Safer Halton Partnership

Drug Strategy

Evidence Paper
2014 to 2018

Draft

Contents

Glossary

Abstinent	Not using substances of abuse at any time.
Addiction	Physical dependence on a substance of abuse. Inability to cease use of a substance without experiencing withdrawal symptoms. Sometimes used interchangeably with the term substance dependence.
Aftercare	Treatment that occurs after completion of inpatient or residential treatment.
Alcohol Treatment Orders (ATR)	Alcohol Treatment Requirement is one on a range of community sentences available to the courts. It provides access to treatment and support programmes for offenders where alcohol use is identified as a significant factor in offending.
Antiretroviral combination therapy	Treatment for HIV/AIDS infection that employs several medications in combination to suppress the HIV virus or delay both the development of resistant viruses and the appearance of AIDS symptoms.
Assessment	A basic assessment consists of gathering key information and engaging in a process with the client that enables the counsellor to understand the client's readiness for change, problem areas, and the presence of mental illness or substance abuse disorders, disabilities, and strengths. An assessment typically involves a clinical examination of the functioning and well-being of the client and includes a number of tests and written and oral exercises.
Benzodiazepines	Group of medications having a common molecular structure and similar pharmacological activity, including anti-anxiety, sedative, hypnotic, amnestic, anticonvulsant, and muscle-relaxing effects. Benzodiazepines are among the most widely prescribed medications (e.g., diazepam, chlordiazepoxide, clonazepam, alprazolam, lorazepam).
Cognitive-Behavioural Therapy (CBT)	A therapeutic approach that seeks to modify negative or self-defeating thoughts and behaviour. CBT is aimed at both thought and behaviour change—that is, coping by thinking differently and coping by acting differently.
Crack	Cocaine (cocaine hydrochloride) that has been chemically modified so that it will become a gas vapour when heated at relatively low temperatures. Also called "rock" cocaine.
Crime Reduction Initiative (CRI)	Provider of Substance Misuse Service at Ashley House Widnes.
Detoxification	A clearing of toxins from the body. The medical and bio psychosocial procedure that assists a person who is dependent on one or more substances to withdraw from dependence on all substances of abuse.
Domestic violence	The use of emotional, psychological, sexual, or physical force by one family member or intimate partner to control another. Violent acts include verbal, emotional, and physical intimidation; destruction of the victim's possessions; maiming or killing pets; threats; forced sex; and slapping, punching, kicking, choking, burning, stabbing, shooting, and killing victims. Spouses, parents, stepparents, children, siblings, elderly relatives, and intimate partners may all be targets of domestic violence.
DSM-IV	Diagnostic and Statistical Manual, 4th edition, published by the American Psychiatric Association, a standard manual used to categorize psychological or psychiatric conditions. Delirium Tremens (DT's), a state of confusion

	accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in people with alcohol use disorders after withdrawal or abstinence from alcohol.
Drug Rehabilitation Requirement (DRR)	The DRR is a community order to provide treatment and support for crime associated with drug use. It is a voluntary punishment option for those facing criminal proceedings for drug related crimes.
Ecstasy	Slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family (for example, speed). At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.
Engagement	A client's commitment to and maintenance of treatment in all of its forms. A successful engagement program helps clients view the treatment facility as an important resource.
Hallucinogens	A broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide (LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.
Hepatitis	An inflammation of the liver, with accompanying liver cell damage and risk of death. Hepatitis may be of limited duration or a chronic condition. It may be caused by viral infection or by chronic exposure to poisons, chemicals, or drugs of abuse, such as alcohol.
Iatrogenic opioid addiction	Addiction resulting from medical use of an opioid (i.e., under physician supervision), usually for pain management.
Integrated treatment	Any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting. It recognizes the need for a unified treatment approach to meet the substance abuse, mental health, and related needs of a client, and is the preferred model of treatment.
Intensive Case Management (ICM)	a thorough, long-term service to assist clients with serious mental illness (particularly those with psychiatric and functional disabilities and a history of not adhering to prescribed outpatient treatment) by establishing and maintaining linkages with community-based service providers. ICM typically provides referrals to treatment programs, maintains advocacy for clients, provides counselling and crisis intervention, and assists in a wide variety of other basic services.
Intervention	The process of providing care to a patient or taking action to modify a symptom, an effect, or behaviour. Also the process of interacting after assessment with a patient who is substance addicted to present a diagnosis and recommend and negotiate a treatment plan. Also frequently used as a synonym for treatment. Types of intervention can include crisis intervention, brief intervention, and long-term intervention.
Marijuana	The Indian hemp plant cannabis sativa; also called "pot" and "weed." The dried leaves and flowering tops can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the person with no tolerance for it, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with sedative-hypnotic drugs such as alcohol. Hashish (or "hash") is a combination of the dried resins and compressed flowers of the female plant.

Medically supervised withdrawal	Dispensing of a maintenance medication in gradually decreasing doses to alleviate adverse physical or psychological effects incident to withdrawal from the continuous or sustained use of opioid drugs. The purpose of medically supervised withdrawal is to bring a patient maintained on maintenance medication to a medication-free state within a target period.
Mental health program	An organized array of services and interventions with a primary focus on treating mental health disorders, whether providing acute stabilization or ongoing treatment.
Methadone	The most frequently used opioid agonist medication. Methadone is a synthetic opioid that binds to mu opiate receptors and produces a range of mu agonist effects similar to those of short-acting opioids such as morphine and heroin.
Mutual self-help	An approach to recovery that emphasizes personal responsibility, self-management, and service users' helping one another. Such programs apply a broad spectrum of personal responsibility and peer support principles, usually including 12-Step methods that prescribe a planned regimen of change.
Opioid	A type of depressant drug that diminishes pain and central nervous system activity. Prescription opioids include morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack," "horse," and "boy."
Paraphernalia	A broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.
Relapse	A breakdown or setback in a person's attempt to change or modify any particular behaviour. An unfolding process in which the resumption of substance abuse is the last event in a series of maladaptive responses to internal or external stressors or stimuli.
Restorative justice	Restorative justice is a process whereby parties with a stake in a specific offence resolve collectively how to deal with the aftermath of the offence and its implications for the future.
Remission	A state in which a mental or physical disorder has been overcome or a disease process halted.
Screening	A formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder and, in this context, the possibility of a co-occurring substance or mental disorder. The screening process for co-occurring disorders seeks to answer a "yes" or "no" question: Does the substance abuse [or mental health] client being screened show signs of a possible mental health [or substance abuse] problem? Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether further assessment is warranted.
Stigma	A negative association attached to some activity or condition. A cause of shame or embarrassment.
Substance abuse	A maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Sometimes used interchangeably with the term substance dependence.
Substance dependence	A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to

	avoid withdrawal symptoms, and other serious behavioural effects, occurring at any time in the same 12-month period.
Therapeutic Community (TC)	A consciously designed social environment or residential treatment setting in which the social and group process is harnessed with therapeutic intent. The TC promotes abstinence from alcohol and illicit drug use, and seeks to decrease antisocial behaviour and to effect a global change in lifestyle, including attitudes and values. The TC employs the community itself as the agent of healing. The TC views drug abuse as a disorder of the whole person, reflecting problems in conduct, attitudes, moods, values, and emotional management. Treatment focuses on drug abstinence, coupled with social and psychological change that requires a multidimensional effort involving intensive mutual self-help typically in a residential setting.
Treatment	Substance abuse treatment is an organized array of services and interventions with a primary focus on treating substance abuse disorders. For the Treatment Episode Data Set, the Centre for Substance Abuse Treatment defines treatment to include the following general categories: hospital, short- and long-term residential, and outpatient. Mental health treatment is an organized array of services and interventions with a primary focus on treating mental disorders, whether providing acute stabilization or on-going treatment. These programs may exist in a variety of settings, such as traditional outpatient mental health centres (including outpatient clinics and psychosocial rehabilitation programs) or more intensive inpatient treatment units.
Treatment retention	Keeping clients involved in treatment activities and receiving required services.

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Foreword

This document provides an overview of the impact of drugs within Halton. It is intended to provide the evidence base that supports Halton's Drug Strategy 2014 to 2018 which describes the strategic approach to tackle the impact of drug misuse within the Borough of Halton. The findings of the evidence paper will enable partners, stakeholders and the wider community to understand the impact that drug misuse has within the Borough.

This paper provides an overview of the national policies that have influenced the Drug Strategy, and in more detail the local context is provided utilising a range of resources and information as well as key statistical information to demonstrate the work that has taken place within Halton by all partners.

Halton's approach is based on a prevention and recovery model ensuring effective use of scarce resources with the ultimate aim of improving the quality of life for individual residents and communities of Halton.

For further information on this paper and the Drug Strategy 2014 -18 please contact John Williams, Halton Borough Council, on 0151 511 8857 or email john.williams@halton.gov.uk: this evidence paper is available in different formats on request.

Part One – National Context

1.1. The National Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life.

Since 2001, the focus of the national drug strategy had been on a rapid expansion of treatment services for people who were using heroin and crack cocaine. This approach sought to reduce the impact of drug related crime on communities and drug related harms such as hepatitis and HIV infection to the individual.

Building on the success of this approach the Coalition's 2010 strategy recognises that the age and patterns of drug use are changing. In addition to illicit drugs, the strategy acknowledges the problems caused by addiction to legal substances such as prescribed medication and alcohol.

The ambition for individuals and families experiencing problematic drug use is also raised with an expectation that help and support will be more oriented towards recovery so that people can overcome their addiction and move on to participating fully within society.

The 2010 national strategy is structured around three themes:

1. **Reducing demand** –

   Creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so, and making it easier for those that do to stop. This is key to reducing the huge societal costs, particularly the lost ambition and potential of young drug users. The UK demand for illicit drugs is contributing directly to bloodshed, corruption and instability in source and transit countries, which we have a shared international responsibility to tackle.

2. **Restricting supply** –

   Drugs cost the UK £15.4 billion each year. Government action will continue to make the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks.

3. **Building recovery in communities** –

   Working with people who want to take the necessary steps to tackle their dependency on drugs and alcohol, offering a route out of dependence by putting the goal of recovery at the heart of the national strategy.

1.2. The Health & Social Care Act 2012

The Health and Social Care Act 2012 is bringing about a major reorganisation of the National Health Service. From April 2013, upper tier local authorities assumed lead responsibility for improving public health, coordinating local efforts to protect the public's health and wellbeing, for ensuring health services effectively promote population health and for addressing health inequalities. At a local level these issues are overseen by Health and Wellbeing Boards (HWBBs), whilst the national lead comes from a new agency, Public Health England. Directors of Public Health, employed by local authorities and members of Health and Wellbeing Boards, are responsible for delivering public health outcomes, of which drug and alcohol treatment is one. The National Treatment Agency, which previously had oversight of drug and alcohol treatment across the country, has been abolished, with its key functions transferring to Public Health England.

Clinical Commissioning Groups (CCGs) are the new body responsible for the design and commissioning of local health services such as acute hospital services and mental health services. CCGs are comprised of local GPs and in addition to being statutory members of HWWBs, are required by law to consult with HWBBs over their plans.

Prison health services, which include their drug and alcohol treatment services, are the responsibility of the NHS Commissioning Board. A Local Area Team (LAT) in each of the 10 regions is taking the lead for commissioning these services.

In separate developments outside of the NHS, elected Police and Crime Commissioners have replaced Police Authorities and are now responsible for ensuring effective policing and commissioning services to reduce crime within a force area. There is a good evidence base for the impact of drug treatment on reducing offending. Police and Crime Commissioners though have no statutory representation on HWBBs.

1.3. Crime & Disorder Act 1998

Section 17 of the Crime & Disorder Act, as amended by the Police and Justice Act 2006, requires responsible authorities to consider crime and disorder, of which drug and alcohol misuse is one aspect, in the exercise of all their duties, activities and decision making. Responsible authorities include Local Authorities, the Police, Fire Authorities and Health.

1.4. Welfare Reform Act 2012

The Welfare Reform Act received Royal Assent on 8th March 2012. The Act has been described as the biggest shake up of the benefits system in 60 years. It aims to simplify the system and create the right incentives to get people into work by ensuring that no individual is better off by not working. Key features of the Act that will have the most significant impact on Halton's residents are:

- Introduction of Universal Credit. The level of Universal Credit is to be capped at £26,000. While it is estimated that only a small number of Halton residents will see their income reduce as a result of the cap, some will be significantly affected. In addition, Housing Benefit is to be included in Universal Credit and will consequently be paid directly to tenants of social housing.
- Replacement of Disability Living Allowance with a Personal Independent Payment (PIP) for those of working age. Halton, which has been selected as a pilot area for the scheme, has a disproportionate amount of disabled residents and the change to PIP will involve a reduction in the numbers of those receiving financial assistance.
- Changes to Housing Benefit including the introduction of an under occupancy penalty for households whose homes are deemed to be too large for their needs. Described as the "Bedroom Tax", this change will have a very significant impact in Halton residents.

It is too early to assess the impact of other reforms such as the on-going reassessment of Incapacity Benefit claimants against the stricter criteria of the Employment Support Allowance, changes to Community Care Grants and Crisis Loans and forthcoming reforms to Council Tax benefit which will include a 10% cut in scheme funding and "localised" benefit schemes.

1.5. Children and young people

Education is one of the most effective ways of preventing drug and alcohol misuse. The National Drug Strategy outlines the need for young people to have access to universal drug and alcohol education and specifically states that school staff should have the information, advice and power to provide accurate information on drugs and alcohol via drug education as well as targeted information to support them to tackle problem behaviour in schools and work with local voluntary organisations, the police and others on prevention.

Some young people are more at risk of developing substance misuse problems than others. Areas of vulnerability can include those who have parents with substance misuse problems, those with mental

health problems and those who truant or are excluded from school. Such groups of young people at risk require a more targeted approach to help prevent drug or alcohol misuse.

Meeting the needs of these young people is best achieved by decisions that are taken at a local level as part of a broader approach to supporting vulnerable young people to enable flexible planning for local government to focus upon prevention and early intervention to reach and support vulnerable groups most effectively.

Young people who already have a serious substance misuse problem or are at risk of becoming dependent should be able to access specialist support quickly to help address their misuse as well as the wider issues that may have led to their misuse in the first place. Substance misuse services, youth offending services, mental health services and children's services need to work together to ensure the relevant support is in place for those who are most vulnerable. The relevant support for those in transition from child to adult services will also require consideration at the local level.

The National Treatment Agency (NTA) for substance misuse is responsible for overseeing intensive support for young people misusing drugs or alcohol. The latest report on young people's substance misuse (2011/12) is available to download,[1] and indicates that, on a national level:

- The overall number of young people accessing specialist substance misuse services has fallen for the third year running, to 20,688 from a peak of 24,053 in 2008-9.
- Very few are treated for Class A drugs such as heroin, cocaine or ecstasy, and the number has again reduced since last year from 770 (in 2010-11) to 631 in 2011-12. This compares to 1,979 five years ago.
- The vast majority of under-18s (92%) receive support for primary problems with cannabis or alcohol. The numbers seeing specialist services for alcohol dropped again, from 7,054 last year to 5,884 this year.
- The proportion of under-18s who left specialist services having successfully completed their programme rose to 77% in 2011-12 from 50% five years ago.
- The number of cases seen by specialist services for primary cannabis use was up from 12,784 in 2010-11 to 13,200 this year. As evidence suggests that overall young people's cannabis use is declining, the rise in numbers seeing specialist services could be down to a combination of stronger strains of the drug causing more harm, greater awareness of the issues surrounding cannabis, and specialist services being more alert and responsive to the problems the drug can cause for under-18s.

[1] http://www.nta.nhs.uk/uploads/yp2012vfinal.pdf

1.6. National Standards

Issued in November 2012, the National Institute for Clinical Excellence (NICE) quality standard on Drug Use Disorders (QS23), covers the treatment of adults (18 years or over) who misuse opioids, cannabis, stimulants or other drugs in all settings in which care is received, in particular inpatient and specialist residential, community-based treatment settings and prisons. This quality standard describes markers of high-quality, cost-effective care that, when delivered collectively, should contribute to improving the effectiveness, safety and experience of care for people with drug use disorders in the following ways: preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people to recover from episodes of ill health or following injury; ensuring that people have a positive experience of care; and treating and caring for people in a safe environment and protecting them from avoidable harm. These overarching outcomes are from The NHS Outcomes Framework 2012/13.

The quality standard is also expected to contribute to the following overarching outcomes from the Public Health Outcomes Framework; improving the wider determinants of health; health improvement; health protection; and preventing premature mortality.

The quality standard is also expected to contribute to the following overarching indicators from the Adult Social Care Outcomes Framework; enhancing quality of life for people with care and support needs; ensuring that people have a positive experience of care and support; safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

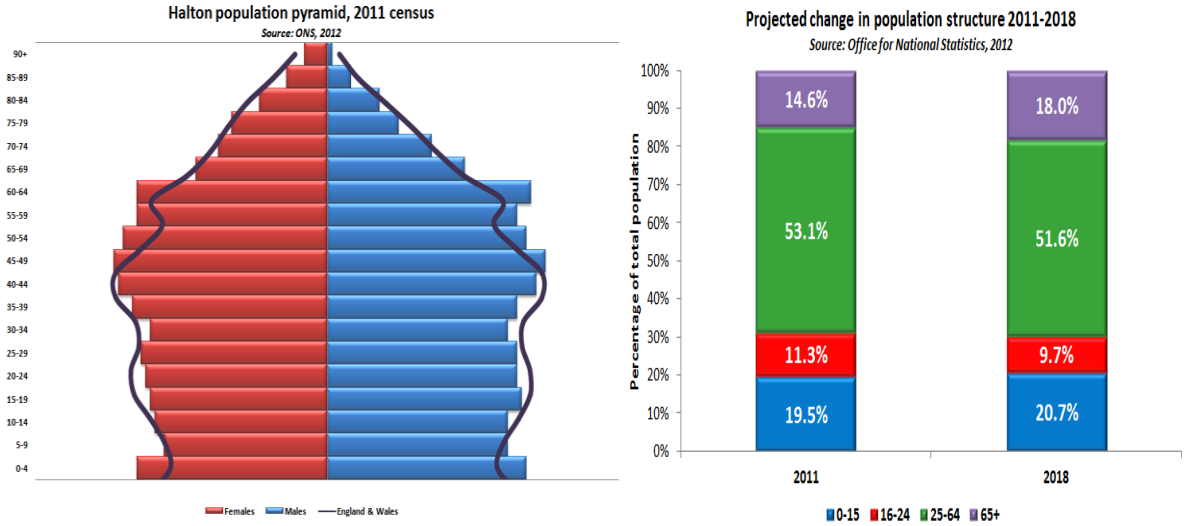
The quality standard requires that services should be commissioned from and coordinated across all relevant agencies encompassing the whole drug use disorder care pathway. An integrated approach to provision of services is fundamental to the delivery of high quality care to adults with drug use disorders.

Community, in-patient and residential drug treatment, where the service employs a doctor, nurse or social worker, are required to be registered with the Care Quality Commission (CQC). It is expected that the CQC will align any future work it does with the NICE Quality Standards.

Part Two – Demographic Profile, Risk Factors and Levels of Need

2.1 Population

Halton is a largely urban area of 125,700 (2011 Census) people. Its two biggest settlements are Widnes and Runcorn. The population is predominantly white (98.6%) with relatively little variation between wards.



Halton's population structure is slightly 'younger' than that seen across England as a whole. However, in line with the national trend, the proportion of the population in the working age bands i.e. 16-24 years and 25-64 years, is projected to fall with the younger age band i.e. 0-15 years, projected to rise slightly. The most significant shift is the proportion of the population in the older age band. If current drugs prevalence patterns continue (see section 2.5) this shift in population pattern may result in drug use continuing to fall.

2.2. Deprivation

Deprivation is a major determinant of health. Lower income levels often lead to poor levels of nutrition, poor housing conditions, and inequitable access to healthcare and other services. Deprivation, measured using the English index of Multiple Deprivation (IMD) 2010, ranks Halton as ranked 27th most deprived out of 326 local authorities (a ranking of 1 indicates the area is the most deprived).

The 2010 IMD shows that deprivation in Halton is widespread with 60,336 people (48% of the population) in Halton living in 'Lower Super Output Areas' (LSOA's) that are ranked within the most deprived 20% of areas in England.

2.3 Health

In terms of Health and Disability, the IMD identifies 53 SOA's (Super Output Areas) that fall within the top 20% most health deprived nationally and that approximately 40,000 people in Halton (33% of the population) live in the top 4% most health deprived areas in England. At ward level, Windmill Hill is the most deprived area in terms of health. However, health deprivation is highest in a LSOA within Halton Castle, ranked 32nd most deprived nationally.

Health is also a key determinant of achieving a good quality of life and the first priority of Halton's Sustainable Community Strategy. This states that 'statistics show that health standards in Halton are amongst the worst in the country and single it out as the aspect of life in the Borough in most urgent need of improvement'.

2.4. Risk factors

Most adult drug users have their first drug use experience in mid-to-late adolescence. Indeed, the highest proportion of drug use is in the 16-24 year age group. Most young people do not use illicit drugs or binge drink, and among those who do only a minority will develop serious problems. Some young people are more at risk of developing substance misuse problems than others. Risk factors include[1]:

Physiological factors:

- Physical disabilities.

Economic factors:

- Neighbourhood deprivation and disintegration.

Family factors:

- Belonging to families who condone substance misuse;
- Parental substance use;
- Poor and inconsistent family management; and
- Family conflict.

Psychological and behavioural factors:

- Mental health problems;
- alienation;
- Early peer rejection;
- Early persistent behaviour problems;
- Academic problems;
- Low commitment to school;
- Association with drug using peers;
- Attitudes favourable to drug use; and
- Early onset of drug or alcohol use.

There are some identifiable groups or categories of young people who are more likely than others to experience 'multiple' risk factors. These groups include:

- Young offenders;
- Looked after children;
- Young homeless;
- Young people involved in prostitution.
- Children whose parents misuse drugs;
- Young people who truant or are excluded from school; and

While not all young people in these groups do or will use drugs, these groupings can provide a valuable mechanism for targeting preventive action and early interventions towards some of the most vulnerable young people. Local data and/or estimated numbers are available on some of the above risk factors and vulnerable groups.

Table 1: Relative rates of social risk factors for the development of substance misuse problems, Halton and England

	Risk factor	Numbers affected locally	Percentage of population affected	Comparison to England	Relative Risk
1	Deprivation (% population in top 10% most deprived areas, IMD 2010)	7,792 (based on 2013 population estimate 0-18 years)	26%	10%	2.6
2	Children living in poverty (under 20 years) (2010)	7,800	26.5%	20.6%	1.29
3	Unauthorised school absences (2011/12)	192	1.2%	1.0%	1.2
4	School exclusions (2011/12)	Fixed period: 790 Permanent: 10	Fixed period: 4.41% Permanent: 0.07%	Fixed period: 4.05% Permanent: 0.07%	Fixed period: 1.1 Permanent: 0.0
5	Not in Education, Employment of Training (NEET) (2012)	383 (January 2013)	7%	5.7%	1.23
6	Young offenders: (2012)	74 juvenile first time entrants to the criminal justice system, 12 months ending September 2012	599, per 100,000 people aged 10-17 receiving first reprimand, warning or conviction	593, per 100,000 people aged 10-17 receiving first reprimand, warning or conviction	1.1
7	Looked After Children (2013)	145	51 per 10,000 children under 18 years	60 per 10,000 children under 18 years	0.85

Sources: 1 – Office of National Statistics; 2 – HM Revenue & Customs; 3 -5,7: Department for Education; 6 – Ministry of Justice

Estimated number of children who live with a parent with substance misuse problems

There are a number of impacts experienced by children living with parents who are substance misusers and/or problematic drinkers. Almost 4 million people in the 16–65 age group in the UK are dependent on alcohol and/or drugs. Assuming (conservatively) that every substance misuser will negatively affect at least two of their close family, this suggests that about 8 million family members (spouses, children, parents, siblings) in the UK are living with the negative consequences of someone else's drug or alcohol misuse[2]. Figure 1 summarises of the impacts this can have.

Figure 1: Negative effects of living with a parent with a substance misuse problem

Children

- behavioural disturbance, antisocial behaviour (conduct disorders)
- emotional difficulties
- behavioural problems and underachievement at school
- social isolation, because they feel that it is too problematic or shameful to bring friends home, or because they are not able to go out with friends as they have responsibilities of caring for other family members (e.g. siblings or the misusing parents)
- 'precocious maturity'

They also tend to have a more difficult transition from childhood to adolescence and increased likelihood of being referred to social services because of child protection concerns

Adolescents

Two common patterns often emerge:

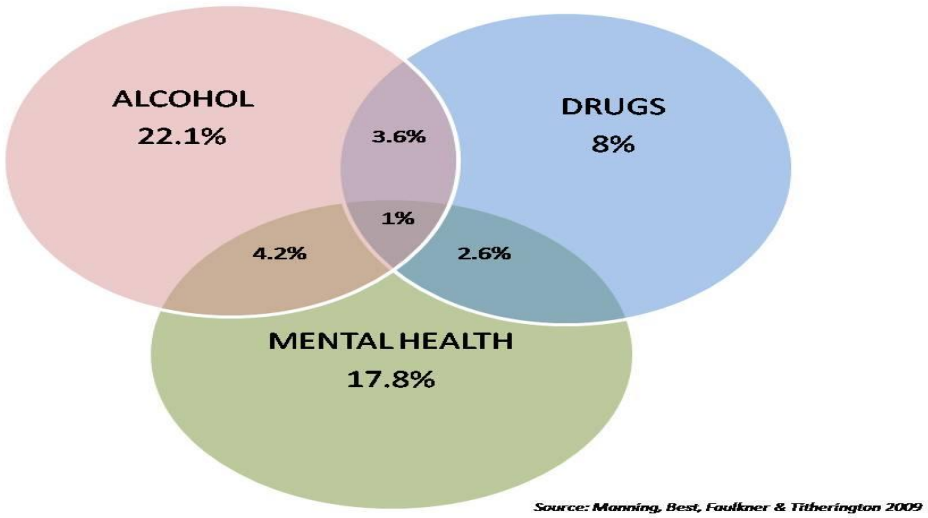
- increasing introspection and social isolation, with friendship difficulties (e.g. the young person is
- unlikely to visit or invite friends to their own home), anxiety or depression (for which psychoactive
- medication may be prescribed); attempts to escape their family home (e.g. by leaving home at an early age or entering into a long-term relationship)
- development of strong peer relationships which are kept separate from their own family; these
- relationships may themselves involve early alcohol or drug use, participation in sub-cultures perceived to be 'deviant', in antisocial activity, unsafe sex and unplanned and/or early pregnancy

Adulthood

Some of the problems of childhood and adolescence can continue into adulthood there is some (although not as great as previously thought) evidence that adult offspring of substance-misusing parents have greater problems in terms of substance misuse or areas of adulthood adjustment

Research[3] suggests that about 22% of children under the age of 16 live with at least one adult drinking to hazardous levels, 8% with an adult who has a substance misuse problem and 17.8% with an adult with mental health problems. Many individuals experience more than one of these problems. Figure 2 shows the estimated percentages of children exposed to various combinations of alcohol, illicit drugs and mental health problems.

Figure 2: cumulative risk of harm estimated from the National Adult Psychiatric Morbidity Survey



Applying the findings from this study to the local population of under 16 year olds can give an estimate of the numbers of children likely to be exposed to various combinations of substance misuse and mental health problems.

Table 2: Estimated percentages of children under the age of 16 living with an adult with substance misuse problems

Percentage of children exposed to various types of substance misuse	Estimated number of 0-16 years olds locally (25,335 population estimate 2013)
8% living with an illicit drug user	2,027
3.6% living with a problem drinker who also uses drugs	912
2.6% living with a drug user who has concurrent mental health problems	659
1%% living with a problem drinker who has concurrent mental health problems and uses drugs	253

Source: Manning, Best, Faulkner &Titherington, 2009 & ONS 2013

However, studies also show that children can and do grow through difficult circumstances without ill effects and many show great resilience. Practitioners working with parents with substance misuse problems should aim to work on family disharmony, reducing conflict, and work on inconsistent, neglectful and ambivalent parenting. This will to reduce risk, develop protective factors and promote resilience in young people.

Estimated Prevalence of Mental Health Conditions

Recent research has shown that having a mental health problem increases the chances of a person's developing substance misuse problems, independently of adverse childhood impacts[4].

Research by Green et al[5] showed that 7.7% of 5-10 year olds and 11.4% of 11-16 year olds were likely to have experienced a mental health disorder. As well as age differences, there were gender differences, with prevalence being greater amongst boys (11.4%) than girls (7.8%). Applying prevalence rates for the different mental health disorders to the 2013 population estimates for Halton residents aged 5 to 19, the numbers likely to have mental health disorders and been estimated. Numbers for all types and each type do not add us as some children will have more than one disorder.

Table 3: Estimated number of children with mental health disorders, by age group and gender, 2013

			Mental Health Disorder		Conduct Disorder		Emotional Disorder		Hyperkinetic Disorder		Less Common Disorders		Totals
Gender	Age group	Population	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	
females	5 to 10	4,586	*5.1%*	**234**	*2.8%*	**129**	*2.5%*	**115**	*0.4%*	**18**	*0.4%*	**18**	**514**
	11 to 16	4,485	*10.3%*	**462**	*5.1%*	**229**	*6.1%*	**274**	*0.4%*	**18**	*1.1%*	**49**	**1032**
	17 to 19	2,170	*10.3%*	**224**	*5.1%*	**111**	*6.1%*	**132**	*0.4%*	**7**	*1.1%*	**24**	**498**
males	5 to 10	4,784	*10.2%*	**488**	*6.9%*	**330**	*2.2%*	**105**	*2.7%*	**129**	*2.2%*	**105**	**1117**
	11 to 16	4,476	*12.6%*	**564**	*8.1%*	**363**	*4.0%*	**179**	*2.4%*	**107**	*1.6%*	**72**	**1285**
	17 to 19	2,387	*12.6%*	**301**	*8.1%*	**193**	*4.0%*	**96**	*2.4%*	**57**	*1.6%*	**38**	**685**
persons	5 to 10	9,370	*7.7%*	**722**	*4.9%*	**459**	*2.4%*	**225**	*1.6%*	**150**	*1.3%*	**122**	**1556**
	11 to 16	8,961	*11.5%*	**1031**	*6.6%*	**591**	*5.0%*	**448**	*1.4%*	**125**	*1.4%*	**125**	**2320**
	17 to 19	4,557	*11.5%*	**524**	*6.6%*	**301**	*5.0%*	**228**	*1.4%*	**64**	*1.4%*	**64**	**1181**
total all ages		*22,888*		***2277***		***1351***		***901***		***339***		***311***	**5179**

Source: Green 2005 & ONS 2012

The numbers for 17-19 year olds may be underestimates as mental health problems are more prevalent in 18 year olds than 15 year olds as studies in New Zealand[6] and the USA[7] have shown. Other studies confirm the finding that the late teens and early twenties are periods of especially high risk of mental disorder– possibly the highest of any stage in the life course[8]. Young people over the age of 16 were included in the Adult Psychiatric Morbidity Survey in England 2007[9]. The mental disorders classified in the adult's survey are different to children's disorders. The adult mental disorders are:

- Depressive episodes
- Obsessive compulsive disorders
- Psychotic disorders

The Adult Psychiatric Morbidity Survey (APMS) was a point prevalence survey of UK residents aged between 16 and 75 years old. Prevalence estimates for young people aged 16 to 24 are presented in Table 3 and applied to the estimated Halton population of 16-19 year olds at 2013 and projected population for 2021 (the population aged 16-19 is projected to fall from 6090 in 2013 to 5455). These estimates assume no change in prevalence over this time.

Table4: Estimated number of children aged 16-19 with neurotic disorders

	Men			Women			Persons		
		Estimated Numbers			Estimated Numbers			Estimated Numbers	
	%	2013	2021	%	2013	2021	%	2013	2021
mixed anxiety and depressive disorder	*8.2%*	257	221	*12.3%*	364	340	*10.2%*	621	556
Generalised anxiety disorder	*1.9%*	60	51	*5.3%*	157	146	*3.6%*	219	196
Depressive episode	*1.5%*	47	40	*2.9%*	86	80	*2.2%*	134	120
All phobias	*0.3%*	9	8	*2.7%*	80	75	*1.5%*	91	82
Obsessive compulsive disorder	*1.6%*	50	43	*3.0%*	89	83	*2.3%*	140	126
Panic disorder	*1.4%*	44	38	*0.8%*	24	22	*1.1%*	67	60
Any Common Mental Health Disorder	*13.0%*	407	350	*22.2%*	656	613	*17.5%*	1066	955

Source: McManus et al 2009 and ONS 2012

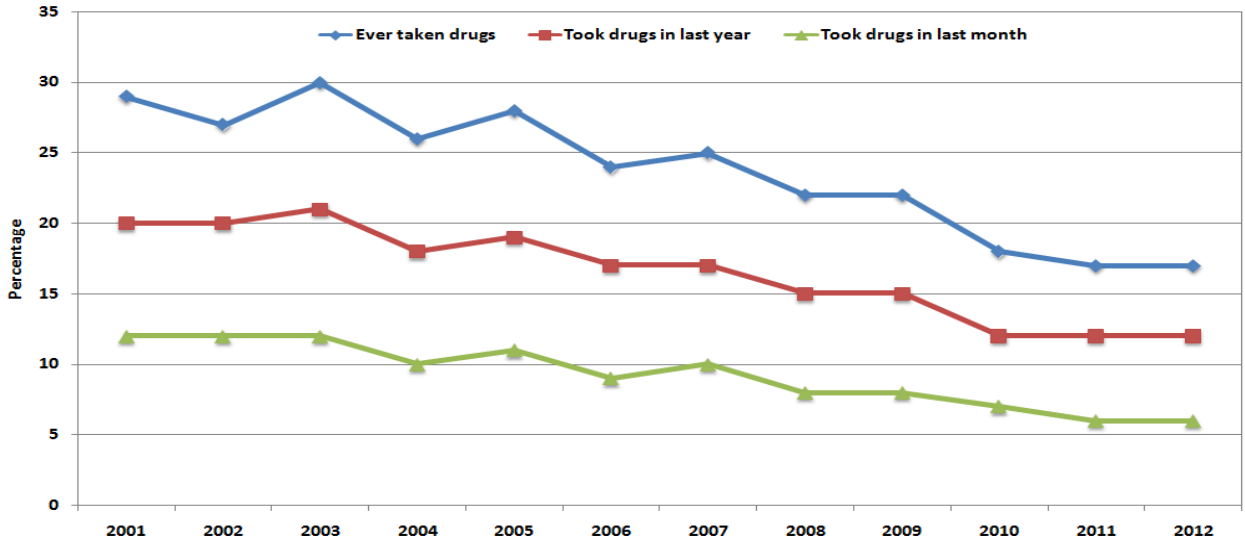
2.5. Estimated Prevalence of substance misuse in Halton

Data from service provision will only show the number of people with substance misuse problems who are in treatment. This does not give an overall figure of total drug users in the community. There are likely to be a number unknown to services, sometimes called 'unmet need' or 'hidden populations'. There is no routinely available data at a local level on these total numbers. However, annual national surveys do allow an estimation to be made. Such figures are likely not to be exact, due to local variations in levels of risk. They do however provide a snapshot of the expected prevalence of drug use in Halton.

2.5.1. Drug misuse among children (11 - 15 years)[10]

In England, there has been an overall decrease in drug use reported by 11- 15 year olds since 2001. The prevalence of lifetime drug use fell from 29% in 2001 to 17% in 2012. There were also decreases in the proportion of pupils who reported taking drugs in the last year from 20% in 2001 to 12% in 2012 and in the last month from 12% in 2001 to 6% in 2012.

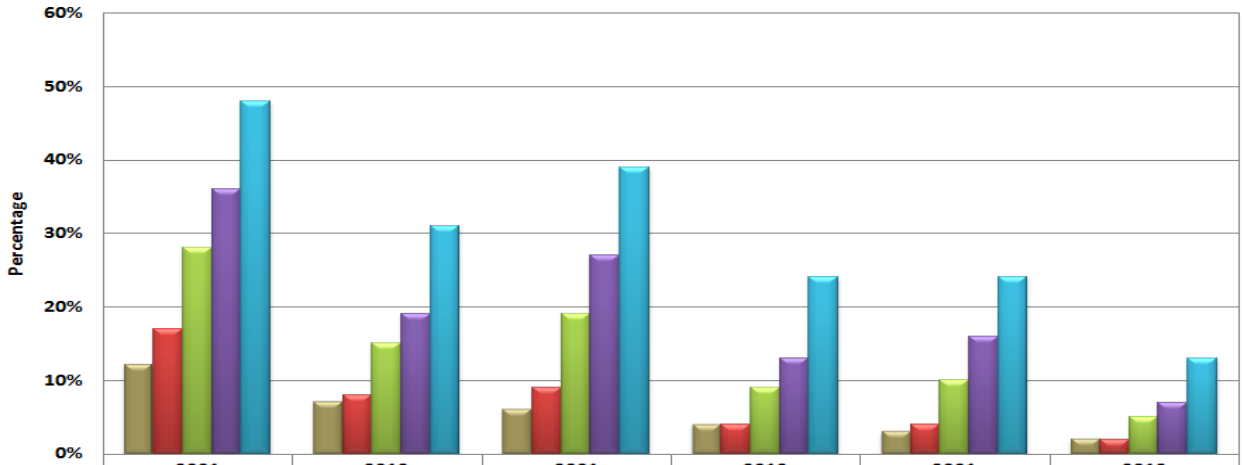
Figure 3: National trend in drug use amongst 11-15 year olds, 2001 to 2012



Source: Fuller E. et al (2013)

Reported drug use was more common among older pupils; for example, 4% of 11 year olds said they had used drugs in the last year, compared with 24% of 15 year olds in 2012. As seen in previous years cannabis was the most widely used drug in 2012; 7.5% of pupils reported taking it in the last year, a long term decrease from 13.4% in 2001.

Figure 4: Percentage of young people who have ever taken drugs, taken them in the last year and taken them in the last month, by age, national picture 2012 compared to 2001

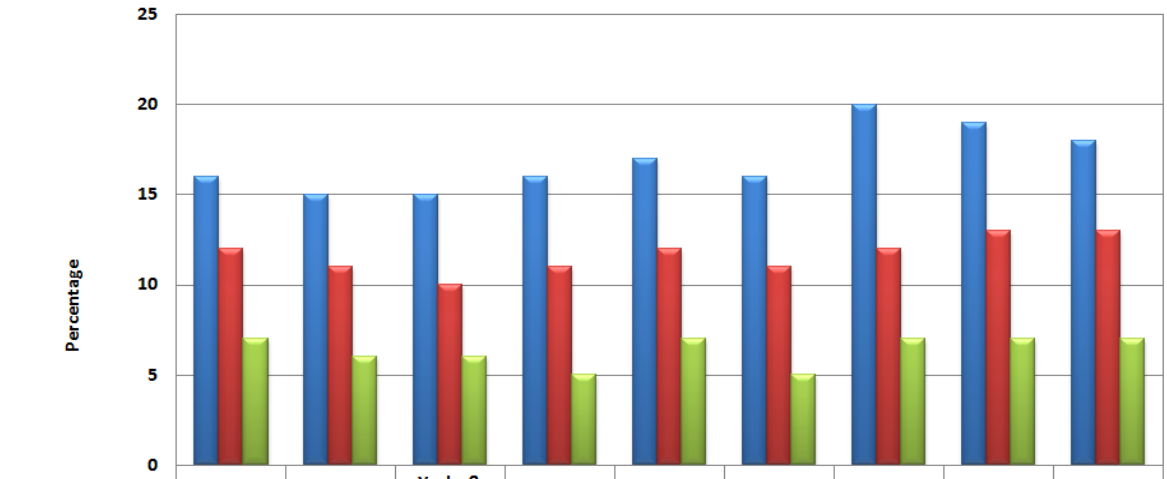


	2001	2012	2001	2012	2001	2012
	ever taken drugs		taken in last year		taken in last month	
11 years	12%	7%	6%	4%	3%	2%
12 years	17%	8%	9%	4%	4%	2%
13 years	28%	15%	19%	9%	10%	5%
14 years	36%	19%	27%	13%	16%	7%
15 years	48%	31%	39%	24%	24%	13%

Source: Fuller E. et al (2013)

The proportions of pupils who had ever tried drugs were generally higher in the south of England than elsewhere. In regions in the North and Midlands, between 15% and 17% reported having tried drugs but this proportion was 19% in the South East and South West and 20% in London. There was a similar but not identical pattern in the proportions of pupils who has taken drugs in the last year which varied between 10% in the East and West Midlands to 15% in the South West.

Figure 5: Regional variation in levels of drug use amongst 11 to 15 year olds.



	North East	North West	Yorks & the Humber	East Midlands	West Midlands	East of England	London	South East	South West
Ever	16	15	15	16	17	16	20	19	18
In the last year	12	11	10	11	12	11	12	13	13
In the last month	7	6	6	5	7	5	7	7	7

Source: Fuller E. et al (2013)

Using the national and regional prevalence for 2012, and applying it to the 2013 mid-year population estimate of Halton 11-15 year olds (7,427), gives the following local estimates of the numbers who have ever taken drugs.

Figure 6: estimated number of Halton 11-15 year olds who have ever taken drugs, 2013

	North West prevalence (%)	England prevalence (%)	Halton estimated number
Ever taken drugs	15%	17%	1,114 - 1,263
Taken drugs in last year	11%	12%	817 - 891
Taken drugs in last month	6%	6%	446

Source: Fuller E. Et al (2013) & ONS (2013)

Nationally, the number of young people (aged 18 and under) accessing specialist substance misuse services during 2011/12 was 20,688. This is a decrease of 1,267 individuals (5.8%) since 2010-11 and a decrease of 2,840 individuals (12.1%) since 2009-10 2010/11. The number of young people accessing services for

primary use of Class A drugs such as heroin and cocaine has fallen year-on-year to fewer than 800 nationally by 2011/12. The proportion of young people dropping out before completing a course of therapy has continued to fall, from 29% in 2005/06 to 16% last year and 13% 2011/12[11].

Locally the TellUs school survey had included questions on drug use. Since the government discontinued this survey a local version has been run. It found:

In answer to the question: ***Have you ever taken drugs (this does not include medicine or alcohol, but does include solvents, glue and gas)?***

- 9% said that they have taken drugs.

This is lower to the lifetime use identified in the national survey where 17% of 11-15 year olds stated that they had taken drugs at some time. It should be noted that differences in methodology may affect the validity of direct comparison.

In answer to the question: ***Why did you try the drugs, the first time? The main reasons stated given were:***

- I wanted to get high or feel good
- I wanted to see what it was like
- Because my friends were doing it
- I had nothing better to do

In answer to the question: ***In the last 4 weeks, how often have you taken any of the following drugs? (Don't worry if you don't know exactly, just give us a rough idea).***

- Cannabis or Skunk was taken the most in 'the last four weeks'
    - 13 had taken once
    - 8 had taken twice and
    - 31 had taken 3 or more times

Respondents were also asked a number of questions designed to test their knowledge and understanding about drugs. The responses show a good level of knowledge of the dangers of drugs amongst Halton young people. A quarter did not feel that injecting drugs can lead to HIV. However, research does show that sharing needles increases risk of contracting blood borne virus's such as hepatitis and HIV (see section 2.6).

- **Cannabis is more dangerous than Heroin** : 35% said TRUE
- **Injecting drugs can lead to HIV:** 26% said FALSE
- **Ecstasy always makes you feel great with no side effects** : 17% said TRUE

2.5.2. Drug misuse among young adults (16 – 24 years)

Data from the Health & Social Care Information Centre[12] shows that in England and Wales, in 2011/12,an estimated 37.7% young adults have ever taken an illicit drug, 19.3% had done so in the last year and 11.1% in the last month.

Based on a 2013 population estimate of 13,793 16 to 24 year olds living in Halton, this would mean that **5,200** young adults have ever taken an illicit drug, with **2,662** having done so in the last year and **1,531** in the last month.

Last year use of any illicit drug fell from 29.7% to 19.3% between 1996 and 2011/12. This was due in large part to notable declines in cannabis (26.0% to 15.7%) and amphetamine use (from 11.8% to 2.0%).

Last year Class A drug use among 16 to 24 year olds has fallen in the long term from 9.2% in 1996 to 6.3% in 2011/12. (This would be equivalent to **869** young people in Halton).

2.5.3. Drug misuse among adults (16 - 59 years)

In England and Wales, in 2011/12[13], an estimated one in three adults (36.5%) have ever taken an illicit drug in their lifetime (around 12 million people), 8.9% of adults have used an illicit drug in the last year (nearly three million people) and 5.2% of adults have used an illicit drug in the last month (an estimated 1.7 million people).

Between 1996 and 2011/12 the last year use of any illicit drug fell from 11.1% to 8.9%. Any last year drug use remains around the lowest level since measurement began.

For Halton (based on 2013 population estimate of 72,827 people aged 16 to 59 years), this would mean approximately **26,582** people will have ever taken an illicit drug in their lifetime, **6,482** adults will have used an illicit drug in the last year and **3,787** adults will have used an illicit drug in the last month.

Nationally, in 2011/12 around 15.6% of adults have ever taken a Class A drug in their lifetime (around 5 million people), 3.0% have done so in the last year and 1.5% in the last month. The long term trend in Class A drug use in the last year shows no statistically significant difference between 1996 (2.7%) and 2011/12 (3.0%).

For Halton, this would indicate that the local usage figures would be 11,361 adults having ever taken a Class A drug in their lifetime, with 2,2185 having done so in the last year and 1,092 in the last month.

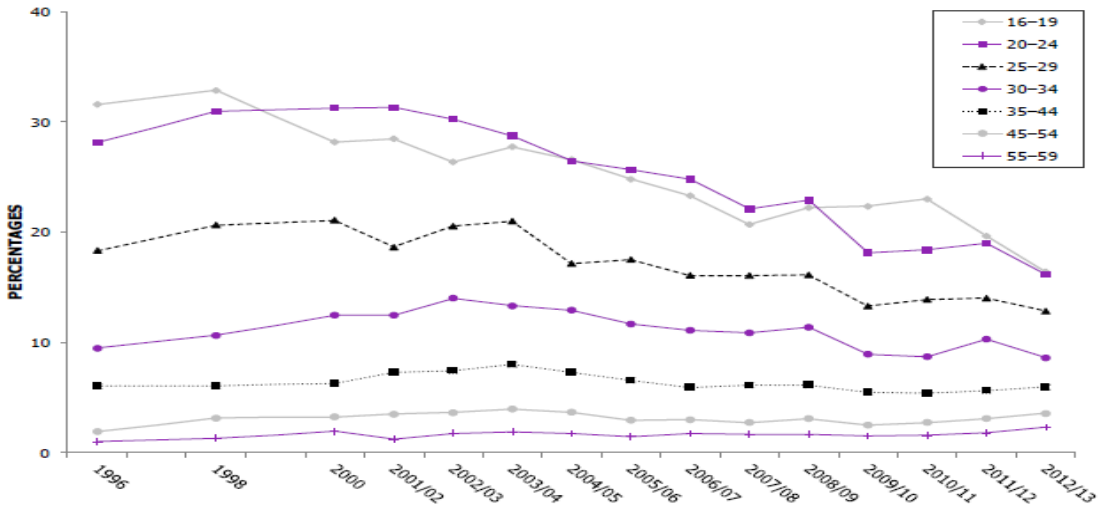
As in previous years cannabis was the most commonly used type of drug in the last year, in 2011/12 6.9% of 16-59 years (equivalent to 5,025 Halton residents) had used cannabis in the last year followed by powder cocaine (2.2% or 1,602 Halton residents) and ecstasy (1.4% or 1,020 Halton residents).

In 20010/11 it was estimated that there were **818** opiate and/or crack users in Halton. This corresponds to a rate of 10.33 per thousand of the population aged 15-64, a lower rate than in the North West (10.83 per 1,000 population aged 15-64) but statistically significantly higher than that across England as a whole (8.67 per 1,000 population aged 15-64)[14].

2.5.4. Drug use and age

Section 2.5.3 showed the estimated levels of drug use amongst the total 16 to 59 year old population. Within this group there is significant variation as the results of the latest Crime Survey for England & Wales shows[15].

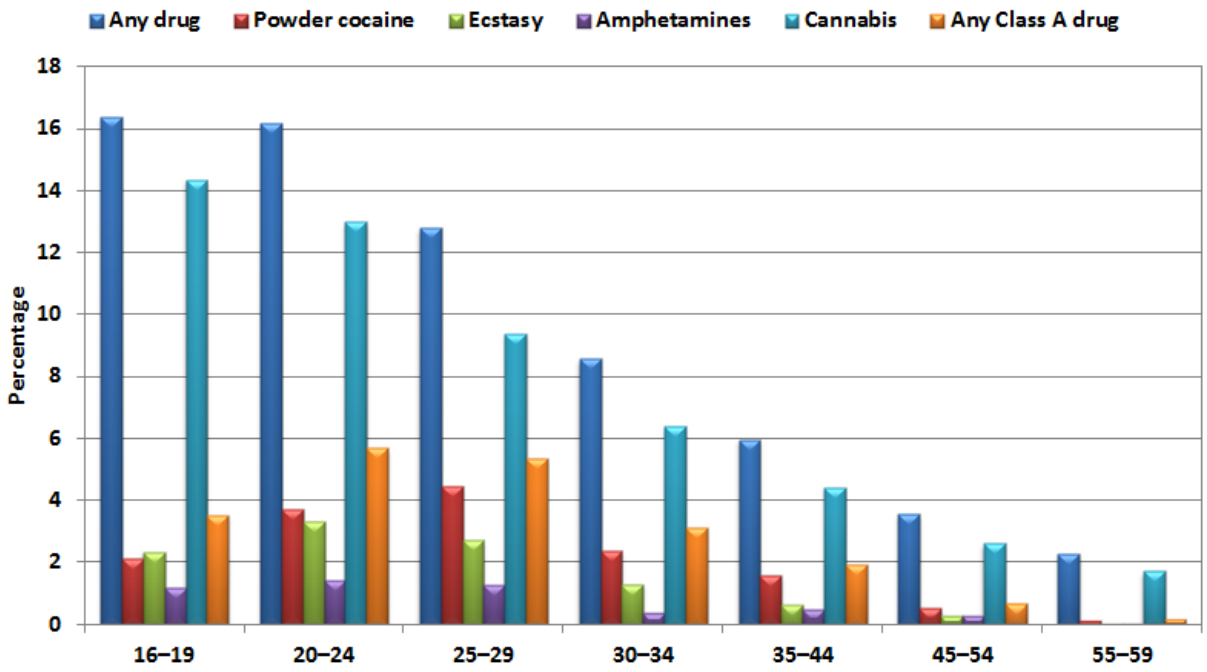
Figure 7: Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012/13 Crime Survey for England and Wales



Source: Home Office 2013

The pattern is similar when looking at different types of drugs, although whilst the peak for cannabis is 16-19 year olds - most adult drug users report they started using cannabis at age 13-15[16] - the peak age for ecstasy is 20-24 and for powder cocaine is 25-29.

Figure 8: Proportion of 16 to 59 year olds reporting use of powder cocaine, ecstasy and cannabis in the last year by age group, 2012/13 Crime Survey for England and Wales



Source: Home Office, 2013

If this pattern were repeated across Halton the following number of drug users would be seen:

Figure 9: Estimated number of adults in Halton who have used drugs in the last years, by age band

	Halton population	Any drug	Powder cocaine	Ecstasy	Amphetamines	Cannabis	Any Class A drug
16–19	6090	999	128	140	73	871	213
20–24	7703	1248	285	254	108	1001	439
25–29	8358	1070	368	226	109	786	451
30–34	8094	696	194	105	32	518	251
35–44	16250	959	260	98	81	715	309
45–54	18104	634	91	54	54	471	127
55–59	8228	189	8	0	0	140	16
16-59	72827	5795	1334	877	457	4502	1806

Source: Home Office, 2013

The overall figure of 5,795 is lower than that calculated using the Health & Social Care Information Centre findings, which put the figure at 6,482. As these reports analyse the data differently, it is more appropriate to put the estimated number as a range of **5,795 – 6,482**, rather than choosing one figure over the other.

2.5.5. Drug use by gender

Levels of use of any illicit drug and any Class A drug during the last year were higher among men than women in 2012/13, a pattern that has been seen every year since 1996. This pattern can also be seen for individual drugs, for example, according to the 2012/13 survey, men were twice as likely to report use of cannabis in the last year as women (8.6% and 4.1% respectively).

2.5.6. Drug use amongst vulnerable groups

Drug use is higher amongst some of the vulnerable groups identified in section 2.4. In 2003, 24% of vulnerable young people reported using illicit drugs frequently during the preceding 12 months, compared with 5% of their less vulnerable peers. There were significantly higher levels of drug use among those who belonged to more than one vulnerable group. Becker and Roe (2005)[17] define five groups of vulnerable young people: 'those who have ever been in care (22.7% had taken drugs), those who have ever been homeless (22.7% had taken drugs), truants (43.1% had taken drugs), those excluded from school (31.6% had taken drugs) and serious or frequent offenders (35.7%)'. The following are crude estimates, based on best available data. Given that substance misuse has been falling these may be overestimates. However, the 2003 crime survey is the last time this issue was explored and so provides the most up-to-date national prevalence data available.

Table 5: Estimated number of vulnerable young people in Halton who have taken drugs

Number of vulnerable young people in Halton	Estimated number who have taken drugs
145 children in care (2013)	33
192 Unauthorised school absences (2011/12)	83
790 fixed-term schol exclusions (2011/12)	250
10 permanent school exclusions (2011/12)	3
74 young offenders (2012)	26

2.5.7. Drug use amongst people with mental health problems

Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms or syndromes. Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction). The most common associations for substance misuse are with depression, anxiety and schizophrenia, post-traumatic stress, attention deficit, hyperactivity and memory disorders also occur[18].

For young people, emotional and behavioural disorders are associated with an increased risk of experimentation, misuse and dependence[19]. Recent research showed that pupils with a wellbeing score less than 10 (considered to be relatively low level of wellbeing) were more likely than pupils whose wellbeing scores were higher to have taken drugs in the last year (odds ratio=1.55)[20].

Research suggests 21.4% of people in contact with community mental health services also have a problem with drugs[21]. Other studies suggest the prevalence of dual diagnosis is between 30% and 50% of psychiatric caseloads, with some mental health conditions being more often associated with substance misuse than others e.g. Schizophrenia, Psychosis, Severe Depression: and Personality Disorder[22]. Indeed, a study using data from the Scottish Drug Misuse Database, April 2001 and March 2002, revealed that over 40% of individuals who sought treatment for problem drug use (3,236 out of a total of 10,798 individuals) reported that their mental health was one of the issues which led them to seek treatment[23].

With an estimated 2277 young people under age 16 (Table 3), 1066 young adults aged 16-19 years (Table 4), 12,583 adults aged 18-64 years estimated to have common mental health disorders and 5,606 two or more psychiatric disorders in Halton a significant proportion of these are also likely to have substance misuse issues. Even applying the lowest estimated prevalence rate of 21.4% identified in the research to the number of adults estimated to have common mental health problems and two or more psychiatric disorders would suggest **3,813** people in Halton with mental health problems also use drugs.

Table 6: People aged 18-64 predicted to have a mental health problem, projected to 2020

	2012	2013	2014	2015	2016	2018	2020
Common Mental Disorder	12,608	12,583	12,499	12,442	12,365	12,269	12,172
Borderline Personality Disorder	353	353	350	349	347	344	341
Antisocial Personality Disorder	270	268	267	265	263	261	259
Psychotic Disorder	313	313	311	309	307	305	303
Two or more Psychiatric Disorders	5,620	5,606	5,570	5,542	5,506	5,463	5,420

Source: PANSI, 2013

2.6 Health Impacts of substance misuse

Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. It may also lead to an increased risk of sexually transmitted infections.

Table 7: Health impacts of different types of drugs

Drug	Effects on health
Cannabis	Linked to mental health problems such as schizophrenia, and, when smoked, to lung diseases including asthma. It affects how the brain works, so regular use can make concentration and learning very difficult. Can have a negative effect fertility. It is also dangerous to drive after taking cannabis. Mixing it with tobacco is likely to increase the risk of heart disease and lung cancer.
Cocaine	• Overdose from over stimulating the heart and nervous system, which can lead to a heart attack. • Depression, insomnia, extreme paranoia • Weight loss and malnutrition • If pregnant, it can harm the baby e.g. low birth weight and birth defectsand miscarriage. • Increased the chance of serious mental health problems returning. • Impotence in men • Damage to nasal passages • Injecting increases the risk of overdosing is higher and veins and body tissues can be seriously damaged. • Sharing needles this puts users at risk of catching HIV or viral hepatitis.
Mephedrone (meow meow, miaowmiaow,	Mephedrone can overstimulate the heart and nervous system. It can cause periods of insomnia, and its use can lead to fits and to agitated and hallucinatory states. It has been

meph)	identified as the cause of a number of deaths.
Ecstasy	• Anxiety, panic, confusion and difficulty in calming down. • Long-term use has been linked with memory problems, depression and anxiety. • Ecstasy use affects the body's temperature control and can lead to dangerous overheating and dehydration. This can cause dehydration, coma or even death. But a balance is important as drinking too much fluid can also be very dangerous for the brain, particularly because ecstasy tends to stop the body producing enough urine, so the body retains the fluid.
Speed (amphetamine)	Can cause high blood pressure and heart attacks. It can be more risky if mixed with alcohol, or if used by people with blood pressure or heart problems. Injecting speed is particularly dangerous, as death can occur from overdose. Speed is usually very impure and injecting it can cause damage to veins and tissues, which can also lead to serious infections in the body and bloodstream. Any sharing of injecting equipment adds the risk of catching hepatitis C and HIV.
Tranquillizers	• Severe headache • Nausea • Anxiety and confusion • If crushed up can cause veins to collapse, leading to infection and in extreme cases gangrene
Heroin	• Chemicals used to bulk out pure heroin can cause allergic or toxic reactions • Can cause heart failure. • Risk of choking on own vomit if sick whilst unconscious • Sharing needles increases risk of catching hepatitis C and HIV. • Long-term use can damage veins and lead to serious infections such as abscesses and severe constipation.
Source: NHS choices http://www.nhs.uk/Livewell/drugs/Pages/Drugsoverview.aspx and NHSInform http://www.nhsinform.co.uk/health-library/articles/d/drug-misuse/risks	

Wider impacts on families and society

Substance misuse is also a key factor in a significant number of child protection cases and domestic violence. Users can lose their families, homes and jobs. Users can also find themselves resorting to crime to pay for their drugs. Some of these are looked at in Part 7.

Part Three – Treatment and Care

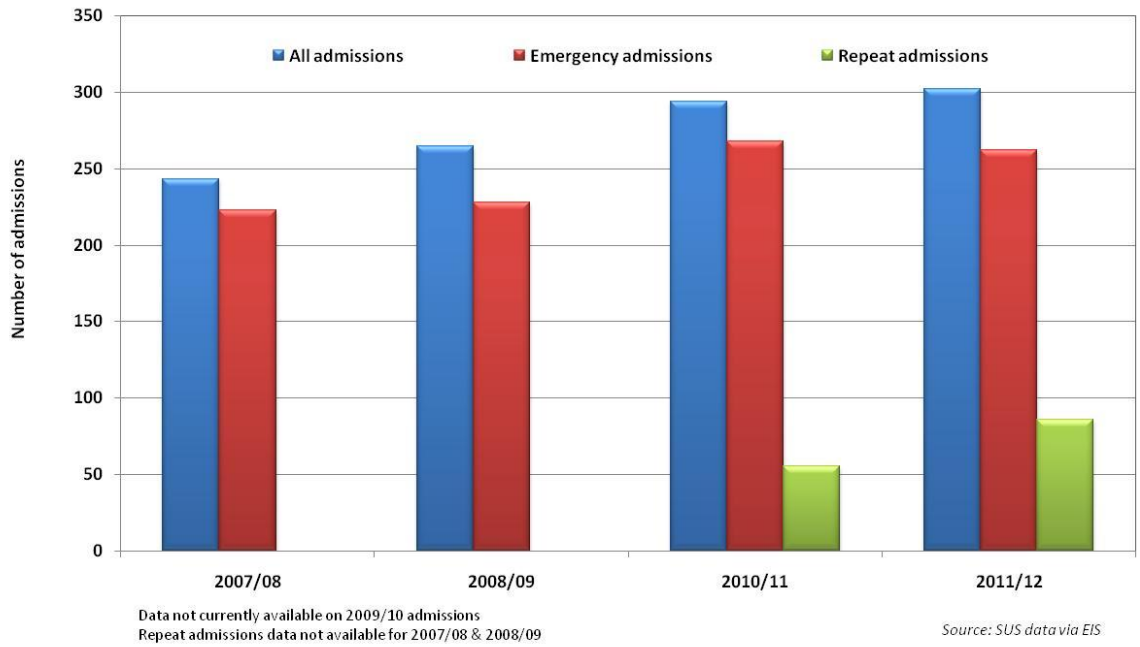
3.1. Hospital Admissions

3.1.1. Drug related admissions

Drug related admissions include any hospital admission where there is a drug diagnosis in any part of the record, although the primary reason for admission could be different.

There has been an upward trend in drug related hospital admissions and repeat admissions. In 2007/08 there were 243 admissions, rising to 302 in 2011/12. Repeat admissions stood at 55 in 2010/11 and 86 in 2011/12.

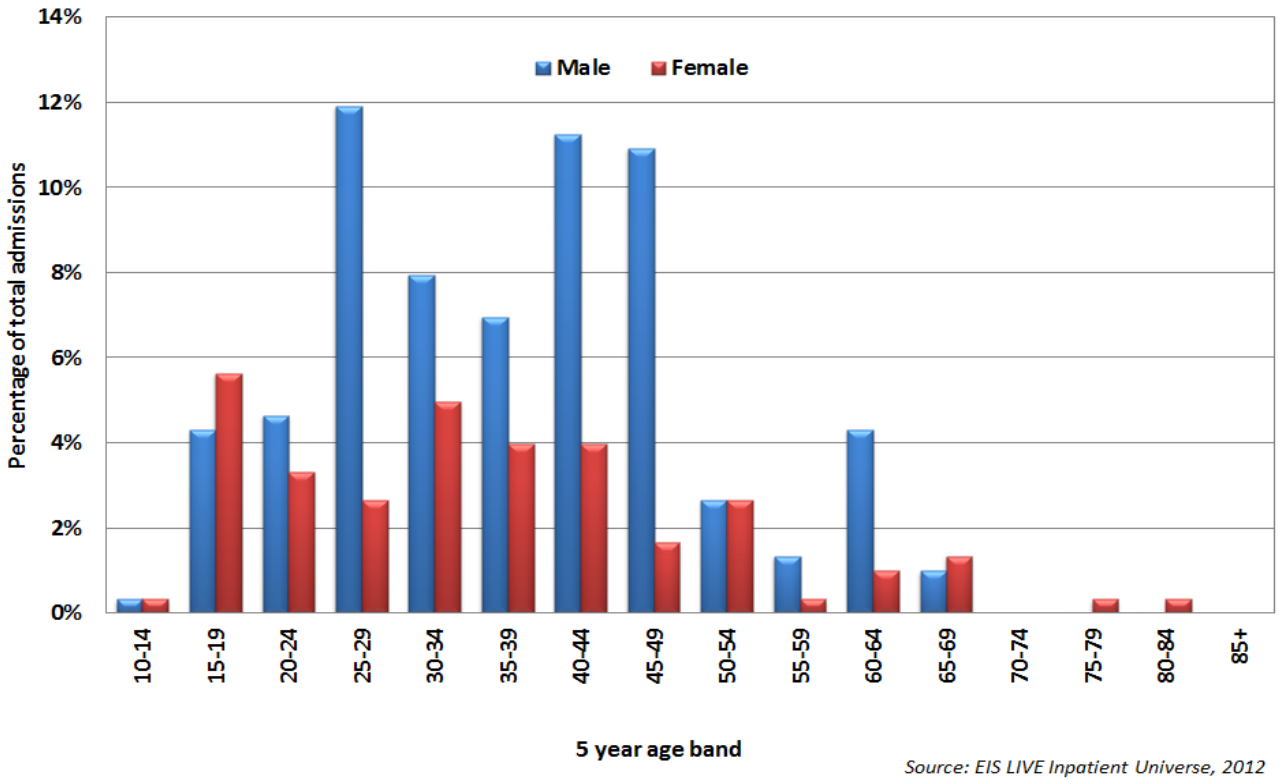
Figure 10: Trend in drug related hospital admissions in Halton



Age and sex

The percentage of the cohort that was male is also rising, with 68% of the admissions being male in 2011/12, compared to 53% in 2008/09. In terms of age, most admissions occur in the 40 to 44 age bracket, followed by those aged 25 to 29. However the pattern is different for males and females; for males, most occur aged 25 to 29, followed by ages 40 to 49, whereas for females, most occur aged 15 to 19, followed by ages 30 to 34.

Figure 11: Percentage of drug related admissions by sex and age band, 2011/12



Source: EIS LIVE Inpatient Universe, 2012

Reason for admission

There is also a changing picture with regards to reasons for admissions. The International Classification of Diseases, ICD 10, is a system that standardises codes for diseases, signs and symptoms. The table below shows over the four years between 2009/10 and 2011/12, the ICD 10 codes for drug related hospital admissions show:

- A decrease with regards to:
  - 'Mental and behavioural disorders due to use of opioids' from 81 to 58. Opioids include heroin, morphine, methadone and codeine.
- An increase in:
  - Mental and behavioural disorders due to use cannabinoids from 27 to 49
- Similar numbers for:
  - Mental and behavioural disorders due to cocaine.

- Mental and behavioural disorders due to use of other psychoactive substances
- Poisoning by benzodiazepines
- 'Intentional self-poisoning and exposure to narcotics and hallucinogens'.

The most common diagnoses in 2011/12 were mental and behavioural disorders due to use of opioids (19%) and Intentional self-poisoning by and exposure to narcotics and hallucinogens.

Table 8: Number of drug related admissions by ICD 10 sub-chapters, Halton 2008/09 to 2011/12

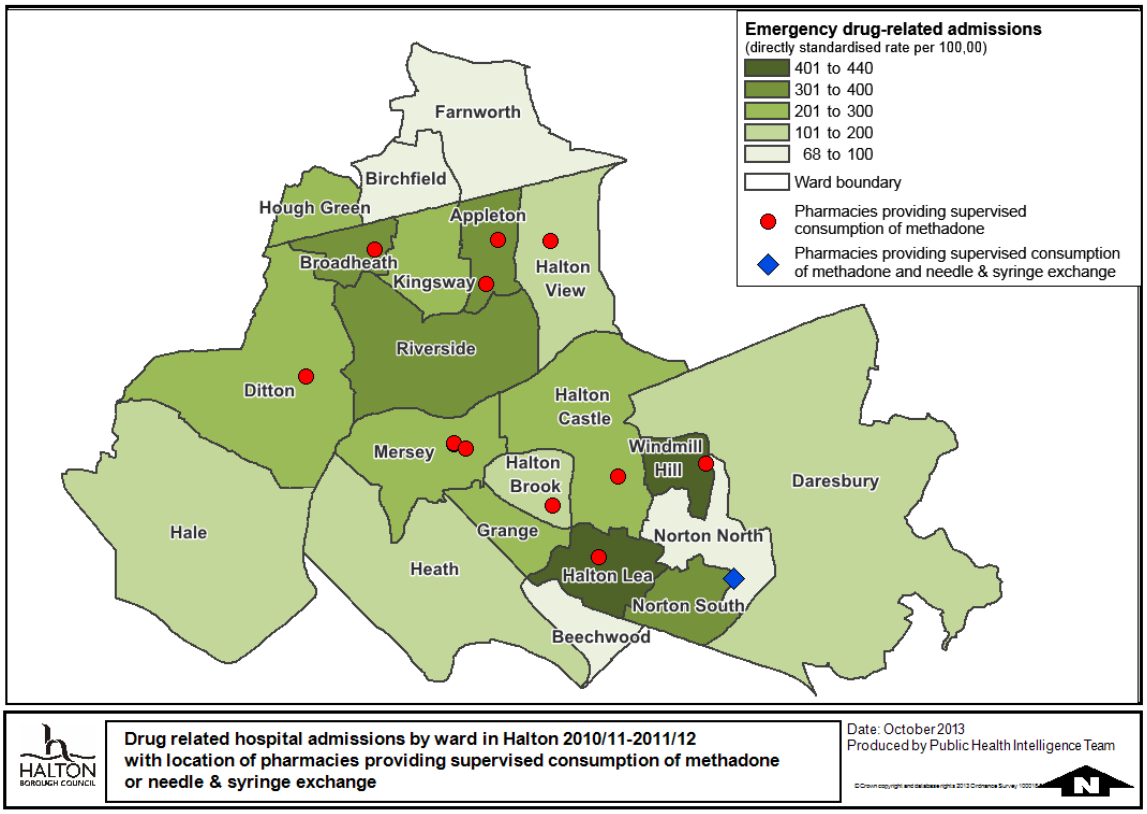
ICD 10 code	ICD Description	No. of admissions 2008/09	No. of admissions 2010/11	No. of admissions 2011/12
F11	Mental and behavioural disorders due to use of opioids	81	72	58
F12	Mental and behavioural disorders due to use of cannabinoids	27	20	49
F13	Mental and behavioural disorders due to use of sedative or hypnotics	3	5	3
F14	Mental and behavioural disorders due to use of cocaine	17	13	19
F15	Mental and behavioural disorders due to use of other stimulants, including caffeine	0	8	7
F16	Mental and behavioural disorders due to use of hallucinogens	0	1	1
F19	Mental and behavioural disorders due to use of other psychoactive substances	30	43	38
T38.7	Poisoning by androgens and anabolic congeners	0	0	1
T40	Poisoning by narcotics and psychodysleptics	8	27	27
T41.2	Poisoning by anaesthetics	1	1	1
T42.4	Poisoning by benzodiazepines	21	27	22
T43.6	Poisoning by psychotropic drugs: psycho stimulants with abuse potential	6	10	11
T59.8	Toxic effect of other gases, fumes and vapours	3	3	3
X42	Accidental poisoning by and exposure to narcotics and hallucinogens	13	1	0
X62	Intentional self-poisoning by and exposure to narcotics and hallucinogens	55	62	61
Z503	Drug rehabilitation	0	1	1
Total		**265**	**294**	**302**

Admissions by residence of patient

The map below shows the distribution of drug related admissions by ward of residence of patient over two years. Halton Lea ward has the highest rate of 440 per 100,000 population (55 admissions) and Beechwood

the lowest with 68 per 100,000 (5 admissions). There are pharmacies which provide supervised consumption of methadone in or within close proximity to the wards with the highest rates of admission.

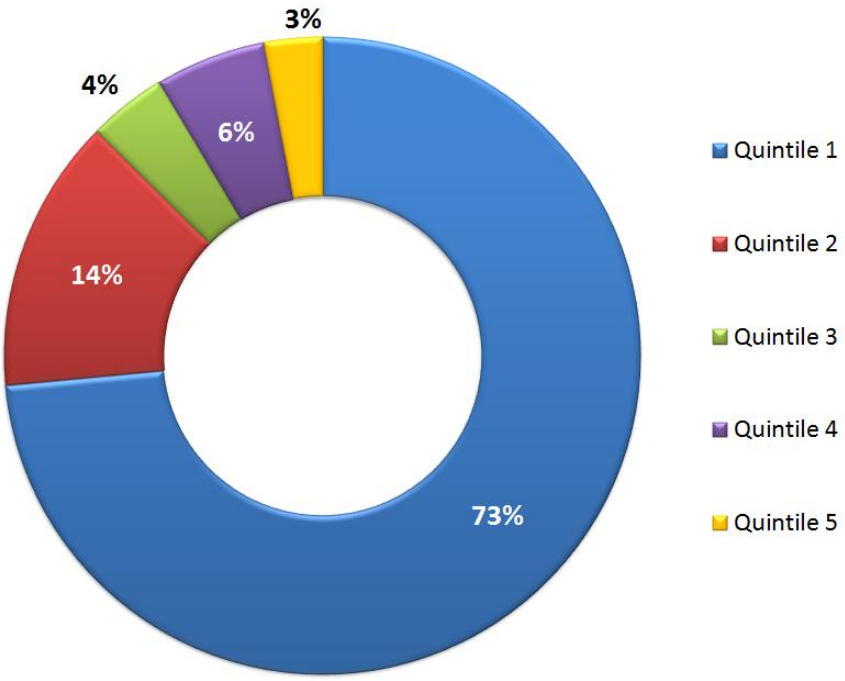
Figure 12: Drug-related hospital admissions (directly standardised rate per 100,000 population) by ward in Halton 2010/11 - 2011/12, with location of pharmacies providing supervised consumption of methadone or needle and syringe exchange.



Admissions and deprivation

The chart below shows that for admissions in 2011/12, 73% lived in the most deprived quintile (20%) nationally. Analysing admissions over the two years from 2010/11 to 2011/12, there is a strong relationship between rate of admission by ward and level of deprivation (r=0.87).

Figure 13: Percentage of drug related admissions by 2010 national deprivation quintile (IMD 2010), Halton, 2011/12 (Quintile 1 = most deprived, Quintile 5 = least deprived)



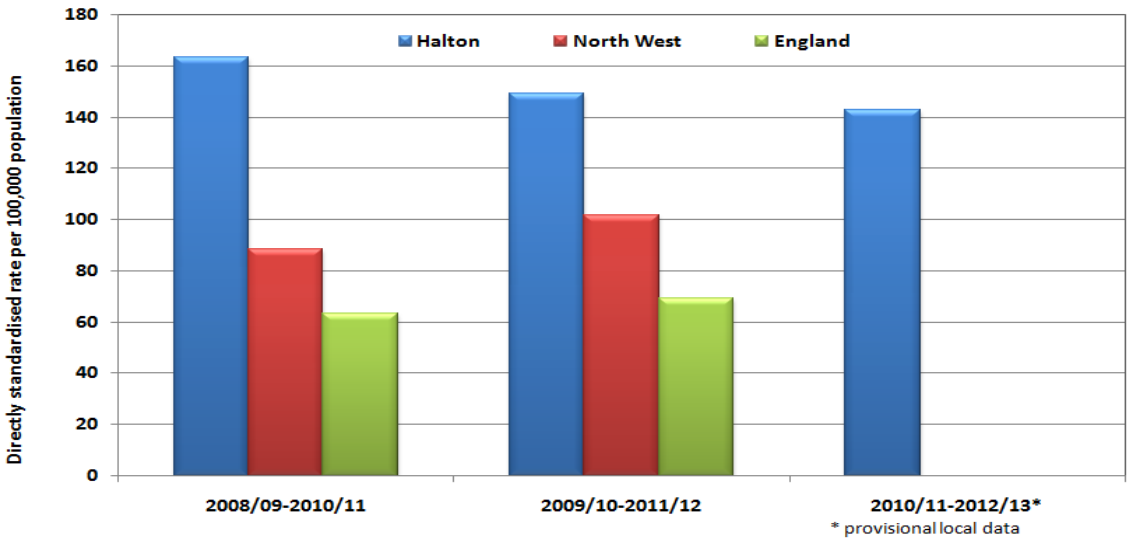
3.1.2. Substance misuse

Whereas drug related admissions could include activity not directly caused by drugs (but where the patient has a drug diagnosis on their admission record), substance misuse hospital admissions focus on those due directly to the harmful use of substances (physically or psychologically).

Children and young people

Data is collected nationally on substance misuse hospital admissions for 15-24 year olds. The chart below shows the trend since 2008/09 and the latest information for Halton, using local data. Due to the relatively small numbers involved, published data is based on a 3 year directly standardised rate per 100,000 population. Halton's rate has decreased since 2008/09-2010/11 but was significantly higher than the England average for both years' that comparator data is available; in 2008/09-2010/11 Halton had the highest rate of any Local Authority in England.

Figure 14: Trend in hospital admissions due to substance misuse (ages 15-24), 2008/09 to 2012/13



Source: ChiMat health profile; Cheshire & Merseyside Commissioning Support Unit

In terms of actual numbers, between 2010/11 and 2012/13, there were 69 admissions for substance misuse in those aged 15-24, an average of 23 per year.

Using local data over the last 4 years (2009/10 to 2012/13) for those aged 15-24:

- All were emergency admissions
- The majority were admitted via Accident and Emergency (92%)
- The most common types of substances diagnosed were:
  - Codeine/morphine (49%)
  - Multiple or unknown substances (13%)
  - Cocaine (10%)
  - Psychostimulants with abuse potential (excl cocaine) (10%)

All ages

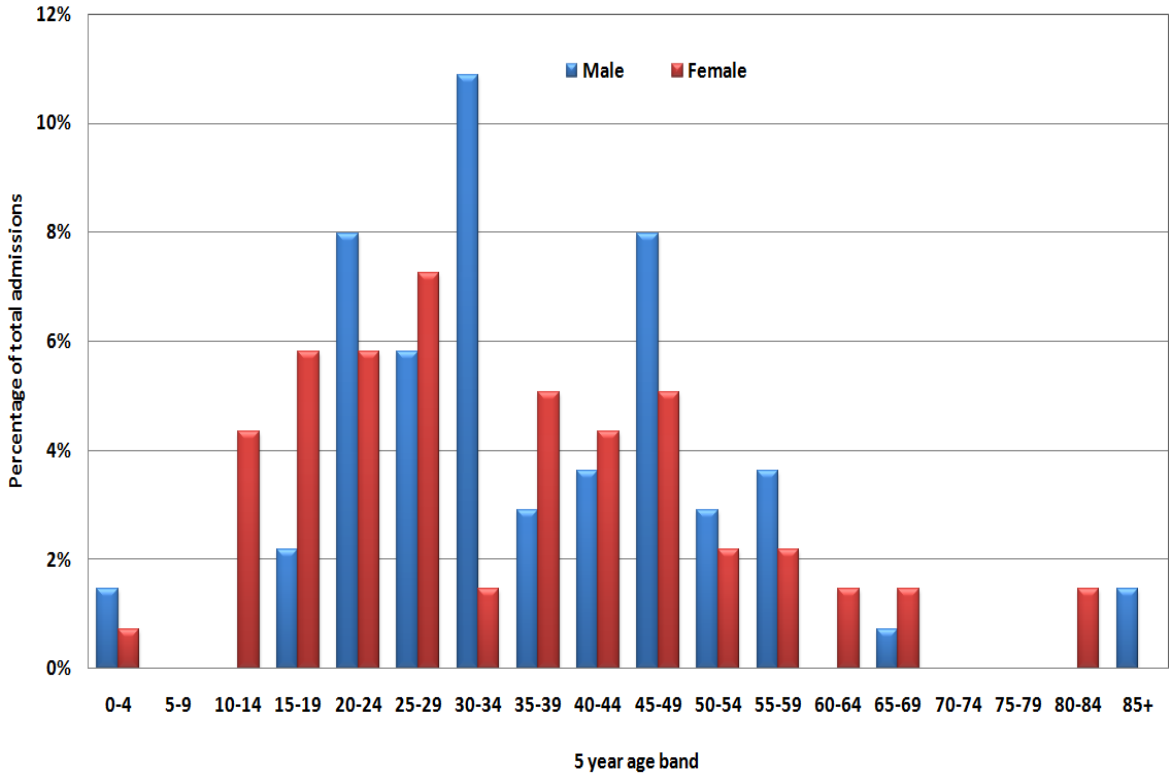
Data relating to substance misuse hospital admissions is not published nationally for all ages, but local data shows that the number has increased to 138 in 2012/13.

Table 9: Number of admissions due to substance misuse in Halton, 2009/10 to 2012/13

Year	No. of admissions
2009/10	84
2010/11	80
2011/12	76
2012/13	138

In 2012/13 there were approximately the same numbers of admissions in males and females. The chart below shows the age and sex breakdown in detail.

Figure 15: Percentage of substance misuse hospital admissions by sex and age band, 2012/13



Source: Cheshire & Merseyside Commissioning Support Unit, 2013

Overall, most admissions occurred in those aged 20 to 24; however females saw the highest number in those aged 25 to 29, whereas for males the most common age bracket was 30 to 34.

3.2 Accessing Treatment Services

The national standard regarding waiting times for treatment is that individuals should not wait longer than 3 weeks. Halton has no waiting time for treatment, offering a 'same day' service.

The largest group of people accessing services has been through self-referral. In seeking to reduce drug related crime, services have also been delivered at different points throughout the criminal justice system – custody suites, prison, courts. Between 2010 and 2012 the numbers entering treatment via the criminal justice system was low. 2012/13 has seen a significant increase in referrals via this route. However referrals from partner agencies where it would be anticipated that individuals with drug misuse problems would also appear, such as hospitals, social care and Job Centre Plus, remain low.

3.2.1. Treatment Services - Drugs used by individuals accessing treatment.

Data provided by Halton treatment service to the National Drug Treatment Monitoring System (NDTMS) identifies the patterns of drug use of people in treatment services. Heroin overwhelmingly remains the main drug of use. Cannabis and cocaine are the second and third main drugs of use. However, when examined in further detail, 2012/13 data indicates rises in cannabis and cocaine as primary drugs of use and increases in numbers of people using in combination alcohol and cocaine or cannabis and cocaine. In terms of secondary use, crack cocaine is the largest group, followed by alcohol, methadone and cannabis.

Table 8 shows that the percentage of people, in Halton, using heroin as the primary drug during 2012/13 is lower than the England and North West percentages. Due to this, the percentage of people using cocaine and cannabis as their primary drug in Halton is higher than England and the North West.
(See table below for percentages).

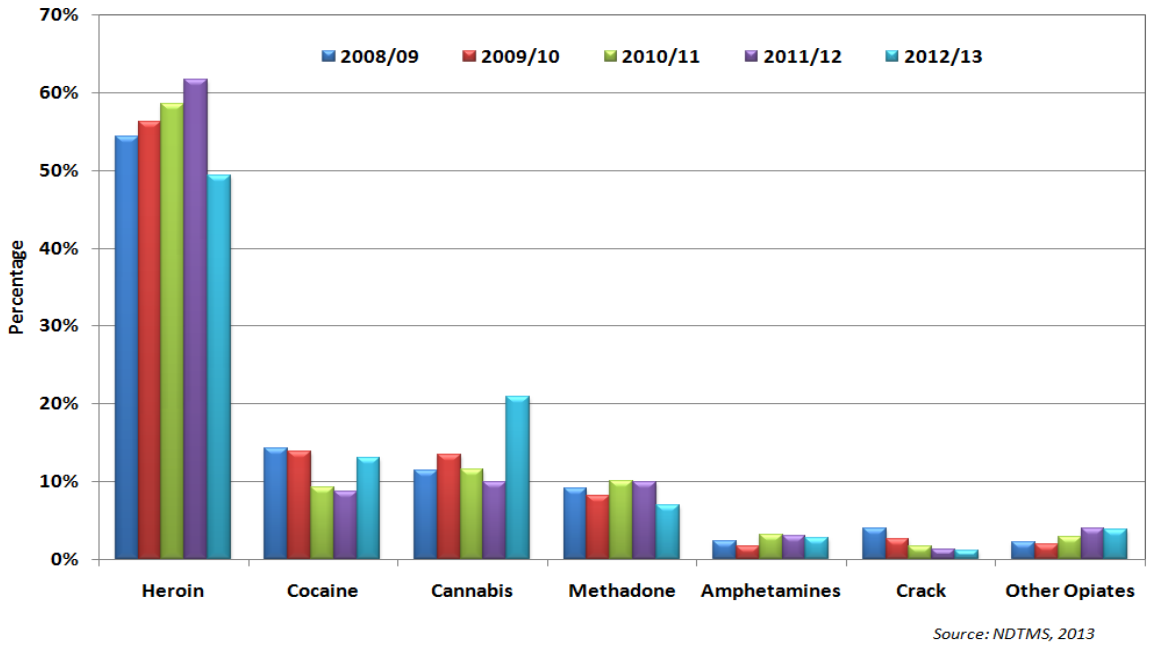
Table 10: Primary drug used

	Halton										North West	England
	2008/09		2009/10		2010/11		2011/12		2012/13		2012/13	2012/13
Main drug	***Number***	***Percent***	***Number***	***Percent***	***Number***	***Percent***	***Number***	***Percent***	***Number***	***Percent***	***Percent***	***Percent***
Heroin	376	54.3%	388	56.3%	370	58.6%	325	61.7%	323	49.3%	65.3%	67.3%
Methadone	63	9.1%	56	8.1%	64	10.1%	52	9.9%	46	7.0%	5.8%	4.2%
Other Opiates	15	2.2%	13	1.9%	18	2.9%	21	4.0%	25	3.8%	3.6%	4.6%
Benzodiazepines	*	*	*	*	*	*	0	0.0%	*	*	0.9%	0.9%
Amphetamines	16	2.3%	12	1.7%	20	3.2%	16	3.0%	18	2.7%	2.5%	2.4%
Cocaine	99	14.3%	95	13.8%	58	9.2%	46	8.7%	85	13.0%	7.6%	5.5%
Crack	28	4.0%	18	2.6%	11	1.7%	7	1.3%	7	1.1%	2.0%	3.7%
Hallucinogens	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.1%	0.3%
Ecstasy	*	*	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.1%	0.1%
Cannabis	79	11.4%	93	13.5%	73	11.6%	52	9.9%	137	20.9%	10.0%	9.3%
Solvents	*	*	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.1%
Barbiturates	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.0%
Major Tranquilisers	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.0%
Anti-depressants	*	*	*	*	*	*	0	0.0%	0	0.0%	0.0%	0.0%
Other Drugs	*	*	*	*	*	*	0	0.0%	*	*	0.4%	0.5%
Poly Drug	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0.0%	0.0%
Prescription Drugs	6	0.9%	9	1.3%	10	1.6%	8	1.5%	7	1.1%	1.9%	1.1%
Total	**692**	**100.0%**	**689**	**100.0%**	**631**	**100.0%**	**527**	**100.0%**	**655**	**100.0%**	**100.0%**	**100.0%**

*indicates numbers of 5 or less

As can be seen from the graph below, the percentage using heroin as main drug in Haltonhas increased year on year up to 2012/13 which saw a drop. Actual numbers presenting with Heroin as primary drug have fallen since 2009/10.

Figure 16: Primary drug used by people receiving treatment in Halton, 2008/09 to 2012/13



Crack is the most frequently cited secondary drug for Halton, North West and England. The percentage has decreased since 2010/11 in Halton, however, the percentage of people citing alcohol and cannabis has increased.

Table 11: secondary drug used

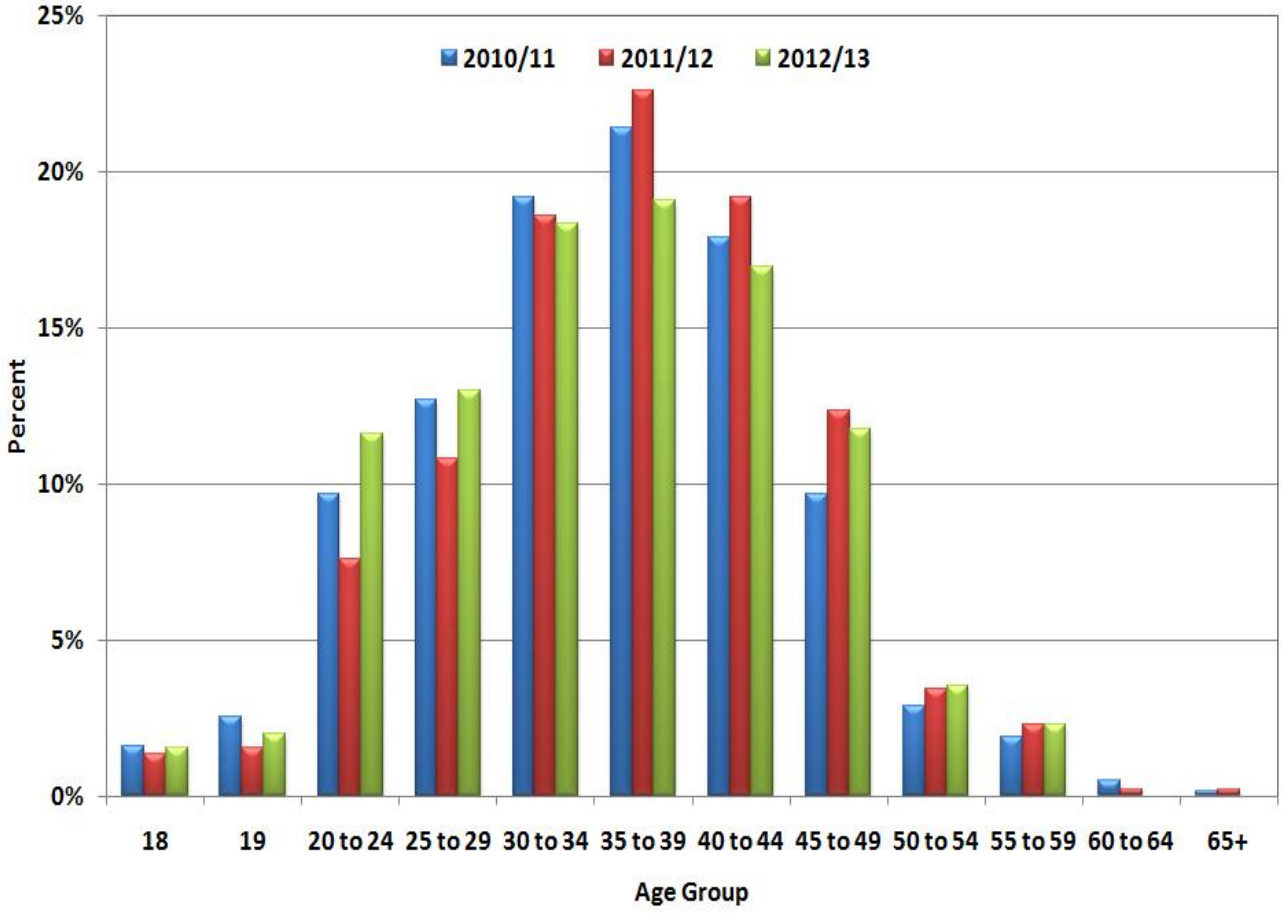
	Halton			North West	England
	2010/11	2011/12	2012/13	2012/13	2012/13
Crack	29.5%	27.5%	26.4%	19.9%	22.3%
Alcohol	10.8%	9.1%	12.5%	10.2%	11.5%
Methadone	6.8%	8.0%	5.3%	6.3%	4.3%
Cannabis	4.3%	3.2%	5.3%	6.2%	8.1%
Cocaine	4.4%	3.8%	3.5%	2.8%	3.1%
Amphetamines	0.8%	0.8%	2.3%	2.6%	2.5%
Heroin	2.9%	2.7%	1.5%	3.3%	3.2%
Other Opiates	0.6%	0.8%	1.4%	1.1%	1.6%
Benzodiazepines	1.4%	2.1%	0.8%	4.8%	4.5%
No other drugs used	37.2%	41.7%	39.7%	41.7%	37.3%

3.2.2. Age and Gender Profile

The balance of males and females has remained constant for a number of years in Halton. Of the total population of people in treatment during 2012/13, 26% were female and 74% male. This is very similar to the national (27% female and 73% male) and North West (28% female and 72% male) picture.

'Age group at mid-point' data over the past 3 years shows that the vast majority of people receiving treatment are aged between 20 and 49 years. The percentage of 20 to 29 year olds decreased during 2011/12, however the total number of people receiving treatment during this year (527) was lower than in 2010/11 (631) and 2012/13 (655).

Figure 17: Percentage of people receiving drug treatment by age group (at the mid point of the year), 2010/11, 2011/12 and 2012/13



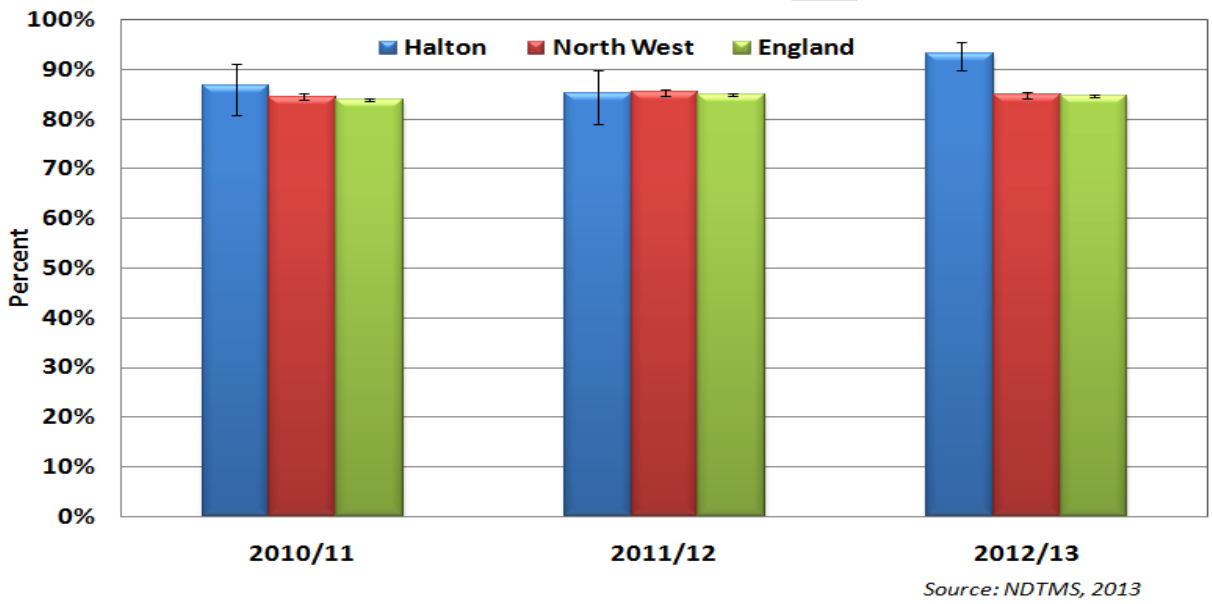
Source: NDTMS, 2013

3.2.3. Treatment Success

Research has shown that for drug treatment to be effective, individuals need to remain in service beyond 12 weeks. This data in the chart below relates to new treatment journeys within each year, and includes the number of people retained for 12 weeks or more and the number of completed (planned) exits.

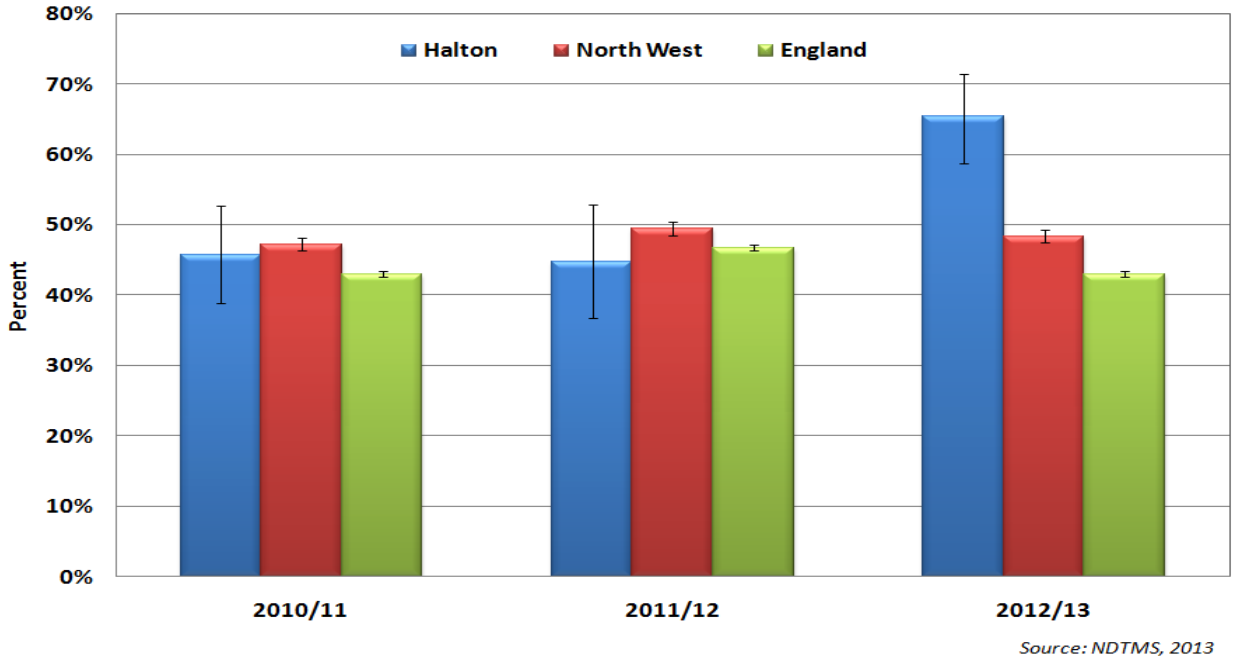
In Halton during 2012/13, 93% of people were 'successfully retained in effective treatment' compared with 87% in 2010/11. This means that the Halton 2012/13 percentage was significantly higher compared to the North West and England.

Figure 18: Percentage of people 'successfully retained in effective treatment' (new journeys), 2010/11 to 2012/13



In Halton, the percentage of people successfully leaving treatment is also continuing to improve – 65% in 2012/13 compared with 45% in 2011/12. During 2010/11 and 2011/12 the Halton percentage was similar to the England and North West percentages, however, in 2012/13 the Halton value was significantly higher. This data relates to the number of people whose exits from the treatment system were planned. This includes: 'Treatment completed – drug free' and 'Treatment completed – occasional user'.

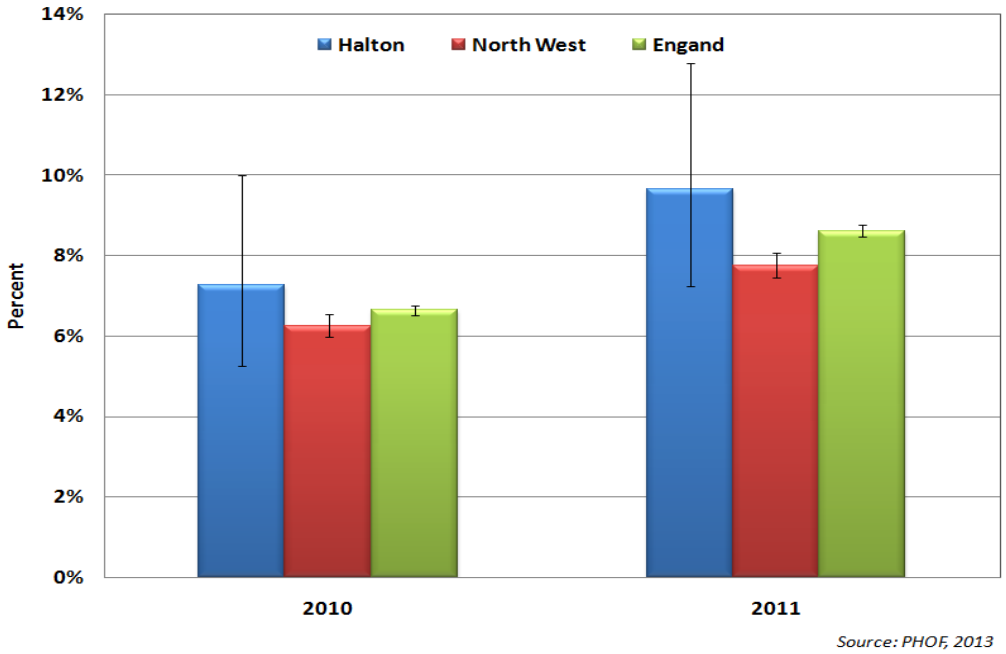
Figure 19: Percentage of exits which are completed (planned) during each year, 2010/11 to 2012/13



In Halton, the percentage of opiate users aged 18 to 75 years, who have successfully completed drug treatment, is higher than the North West and England figures, but not significantly so.

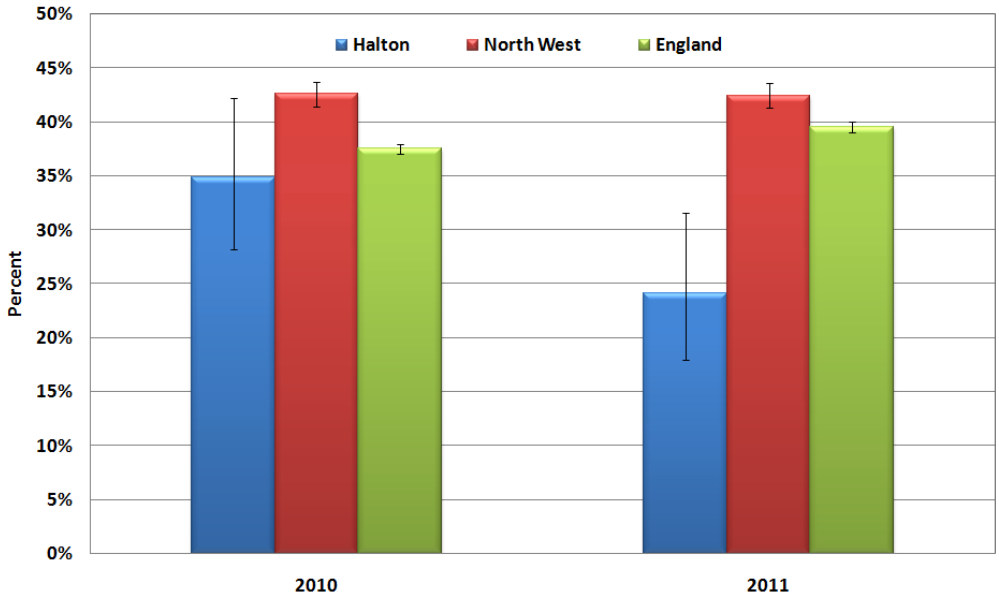
This data relates to people who have successfully left drug treatment and do not re-present to treatment within 6 months.

Figure 20: Successful completion of drug treatment,- opiate users, aged 18 to 75 years, 2010 and 2011



For non-opiate users, the percentage of people who do not re-present within 6 months is higher than opiate users. The chart below shows that the Halton percentage was similar to the England average in 2010, but decreased by over 10% in 2011. Due to this, the 2011 Halton value was significantly lower than the England and North West percentages.

Figure 21: Figure 17: Successful completion of drug treatment, non- opiate users, aged 18 to 75 years, 2010 and 2011



Source: PHOF, 2013

The Treatment Outcome Profile (TOP) is a measure that focuses on the four treatment domains as defined by the National Treatment Agency: substance use, injecting risk behaviour, crime and health and social functioning, measuring the progress an individual makes in drug treatment.

In 2011/12, TOP data shows that 42 exits from drug treatment were 'planned'. The majority of those leaving treatment at this time reported either abstinence or reduced drug use at exit. Individuals also reported that they were no longer committing crime, the number of people reporting being in paid work had increased, and health, psychological health and quality of life had also significantly improved.

3.3. Harm Reduction and Health Improvement

Chronic Hepatitis B and C are the leading cause of liver disease worldwide and the second most common cause of liver disease in the UK, after alcohol. The hepatitis B virus is transmitted perinatally from mother to child and through contact with infected blood. 95% of people who people with new chronic hepatitis B in the UK are migrants, most of whom acquired the infection in early childhood in the country of their. The remaining 5% of people with chronic hepatitis B acquired the infection in the UK, either through vertical transmission from mother to child or through exposure between adults. Hepatitis C is a blood-borne viral

infection transmitted through contact with infected blood. In the UK, hepatitis C is primarily acquired through injecting drug use. Approximately 70–75% of people with acute hepatitis C develop a chronic condition that can result in liver failure and liver cancer[24].

Preventing the spread of hepatitis, also known as a blood-borne viruses (BBVs), is a key public health issue, and a key outcome in the 2010 Drug Strategy[25]. Ensuring people who use drugs do not contract BBVs is one way of keeping them and their communities' safe before and during their recovery journeys.

Preventing BBV transmission also has benefits for wider society, both in terms of reducing health harms, and reduced treatment costs. Effective local action to prevent BBVs will include a range of services and interventions such as; needle and syringe exchange services; offers of testing and vaccination; providing harm reduction advice and information; promoting programmes that encourage a change of behaviour from injecting to some other form of administration.

Individuals that inject drugs are also at risk of HIV, skin and soft tissue infections, respiratory infections, wound botulism and tetanus. Over the past few years there have been a number of cases, both in the UK and main land Europe, of individuals contracting anthrax as a result of injecting contaminated drugs. There are currently 3 sites in Halton where a needle exchange scheme is provided. The largest is established at Ashley House, the other two are in Pharmacies within the community.

Of those individuals that began drug treatment in the past 3 years, over 90% have been offered a course of Hepatitis B vaccinations. However, of these, only 21% had a vaccination, comparing poorly to the regional figure of a third, and the national figure of 40%. With regards to Hepatitis C, nearly all people new to treatment who had a history of injecting were offered a Hepatitis C test, and this offer was taken up by over two thirds of individuals.

Anabolic Steroids

In 2010 the Advisory Council on the Misuse of Drugs (ACMD), a body that provides expert advice to Government, published its report into Anabolic Steroids[26]. In addition to the risks of contracting and/or transmitting BBVs, it reported a range of potential harms associated with their use including acne, cardiovascular symptoms, aggression and liver dysfunction. It also reported that their use by young people could potentially disrupt their normal pattern of growth and behavioural maturation.

The issue of substandard and counterfeit anabolic steroids was also raised. To address these issues the ACMD advised that steroid users should have access to sterile injecting equipment and that there was also a need for widespread, credible, information and advice to counteract mis-information provided by various web sites that actively promote anabolic steroid use.

A total of 507 individuals were reported as accessing the specialist agency needle and syringe programme in Halton in 2011/12. Of these, 403 were reported as steroid users (1 female, 402 male). Over 70% of steroid injectors were aged between 18 and 34. Of those individuals that were not injecting steroids, the age cohorts are evenly spread, although there is a small rise in the 30 to 34 age band.

Healthy Lifestyles Advice to people in treatment services

Many of the individuals presenting to treatment services also experience poor physical and mental well-being as a result of their lifestyles. In particular this can be poor respiratory health as a result of smoking, and poor mental wellbeing such as anxiety and depression. As a first step individuals are able to access a Health Checks Plus assessment. Over the first 6 months of 2012/13, 58 individuals were assessed there were also 77 referrals of people back to their GP for further assessment.

The Bridgewater Community NHS Trust also provides staff to work in Ashley House from their Health Improvement Team. This service aims to support people back into healthier lifestyles through accessing community facilities. Over the first 6 months of 2012/13 there were 37 referrals to the Health Improvement Team.

3.4 Dual Diagnosis

Dual diagnosis is the term used to describe people with mental illness and problematic drug and/or alcohol use. Historically the term has been used for those with “severe and enduring mental illnesses” such as psychotic/ mood disorders. More recently there has been an acceptance that personality disorder may also co-exist with psychiatric illness and/or substance misuse. The relationship between both conditions is complex. Concurrent mental health problems and substance misuse increases potential risks to the individual and is associated with; increased likelihood of suicide; more severe mental health problems; increased risk of violence; increased risk of victimisation; more contact with the criminal justice system; family problems; more likely to slip through services; less likely to adhere to medication or engage with other services; and more likely to lose accommodation and be at risk of homelessness.

With regards to prevalence; about half of patients in drug and alcohol services have a mental health problem, most commonly depression or personality disorder; about a third to a half of those with severe mental health problems will also have substance misuse problems; and alcohol misuse is the most common type of substance misuse and, where drug misuse occurs, it tends also to coexist with alcohol misuse.

In Halton, adult mental health services are delivered by the 5 Boroughs Partnership NHS Foundation Trust and the Council's mental health social care team. Following a recent configuration, the social care team are co-located with the Trust's Recovery Team. A recent audit of individuals in these mental health services identified 51% (n=198) individuals as having previous or current substance misuse. The main substances of use were alcohol, cannabis, amphetamine, benzodiazepines and cocaine. Only 1.5% (n= 6) identified methadone and heroin misuse.

In 2012, NHS Mersey led on a review of the response to Dual Diagnosis involving substance misuse in Liverpool, St Helens, Knowsley, Sefton and Halton. Two of the aims of the review were to 'highlight opportunities for change which could benefit all areas, and to identify gaps in provision'. The key issues that arose from the review and discussions with key stakeholders were;

- Transitions between services are problematic and are the points at which some individuals drop out of treatment.
- Clarification of the roles and responsibilities of the service and staff working within them in relation to dual diagnosis.
- Creating a network between the medical professionals working in substance misuse, mainstream mental health services and primary care.
- Both substance misuse and mental health services are increasingly 'recovery driven' and subject to 'payment by results', presenting opportunities for shared learning and development between the two sectors.
- Service users and their carers need to be involved at every stage in service improvement and development.

3.5 Carers

NICE Guidance identifies the need for services to discuss with families and Carers the impact of drug misuse on themselves and other family members, including children; offer an assessment of their personal social and mental health needs; and give advice and written information on the impact of drug misuse.

Since 2009, drug treatment services in Halton have been allocated a budget by the Carers Strategy Group to provide breaks to those individuals who have been assessed and are caring for someone with a drug and/or alcohol problem. There is currently 2 Carers support groups running at Ashley House. The assessment of carers needs, and the provision of information and advice has been mainstreamed into service delivery.

Between January 2009 and May 2012, 200 assessments were undertaken of Carers attending Ashley House. Age at assessment date ranged between 19 and 85 years with an average age of 47 years (n=73). 158 out of 200 (79%) carers were female. 79 Carers were caring for their son or daughter and 61 caring for their spouse/ partner. The largest cohort with regards to 'caring hours per week' was the 50+ hour's group, the majority of which were aged over 40.

3.6 Drug Related Deaths

The thirteenth annual report from the national programme on Substance Abuse Deaths (np-SAD) at St George's University of London presents information on drug-related deaths that occurred during 2011 and for which Coroner inquests and similar formal investigations have been completed. The Programme's principal function is to provide high-quality and consistent surveillance and to detect and identify emerging trends and issues in respect of this phenomenon. In this way, it contributes to the reduction and prevention of drug-related deaths in the UK due to the misuse of both licit and illicit drugs.

The main changes noted nationally in 2011 are a further overall fall in the proportion of deaths involving heroin/morphine but an increase in the contribution played by methadone. Whilst opiates and opioids continue to dominate, towards the end of 2009 there was a noticeable decline in the number and proportion of cases involving stimulants. To some extent these changes appear to have been reversed slightly for amphetamines, cocaine and ecstasy-type drugs.

The principal demographic characteristics of the decedents have remained consistent with previous reports. The majority of cases were males (72%), under the age of 45 years (66%), and White (97%). Most deaths (78%) occurred at a private residential address.

Substances which at the time of the 2009 report were 'legal highs' but became controlled drugs; continue to be present in post-mortem toxicology reports. Towards the end of 2009 new 'legal highs' such as mephedrone started to appear in reports to np-SAD. These increased during 2010 and 2011. The speed with which these and other new substances are continuing to replace established recreational drugs means it is important that surveillance and monitoring of the situation continues. The most commonly prescribed medications implicated in death were anti-depressants followed by hypnotics/sedatives (mainly the benzodiazepines diazepam and temazepam).

The report identifies 2 Substance Abuse Deaths (np-SAD, Table C) in 2011 of individuals whose usual area of residence is Halton. The illicit drugs implicated were cocaine, amphetamine and ecstasy. In Warrington in the same period there were 11 deaths and in Cheshire, 14

Part Four – Wider Impacts of Drug Use

4.1. Drugs and Crime

In 2010/11, 222 people were arrested in Halton for drug's offences. Not all of these individuals were residents of Halton. Of the 222 arrests, 27 were female and 195 male. 57 people were under the age of 20. The number of arrests for drugs supply were only a little under the number of arrests for drugs possession. Cannabis was the drug for which the highest number of individuals was arrested, either for supply or possession. Cocaine was the second highest drug. Arrests for supply or possession of either heroin or crack cocaine was exceptionally low. There were also 37 arrests for cannabis cultivation.

The Drug Intervention Programme (DIP) is the national criminal justice initiative aimed at engaging substance misusing offenders in drug treatment. Individuals are identified at the various points of the criminal justice system, such as arrest, in prison or in court, and encouraged into treatment services thereby addressing the causes of their offending. For 2010/11 and 2011/12 the number of people entering treatment via this route in Halton was 16 and 17 respectively. However, since the arrival of the new treatment provider in February 2012, the number of people being both assessed and starting treatment via this route has increased significantly with 47 people entering treatment via DIP between April and November 2012. There have also been changes in the 'presenting drug' of individuals seen in the DIP. The numbers presenting using cannabis and cocaine have increased whilst those using heroin have decreased. Of the heroin using cohort only 1 individual is currently injecting.

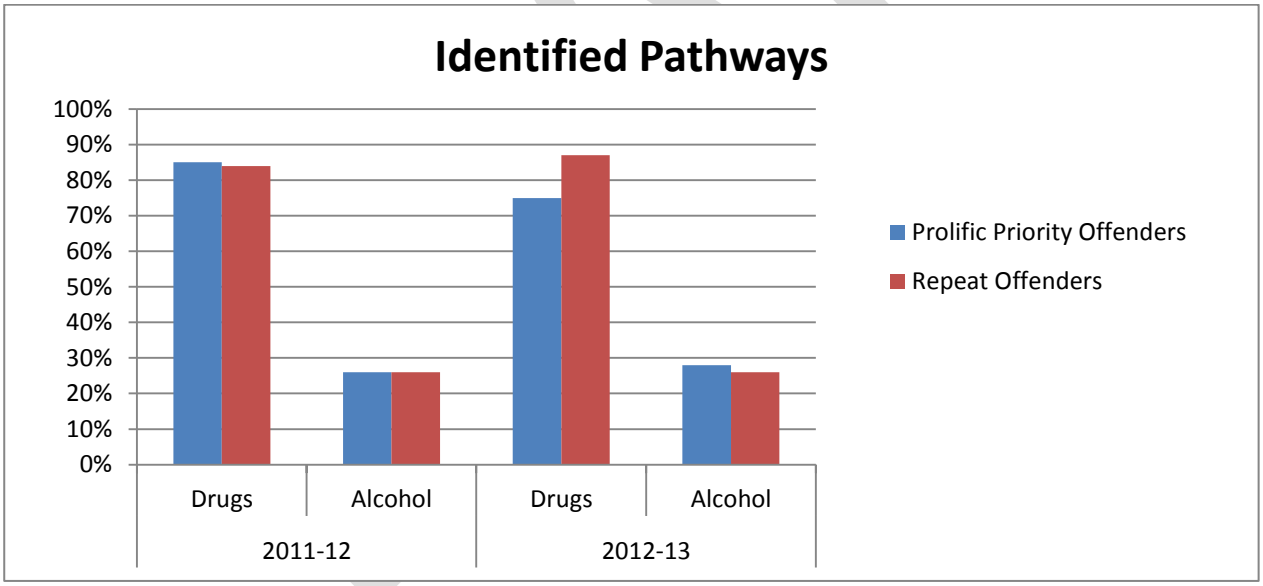
The National Probation Service for England and Wales is a statutory Criminal Justice Service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties. Information extracted from the Strategic Needs Analysis of the Cheshire Probation caseload published in July 2011, based on all Initial Sentence Plan Assessments showed that over two thirds of Halton offenders had experienced some level of substance misuse, with nearly one third of those individuals still using. Substance misuse was linked to offending behaviour in over half of the Halton cohort analysed.

In a sample of 120 Halton offenders, 63% were using cannabis. For 49% of this cohort, cannabis was their sole drug of use. There were also correlations between age, gender and drug use. Cannabis use was much higher for the under 25 age range, whilst heroin and crack use was more prevalent amongst those aged over 40. Nearly a half, 46% of offenders aged between 18 and 20 were 'currently using' compared to 35% in the 21 to 40 age range and 17% for those aged over 40. Women offenders were also slightly more likely to

be ‘currently using’ than male offenders, and a higher proportion were using Class A drugs (heroin, crack cocaine & cocaine). Women were also more likely to have previously injected compared to men.

A Drug Rehabilitation Requirement (DRR) is one of a range of community sentences available to the courts. It provides access to drug treatment programmes with a goal of reducing drug related offending. Once a DRR is imposed by the courts the individual must agree to a treatment plan with probation and the treatment service. This plan then sets out the level of treatment and testing required throughout the order. In 2010/11 10 DRRs were started, of which 7 were completed.

The Integrated Offender Management Team, based at Ashley House, is composed of staff from the police, probation service, youth offending service, and substance misuse team. Their remit is to target the individuals in the Borough whose criminality has been identified as causing significant harm to the community, and working assertively with that person to address the causes of their offending and reduce their offending. Where there is little change in an individual’s offending they are brought swiftly before the courts. In 2012/13, 75% of Prolific Offenders and 87% of Repeat Offenders had ‘drugs’ as an identified area for improvement.



4.2 Parental Impact of Drug Misuse

National figures show that a third of the adult drug treatment population has childcare responsibilities (NTA, 2010). For some parents this will encourage them to enter treatment, stabilise their lives and seek support. For others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm. Having a parent in drug treatment is a protective factor for children. The Munro Review of front line social work highlighted that children are too often 'invisible' to services, including substance misuse services, which tend to focus on the adult in front of them. For several years in Halton, the Commissioners and treatment providers have taken a safeguarding approach to protecting children who may be adversely affected by their parent's drug misuse. This is a wider, more preventative approach to meet the needs of children and involves the treatment services working with a range of agencies to prevent problems before they reach crisis point or formal proceedings need to be taken.

Halton's approach has been to; ensure representation and participation in the Safeguarding Children Board and its sub groups; ensure effective working relationships between treatment services and Children's services; identify, assess and if necessary refer parents misusing drugs; identify, assess and if necessary refer children who need to be safeguarded; and develop staff competencies and training.

A snapshot of treatment service data in February 2013 has shown that just under half of the 700 adults in drug and alcohol treatment services were parents. A similar proportion can also be seen in the 'new treatment journey' data. Between April and September 2012, Ashley House made 59 referrals to the service that provides early help and support to families, Children's Social Care's Integrated Working Support Team (IWST).

A training needs assessment carried out by Halton Adult and Safeguarding Children Boards identified that for the treatment service provider, the priority for training was those staff identified as belonging to Groups 5 and 6. 'Workers considered Professional Advisors, named and designated lead professionals' and 'Operational managers at all levels'. For Adult Safeguarding this means completing the Adult Referrers course or employer equivalent and for Safeguarding Children it means the completion of Effective Supervision or an employer equivalent.

Substance use problems are commonly identified for families which are the subject of Serious Case Reviews in Children's Services. Building on the learning from serious case reviews: A two-year analysis of child protection database notifications 2007-2009, which analysed 268 such reviews, parental drug use was mentioned in 22% of cases, and 22% also noted parental alcohol use. Research evidence suggests that around half of all survivors of domestic violence use substances problematically (Humphreys et al, 2005), with survivors who have experienced more than one sexual assault being 3.5 times more likely to begin or increase substance use (McFarlane et al, 2005).

Part Five –Delivering effective services

Substance misuse can be defined as intoxication by – or regular excessive consumption of and / or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances)[2].

Early use of drugs increases a person's chances of more serious drug abuse and addiction so it is clear that preventing early use of drugs or alcohol may reduce the risk of progressing to later abuse and addiction. If we can prevent drug abuse, we can prevent drug addiction.

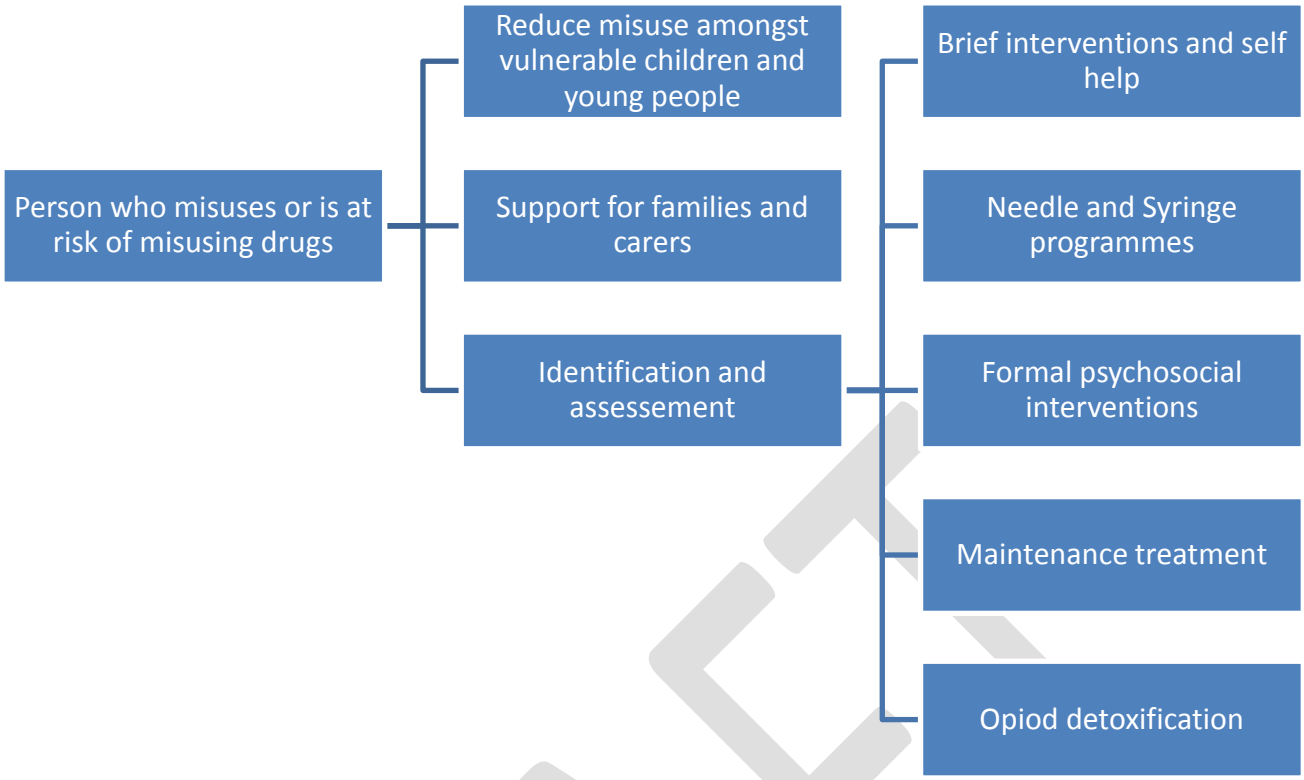
In early adolescence, children are often exposed to legal and illegal substances such as cigarettes and alcohol for the first time. When they enter secondary school, teens may encounter greater availability of drugs and social activities where drugs are used. At the same time, many behaviours that are a normal aspect of their development, such as the desire to do something new or risky, may increase teen tendencies to experiment with drugs. Others may think that taking drugs (such as steroids) will improve their appearance or their athletic performance or that abusing substances such as alcohol or ecstasy (MDMA) will ease their anxiety in social situations.

Drug misuse amongst young people is different from adults. Few young people use heroin or crack and very few are addicted. The most common illicit drug for which young people seek support is cannabis.

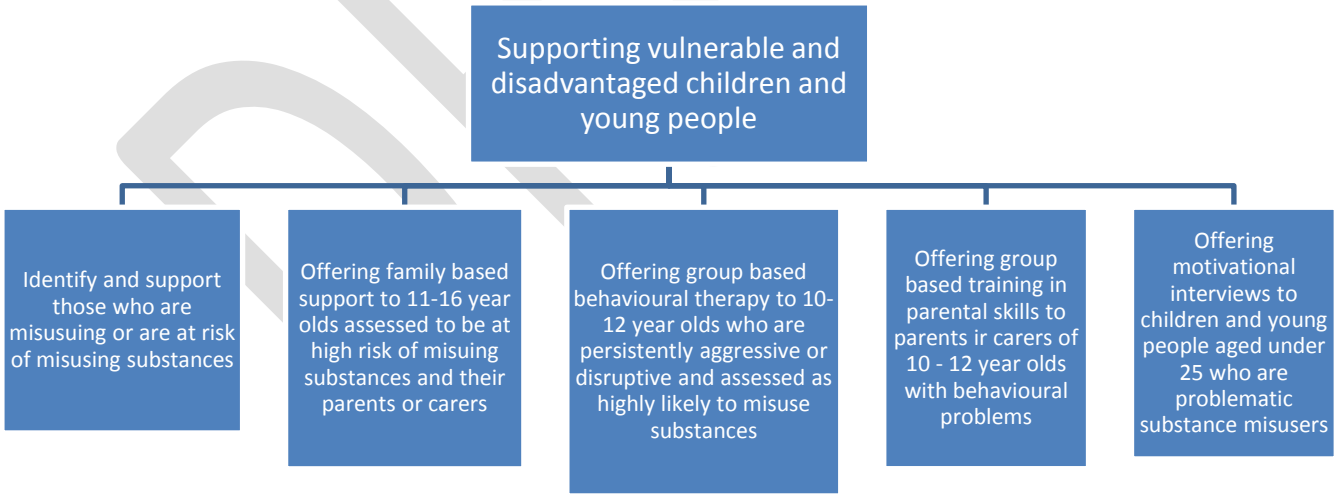
Family support plays a central part, including very early intervention with vulnerable families (particularly parents using drugs themselves). Drug Education and prevention work is delivered through schools and nationally through the FRANK campaign although review is needed to determine how to support schools to improve the quality of all PSHE teaching. NICE proposes that a number of pathways should be in place to support the effective delivery of local services to prevent and reduce the impact of substance misuse[3], particularly amongst vulnerable and disadvantaged children and young people.[4]

The NICE pathway suggests that Local Authorities and their partners should have a strategy and system in place to effectively **identify and support and treat those who misuse or are at risk of misusing drugs**.

[2] http://www.drugabuse.gov/publications/science-addiction
[3] http://pathways.nice.org.uk/pathways/drug-misuse
[4] http://pathways.nice.org.uk/pathways/reducing-substance-misuse-among-vulnerable-children-and-young-people/working-with-vulnerable-and-disadvantaged-children-and-young-people



In addition, NICE suggests that the following pathway should be in place for practitioners and others who work with **vulnerable and disadvantaged children and young people aged under 25.**



Substance Misuse Prevention

Drug use prevention approaches tend to fall into two categories – universal and targeted:

- Universal approaches are designed to reach everyone within a particular population regardless of their risk of substance misuse
- Targeted approaches focus on high-risk sub-groups of individuals or those already engaged in problematic behaviour. In the drugs field the main (but not sole) focus for the primary prevention of drug use has been adolescents in schools.

It has been predicted that roughly 10% of drug users become problem users, and from a public health point of view, it has been argued that greater attention and resources should be paid to those 'at risk' of becoming problem drug users and also those with problematic drug use in order to reduce the associated harm. Others identified as 'at risk' within the current drugs strategy include school excludes/truants, those leaving care, sex workers, young offenders and homeless people.

Research[5] has indicated that there is an association between licit and illicit drug and while both might be considered together as there are similarities in the intervention approaches used to reduce licit and illicit drug use, behaviour varies from drug to drug. Whilst one intervention may be effective in reducing licit drug use, it does not necessarily follow that it will be effective with illicit drugs. Whilst there are clearly advantages to sharing the learning across all substances it has been argued that drug prevention approaches should be drug specific.

Studies have also shown that drug use is strongly associated with early drinking, smoking and sexual activity, indicating that it is part of a repertoire of 'risk-taking' behaviours in young people. The concept of risk has a number of dimensions and, for some, riskiness is itself attractive or for others certain levels of risk can be accepted and rationalised. Whilst drug use is found across all social groups, there is a common assumption that the more damaging forms are to be found particularly among those who are relatively disadvantaged as there appears to be a direct link between drugs and deprivation.

Drug prevention approaches have encompassed a number of different positions - the information dissemination approach aims to increase public' knowledge about the health aspects of drug use, while affective education approaches adopt a broader stance that focus on increasing self-understanding and awareness and enhancing personal development and self-esteem. These approaches to health promotion have tended to assume that as rational individuals, people will make sensible choices about their health if they are given sufficient information.

Until recently, drug misuse was treated largely in isolation from other social and environmental factors and this strategy advocates a multi-agency approach to tackling drug misuse and there is a widely recognised need for public health measures to deal with the issue of illicit drugs and to support people to recognise the need to make a full positive contribution to their communities and make informed decisions about their lifestyle and future choices.

[5] http://www.nice.org.uk/niceMedia/documents/drug_use_prevention.pdf

Towards recovery

The effective commissioning and oversight of drug and alcohol treatment services is a core part of the work of the Director of Public Health. Directors play a key local leadership role around delivering public health outcomes and work with local partnerships – including Police and Crime Commissioners (PCCs), employment and housing services, and prison and probation services – to increase the ambition for recovery. The Health and Wellbeing Board looks to the Director of Public Health, along with local partners, to ensure that the drug treatment and recovery services, and those for the more severely alcohol dependent, are delivered in line with best practice and are aligned and locally led, competitively tendered and rewarded and transparent about performance.

Key to successful delivery in a recovery orientated system is that all services are commissioned with the following best practice outcomes in mind:

- *Prevention of children, young people and adults using drugs*
- *Freedom from dependence on drugs or alcohol;*
- *Prevention of drug related deaths and blood borne viruses;*
- *A reduction in crime and re-offending;*
- *Sustained employment;*
- *The ability to access and sustain suitable accommodation;*
- *Improvement in mental and physical health and wellbeing;*
- *Improved relationships with family members, partners and friends; and*
- *The capacity to be an effective and caring parent.*

Recovery can only be delivered through working with education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth justice services to address the needs of the whole person.

Halton is committed to ensuring that it can offer every opportunity to those people who face up to the problems caused by their dependence on drugs, and wish to take steps to address them. We now need to become much more ambitious for individuals to leave treatment free of their drug dependence so they can recover fully. We will strive to create a recovery system that focuses not only on getting people into treatment but also in getting them into full recovery and off drugs for good. It is only through this permanent change that individuals will stop harming themselves and their communities, cease offending and successfully contribute to society.

Recovery involves three overarching principles– wellbeing, citizenship, and freedom from dependence. it is an individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore, put the individual at the heart of any recovery system and commission a range of services to provide tailored packages of care and support. This means that local services must take account of the diverse needs of the community when delivering services.

Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification. However, for too many people currently on a substitute prescription, what should be the first step on the journey to recovery risks ending there. Recovery is not just about tackling the symptoms and causes of dependence, but about enabling people to successfully reintegrate into their communities. It is also about ensuring that they have somewhere to live, something to do and the ability to form positive relationships. Those already on the

recovery journey are often best placed to help, and we will support the active promotion and support of local mutual aid networks such as narcotics anonymous.

Evidence also shows that treatment is more likely to be effective, and recovery to be sustained, where families, partners and carers are closely involved. We will encourage local services to promote a whole family approach to the delivery of recovery services, and to consider the provision of support services for families and carers in their own right.

It is estimated that a third of the treatment population has child care responsibilities and for some parents, this will encourage them to enter treatment, stabilise their lives and seek support. Halton is committed to supporting those working with children and families affected by substance misuse to undertake appropriate training so they can intervene early to protect children from harm. Playing a more positive role in their child's upbringing is often a motivating factor for individuals in making a full recovery.

Evidence also suggests that housing and employment, along with appropriate support, can contribute to improved outcomes for drug users in a number of areas, such as increasing engagement and retention in drug treatment, improving health and social well-being, improving employment outcomes and reducing re-offending, and we will ensure that support is in place to work with individuals to maximise their life chances.

The following NICE quality standards and clinical guidelines are also available to support local implementation of both prevention and treatment activities.

- **QS23 Drug use disorders: quality standard (web format)**
- **Interventions to reduce substance misuse among vulnerable young people**. NICE public health guidance 4 (2007).
- **NICE clinical guideline: CG113 Anxiety**
- **NICE clinical guideline: CG91 Depression with a chronic physical health problem**
- **NICE clinical guideline: CG90 Depression in adults (update)**
- **NICE public health guidance: PH18 Needle and syringe programmes**
- **NICE clinical guideline: CG52 Drug misuse - opioid detoxification**
- **NICE clinical guideline: CG51 Drug misuse - psychosocial interventions**
- **NICE clinical guideline: CG113 Anxiety**
- **NICE clinical guideline: CG91 Depression with a chronic physical health problem**
- **NICE clinical guideline: CG90 Depression in adults (update)**
- **Drug misuse and dependence: UK guidelines on clinical management - Department of Health (England) and the devolved administrations (2007)**
- Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).
- Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).
- Behaviour change. NICE public health guidance 6. (2007).
- Drug misuse - naltrexone. NICE technology appraisal 115 (2007).
- Drug misuse - methadone and buprenorphine. NICE technology appraisal 114 (2007).
- Brief interventions and referral for smoking cessation. NICE public health intervention guidance 1 (2006).
- **Service user experience in adult mental health**. NICE clinical guideline 136 (2011)
- **Self-harm: longer-term management**. NICE clinical guideline 133 (2011)
- **Psychosis with coexisting substance misuse**. NICE clinical guideline 120 (2011)
- **Alcohol use disorders**. NICE clinical guideline 115 (2011)

- **Anxiety**. NICE clinical guideline 113 (2011)
- **Depression in adults**. NICE clinical guideline 90 (2009)
- **Obsessive-compulsive disorder**. NICE clinical guideline 31 (2005)
- **Post-traumatic stress disorder (PTSD)**. NICE clinical guideline 26 (2005)
- **Self-harm**. NICE clinical guideline 16 (2004)
- **Eating disorders**. NICE clinical guideline 9 (2004)

Systems, processes and pathways must be put in place to best meet the national guidance and ensure that the best possible services are available on a local level to provide cost effective, efficient and timely services to those who need them.

Part Six –Service User & Carer Involvement and Patient Opinion

Empowering people to shape their own lives and the services they receive through policies such as*;* Putting People First, the Localism Bill, and Liberating the NHS*,* has been a central feature of public sector delivery for a number of years. A more personalised approach to health and social care based on giving service users and carers a more direct say over service quality and improvement underpins the regulatory functions performed by the Care Quality Commission. In addition, commissioning guidance in general states the importance of not only incorporating service user and carer views in the shaping of delivery, but also in the monitoring of provider performance.

In Halton, this issue is being addressed through a variety of means. Earning the trust and respect of service users and carers is central to successful engagement and listening to local people requires time, energy and effort to create and cultivate trusting relationships that are based on respect and understanding. By doing so, people are more likely to be motivated and inspired to give insight from some of their most personal experiences.

Unsuccessful relationships between users and providers are often when service users feel that the service provided is being done **'to'** rather than **'with'** them. Service users are central to their own treatment plans so that individual needs are considered and more integration and coordination with other institutions is possible. Each service provider is challenged to provide robust evidence of active engagement with service users, their carer's and families and demonstrate how the voice of the service user has informed and influenced service design and delivery. Services are monitored on any comments, compliments or complaints that are provided directly and, in the case of the Substance Misuse contract, an organisation known as Patient Opinion, which is an independent, not for profit organisation that works across the NHS has been commissioned to provide a point of communication for service users.

The work of Patient Opinion has been exampled in several Government publications, most notably a House of Commons Health Committee report that said, ' the Committee sees great value in providers constantly viewing the comments left about them on websites such as Patient Opinion and NHS Choices. Or the Cabinet Office report 'Making Open Data Real' that said 'by creating structured public conversations about recent experiences of a local health service, Patient Opinion aims to both stimulate improvement and show transparently whether services are listening to those they serve' and that 'feedback posted by patients and carers can be directed not just to the providers of care, but also to commissioners, regulators, civil society organisations and others'. One of the examples quoted in the report was where feedback from a Halton service user resulted in a change of

prescribing practice by the drug treatment service with a subsequent reduction in risks of re-offending and health.

Part Seven –Workforce

The development of skills, knowledge and expertise with regards to substance misuse has focused on two areas; ensuring staff employed within the substance misuse service are appropriately skilled and qualified to deliver effective drug treatment; and improving the awareness and knowledge of front line professionals in order to recognise, and where appropriate, either intervene through a brief intervention, or signpost individuals to more specialist support.

Since taking up the contract to deliver drug and alcohol treatment in February 2012, Crime Reduction Initiative (CRI) has instigated a comprehensive training programme with their staff. In addition to learning around key drug treatment skills such as the International Treatment Effectiveness Programme and Motivational Interviewing, colleagues have also received training in key areas such as Safeguarding Adults, Safeguarding Children and Equality and Diversity

Delivering learning to non-drug treatment staff has taken a two pronged approach; through the provision of e-learning and a wide variety of one day courses covering key areas.97 individuals across a wide range of organisations completed the 'awareness of alcohol and substance misuse' e-learning course. In terms of course evaluation, 96% of respondents would recommend the course to colleagues; 86% rated the course highly in terms of giving confidence to deal with these issues and in terms of content.

In 2012/13, 10 courses were available to individuals looking to acquire a more in depth knowledge of substance misuse. The courses; key concepts for Understanding Drug Use, Keep off the Grass – People and cannabis, Alcohol awareness – Identification and Brief Advice, Cocaine – Whose Line is it Anyway, and Drug Trends and Legal Highs. In 2012/13 a total of 127 people attended these courses. 74 were from within the Council, and 53 from external agencies. In the year previously 38 people attended these types of courses. The reason for the considerable increase in attendance was that following the termination of a contract with a Liverpool based specialist drugs training company, the resource was re-invested in providing more appropriate training delivered in Borough.

Over the past 2 years, 4 courses on parental substance misuse have been delivered by the treatment providers on behalf of Halton's Safeguarding Children Board. 30 individuals attended in 2012/13 and 33 individuals in 2011/12.

Part Eight- Funding

8.1. Introduction

As the Government's policy of deficit reduction continues, the impact on the public sector is significant and with the public sector having to make unprecedented decisions about the services that it continues to deliver, this ultimately has an impact on service delivery and residents expectations. The current position with regards to financing substance misuse service will be discussed within this part of the document.

Figure 22: Funding for Substance Misuse Service 2013/14

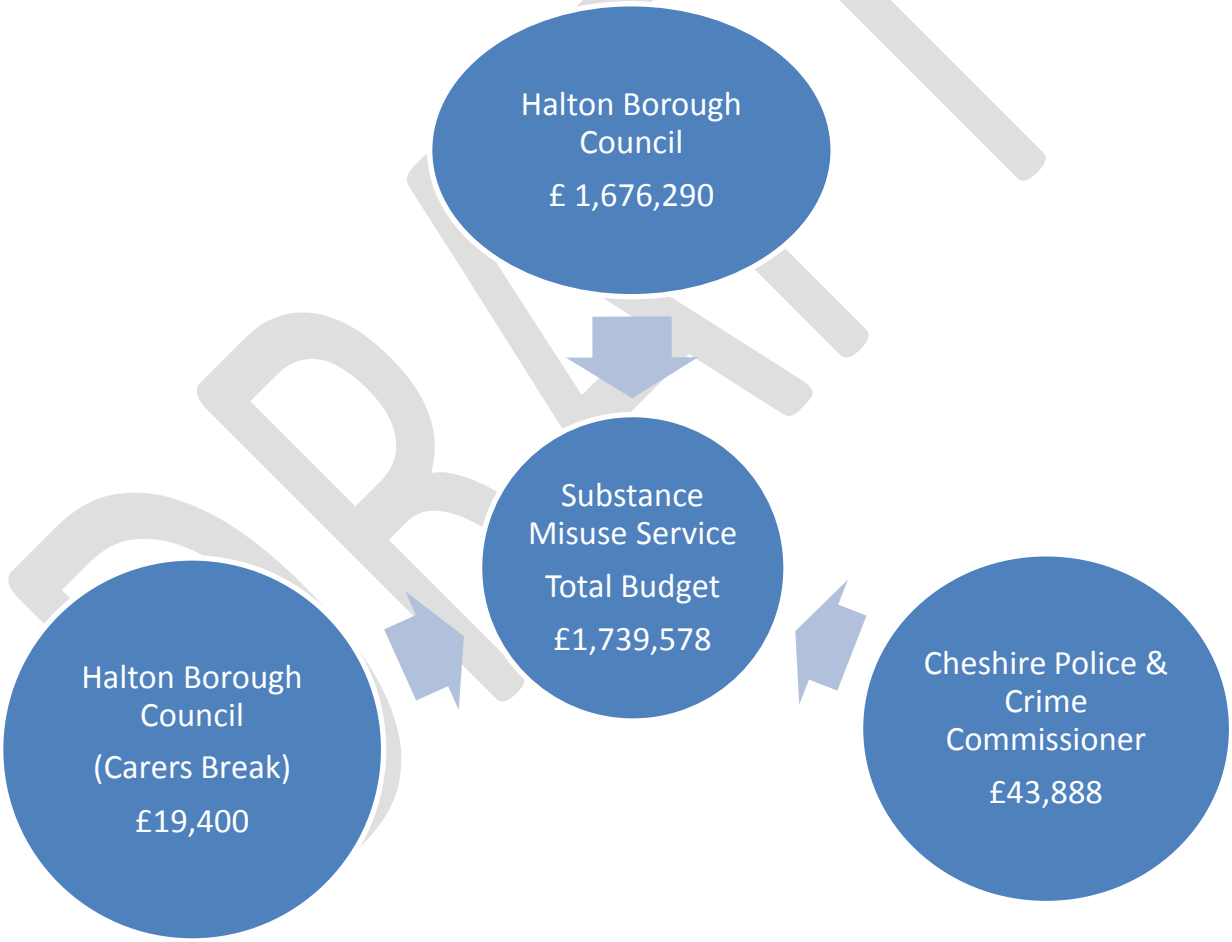


Table 12: Budget received for 2012/13 for substance misuse service (including drugs and alcohol)

Halton Borough Council	£1,676,290
Cheshire Police and Crime Commissioner	£43,888
Halton Borough Council (Carers Breaks Funding)	£19,400
Total	**£1,739,578**

From April 2013, all of the funding streams changed now all Government funding for Drugs is via Public Health (England) with the exception of the Home Office DIP funding, which transferred to the Police and Crime Commissioner. In-patient and Community treatment budgets for alcohol, used to contract provision from Mersey Care NHS Trust and Crime Reduction Initiatives (CRI) respectively also transferred into the Public Health allocation.

8.2 Pooled Treatment Budget (PTB) Allocation Funding Formula

The formula used by the National Treatment Agency to allocate Pooled Treatment Budgets in 2012/13 for each individual area was comprised of 3 parts:

- Complexity of partnership; 24% of the allocation is based on the 'York formula' which reflects deprivation, health and socio-economic conditions
- Activity; 56% is based on the number of adult drug users in treatment for 12 weeks or more, or if left treatment before 12 weeks, did so 'successfully'. This data is also segmented to identify heroin/crack users and other drug users, with the former attracting twice the tariff of the latter. A Department of Health 'Market Forces Factor' is also applied.
- Reward; 20% is allocated on the basis of activity in relation to the number of successful completions that did not re-present for treatment anywhere in England for at least 6 months

The Advisory Committee on Resource Allocation has recommended that this formula should continue beyond April 2013. This is in effect a 'payment by results' approach.

8.3 Payment by Results

The 2010 national drug strategy committed to introduce pilots to test how payment by results could work for drug services. The intention was based of the outcomes expected to be seen; free from drug(s) of dependence, reductions in offending and improvements in health and wellbeing, providers are freed up to innovate rather than follow target-driven processes, and are encouraged to support more people to full recovery. At present there are a number of areas around the country that are piloting this approach to commissioning drug treatment. A similar exercise is taking place with alcohol treatment. A formal evaluation over 3 years is currently being undertaken by the National Drug Evidence Centre (NDEC) at the University of Manchester, regular updates can be found on the Department of Health website.

8.4 Value for Money

During 2010, the National Treatment Agency (NTA) worked closely with economists in the Department of Health and the Home Office to develop a Value for Money (VFM) model of drug treatment which models the costs, cost savings and natural benefits of providing effective drug treatment. For 2010/11 the VFM Tool identifies £5.3 million of crime savings and £4.5 million of health savings as a result of providing drug treatment in the Borough. For the period of 2005/06 to 2010/11 the tool also identifies that for every pound spent on drug treatment £5.47 was gained in total benefits. This compares favourably to the national figure presented by the National Treatment Agency of £1 spent generating £2.50 of benefits.

8.5 Financial Constraints

There are a number of financial pressures anticipated in delivering this drug strategy

- A significant proportion of the Pooled Treatment budget is allocated on activity with regards to individuals who use heroin and/or crack cocaine. Current evidence is highlighting that there are very few individuals remaining in the community with this issue, and therefore activity with regards to this cohort will be fairly static this follows a national trend of reduced numbers of heroin and crack use. The area of increasing activity is with people using other types of drugs. They however only attract half the tariff. Therefore income for this funding stream may continue to reduce, despite good performance.

- To date there has been little pressure on the community care budget to fund residential rehabilitation. Were there has, this been around alcohol using adults. However, as the patterns of drug use change and work extends into what have previously been 'hidden' populations such as older people, people addicted to prescribed medications, women with children etc this may change. Management of demand for this form of intervention will rely heavily on the front line professionals in the treatment service and their integrated working with partners such as the Local Authority and Primary Care.

Part Nine–Current Service Provision

9.1 Introduction

Drug users have to take responsibility for their actions, and also their recovery. Services are there to support them by providing appropriate information, support and advice to enable individuals to make informed choices. In order to support an individual to recover from drug use or dependency it is essential to have services available at the time a drug user chooses to ask for help, any delay in the initial contact may miss the opportunity to support an individual to change their drug habits, dependency or behaviours. Those that use drugs will do so for a range of reasons and the interventions required will vary from person to person. The services available in Halton have been designed to meet a diverse range of needs with partner agencies working together.

The service model in Halton is one of prevention and recovery with the service user as the focal point and agencies working together to maximise resources and to promote individual growth, reducing the risk of dependency, and the impact on family members and the community (see diagram on pg. 43).

The services offered in Halton are themed:

- Reducing Crime
- Improving Health
- Reducing parental impact of drug use
- Promoting recovery for individuals

Table 13: How the budget was allocated 2013/14 for

Workforce Development:	£14,000
User Involvement	£5000
Carer Involvement	£31,250
Harm reduction	£165,000
Re-Integration	£113,000
Open Access Drug Treatment	£127,750
Structured Community Based Treatment	£360,110
In-patient rehab/detox	£170,120
Drug Intervention Programme	£107,750
Children's Service (Specialist Provision)	£79,000
Commissioning System	£25,380
Operational	£179,218
Alcohol Services	£362,000

9.2. Ashley House (Substance Misuse Service)

Halton's Integrated Support Service based at Ashley House, Widnes is a 24 hour 'One-Stop Shop' for substance misuse services, offering support in Halton. The services at Ashley House include advice, treatment and information for anyone to get help and support for drug and alcohol related issues.

Ashley House has a team of supportive staff, who are always on hand to offer advice and support and work towards helping people get their lives back on track and drug free. Some individuals are unable to be drug free but substitute illegal drugs for prescribed medication e.g. methadone; their journey through drug treatment programmes takes many years but the absence from illegal drugs reduces the risk and impact on the individual, family members and communities.

9.3. Children and Young People's Services

The Early Intervention / Targeted Outreach provision is delivered through the VRMZ outreach bus and street based teams. It identifies and targets those young people who are vulnerable to substance misuse.

Through Halton Youth Provision, we continue to support young people to recognise the need to make a full and positive contribution to their communities and make informed decisions about their lifestyle and future choices.

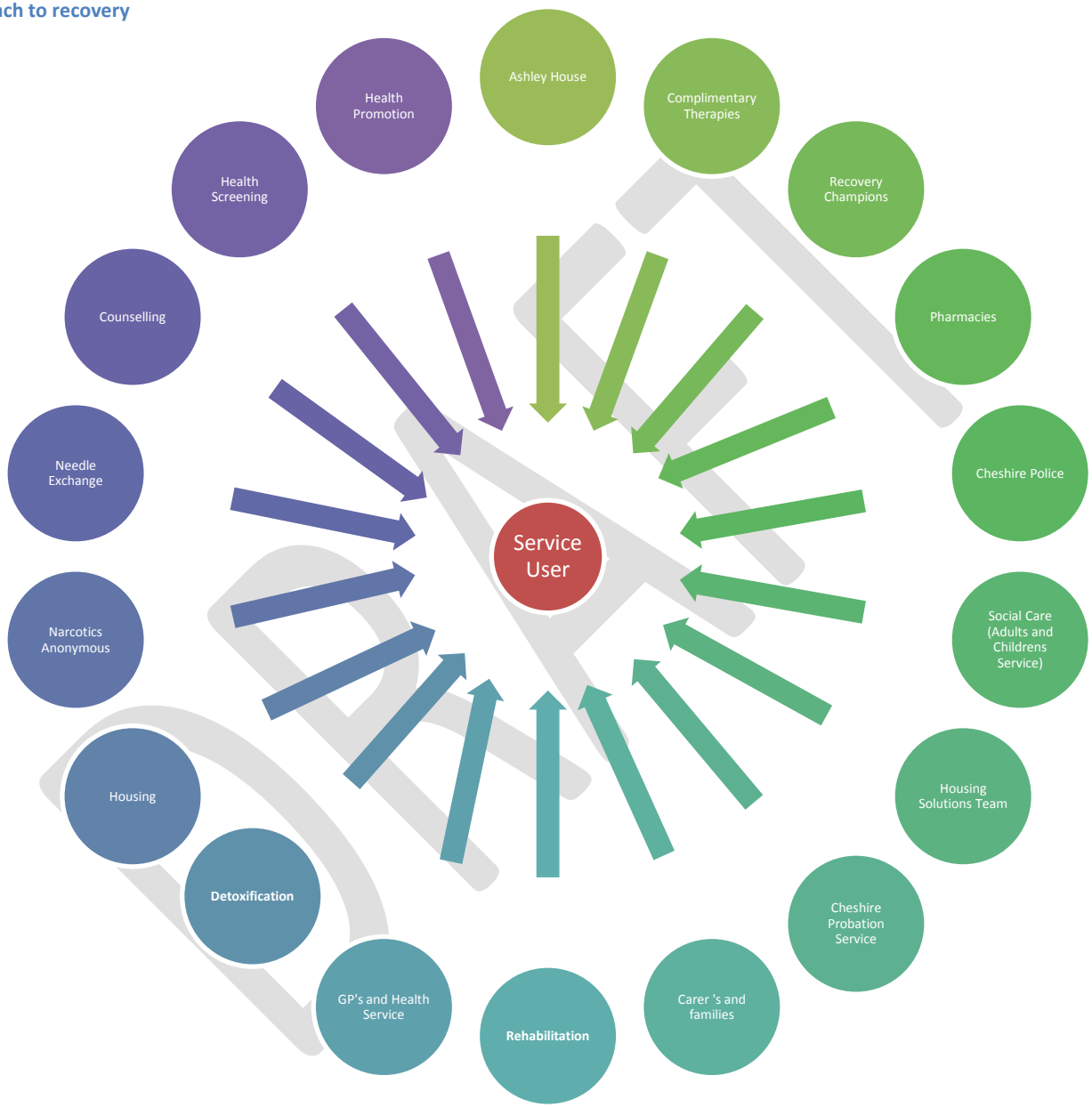
Halton Youth Provision actively engages with and works alongside other agencies to meet the needs of young people at risk of substance misuse, including Youth Offending Service, Health Improvement Team, School Health, Social Care, Community Safety and the Voluntary and Community Sector.

School based interventions are provided through the "Healthitude" programme, which aims to provide information, advice and guidance on a number of key health areas, including substance misuse, and to build the resilience of young people against risk taking behaviour.

Halton Early intervention and targeted Youth Provision also provides a range of one-to-one or group-based activities, for example:

- Reducing anti-social behaviour and substance misuse
- Support for young people affected by parental substance misuse, through the Skills for Change and Amy Winehouse Foundation.
- Debate with young people and communities issues related to ASB and substance misuse
- Cognitive restructuring interventions
- Interventions on positive substance misuse and sexual health
- Motivational strategies
- Positive Activities for Young People programmes which aim to engage young people in productive activities during school or college, holiday periods;

Figure 23: Service User focused approach to recovery



The choices individuals make can have a significant impact on their future health and well-being, the earlier individuals make informed choices about their drug use and the problems this can cause to their health and well-being, the earlier they can either stop using drugs or ask for help to reduce the dependency.

In order to enable individuals to make informed choices they need to have valid information and advice to understand the implications that their actions and choices have. Investing time and resources to address the broader determinants of health and wellbeing has been shown to not only lead to the prevention of disease in the longer term, but have a positive outcome beyond disease prevention, such as improved physical health, more social cohesion and engagement, better educational attainment, improved recovery from illness, stronger relationships and improved quality of life.

9.4. Peer mentoring (Recovery Champions)

Peer mentoring and support are invaluable when an individual asks for help; a person that has travelled the same journey and is in recovery holds a significant influence on those new to treatment. As services develop and information campaigns are designed it is key to success to have former and current users, family members, parents and carers involved in the design of information campaigns and sharing the news.

The Recovery Champion Programme at Ashley House provides training to individuals that have successfully recovered from drug use/dependency to enable them to provide a consistent approach when supporting other recovering drug users.

9.5. Carers and Families

Carers and family members of drug misusers are a diverse group and the stresses or problems that they may experience will be influenced by a number of factors which may include for example their own coping skills and mechanisms, culture and other stresses that they may be experiencing at that time in their life. Ashley House has a dedicated carers group that supports new and existing members in a range of ways to relieve the stress and pressure of the informal caring role; carers are also signposted to the Halton's Carers Centre for information, advice and support. The role of the carer is essential in the journey of recovery for the person dependent on drugs.

9.6 Narcotic Anonymous

Each week at Ashley House there is a Narcotic Anonymous meeting, the key to this meeting is those attending build a trusting relationship with services and others recovering from drug dependency, but the key theme is that drug misuse and dependency didn't happen overnight, so recovery will also take time and is designed to promote resilience and empower individuals to recover from drug dependency.

9.7. Community Pharmacies (Needle Exchange)

The community pharmacies have a key role to play in enabling a person to recover from their drug dependency. The knowledge and skills of pharmacists enable them to offer advice and signpost individuals to other more specialist resources for on-going support. In particular the needle exchange that is offered within two of Halton's Pharmacies and Ashley House reduces the risk of cross contamination of Blood Bourne Viruses, through the provision of free sterile needles. The pharmacists also work with the Substance Misuse Service at Ashley House in relation to supervised consumption of recovery drugs, the relationship is key in this partnership as drug users miss a pick up the Pharmacist will alert Ashley House staff who contact the individual, the benefit of this procedure is that the person in recovery stands a greater chance of maintaining their recovery.

9.8 Health and Wellbeing

An individual's health and well-being can be affected in numerous ways; this may be poor physical and mental health, housing related problems or homelessness, unemployment or financial hardship all of which can have a direct impact on the individuals drug use.

Primary health services have a role to play in the promotion and improvement of individual's health and wellbeing, this may be advice and guidance at the early stages of drug misuse, or advice for family and carers who are concerned about their family members. Under the NHS reorganisation, the responsibility of commissioning primary care to deliver drug treatment services transfers from the Primary Care Trusts to the Local Authority. Currently there are 3 GP practices delivering this service in Halton.

Health improvement initiatives are essential tools for ensuring drug users have the appropriate support and care they need:

- Health Checks
- Blood Bourne Virus Screening (HIV, Hepatitis C and B)
- Smoking Cessation programmes
- Sexual Health programmes
- Access to early detection and prevention of cancer.
- Screening and treatment associated with Chronic Pulmonary Obstructive Disease (COPD)

There is a growing trend of dependency on prescription medication, over the counter medication, steroids and human enhancing drugs such as weight loss, anti-ageing, and sexual enhancing drugs, the long term health implications are not known but research continues both nationally and internationally. Services need to work together, to ensure that drug users are appropriately supported, at the time of asking for help.

When a drug user comes into contact with services (Health Care, Social Care, Housing providers, criminal justice services or education) it may be the opportunity for them to turn their lives around, at that point referral pathways between services are essential alongside awareness training for front line practitioners of the local specialist drug services available.

Recovery can maximise the health and wellbeing of the individual, this then has a positive impact on the wider communities. The hardest part and the first step of recovery is for the drug user to acknowledge they have a drug problem. Individual wellbeing is about how people experience their own quality of life, and includes family relationships, financial situation, work, community and friends, health, personal freedoms and personal values. Individuals and communities are resilient and are able to cope with change, challenge and adversity.

Recovery embraces inclusion, or a re-entry into society and the improved self-identity that comes with a productive and meaningful role. For many people this is likely to include being able to participate fully in family life and be able to undertake work in a paid or voluntary capacity.

9.9. Public Health

Public health is "The science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society" UK Faculty of Public Health (2010)

As a function of the Local Authority, Public Health is concerned with the health of the entire population, requiring a collective multi-disciplinary effort. Public Health has a responsibility for:

- commissioning health services
- monitoring health status and investigating health problems
- health protection
- informing, educating and empowering people
- creating and supporting community partnerships
- developing policies and plans
- linking people to needed services
- conducting evaluations and research

One of the main concerns of public health is to reduce inequalities in health; in Halton compared to other areas in England and also within various communities across Widnes and Runcorn. Health in Halton is generally improving, with life expectancy increasing each year and rates of people dying from heart disease

and most forms of cancer are decreasing. However, this is not the case for all people in Halton and as a result the health of the population in Halton is below average compared to England as a whole. We can improve this, and we aim to encourage people to lead a healthy lifestyle to help improve health and tackle inequalities in health. Leading a healthy lifestyle means eating healthily, drinking sensible amounts of alcohol, taking exercise, quitting smoking and leading a healthy and safe sex life.

9.10 Public information campaigns, communications and community engagement

Information and advice are key to the prevention of drug use, ensuring young people, parents and adults are provided with factual, accessible information about the risks involved in taking drugs. Parents and schools also require information and advice to enable them to identify when young people may be taking drugs.

There is an increase in the use of social media, and also internet available advice and support via a variety of media, in order to meet the changing needs of young people and adults information needs to be available using a range of formats linking to self-assessment and self-help tools so individuals take responsibility for their health and lifestyle.

The overall aim of information and advice is to prevent drug use or to enable an individual to access information to prevent the drug use becoming an issue or dependency. As drug use takes many forms from illegal drugs to over the counter or prescription medication; information and advice will cover all forms of drug use and the associated risks.

Public information campaigns are an essential tool in getting the information to the public, this can be achieved through national campaigns as well as television programmes that highlight the issues of drug use. Locally information and advice is provided to schools, homeless hostel accommodation, community centres and GP surgery's etc.

9.11 Halton Clinical Commissioning Group (CCG)

Halton Clinical Commissioning Group is made up of representatives from each of the 17 practices across Runcorn and Widnes. The CCG is responsible for planning NHS services across the borough, and work with other clinicians and healthcare providers to ensure they meet the needs of local people.

Creation of CCGs forms part of the government's wider desire to create a clinically-driven commissioning system that is better aligned to the needs of patients.

The CCG works with patients and healthcare professionals, as well as in partnership with local communities and Halton Borough Council to make sure that health and social care is linked together for people whenever possible. In addition to GPs, our governing body will have at least one registered nurse and a doctor who is a secondary care specialist.

9.12 Cheshire Constabulary

The police sit at the heart of local enforcement. Good neighbourhood policing will gather intelligence on local drug dealers, provide reassurance and be visible to the public and deter individuals who seek to threaten and intimidate neighbourhoods. The supply, dealing and possession of drugs continues to be a priority for neighbourhood policing, thus providing reassurance to communities that anti-social or illegal behaviour will not be tolerated within Halton.

Cheshire Constabulary will continue to invest in key individuals dedicated to the role of drug experts. These individuals will act as a source of expertise and advice for officers and will be an effective conduit for updated information regarding the changing drug landscape and legislation.

It is essential that appropriate information sharing across agencies is maintained to ensure that a co-ordinated strategic approach to tackling drug supply is achieved; this is supported by national information sharing protocols with other police forces and the National Crime Agency.

9.13 Cheshire Probation Service

The National Probation Service for England and Wales is a statutory Criminal Justice Service, mainly responsible for the supervision of offenders in the community and the provision of reports to the criminal courts to assist them in their sentencing duties. Information extracted from the Strategic Needs Analysis of the Cheshire Probation caseload published in July 2011, based on all Initial Sentence Plan Assessments showed that over two thirds of Halton offenders had experienced some level of substance misuse, with nearly one third of those individuals still using. Substance misuse was linked to offending behaviour in over half of the Halton cohort analysed.

9.14 Integrated Offender Management Programme

The Integrated Offender Management (IOM) Programme is a joint scheme by Cheshire Probation Service, Cheshire Police and Halton Borough Council and is co-located with other services at Ashley House. The IOM service focuses on the most Prolific and Priority Offenders (PPO). Under the programme, once an individual

has been identified as a PPO they have two options: either to work with the PPO officers and team at Ashley House, or choose 'not' to accept any help. If they choose to work with the PPO Officer and team to change their behaviours and lifestyle they are supported to overcome their drug and/or alcohol addiction and find suitable accommodation. By choosing not to work with the PPO Team the individual opens themselves up to robust and proactive targeting by all agencies involved in the programme; this will include close supervision and several unplanned visits per day by the joint agencies to manage both the offending behaviour and their behaviour in the community, with any evidence of criminal activity being dealt with as a priority by the court. Cheshire Police are using the Restorative Justice process to support some individuals found in possession of cannabis directly into treatment rather than being subject to criminal procedures. The ultimate aim is to reduce crime and ensure individuals take responsibility for their actions.

9.15 Social Care (Children and Adults)

"Social workers are ideally placed to offer a holistic approach to understanding the relationship between the person's substance use and their family, home and community." (Galvani and Forrester, 2010)

9.15.1. Children's Social Care

National figures show that a third of the adult drug treatment population has childcare responsibilities (NTA, 2010). For some parents this will encourage them to enter treatment, stabilise their lives and seek support. For others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm. Having a parent in drug treatment is a protective factor for children. The Munro Review of front line social work highlighted that children are too often 'invisible' to services, including substance misuse services, which tend to focus on the adult in front of them. For several years in Halton, the Commissioners and treatment providers have taken a safeguarding approach to protecting children who may be adversely affected by their parent's drug misuse. This is a wider, more preventative approach to meet the needs of children and involves the treatment services working with a range of agencies to prevent problems before they reach crisis point or formal proceedings need to be taken.

A snapshot of treatment service data in February 2013 has shown that just under half of the 700 adults in drug and alcohol treatment services were parents. A similar figure proportion can also be seen in the 'new treatment journey' data. Between April and September 2012, Ashley House made 59 referrals to the service that provides early help and support to families, Children's Social Care's Integrated Working Support Team (IWST).

9.15.2. Adult Social Care

Individuals that misuse drugs can suffer from a range of physical health and mental health problems. Yet the complex nature of health and social care issues alongside a dependency on substances can make it difficult to support an individual. Halton Borough Council Social Care teams and a Mental Health Recovery Team provide assessments of individual needs and offer appropriate advice and support, utilising a person centred approach to promote independence. It is the co-ordinated approach of care management that enables professionals to work together to achieve outcomes for the service user. The link between services is evolving social care and the substance misuse service co-ordinate case management for individuals.

9.16 Housing Solutions Team

The Housing solutions team work with individuals who are threatened with homelessness or who are homeless, the team's aim is to prevent homelessness where possible. The Housing solutions team offer advice and guidance to individuals and families. The team work closely with the Welfare Rights, Citizens Advice Bureaux (CAB), Register Social Landlords, and private landlords, and providers of temporary accommodation within the borough as well as statutory services to ensure that appropriate advice and support is provided to the individual and/or family.

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