the oldest age distribution. Nationally, the number of under-25s accessing treatment has fallen by 50% since 2005-2006. This reflects changes in the patterns of drinking and drug use in this age group over the last 12 years. A similar pattern has been witnessed in Leicestershire, with the number of under-25s presenting to treatment has fallen from 200 in 2009-10 to 103 in 2017-18; a 48.5% decrease. Please note these figures also include those who are in treatment for alcohol misuse.

Data shows that drugs misuse is often concurrent with alcohol misuse, tobacco use, and mental health and wellbeing problems. In 2017/18 in Leicestershire, there were 196 individuals in treatment for non-opiate and alcohol use, accounting for 9% of all those in treatment. While this is a small proportion of the total, this group saw the largest increase for numbers in treatment compared to the previous year (37%) and the largest increase of new presentations compared to the previous year (48%) accounting for 50 and 41 individuals respectively. The proportions using tobacco when starting treatment in Leicestershire are all either lower than, or similar to the national average for different drug

groups. However, a higher proportion of adults in Leicestershire who entered treatment said they had a mental health treatment need, for reasons other than substance misuse, compared to the national average. The majority of these were opiate using clients locally (52%), although nationally this group had the lowest mental health need when compared to other groups (39%). Although a lower number of females entered treatment compared to males, a higher proportion of them were identified as having a mental health need, with 64% identified as having a mental health need, compared to 51% nationally. For males, figures were 48% and 38% respectively.

In 2016, 80% of drug misuse deaths in England and Wales were due to accidental poisoning. In 2017/18 in Leicestershire the rate of hospital admissions for drug poisoning was significantly lower than England (34.3 per 100,000 population and 54.2 per 100,000 population respectively). As well as being a key issue to be addressed in themselves, poisoning admissions can be an indicator of future deaths. For those in drug treatment in Leicestershire, the standardised mortality ratio for 2014/15-16/17 was 0.54, meaning there was a significantly lower number of deaths in treatment than expected (around half the expected amount). This equalled 18 deaths during this time. Published figures examining deaths from drug misuse, for people either accessing or not accessing treatment, show that the rate of deaths from drug misuse in Leicestershire is significantly lower than the national rate, and has been so since data was first reported in 2001-03. Further, Leicestershire's value is lowest when compared to other areas with similar demographics (CIPFA neighbours).

4. How does this impact?

Drug misuse and dependency can lead to a range of harms for the user including:

- poor physical and mental health and ultimately death
- unemployment
- homelessness
- family breakdown
- criminal activity

But drug misuse also impacts on all those around the user and the wider society. The Home Office estimated in 2010 to 2011 that the cost of illicit drug use in the UK was £10.7 billion per year.[32]

4.1. Employment and Economy

Drug misuse and dependency can make it difficult for people to find and sustain employment. The NDTMS data shows that in 2017-18, only 27% of those newly presenting to service were in regular employment. A further 27% were either unemployed or economically inactive, and 41% were long term sick or disabled. These figures are based off self-reported employment status.

4.2. Crime

Victims of partner abuse in year ending March 2015 reported that they believed the offender was under the influence of illicit drugs (10%). Around 3 times as many adults aged between 16 and 59 who had taken illicit drugs in the last year reported being a victim of partner abuse compared with those who hadn't taken drugs in the last year (11% compared with 4%).[33] However caution should be taken when making inferences about the relationship between illicit drug-taking and partner abuse victimisation. The victims' illicit drug use may affect or be affected by their experience of partner abuse.

In 2016/17 in Leicestershire, the rate of domestic abuse-related incidents and crimes was 18.7 per 1000 population, compared to 20.3 in the East Midlands region, and 22.5 in England overall.[2]

4.3. Childhood/Parenting

Parental drug dependence can have a significant impact on families, particularly children, and can limit the parent's ability to care for their child and/or children. Parents are role models for their children, and parental dependence increases the likelihood of children misusing drugs and alcohol themselves. It can also mean that children take on inappropriate caring roles for their parents. For some families, substance misuse is one of a number of other complex problems which can have a compound effect[34]

Growing up with substance misuse can also create an intergenerational cycle of violence, with these children being more likely to expose their own children to adversity and trauma.[35] In 2011/12, in Leicestershire 73 parents who lived with their children (aged 0-15 years) attended treatment for substance misuse. This is a rate of 62.3 per 100,000 population which is significantly lower than the national rate of 110.4 per 100,000 population. Please note, these figures are the number of parents in treatment, not the number of parents who are misusing drugs or alcohol. Local data from the National Drug Treatment Monitoring System (NDTMS) presents information on alcohol and drug treatment services, hospital admissions and drug/alcohol related deaths. The data shows in Leicestershire there were 91 drug users who entered treatment who lived with a total of

151 children in 2017-18. These drug users represented 18% of new presentations to treatment services in the year, an identical percentage to the national average.[22]

Children who experience four or more adversities, are twice as likely to binge drink, and eleven times more likely to go on to use crack cocaine or heroin. Misuse of substances can often escalate, with young people coming into contact with the police or youth justice system .

4.4. Return on Investment

Investing in treatment services to reduce drug misuse and dependency will not only help to save lives but will also substantially reduce the economic and social costs of drug-related harm.

Research has shown that every £1 invested in drug treatment results in a £2.50 benefit to society. For many drug users, engaging in treatment can be the catalyst for getting the medical help they need to address their physical and mental health problems.

The public values drug treatment because it makes their communities safer and reduces crime; 82% said that the greatest benefit of treatment was improved community safety.[32]

Decision-makers have been enabled to understand the potential return on investment from alcohol and drug interventions and the possible cost of under-investment. Tools like the Value for Money Commissioning Support Tool (https://www.ndtms.net/VFM) can help commissioners demonstrate the benefits derived from local investment and help local areas understand and improve the cost-effectiveness of local treatment systems.

5. Policy and Guidance

5.1. 2017 Drug Strategy (2017)

The overall aims of the 2017 Government Drug Strategy are to reduce all illicit and other harmful drug use, and to increase the rate of individuals recovering from their dependence. The strategy has four key themes;

Reducing Demand – focus on expert guidance to develop a universal approach across the life-course, including midwifery, school nurses, health visitors, to build confidence and resilience; and an emphasis on targeted prevention approach for high priority groups – including offenders, homeless, sex workers, veterans, vulnerable young people, and older cohort. It further outlines a targeted approach for evolving and emerging threats, including New Psychoactive Substances (NPS), Chemsex, Image & Performance Enhancing Drugs, and the misuse and dependence on prescribed medicines.

Reducing Supply – focus on tackling production and distribution via overseas transit routes, and drugs at the border; tackling domestic cannabis production, and tackling supply gangs who work across county lines, and managing information and intelligence. In addition drug related offending remains a priority, with an emphasis on better integration with community based mental health and treatment services, including test/arrest/custody/liaison.

Building Recovery – builds on the recognition that progress has been made in supporting people to recover from their dependency and confirmed the continuation of the ring-fenced Public Health Grant. It describes the need for a balanced evidence-based recovery system tailored to specific cohorts, and promotes peer-led recovery support. There is also a focus on the importance of employment and meaningful activity, and stable and appropriate housing as crucial to long term recovery. Local treatment systems should also support interventions and integrated pathways to prevent and treat physical and mental health problems.

Global Action – outlines how the UK will strengthen international cooperation, and shape international policy and practice.

5.2. Drug Misuse and Dependence – UK guidelines on Clinical Management (2017)

Often referred to as the 'Orange Book' this version updates and replaces the 2007 edition. The 2017 Drug Misuse and Dependence guidelines provide guidance on the treatment of drug misuse and dependence in the UK. They are intended primarily for clinicians providing drug treatment for people who misuse or are dependent on drugs, and are based on current evidence and professional consensus.

The guidance includes chapters on, essential elements of treatment provision, psychosocial components of treatment, pharmacological interventions, criminal justice system, health considerations, and, specific treatment situations and populations.

5.3. NICE Guidance

NICE (National Institute for Health and Care Excellence) has published a number of clinical guidelines, guidance and quality standard documents relating specifically to substance misuse including;

- CG 51 (2007) Drug Misuse in over 16's: psychosocial Interventions
- CG 52 (2007) Drug Misuse in over 16's: opioid detoxification
- QS 23 (2012) Drug use Disorders in Adults

- PH 52 (2014) Needle and Syringe Programmes
- NG 64 (2017) Drug Misuse Prevention: targeted interventions
- QS 165 (2018) Drug Misuse Prevention

6. Current Services

In 2016, following consultation, a new model of delivery of substance misuse treatment services were commissioned across Leicestershire and Leicester city bringing together previously separate cohorts (young people, adults and criminal justice) into an integrated substance misuse treatment service.

People with substance misuse problems (not including alcohol) are in most cases provided support and treatment from specialist substance misuse services, currently provided by Turning Point across Leicestershire. However people who use drugs may contact or be referred to other non-specialist services including their GP.

6.1. First Contact Plus

The service is provided by Leicestershire County Council Public Health Department and offers access to a range of low level preventative services through a single point of contact. This is an online service ensuring that people can access information, advice and support across a range of issues. This includes a range of health and wellbeing topics including alcohol, drugs and mental health, and advice and support on topics that have the potential to impact on mental wellbeing, such as debt and welfare benefits, housing support, and families and relationships. The service provides early identification of needs and brief opportunistic interventions, support for self-help, or referral to a service provider. As well as providing advice pages, and signposting to useful resources, there is an option to self-refer for further contact.

Whilst the service does not receive a high number of contacts/referrals relating to drug misuse the service does signpost and/or refer to specialist treatment services (Turning Point) where appropriate, and to peer support services such as Dear Albert, Narcotics Anonymous (NA) and SMART Recovery.

6.2. Local Area Co-ordination

This is a community based intervention delivered in specific areas by Local Area Co-ordinators (LAC's) and is delivered by Leicestershire County Council Public Health department. Local Area Co-ordination is focused on helping isolated, excluded and vulnerable people. Local Area Co-ordinators build the resources, networks and resilience of

those who need help before they hit crisis, with the aim of diverting people from formal services and supporting people to have a good life as part of their community. Local Area Co-ordinators work with a whole community including those who have a low level of substance misuse and will work collaboratively with specialist substance misuse treatment services (Turning Point) to secure positive engagement with an individual. The team regularly work and refer into specialist substance misuse treatment services and support that introduction and engagement.

6.3. QuitReady Leicestershire (smoking cessation)

The service is provided by the County Council Public Health department and offers free stop smoking support and advice to anyone wanting to give up smoking. Support is usually provided via telephone and online behavioural support and pharmacotherapy including nicotine replacement therapy and e-cigarettes. Whilst the service does not receive many calls/referrals from people with other substance related problems where this has been the case, for example with cannabis users, clients have been signposted or referred to either First Contact Plus or specialist substance misuse treatment services (Turning Point).

6.4. Public Health Programme Delivery Team

Leicestershire County Council Public Health Programme Delivery Team focus on health improvement and promoting better health and wellbeing, including substance misuse and alcohol. The Health Improvement Practitioners use a range of health promotional resources, communications and campaigns to deliver initiatives in a variety of settings including workplaces, communities, pharmacies, schools, nurseries and the media.

6.5. Pain Management Service – Leicester General Hospital

The Pain Management Service, managed by University Hospitals Leicester NHS Trust, consists of a team of consultants, specialist nurses, psychologists, and physiotherapists providing assessment and treatment for acute and chronic pain sufferers.

In addition to the Pain Management Service there is a specialist clinic for iatrogenic opioid addiction (one of the only such specialist clinics in the country). The iatrogenic opioid addiction clinic is held fortnightly at the Leicester General Hospital. There are currently approximately 300 patients in the service and long waiting lists of 6-8 months. Patients are referred via general practice and have often been addicted to non-illicit opiates for a number of years. Due to the complexity of the individual patients the clinic has only 4 appointments at each session. The team consists of medical consultants, specialist nurse, and a consultant psychiatrist.

6.6. Integrated Substance Misuse Treatment Service – Turning Point

The Integrated Substance Misuse Treatment Service is provided by Turning Point and commissioned jointly by Leicestershire County Council Public Health Department and Leicester City Council with additional funding contribution from the Office of the Police and Crime Commissioner.

Turning Point provides a community based drug and alcohol misuse treatment service for adults and young people with the purpose of achieving freedom from dependence on drugs and/or alcohol, reducing the harm arising from dependence, and sustaining recovery.

The service is provided from 4 main hubs: Leicester City hub (Eldon Street), Coalville hub, Loughborough hub and Young People's hub (based in Leicester City). The service also operates from approximately 30 outreach venues across Leicestershire and Leicester City including GP surgeries, health centres, council offices and community venues. Turning Point operates a single point of access through a single telephone number, email address and website to facilitate ease of access. A single engagement team operates across the city and county triaging all referrals within 48 hours and ensuring all referrals are seen within 21 days, with priority appointments available within a matter of days for those with the highest risks. In addition to referrals through phone and email, self-referrals can be taken at any of the hubs mentioned above.

6.6.1. *Community prescribing and Psychosocial interventions*

Turning Point provides a holistic medical screening and specialist prescribing service as part of a wider treatment programme that addresses the co-existing physical, psychological, and social problems. This is delivered by a clinical team including specialist addictions psychiatrist, psychologists, substance misuse GPwSI's (GP's with Special Interest), and nurses. There are 5 treatment pathways – opiate and complex drugs pathway, non-opiate drugs pathway, risk vulnerability and complex safeguarding pathway, and 2 alcohol pathways (See Alcohol JSNA chapter). The clinical team are supported by skilled Recovery Workers and Support Workers who provide a range of evidence-based psychosocial therapeutic interventions.

6.6.2. *Liaison with primary and secondary healthcare*

Turning Point provides a shared care scheme with 10 GP surgeries across the city and county to enhance access in rural communities. Within these surgeries the GP undertakes prescribing for substance misuse alongside addressing mainstream health issues. Turning Point provides recovery workers who work collaboratively from the GP surgery. In addition, a dedicated GP with a Special Interest (GPwSI) from Turning Point provides supervision and

governance to ensure the quality of clinical interventions delivered. Whilst Turning Point are not responsible for providing a drug and alcohol service within local hospitals, Turning Point does provide hospital liaison recovery workers based within UHL, and available to work from other hospital sites. They see all drug and alcohol related hospital admissions to assess and provide appropriate support (brief interventions to reduce the risk of alcohol and drug related harm, or referral into community treatment). The hospital liaison recovery workers also train staff from across hospital and urgent care settings to provide brief interventions to patients on reducing the risk of alcohol and drug related harm.

In recognition of the link between mental health and substance misuse, Turning Point has a specialist dual diagnosis senior recovery worker who undertakes weekly outreach clinics at the Bradgate Mental Health unit on the Glenfield Hospital site to support service users with substance misuse issues. In addition, Turning Point has developed referral pathways with a range of mental health partners including Community Mental Health Teams and Improving Access to Psychological Therapies (IAPT) services.

6.6.3. *Harm reduction*

Turning Point provides a needle and syringe exchange programme at each hub and from 37 pharmacies across city and county to ensure the availability of clean injecting equipment to limit the spread of infection. In addition, all service users engaged in treatment for opiate misuse are offered Naloxone and are trained to administer it. Naloxone can be used to reverse the effects of an opiate overdose. Naloxone is also provided to family and carers and is also available through the needle and syringe exchange programme.

Turning Point works closely with over 130 pharmacies across the county and city to provide a supervised consumption of medication scheme. The purpose of supervised consumption is to reduce the risk of overdose or diversion of substitute medication prescribed for illicit opiate use. Service users can be supervised by a healthcare professional within the pharmacy when taking their medication.

6.6.4. *Criminal Justice services*

Turning Point provides an arrest referral service within local custody suites whereby individuals who test positive for drugs and/or alcohol are seen by a criminal justice engagement recovery worker who provides brief advice on reducing the risk of alcohol and drug related harm and supports engagement into treatment for those who require it. In addition, Turning Point employs workers (criminal justice recovery workers) who work specifically with criminal justice clients with enforceable treatment requirements in providing treatment and recovery support. The workers have lower caseloads to enable

more intensive working with this cohort. This team co-delivers with probation services (within probation offices) wherever possible to enable regular 3-way working.

Turning Point also has a team based within HMP Leicester (funded by NHS England) comprising of nurses, doctors, healthcare assistants, a pharmacist and recovery workers. The team delivers all the clinical and psychosocial interventions to any prisoner at HMP Leicester including first night prescribing, dispensing of drug and alcohol related medications and delivery of group and 1-2-1 interventions to address substance misuse. Having Turning Point deliver both the prison based service and the community based service enables effective transfers and continuity of care for clients.

6.6.5. *Vulnerable groups*

Turning Point has a dedicated Young People and Young Adults Service which works with individuals under 18 and up to the age of 25 where a young adults approach would be beneficial. The team delivers via outreach to whichever location suits the young person across the county.

Turning Point has a subcontract with Age UK to deliver the 'last orders project'. This comprises of a dedicated worker who delivers awareness sessions and brief interventions to those aged over 50 across the county to raise awareness of the problems associated with alcohol and drug misuse. The worker also refers appropriate individuals into treatment.

In response to a growing trend in the use of image and performance enhancing drugs, Turning Point has setup a clinic (the Smart Muscle clinic) to meet the needs of this cohort. There is also a growing trend in addiction to prescription drugs e.g. strong painkillers. Although the service delivered by Turning Point is primarily focused on illicit drug use, the service does provide input into the pain management clinic delivered by UHL.

Turning Point also has a Communities Development Recovery Worker to provide enhanced outreach to BME communities.

6.6.6. *Recovery*

Turning Point works closely with a range of employability providers, and housing authorities to support service users maximise their opportunity for sustained recovery. Turning Point has a team of approximately 25 peer mentors who are linked to all teams across the service and deliver a range of interventions including running drop-ins, co-facilitating groups and supporting with practical matters such as benefits and food parcels. In addition Turning Point sub-contracts to local social enterprise 'Dear Albert' which delivers aftercare services across the city and county for individuals who have completed treatment and require

ongoing support to maintain recovery.

6.7. Inpatient Drug and Alcohol Detoxification Service – Framework Housing Association

For a relatively small proportion of people with drug problems who are in treatment, their recovery requires a short hospital stay in a specialist inpatient service either to stabilise chaotic and complex drug and alcohol problems or to complete the final stages of detoxification.

Inpatient drug and alcohol services are commissioned by Leicestershire County Council Public Health Department and are currently provided by Framework Housing Trust at a purpose built unit, known as Edwin House, in Nottingham. The authority commissions a number of bed days annually, sufficient for the needs of county residents.

The inpatient service is for both men and women and accessed via referral from the integrated substance misuse treatment service (Turning Point). Edwin House provides specialist assessment, stabilisation, and medically assisted withdrawal from drugs (and/or alcohol) for adults. The service is provided by a multidisciplinary team including addictions consultants/doctors, nursing staff, occupational therapist, and support staff, and provides care and support 24hrs a day, 7 days a week. In addition to medical/clinical treatment all service users have a recovery plan that includes harm reduction and relapse prevention, alongside structured group work, access to mutual aid and leisure and social activities.

The service works closely with the integrated substance misuse treatment service (Turning Point), and Dear Albert to ensure service users have the appropriate support both prior to inpatient treatment and on leaving inpatient treatment.

6.8. Dear Albert - The Stairway Project

Dear Albert is a local social enterprise providing peer led recovery focused community rehabilitation. The service is delivered by peers who are in recovery who have a variety of experience and skills and qualified professional counsellors and therapists. Dear Albert is open to anyone who wants help with their drug (and/or alcohol) use, and does not require referral from a GP or other professional. The service provides a range of groups and activities within a city centre base (The Stairway Project) available to county and city residents. In addition to the drop-in Dear Albert provides a menu of recovery focused activities and holistic treatments, both in groups and one-to-one's. In particular the service delivers evidence –based, abstinence focused, peer-led recovery programmes 'You do the MAFs (Mutual Aid Facilitation), and ACT Peer recovery (Acceptance and Commitment Training).

Dear Albert is sub-contracted by Turning Point to provide aftercare support to people who have completed treatment to maintain recovery, and also delivers individual and group sessions at the inpatient service (Edwin House) for county and city residents. In addition the You do the MAFs and ACT training sessions are sometimes delivered across the county funded by grants.

6.9. Mutual Aid

In addition to commissioned substance misuse treatment services there is a network of local mutual aid support available across the county and city. Mutual aid refers to the social, emotional and informational support provided by, and to, members of a group at every stage of their recovery. These include Narcotics Anonymous (NA), SMART Recovery, ACT Peer-led Recovery, and Alcoholics Anonymous (AA). Some are based on a 12-step fellowship approach and some on cognitive behavioural techniques. The groups are available in a number of venues across the county (although times and venues may change), including Loughborough, Market Harborough, Wigston, Coalville, Melton, Hinckley, Syston, and Oadby.

6.10. Residential Rehabilitation

Following community treatment and inpatient detoxification a small number of people may need to have longer term support to maintain a drug free lifestyle. There are many substance misuse residential rehabilitation facilities across the country, all providing longer term (3-9 months usually) support and care. Whilst the Leicestershire County Council does not directly commission any particular residential rehabilitation facilities it does provide a list of facilities that have been assessed to ensure they provide clinically safe and effective services to a high standard of care. Referral to a substance misuse residential rehabilitation centre would usually come from the integrated substance misuse treatment service (Turning Point) and be a part of an overall recovery care plan.

Whilst living at a substance misuse residential rehabilitation centre residents will take part in an intensive therapeutic programme, alongside life skills, community activities and usually the day-to-day running of the house/centre.

6.11. Mental Health Wellbeing & Recovery Service

The mental health wellbeing and recovery service is commissioned jointly between, Leicestershire County Council, Leicester City Council, Rutland County Council, and the three CCGs. The service is currently provided by 3 different providers, providing coverage across all districts in the county (and Leicester City and Rutland); Richmond Fellowship (operating as Life Links), Mental Health Matters, and Voluntary Action South Leicestershire (VASL).

Whilst not a service aimed at providing support specifically for people who use illicit drugs, it is not uncommon for people accessing the service to have issues with drugs and/or alcohol in addition to mental health/wellness concerns. The service offers support networks focused on wellness and recovery, encouraging independence and developing own personal support networks. It offers flexibility to choose support based on own personal need. This can be face to face, providing information, advice and navigation services, one to one sessions, and group support sessions; online support including a directory of services, and a 24/7 chat feature allowing questions to be asked/answered; and community recovery support.

6.12. PAVE Team (Pro-Active Vulnerability Engagement)

The service is funded by the Office of the Police and Crime Commissioner for Leicestershire. It is a partnership between police, mental health practitioners, and substance misuse practitioners providing targeted support for people who intensively use health and police services. A majority of the service users have entrenched drug and/or alcohol problems. Dedicated recovery workers from Turning Point work alongside police and mental health services to support individuals who are placing a high demand on resources, have complex needs, are difficult to engage, and who pose a risk to themselves or others. In addition clinical support is available as required from a Consultant Psychiatrist. The team work intensively with each individual with the aim of improving their health and wellbeing, reducing crime and reducing the demand placed on public services.

6.13. Mental Health Recovery and Rehabilitation Service – Bridge Street

Commissioned by the local authority Adults and Communities department the service provides supported accommodation with on-site 24 hour support for people with diagnosed serious mental health conditions. Whilst not providing services specifically for people with drug and/or alcohol problems it is not uncommon for residents to also have drug and/or alcohol problems in addition to serious mental health conditions. The service is provided from 11 self-contained apartments in the Shepshed area of Leicestershire. This service enables adults with diagnosed serious mental health conditions recover and develop or regain skills to maximise their independence, reduce their support needs and live in their own homes and consequently also avoids unnecessary moves to residential care. People are resident for a maximum of two years.

6.14. District and Borough Councils

Whilst the individual district councils do not directly commission or provide treatment and support services for substance misuse, many do include tackling alcohol and/or drug misuse within their individual district plans, whether that be Community Safety Plans, Health and

Wellbeing plans or Prevention plans/strategies.

Examples of the interventions and services provided by district and borough councils include;

- Providing meeting rooms for mutual aid and Dear Albert meetings
- Providing funding for specific local initiatives including educational theatre company developing productions covering issues such as homelessness, drug and alcohol issues, relationship breakdown, and funding for local charitable organisations to deliver drug and alcohol outreach support.

7. Unmet needs/Gaps

7.1. Those with substance misuse issues who are not in treatment

Locally, 51% of opiate users and 68% of crack users are not in treatment. This indicates a gap in identifying individuals with substance misuse issues and a gap in referring these individuals into treatment services. For many drug users, engaging in treatment can be the catalyst for getting the help they need to address other issues such as their physical and mental health, housing and financial issues which can have a significant impact on the individual and wider society.

7.2. Addiction to prescription and over the counter medicines

The work of substance misuse treatment services has historically focused on addiction to illicit drugs but over recent years, trends have begun to emerge in relation to addiction to drugs that do not fall under the 'illicit' category, such as prescription drugs. Although data on this area is limited, locally, clinicians from the Pain Management Service estimate there are in the region of 10,000 long-term opioid users across Leicester, Leicestershire and Rutland. This cohort is at risk of developing an opioid addiction. Also, in 2017/18, there were 112 individuals who cited addiction to a prescription only medicine or an over the counter medicine in Leicestershire. Although this only accounts for 8% of those in treatment, which is lower than the national average of 14%, the true demand could be higher.

7.3. Use of anabolic steroids

There is little data available on the use of anabolic steroids in the population and where data is available, it indicates a year on year increase in misuse since 2007/08. Locally 92 steroid users accessed needle exchange services at Turning Point within a 3 month period which indicates a need to support this cohort.

7.4. Use of Chemsex drugs

Chemsex is a term for the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience. It is a practice used predominantly by men who have sex with men. This practice can have an adverse impact on the health and wellbeing of MSM. As this is an emerging issue, very little information is known on the prevalence of Chemsex amongst the population.

7.5. Review of drug related deaths

Drug misuse is a significant cause of premature mortality. Locally, during the period 2015-17 there were almost 4 times more deaths from drug misuse in males compared to females. The substance misuse treatment service undergoes a review of each death that occurs within the cohort accessing treatment services but this approach is not replicated for substance misuse related deaths in those who have not accessed treatment services.

7.6. Smoking cessation support within treatment services

Smoking prevalence among Leicestershire residents accessing substance misuse treatment services is higher than that of the general population (60% and 12% respectively). Both smoking and substance misuse have an impact on health and wellbeing therefore there is a need to support these issues concurrently.

7.7. Dual diagnosis (substance misuse and mental health difficulties)

There are pathways and protocols in place between substance misuse services and inpatient psychiatric services. However separate systems, processes and thresholds across services result in potential gaps in provision. One such gap is support for individuals who have difficulties maintaining engagement with treatment services. Also, whilst there are a high numbers of individuals in substance misuse treatment services who also have mental health problems (which puts a significant demand and expectation on the substance misuse treatment service), indicators relating to dual diagnosis individuals are largely unavailable from other services therefore the true demand is unknown. In 2017-18 in Leicestershire, 51% of adults who entered treatment said they had a mental health treatment need, for reasons other than substance misuse. This is higher than the national average of 41%.

7.8. Improving treatment completion

Although the proportion of individuals who left treatment in an unplanned way is lower in Leicestershire compared to the national average (12% and 18% respectively), this still accounts for 59 individuals over a 12 month period. Preventing early drop out enables more

individuals to recover, which in turn improves their health and wellbeing. In addition, a large proportion of opiate users in treatment have entrenched long-term drug use, are often in ill health and less likely to have access to the personal and social resources that can aid recovery, such as employment and stable housing. This often results in opiate users being less likely to complete treatment successfully or sustain their recovery when compared to people who use other substances. This highlights the importance of the wider determinants of health.

7.9. Reducing risk of blood borne viruses

National evidence indicates that 2 in every 5 people who inject drugs are living with Hepatitis C and that half of those with the infection, who inject drugs, remain undiagnosed. Locally 86% received a Hepatitis C test in Leicestershire in 2016/17. While this is significantly higher than the England average of 83%, the trend has been declining over the past five years.

7.10. Delivery of substance misuse treatment services within a hospital setting

Those individuals who are admitted to hospital as a result of a non-fatal overdose are more likely to suffer a future fatal overdose. In 2017-18 in Leicestershire there were 34.3 hospital admissions for drug poisoning per 100,000 population. Although this is significantly lower than the national rate of 54.2 per 100,000 population, there is an opportunity to engage individuals into treatment while they are an inpatient rather than waiting to refer into community treatment services upon discharge.

7.11. Health and wellbeing outcomes of those completing treatment

The treatment service collects a broad range of outcome information (e.g. housing need, employment, self-reported health etc.) from those in treatment to enable a comparison with the information collected on entry into the service. However, information on specific short-term and long-term health outcomes following treatment completion is not routinely collected. This information would be useful to review health outcomes and to ensure timely access to clinical support for those who require it.

8. Recommendations

i. Explore options to increase identification and referral of individuals with substance misuse issues into treatment services.

ii. Consider awareness raising and training on prescribing practices and regular review of prescribed medications within primary care services.

iii. Consider an approach to implementing recommendations from the PHE review for dependence on, and withdrawal from prescribed medicines following its planned publication later this year.

iv. Take action to better understand (locally) the demand placed on services by new and emerging addictions. These include addiction to prescribed or over the counter medications, anabolic steroid misuse and Chemsex.

v. Consider a partnership approach that focuses on targeted interventions for the most vulnerable individuals and on those individuals placing the most demand on services e.g. frequent A&E attendances.

vi. Take action to better understand (locally) and manage the demand placed on service by individuals with concurrent mental health and substance misuse issues.

vii. Consider the development of a partnership approach to the review of drug related deaths.

viii. Explore an approach to enable the delivery of substance misuse treatment services within a hospital setting.

ix. Consider targeted interventions to tackle potential causes of substance misuse e.g. homelessness, social isolation, unemployment, debt etc. and to address lifestyle factors including smoking and mental health.

x. Continue to support the local Hepatitis C Operational Delivery Network in driving improvements in the diagnosis and treatment of people with Hepatitis C across LLR ensuring all patients can access the treatment they need.

xi. Explore an approach to strengthen pathways and referrals from primary and secondary care services into substance misuse treatment services and vice versa.

xii. Explore an approach to monitoring short and long-term health outcomes of individuals completing treatment.

GLOSSARY OF TERMS

CCG	Clinical Commissioning Group
ELRCCG	East Leicestershire and Rutland Clinical Commissioning Group
GP	General Practitioner
HWB	Health and Wellbeing Board
IDACI	Income Deprivation Affecting Children
IDAOPI	Income Deprivation Affecting Older People
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
WLCCG	West Leicestershire Clinical Commissioning Group

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જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 6803 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 6803 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 6803 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

假如閣下需要幫助，用你的語言去明白這些資訊，請致電 0116 305 6803，我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 6803, a my Ci dopomożemy.

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