Devon PHIT Public Health Intelligence Team

NHS Devon

NHS Devon Substance Misuse Needs Assessment 2012

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3. Glossary

Phrase	Description
BBV	Blood Bourne Virus
DH	Department of Health
CARAT	Counselling, Assessment, Referral, Advice and Through-care
NDTMS	National Drug Treatment Monitoring System
CJIT	Criminal Justice Intervention Team
IVDU	Intravenous Drug User
PDU	Problem Drug User (opiates and crack)
MASH	Multi-Agency Safeguarding Hub
DCC	Devon County Council
DfE	Department for Education
YOT	Youth Offending Team
A&E	Accident and Emergency
CBT	Cognitive Behaviour Therapy
SWAST	South Western Ambulance Service Trust
DSFRS	Devon and Somerset Fire and Rescue Service
SCNR	successfully completing, not re-presenting
ONS	Office for National Statistics
CSEW	Crime Survey for England and Wales
OCU	Opiate and Crack User
MSOA	Middle Super Output Area
TOP	Treatment Outcome Profile
LAPE	Local Alcohol Profiles for England

4. Executive Summary

This aim of the Substance Misuse Needs Assessment is to systematically examine substance misuse in Devon, both for adults and children, drugs and alcohol. It considers the relative needs and harms of a wide range of population groups, and makes evidence-based recommendations on how needs might be most effectively met within available resources. It also examines current provision of substance misuse services in Devon, and where possible compares measured performance against expectation.

This document forms part of the Devon Joint Strategic Needs Assessment (JSNA), the suite of data and resources available to inform the priorities of the Health and Well Being Board.

Section six of this needs assessment provides information on 27 different groups of people (Figure 1). For some groups (e.g. prisoners, the homeless population and people suffering with mental health conditions), a wealth of both local and national intelligence is available and these sections are very detailed. For groups where associations with substance misuse are less significant, there may be little or no local data, and only limited national data available.

There are also a wide range of organisations that make up the wider referral and support system (Figure 1). Throughout section six, information can be found on both the core substance misuse service (which is currently out to tender) and on the wider referral and support system, which is seen as a vital part of delivering effective substance misuse in Devon.

Section seven of this report provides a detailed analysis of the core substance misuse service, currently provided by:

- Y-Smart (youth service for drugs and alcohol)
- Addaction (Adult alcohol service)
- Devon Drug Service (Adult drug and alcohol)

The analysis found that whilst many of the nationally recognised patterns relating to substance misuse apply to Devon, there are a number of specific differences and challenges:

- Opiate and crack users are the most frequent users of adult treatment services, though national estimates suggest that a lower proportion of the Devon opiate and crack using population are known to services or engaging in treatment.

- In Devon, a huge 84% of adult alcohol clients receive structured psychosocial treatment, compared to around only a half of clients nationally. Fewer clients received community prescribing and other structured treatment. The balance of treatment appears to be working well in the adult alcohol service, with over three quarters of clients completing with a planned exit, notably higher than the national percentage of 59.5%.

- A number of measures point towards an increasing service use for users of cannabis amongst young people in Devon, which is occurring alongside a

decrease in service use for Alcohol. Combined use of cannabis and alcohol is notably higher in Devon than nationally.

- Both in Devon and nationally, there appears to be some scope for the development of some referral pathways. Notably in Devon, hardly any referrals for any of the services were received from a hospital setting. Examining and developing these referral routes will form a key part of future service development.

- The cost per adult drug treatment service client is accessing treatment is higher in Devon compared to nationally. A significant contributor to this is higher prescribing costs, which make up 57% of the budget. By focussing on delivering a recovery orientated treatment service, it is anticipated that the proportion of the budget allocated to prescribing will decrease.

Figure 1: The current substance misuse treatment system in Devon and the population groups covered in the needs assessment.

5. Introduction

This document has been created jointly by the Devon Drug and Alcohol Action Team (DAAT), the Social Care and Commissioning Team and a range of providers and partner organisations. The DAAT are responsible for coordinating local and national strategy and policy to address alcohol and drug misuse in Devon. The document will form part of the Devon Joint Strategic Needs Assessment (JSNA), the suite of data and resources available to inform the priorities of the Health and Well Being Board. This aim of the Substance Misuse Needs Assessment is to systematically examine substance misuse in Devon, considering the relative needs and harms within different groups and settings, and make evidence-based recommendations on how needs might be most effectively met within available resources.

Substance abuse can have wide ranging social and economic impacts on society, and this needs assessment provides information on the burden substance misuse places on a number of services, both healthcare and otherwise. Information is provided on ambulance callouts, hospital admissions, accident and emergency attendances, mortality rates and social care data, as well as a range of crime and fire service data.

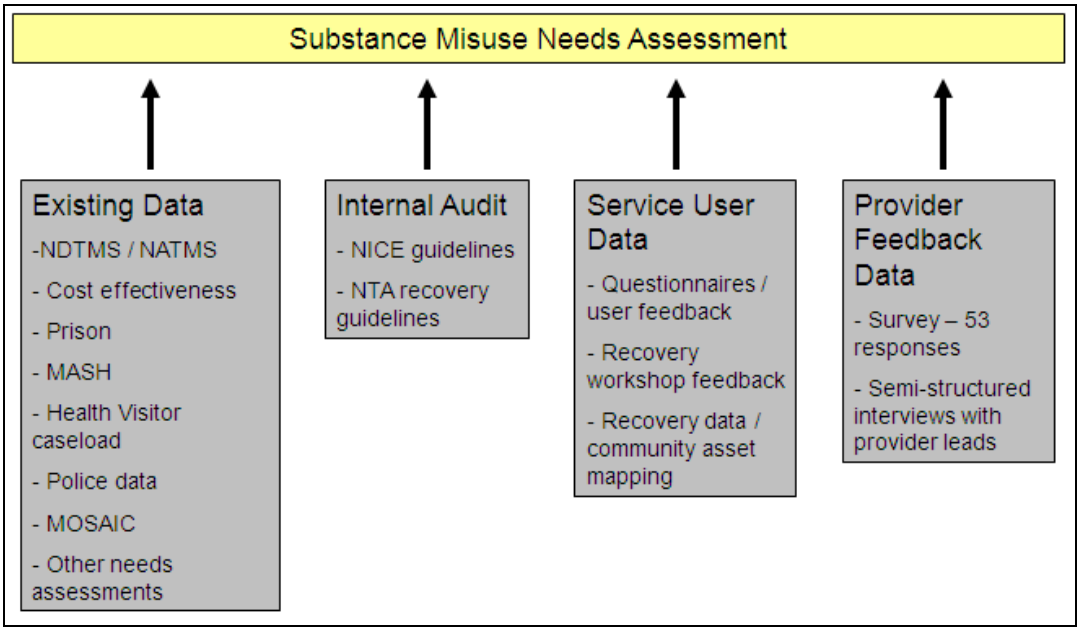
A number of population groups have been identified, whose relationship with substance misuse may, for whatever reason, differ from that of the general population. For each of these groups, local and nationally available data has been used to try and help understand how their needs differ. In keeping with the Health and Wellbeing Strategy of the “Life Course”, these groups have been presented in an order that is roughly ascending with the age of the population group.

Substance misuse services in Devon are currently delivered by a number of core providers, who work with and are supported by a range of partners, in order to be able to provide a comprehensive set of services to meet the often complex needs of individuals with substance misuse problems. The “What is currently being done” section of this needs assessment provides an insight into how these providers and their partners are currently working together and outlines some areas of good practice, as well as some areas where things could be improved.

A detailed breakdown of service users is provided, for the young persons’ service and for the adult alcohol and adult drug services, examining substance type, age, gender, as well as a range of other service based and socio-demographic breakdowns. Cost effectiveness tools have also been used to consider how effectively the service is being run compared to nationally.

A broad range of local and national data has been used to inform this needs assessment (Figure 4). The quality and availability of data have been hugely variable, and where existing information could not be found, attempts have been made to put measures, including local audits and surveys, in place, to gather what was needed. In some areas, where it was still felt insufficient data was available to draw meaningful conclusions, recommendations have been made as to how this could be improved going forward.

Figure 2 - Information sources used to compile the Substance Misuse Needs Assessment



6. What are the challenges presented by substance misuse in Devon?

This section provides an overview of the scale and impact of substance misuse in Devon. It examines:

- the number of people affected by substance misuse (prevalence)
- the impact substance misuse has on a range of public services
- the impact substance misuse has on different population groups
- the way substance misuse impacts differently on locations in Devon
- the way substance misuse interacts with other health and social care conditions.

6.1 Prevalence

Getting an accurate estimate of the prevalence of a population affected by substance misuse can be difficult, particularly when it comes to illegal substances which, for obvious reasons, people are often reluctant to admit they use. There are, however, a range of information sources that can be used to provide national and local estimates. The following sections provide a summary of the information that is available, summarising current and historic prevalence of drug and alcohol misuse.

6.1.1 Prevalence of Drug Misuse

6.1.1.1 National context

One of the main sources for national prevalence information on drug misuse comes from the Crime Survey for England and Wales (CSEW), conducted by the Office for National Statistics (ONS). The survey is a victimisation survey and measures the amount of crime in England and Wales by asking people about whether they or their household has experienced any crimes in the past year. Some of these questions relate to the personal consumption of illegal substances. The CSEW provides a better reflection of the extent of crime than police recorded figures as the survey asks about crimes that are not reported to or recorded by the police.

According to the 2011-12 survey, whilst over a third of the population have, at some point in their lives used an illegal drug, only 9% had done so in the last year, and only 5% in the last month. Cannabis is by far and away the most commonly used drug, accounting for 77% of all recent use, though the number of people using the drug in 2010 has decreased to 7% from the 11% seen in 2001.

An estimated 2.8 million people in England currently use drugs, with use slightly more common among the more affluent, but the number of people addicted to drugs is much lower, and usually affects poorer communities where people are struggling in other areas of life such as education, employment and mental health. The most problematic drugs are heroin and crack cocaine, of which there are currently an estimated 165,000 users. Compared to other countries, England has been able to offer treatment to a high proportion of its addict population. Despite the significantly smaller population size compared to general drug use, heroin and cocaine accounted for 159,542 out of the 197,110 adults in treatment, a huge 81%.

During the 80's and 90's, drug use became an increasing part of every-day existence, with an increasing number of addicts, but since then significant developments of the drug treatment system have helped contribute to a significant reduction in the number of new heroin and crack addicts, and between 2005-06 and 2011-12, the number of people coming into treatment fell from 64,663 to 25,237. The overall number of heroin addicts is also now decreasing, with only 9,249 new entrants in 2011-12, a 74% reduction from the 2005-06 figure of 47,704. This reduction is partly due to the successful recovery of existing addicts, but also due to a reduction in the number of young people starting to use heroin.

Since 1996, overall there has been a reduction in drug use, though this does vary by substance and by age group with the use of some substances, powder cocaine and methadone, having seen an increase in use. Figure 3 summarises the national change in drug use between 1996 and 2012, by drug type for the 16 to 24 and 16 to 59 year age groups. In addition to the substances covered in this table, recent years have seen a notable increase in the use of Novel Psychoactive Substances (commonly known as legal highs), which are new drugs not yet (but likely to be) classified as illegal. This is true both nationally and locally, though the actual level of use is difficult to determine.

Figure 3: Overall national trends in drug use for ages 16-24 and 16-59 between 1996 and 2011-12 (British Crime Survey 2011-12 data)

Drug	16-24	16-59
Powder Cocaine	▲	▲
Crack cocaine	●	●
Heroin	●	●

Key

▲ Statistically higher

● No statistical change

Methadone	●	▲
Tranquilisers	●	●
Anabolic steroids	●	●
Ecstasy	▼	●
LSD	▼	▼
Magic mushrooms	▼	▼
Amphetamines	▼	▼
Cannabis	▼	▼
Amyl nitrate	▼	▼
Overall Class A drug use	▼	●
Overall stimulant use	▼	▼
Overall drug use	▼	▼

▼ Statistically lower

Since 2001, there has also been an overall decrease in drug use reported by children (11- 15 year olds). The prevalence of lifetime drug use fell from 29% in 2001 to 18% in 2010. There were also decreases in the proportion of pupils who reported taking drugs in the last year; from 20% in 2001 to 12% in 2010. The reduction in reported use is matched with a reduction in the number of children accessing specialist substance misuse services[1], the vast majority of whom access treatment for cannabis, alcohol or a combination of the two. The overall number of young people receiving support 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 reduced since last year from 770 to 631 in 2011-12. This compares to 1,979 five years ago. However, from 2010-11 to 2011-12 there was an increase in the number of young people being treated for cannabis, 13,200 up from 12,784. 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.

Further information relating to national prevalence of drugs can be found in the following reports:

www.nta.nhs.uk/drug-treatment-2012.aspx
http://www.crimesurvey.co.uk/

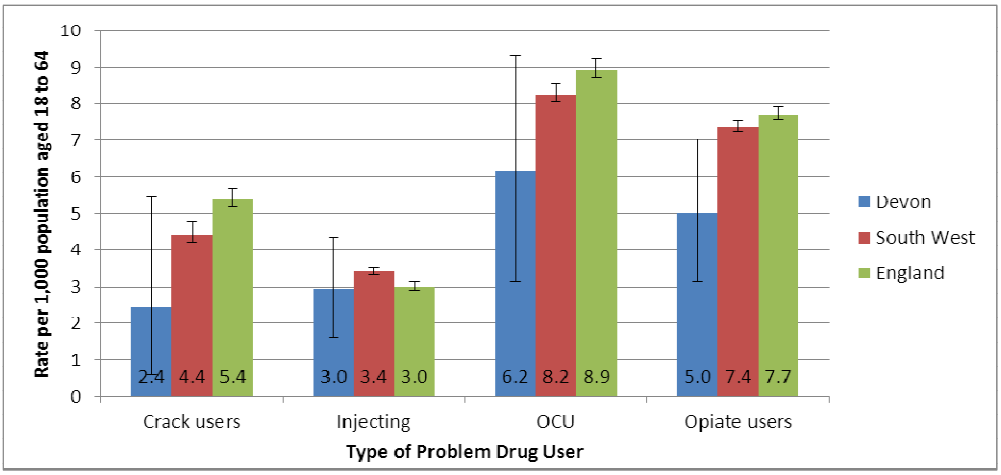
6.1.1.2 Prevalence in Devon

As outlined above, problematic drug users (PDU's), classified by those using opiates and crack cocaine, place a disproportionately large burden on the substance misuse treatment services. A prevalence estimate for opiate and crack users (OCU) released by the NTA[2] estimated that in 2009-10, 6.18 people per 1000 aged 18 to 64 in Devon were opiate and crack users. This was lower, but not statistically different to the southwest rate (8.95 per 1,000) and national rate (9.24

[1] *Substance Misuse among Young People 2011-12, NTA*
[2] Prevalence Estimates 2008/09, National Treatment Agency, www.ndtms.net

per 1,000) and equated to an estimated 2887 users. The breakdown in Figure 4 shows that Devon has a lower estimated rate of all types of problematic drug users.

Figure 4: Graph showing estimated prevalence of Opiates and Crack Users in Devon



Combining prevalence estimates from the CSEW for age, gender, ONS classification and deprivation with Devon population data enables prevalence estimates to be created locally. Using this methodology, the prevalence estimates for Devon for the 16-24 and 16-59 year age groups and gender are shown in Figure 5 and Figure 6. Maps showing prevalence by Middle Super Output Area (MSOA) can be found in the "Substance misuse in relation to place" section of this reports and Appendix 1.

Figure 5: Modelled prevalence estimates of substance misuse (in the last 12 months) in Devon for 16-24 year olds (Source: 2011-12 British Crime Survey (now CSEW) and Exeter System population data)

Drug Type		Number			Percent		
		Males	Females	Persons	Males	Females	Persons
Class A	Powder Cocaine	2101	920	3021	4.96%	2.21%	3.60%
	Ecstasy	1707	765	2472	4.03%	1.84%	2.95%
	Hallucinogens	990	384	1374	2.34%	0.92%	1.64%
Class A/B	Amphetamines	1137	670	1807	2.68%	1.61%	2.15%
Class B	Cannabis	8812	4026	12839	20.81%	9.68%	15.30%
	Mephedrone	2444	940	3384	5.77%	2.26%	4.03%
Class C	Ketamine	807	429	1237	1.91%	1.03%	1.47%
Not classified	Amyl nitrite	1395	423	1818	3.29%	1.02%	2.17%
Any Class A drug		3193	1328	4521	7.54%	3.19%	5.39%
Any stimulant drug		3634	1586	5220	8.58%	3.81%	6.22%
Any drug		10460	4871	15331	24.70%	11.72%	18.27%

Figure 6: Modelled prevalence estimates of substance misuse (in the last 12 months) in Devon for 16-59 year olds (Source: 2011-12 British Crime Survey (now CSEW) and Exeter System population data)

Drug Type		Number			Percent		
		Males	Females	Persons	Males	Females	Persons
Class A	Powder Cocaine	4,625	2,040	6,665	2.23%	0.97%	1.59%

	Ecstasy	2,902	1,305	4,207	1.40%	0.62%	1.01%
	Hallucinogens	1,486	579	2,066	0.72%	0.27%	0.49%
Class A/B	Amphetamines	2,186	1,301	3,487	1.05%	0.62%	0.83%
Class B	Cannabis	16,490	7,647	24,137	7.95%	3.62%	5.77%
	Mephedrone	3,560	1,379	4,939	1.72%	0.65%	1.18%
Class C	Ketamine	1,146	609	1,755	0.55%	0.29%	0.42%
Not classified	Amyl nitrite	2,627	807	3,434	1.27%	0.38%	0.82%
Any Class A drug		6,513	2,731	9,244	3.14%	1.29%	2.21%
Any stimulant drug		7,588	3,345	10,933	3.66%	1.58%	2.61%
Any drug		21,202	10,027	31,229	10.22%	4.75%	7.46%

6.1.2 Prevalence of alcohol misuse

The damage caused by alcohol misuse to individuals and society has become an increasing focus of public concern in recent years. Drinking alcohol has been linked to increased risks of hypertension, stroke, coronary heart disease, liver cirrhosis and some cancers.

The main findings from the 2012 Statistics on Alcohol[3], published by the ONS, stated that just over two thirds of men and one half of women reported drinking in the previous week. Just over a third of men and a quarter of women reported drinking more than the recommended daily amount (four and three units respectively) on at least one day in the past week and around one in five men and one in eight women reported drinking more than twice the recommended daily amount on at least one day in the past week.

When discussing prevalence of alcohol misuse, it is common to group the severity of misuse into categories. The most serious is “Dependent drinkers”, who have a physical addiction to alcohol. Beneath that are “Increasing and Higher Risk” drinkers, who are classified as drinking 15 to 35 units of alcohol per week for men and 15 to 35 units per week for women. The treatment pathways for these groups are usually different, with dependent drinkers usually requiring a more intensive intervention (Tier 4 services) including detoxification and sometimes residential rehabilitation. Figure 8 roughly matches the severity of alcohol misuse with the tier of service used to treat the client, though it should be noted that alcohol dependence is also treated in Tier Three services as well as Tier Four.

Based on national prevalence rate[i] estimates from PANSI 6% of adults (aged 18-64) in Devon have alcohol dependency. Most recorded dependence was categorised as mild (5.4%), with relatively few adults reporting symptoms of moderate or severe dependence (0.4% and 0.1% respectively). Figure 7 shows the number of people this equates to.

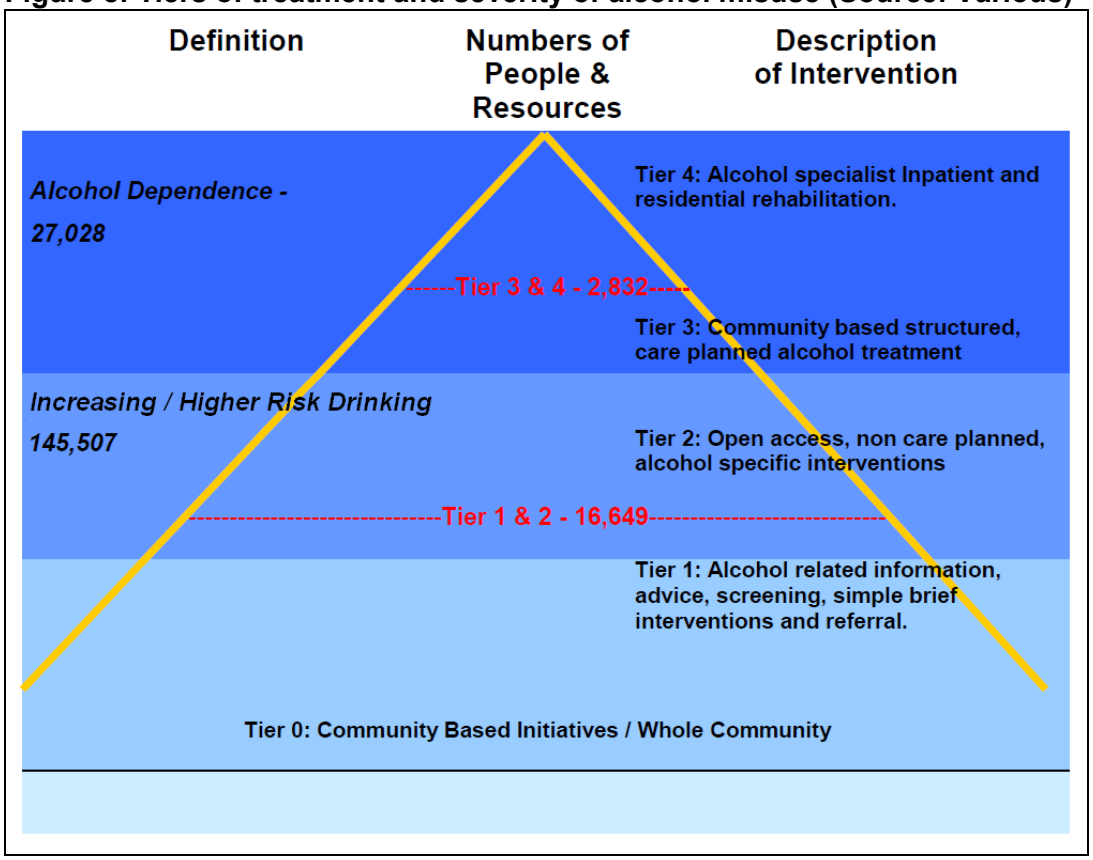
Figure 7: Estimated number of mild, moderate and severe cases of alcohol dependence in Devon for adults aged 18-64 (Source: PANSI)

[3] https://catalogue.ic.nhs.uk/publications/public-health/alcohol/alco-eng-2012/alco-eng-2012-rep.pdf

Severity of Dependence	Number of people in Devon
Severe	458
Moderate	1,832
Mild	24,738
Total	27,028

According to the 2012 APHO health Profile, 23.8% of people in Devon aged 16+ exhibit "increasing and higher risk" drinking behaviour (see definition above). This is higher than the national average of 22.3%, but not statistically so. Based on the June 2012 Devon 16+ population of, this would equate to 145,507 people.

Figure 8: Tiers of treatment and severity of alcohol misuse (Source: Various)



The 2012 LAPE report for Devon[4] provides a range of indicators which show the scale and impact of Alcohol on the Devon population (see Appendix 2 or visit http://www.lape.org.uk/). Devon is statistically worse than the England average for two indicators; the percentage of employees in bars as a percentage of all employees (3.4%) to and the prevalence of alcohol treatment per 1,000 population (3.3). All other indicators show that Devon has a similar, or in most cases statistically better measure than the national average.

[4] Local Alcohol Profiles for England, North West Public Health Observatory, 2012

There has been a fall in recent years in the proportion of pupils who think that drinking is acceptable for someone of their age[5]. In 2010 32% thought it was okay for someone of their age to drink once a week compared to 46% in 2003. Similarly 11% of pupils thought that it was ok for someone of their age to get drunk once a week compared to 20% who thought that in 2003. This change in attitude is complimented by a reduction in the numbers drinking alcohol. In 2010, 13% of secondary school pupils aged 11 to 15 reported drinking alcohol in the week prior to interview, compared to 18% in 2009 and 26% in 2001. The number of pupils saying they had ever drunk alcohol also fell to 45%, compared to 51% in 2009 and 61% in 2003.

The Devon strategy (Muckersie, M. 2012) notes that the Child Health Profile 2011 shows Devon as being significantly worse than the national average for alcohol consumption among children and young people. However the strategy suggests this is based on self-reports from children aged between 8 and 10 years old and is not robust evidence.

6.2 Impact on Services

Substance abuse can have wide ranging social and economic impacts on society, and this needs assessment provides information on the burden substance misuse places on a number of services, both healthcare and otherwise. This section provides information on the impact substance misuse has on ambulance callouts, accident and emergency attendances, hospital admissions, mortality rates as well as fire service call out data. Further information on the impact substance misuse has on crime can be found in the “Offenders” section of the needs assessment.

6.2.1 Ambulance callouts

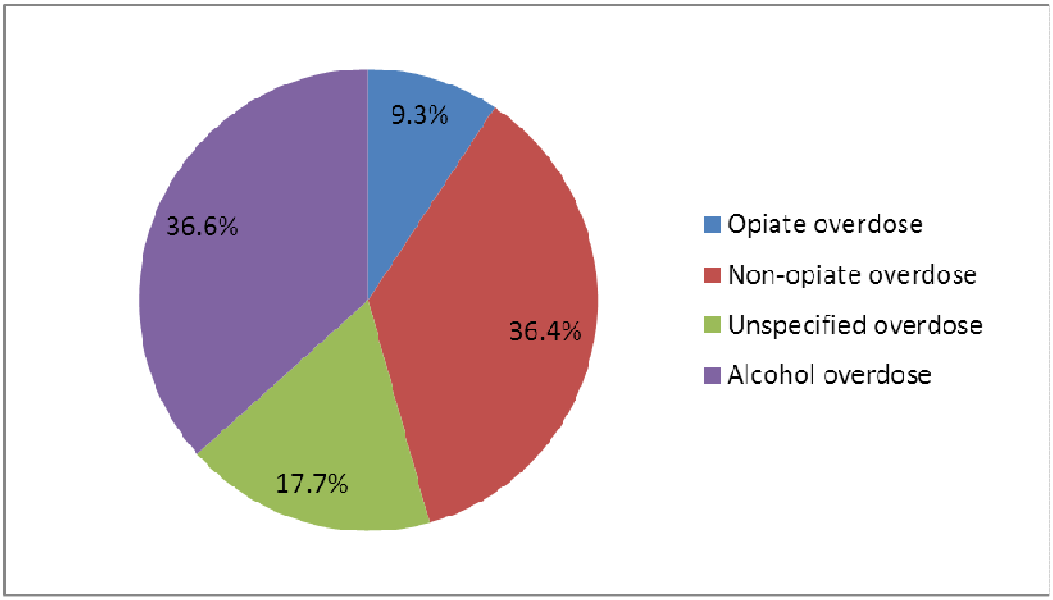
Data from the South Western Ambulance Service Trust (SWAST) for 2010 show the volume of emergency ambulance callouts in Devon which dealt with drug and alcohol overdoses.

In all, 3,250 calls to SWAST from addresses in Devon in 2010 related to overdoses, an average of almost nine per day. It is not possible to tell from the available data which of these overdoses were intentional and which were accidental. The chart below shows the breakdown in these calls between drug types and alcohol.

The number of overdoses due to alcohol misuse (1,191, or 36.6% of the total of such callouts for the year) is almost identical to that for all non-opiate drug overdoses (1,182 or 36.4%), and four times the number of opiate overdoses (303, or 9.3%).

Figure 9: Ambulance overdose callouts (all types), Devon during 2010 (based on 3,250 ambulance callouts) (Source: SWAST)

[5] https://catalogue.ic.nhs.uk/publications/public-health/alcohol/alco-eng-2012/alco-eng-2012-rep.pdf



6.2.1.1 Callouts for Alcohol Overdoses

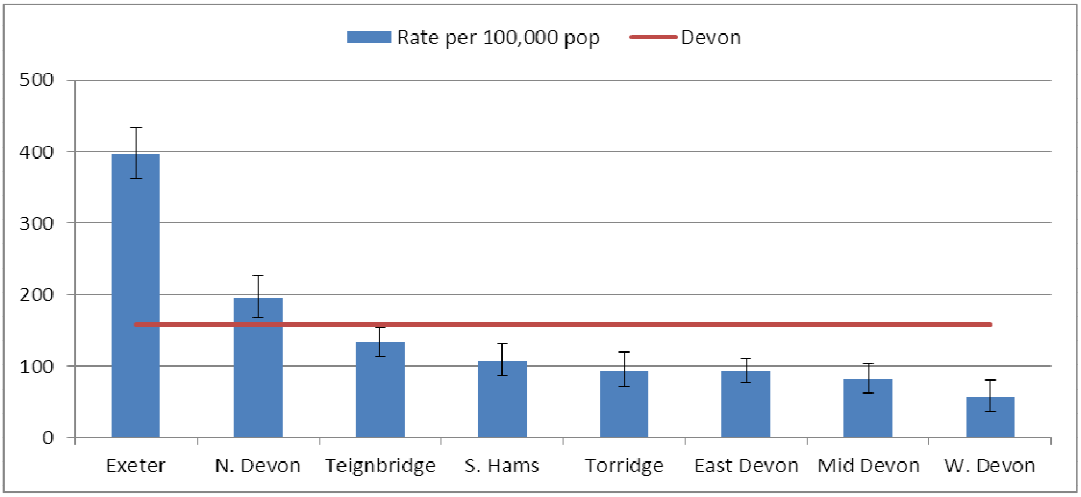
The 1,191 callouts for alcohol overdoses (an average of just over three per day across the county during 2010). The rate of callouts as a rate per 100,000 population varied widely for each of the districts, with Exeter having a rate more than twice as high as any other district, and making up 40% of all callouts relating to alcohol overdoses (see Figures 10 and 11). This elevated rate is, in part, due to Exeter having a younger population that the rest of Devon (see age group information below).

Figure 10: Alcohol Overdose Ambulance Callouts in Devon in 2010 by District (Source: SWAST)

District	Number of Callouts	Percentage	Population*	Rate per 100,000 pop
Exeter	476	40%	120,000	397
N. Devon	178	15%	91,000	196
Teignbridge	169	14%	127,000	133
S. Hams	90	8%	84,000	107
Torridge	62	5%	66,000	94
East Devon	124	10%	133,000	93
Mid Devon	62	5%	76,000	82
W. Devon	30	3%	53,000	57
Devon	1099	-	621,000	177

**ONS mid-year estimates 2010*

Figure 11: Number of alcohol related ambulance callouts by Devon district, crude rate per 100,000 population, 2010 (Source: SWAST)



Using the data, it was possible to calculate an alcohol overdose callout rate by age group for the Devon area (age group data was not provided at district level and so a rate could not be calculated at this geography). This showed that the 18 to 24 age group had by far the highest rate (457 per 100,000), being twice as high as the second highest rate, which was found in the 25 to 39 year age group (227 per 100,000). Overall, there were as many callouts for alcohol overdoses involving the 18 to 24 age group (23.6%) as for all ages from 40 to 65, and slightly more than for those aged 25 to 39.

Figure 12: Number and rate of callouts for alcohol overdoses in Devon by age group (Source: SWAST)

Age Group	Number of callouts	Percentage of callouts	Population*	Crude Rate per 100,000 pop
Under 18	163	14%	141360	115.3
18-24	281	24%	61440	457.4
25-39	256	22%	112,600	227.4
40-65	279	23%	272400	102.4
Over 65	47	4%	160000	29.4
Unknown	165	14%	-	-
All	1191	-	747700	159.3

**ONS mid-year estimates 2010*

An examination of the age profiles of each of the districts suggested that some, but not all of the increased rate of callouts in Exeter is likely due to the number of young people living there. Compared to the rest of the county, Exeter the proportion of the population aged 18 to 24 is around twice as high.

6.2.1.2 Underage drinking

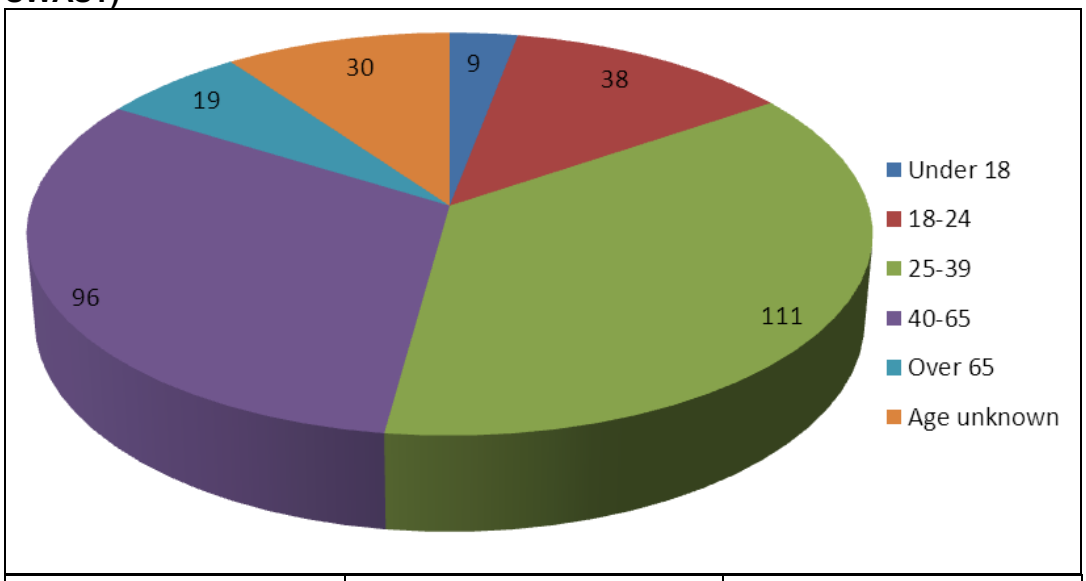
These data also provide evidence of the harmful effects of underage drinking. The number of alcohol overdose patients among the under-18s in 2010 (163, see Figure 12) indicates that on average more than three times a week in 2010 an

emergency ambulance in Devon was committed to a call involving an underage drinker who had overdosed on alcohol.

6.2.1.3 Callouts for Opiate Overdoses

Opiate overdose callouts involved mainly those aged over 25, with two thirds of those in Devon in 2010 involving patients aged between 25 and 65. The proportion of patients aged 18 to 24 who were the subject of opiate overdose callouts in 2010 (12.5%) was half the proportion from that age group who had alcohol overdoses in the same year (23.6%).

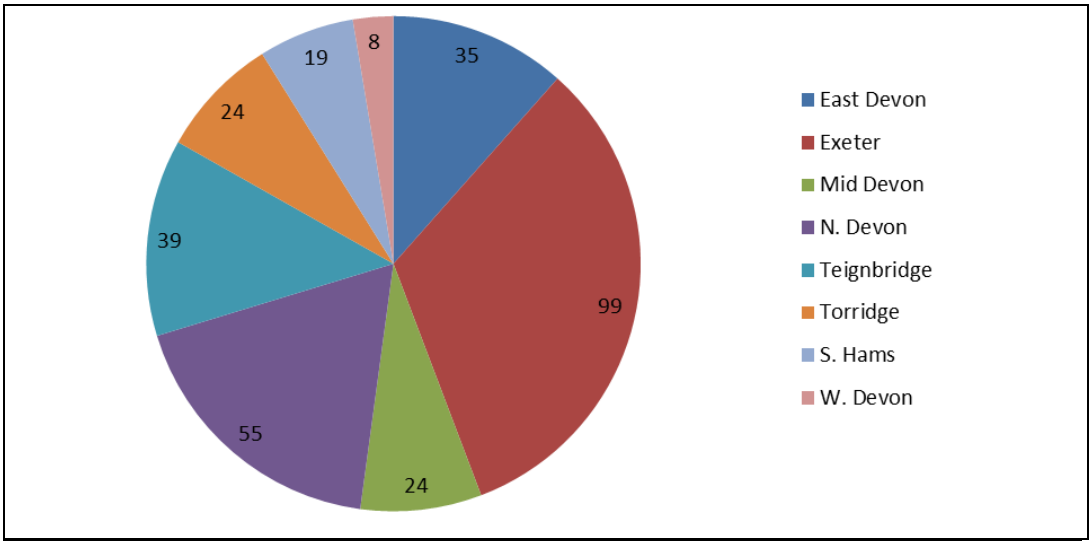
Figure 13: Number of opiate callouts in Devon by age group, 2010 (Source: SWAST)



Age Group	Number	Percent
Under 18	9	3.0%
18-24	38	12.5%
25-39	111	36.6%
40-65	96	31.7%
Over 65	19	6.3%
Age unknown	30	9.9%
All	303	100%

As regards the locations of the 303 opiate overdose callouts in Devon in 2010 (see below), Exeter with 32.7%, and North Devon (18.2%) together accounted for half of all the callouts.

Figure 14: Number of opiate callouts in Devon by district, 2010 (Source: SWAST)



Age Group	Number	Percent
Under 18	9	3.0%
18-24	38	12.5%
25-39	111	36.6%
40-65	96	31.7%
Over 65	19	6.3%
Age unknown	30	9.9%
All	303	100%

Figure 15 below compares the percentages of ambulance callouts for overdoses in each district of Devon in 2010 with that district's percentage of the county's population, as recorded in the 2011 census.

Exeter and North Devon are the only districts which have overdose callout figures which are disproportionately larger than their share of the population. In the case of ambulance callouts for alcohol overdoses, for example, Exeter's 40% share of the total in 2010 was nearly three times its share of the population (15.8%), while the opiate overdose callouts in Exeter (32.7% of the Devon total) were more than double the city's proportion of the population (15.8%).

Figure 15: Callouts for opiate and alcohol overdose in Devon, 2010 (Source: SWAST)

District	Opiate Overdose Ambulance Callouts		Alcohol Ambulance Overdose Callouts		Percentage of Devon Population (2011 Census)
	Number	%	Number	%	
E. Devon	35	12%	124	10%	18%
Exeter	99	33%	476	40%	16%
Mid Devon	24	8%	62	5%	10%
N. Devon	55	18%	178	15%	13%
Teignbridge	39	13%	169	14%	17%
Torridge	24	8%	62	5%	9%

S. Hams	19	6%	90	8%	11%
W. Devon	8	3%	30	3%	7%

6.2.2 *Accident and Emergency Attendances*

Accident and Emergency (A&E) and Hospital Episode Statistics (HES) data relating to attendances do not readily provide an opportunity to identify which admissions are attributable to alcohol or substance misuse. However, nationally, attendances likely to be alcohol-related have been identified using patient group and diagnosis data. At the time of writing this needs assessment, no robust data could be found for attendances relating to drug misuse.

Research has shown that up to 35% of all A&E attendances are alcohol related, increasing to 70% in the early hours. In Devon, during 2011-12 there were a total of 382,357 A&E attendances, which equates to an estimated 109,245 alcohol related attendances.

The research[6] also stated that at peak times in A&E Departments:

- 40% of all attendees have a raised blood alcohol level
- 14% are intoxicated
- 43% are problematic drinkers

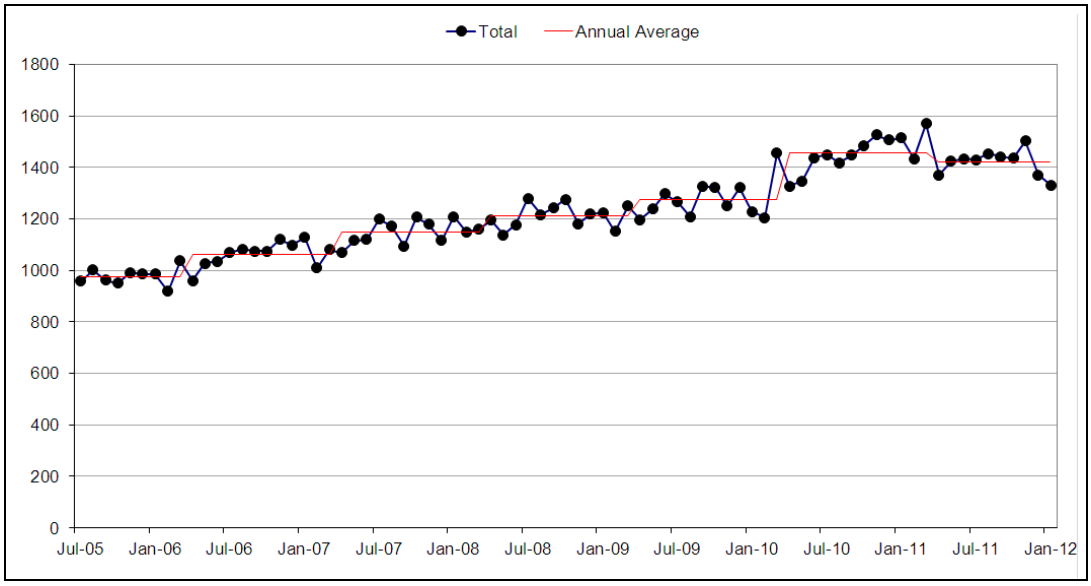
6.2.3 *Hospital Admissions*

The most recent data for the number of alcohol-attributable hospital admissions[7] shows that in Devon during 2010-11 there were 1162 age standardised admissions per 100,000 population for males and 676 for females. These rates are slightly lower than those seen regionally (1361 for males and 779 for females).

Local data for alcohol related admissions shows that, whilst as has been seen nationally rates have been increasing over recent years, the most recent year's data in Devon shows a slight decline in admission rates (Figure 16). This reduction could be a result of a number of things, including the increase in the capacity of the drug and alcohol service that has been seen over the past few years, or possibly due to a larger than average increase in admissions the previous year.

Figure 16: Drug-Related Hospital Admissions by Month, Devon Residents, July 2005 onwards (Source: SUS Data)

[6] Strategy Unit Alcohol Harm Reduction Project – Interim Analytical Report – September 2003
[7] Local Alcohol Profiles for England, NWPHO, 2012



6.2.4 Mortality

In England and Wales, over the past ten years, the number of people dying from alcohol related causes has more than doubled, from 3,109 in 2002 to 6,775 in 2011[8].

In Devon, there has been a less pronounced increase, with a rise of less than 10%, from 211 to 225 estimated deaths. The Local Alcohol Profiles for England (LAPE), show that Devon has a statistically lower alcohol attributable mortality for males (28.8 per 100,000 population) than the national average, and a slightly lower rate for women (13.7 per 100,000 population). These numbers highlight a stark difference between male and female alcohol attributable mortality rates, with the rate for men being more than twice as high.

When population growth is factored in, there has been almost no growth in alcohol admissions in Devon at all. Figure 17 shows how the crude alcohol-attributable mortality rate has changed in Devon over the past ten years.

Figure 17: Crude alcohol-attributable death rate in Devon between 2002 and 2011 (Source: Local SUS Data)

[8] alcohol-related deaths in the United Kingdom , ONS, 2011

6.2.5 *Drug Related Fires*

Using data on fires from the Devon and Somerset Fire and Rescue Service and cost estimates from the Department of Communities and Local Government[9], it is possible to estimate the cost of fires in Devon in which drug or alcohol misuse were assessed to have been a factor. Like the police, DSFRS records do not allow the separation of alcohol and drugs as factors in causing a fire, so in Figure 18 below the two are combined. The cost of a fire is deemed to include the cost of damage caused and response costs by the emergency services.

Figure 18: Fires in Devon 2009-10 to 2011-12 in which drugs or alcohol were a factor

Year	Number of drug and alcohol related fires	Economic cost (excl. Injuries)
2009-10	26	£1,170,000
2010-11	42	£1,890,000
2011-12	32	£1,440,000
Total	100	£4,500,000

The DSFRS figures show that 100 drug and alcohol-related fires occurred in Devon in the three year period, costing a total of £4.5 million[10]. Not surprisingly, the highest total (26 fires costing over £1.1 million) occurred in Exeter (see Figure 19), but even a sparsely-populated area like West Devon saw fires costing over £400,000.

Figure 19: Fires in Devon 2009-10 to 2011-12 in which drugs or alcohol were a factor, by Devon district

[9] *The Economic Costs of Fire, Department of Communities and Local Government, 2011*
[10] *Based on the estimate of £45,000 per fire, The Economic Costs of Fire, Department of Communities and Local Government, 2011.*

District	Number of drug and alcohol related fires	Economic cost (excl. Injuries)
East Devon	15	£675,000
Exeter	26	£1,170,000
Mid Devon	5	£225,000
North Devon	11	£495,000
South Hams	9	£405,000
Teignbridge	16	£720,000
Torridge	9	£405,000
West Devon	9	£405,000
Devon	**100**	**£4,500,000**

In addition to the above costs, each injury in a fire is estimated to cost £185,000[11], and each fatality £1.65 million. In the period 2009-10 to 2011-12, there were 82 injuries and four deaths in the DSFRS area in fires in which alcohol or drugs may have been a factor, costing an estimated £21.8 million. Unlike the data on alcohol- and drug-related fires in the table above, the figures for deaths and injuries in fires are not available at district or county level, but if the proportion of the DSFRS population living in Devon (45%) is used apportion cost to Devon, deaths and injuries cost the county an estimated £9.87 million. This brings the overall economic cost of fires in Devon to an estimated £14.4 million over the three years.

The 100 drug or alcohol-related fires in Devon between April 2009 and March 2012 represent 7.4% of all domestic fires in the county during that period (see table below). However, looking in detail at individual local authority areas we can see that in both Exeter and West Devon these fires formed over 10% of the total.

Figure 20: Drug and alcohol related fires* as a percentage of all fires in Devon, Apr-09 to Mar-12 (Source: Devon and Somerset Fire Rescue Service)

Local Authority	Drug and alcohol related fires*	All fires	Percentage
East Devon	15	250	6.0%
Exeter	26	246	10.6%
Mid Devon	5	124	4.0%
North Devon	11	157	7.0%
South Hams	9	176	5.1%
Teignbridge	16	206	7.8%
Torridge	9	111	8.1%
West Devon	9	88	10.2%
Devon County Council area	**100**	**1358**	**7.4%**

* 'Damage only' fires

[11] Ibid

A total of 100 fires in a three year period is clearly a significant addition to the workload of the Devon and Somerset Fire and Rescue Service, and the fact that in areas such as Exeter and West Devon this figure has reached well above 10% illustrates the wider community impact of drugs and alcohol. It is currently unclear what links and opportunities exist between the fire service and the drug and alcohol services. Given the number of fires that are linked to drugs and alcohol, it would appear there are opportunities to work together to improve referrals and awareness.

6.3 Substance Misuse in relation to 'Place'

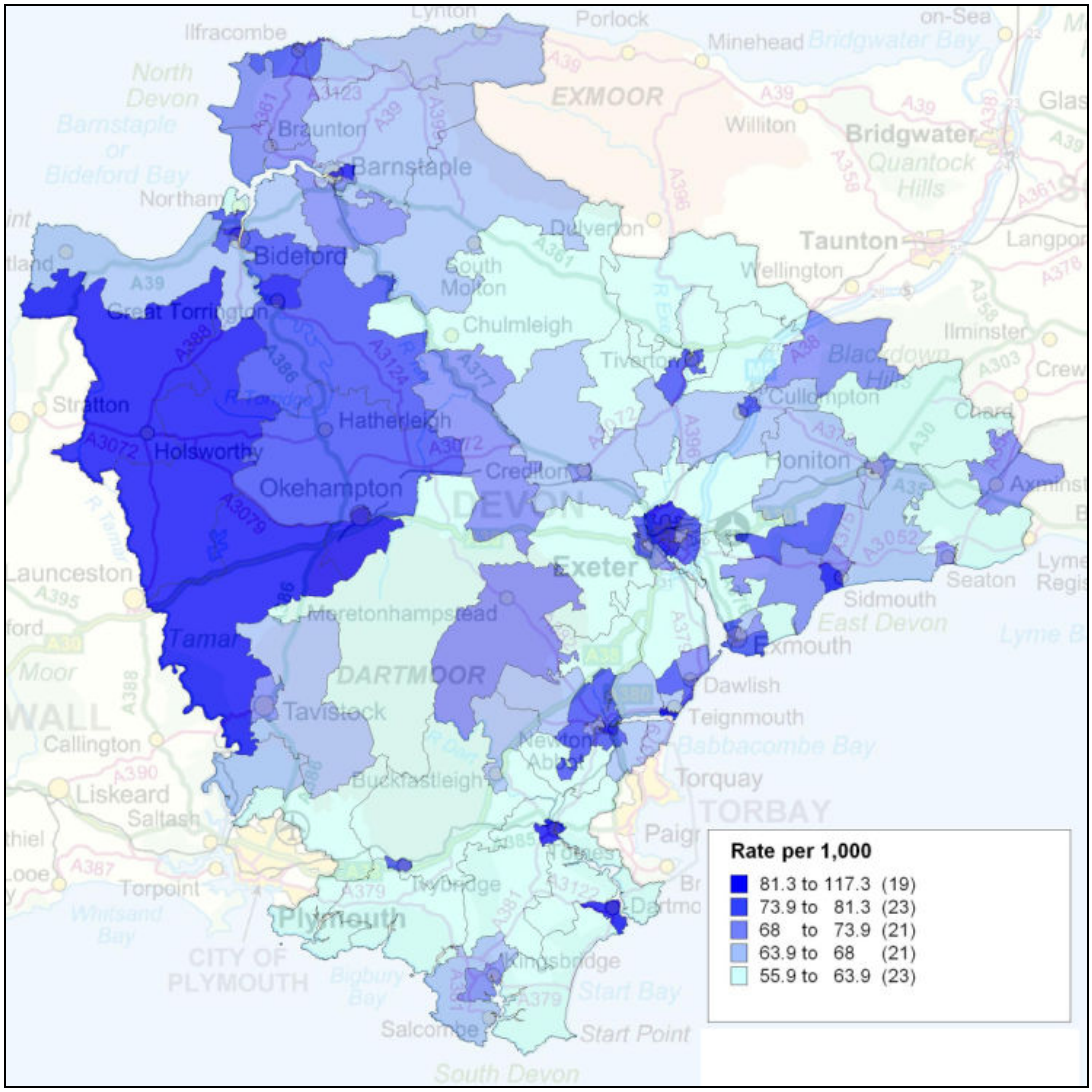
There are well established links between substance misuse and a range of socio-demographic information such as gender, age, deprivation and employment type which means that some areas are likely to have more problems with substance misuse than others. When planning service provision, it is important to understand which areas of the county will need the services being planned.

This section contains a range of maps showing estimated prevalence of substance misuse (need), and information about where people who are currently accessing services live.

6.3.1 Estimated prevalence of drug use

Using age group, gender, deprivation and ONS classification prevalence data taken from the 2011-12 British Crime Survey, and applying it to the population of Devon residents at MSOA level, prevalence estimates for drug use can be mapped for Devon using MSOA quintiles. This has been done for all drugs (Figure 21), Class-A drugs (Figure 22) and a range of other drugs individually (see Appendix 1).

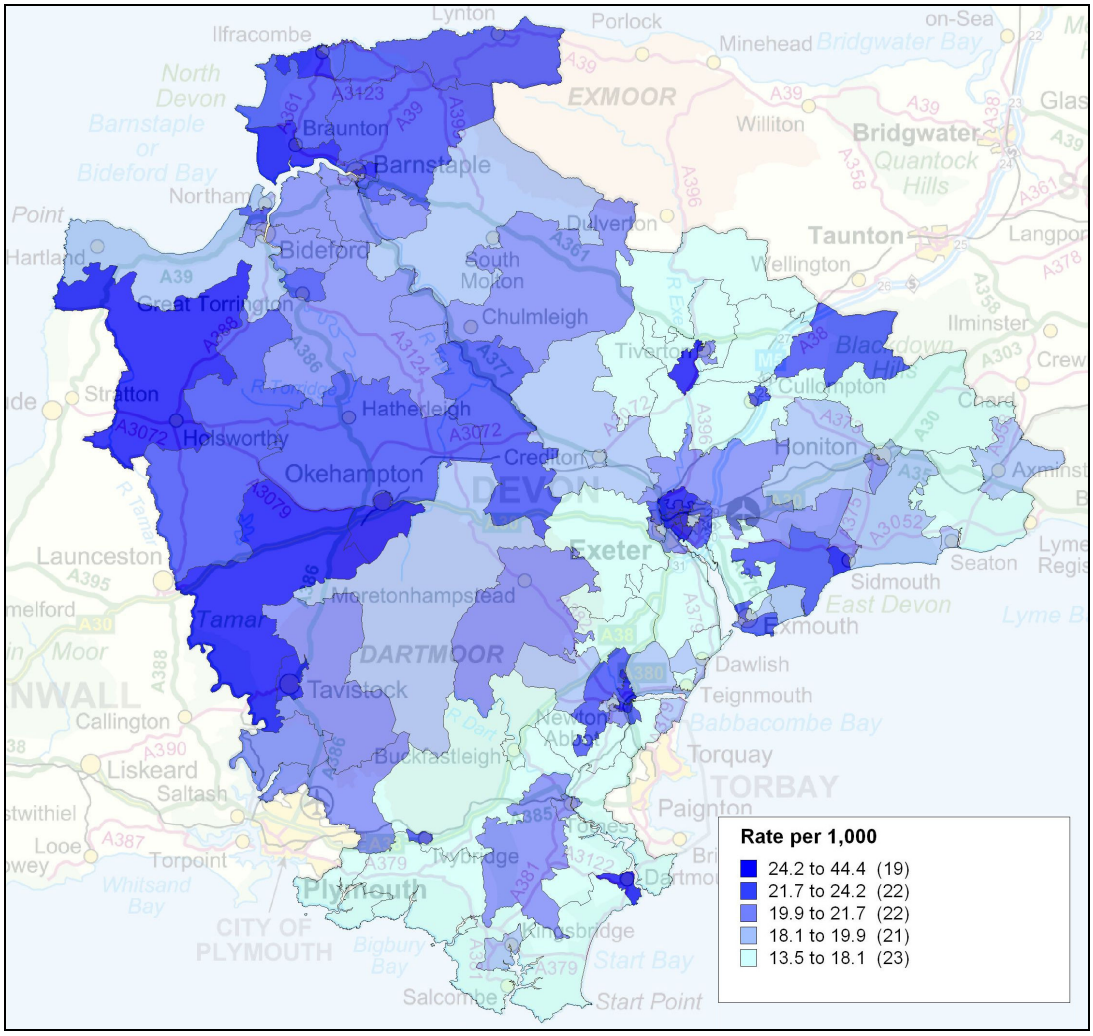
Figure 21: Quintile map showing estimated prevalence of all drug use in Devon (Source: 2010-11 British Crime Survey, Exeter System population data)



It can be seen that the estimated prevalence of drug users by MSOA varies from 55.9 to 117.3 per 1,000 population. Generally, it is estimated that there is a lower prevalence drug users in the south and east of the county (with the exclusion of Exeter, which has some of the highest rates). The north and west of the county have generally higher rates, with more MSOA's being in the top two quintiles.

Class-A drugs, particularly heroin and crack cocaine, place a disproportionately large burden on healthcare services, and as such, prevalence of Class-A drugs should also be considered when planning services. Figure 22 below shows the estimated prevalence of Class-A drugs in Devon by MSOA. As with overall drug use, the west and north of the county appear to have a higher prevalence compared to the south and east of the county, with the exception of Exeter, which generally has higher rates.

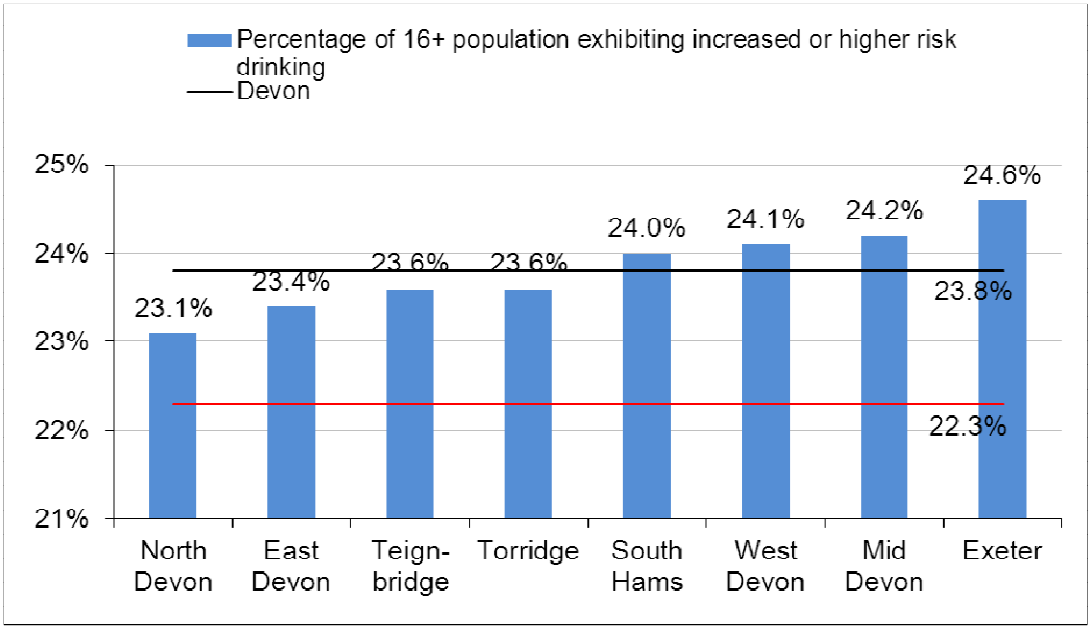
Figure 22: Quintile map showing estimated prevalence of Class-A drug use in Devon (Source: 2010-11 British Crime Survey, Exeter System population data)



6.3.2 *Estimated prevalence of alcohol use*

The 2012 APHO Health profiles for districts provide an estimate of the percentage of adults aged 16+ who are classed as increasing or higher risk drinkers. Quintile maps are not appropriate for use with Devon districts as there are only eight of them. Figure 23 below shows how the estimates prevalence of increasing and higher risk drinkers varies by district.

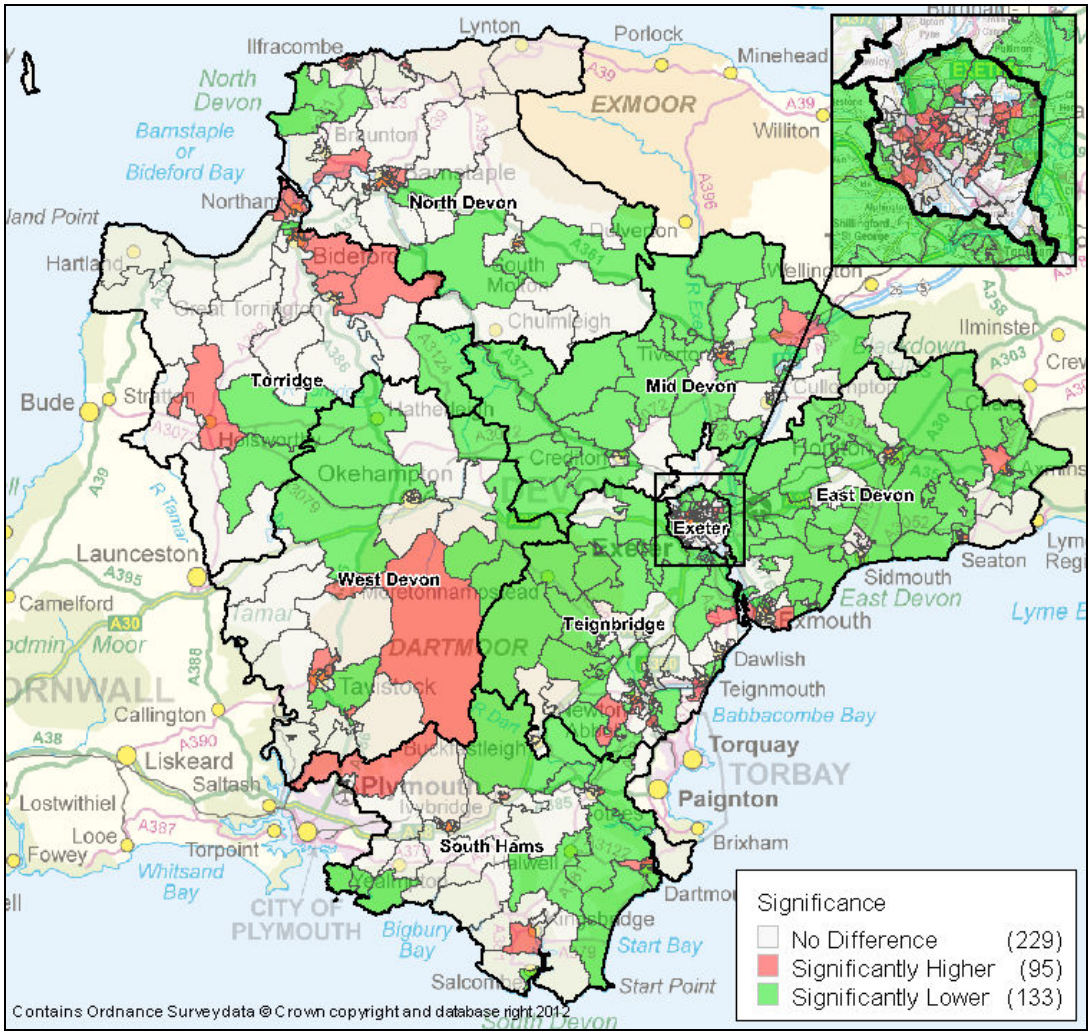
Figure 23: Estimated prevalence of increasing and higher risk drinkers by Devon district (Source: APHO 2012 health profiles)



6.3.3 Hospital admissions

Whilst hospital admission data does not directly record whether or not an admission is due to the use of alcohol or drugs, in the case of alcohol (but unfortunately not drugs) it is possible to use attributable fractions to apportion a percentage of certain types of admission to admissions relating to alcohol. Attributable fraction data was used alongside the home postcode of inpatients to calculate an estimated admission rate at LSOA level. Figure 24 below highlights the LSOA's in Devon that have a statistically higher (red) or lower (green) rate of admissions than the Devon average of 1453.9 per 100,000 population, for admissions occurring between 2009 and 2011.

Figure 24: DASR Alcohol Related Hospital Admissions



Comparing the hospital admission data with the estimated district level prevalence of increasing and higher risk drinking, Exeter has both the most MSOA's with a statistically higher admission rate and the highest estimated prevalence. Data for Mid-Devon is somewhat less consistent, with the majority of MSOA's having a statistically lower admission rate (and only a couple statistically higher) accompanying the second highest estimated prevalence of increasing and higher risk drinkers. Generally, the north and West of the county appear to have the higher admission rates, which matches the pattern seen in the estimated drug prevalence data, but not the estimated prevalence of increasing and higher risk drinkers, where both North Devon and Torridge have a prevalence below the county average. Given the difficulties with accessibility faced in these rural areas, it is surprising that admission rates are higher than prevalence would predict and the discrepancy between estimates prevalence and admission rates should be investigated further.

6.3.4 MOSAIC analysis of existing drug service users

MOSAIC Public Sector is a classification developed specifically to provide a description of the UK population and their needs for public services. It combines 440 sources of data to classify the population into 15 groups and 69 more detailed

household types. These data come from the Census, other official sources such as DVLA, the British Crime Survey, the Index of Multiple Deprivation, and Hospital Episodes Statistics, as well as YouGov surveys and a wide range of private sector surveys and databases.

MOSAIC profiling of 2,383 opiate and cocaine users in treatment in Devon in the three year period 2009-10 to 2011-12 revealed that MOSAIC type G33 - Transient singles, poorly supported by family and neighbours, was the one which was both most numerous among the service users, and most over-represented (i.e. was present in numbers disproportionate to their numbers in the population as a whole).

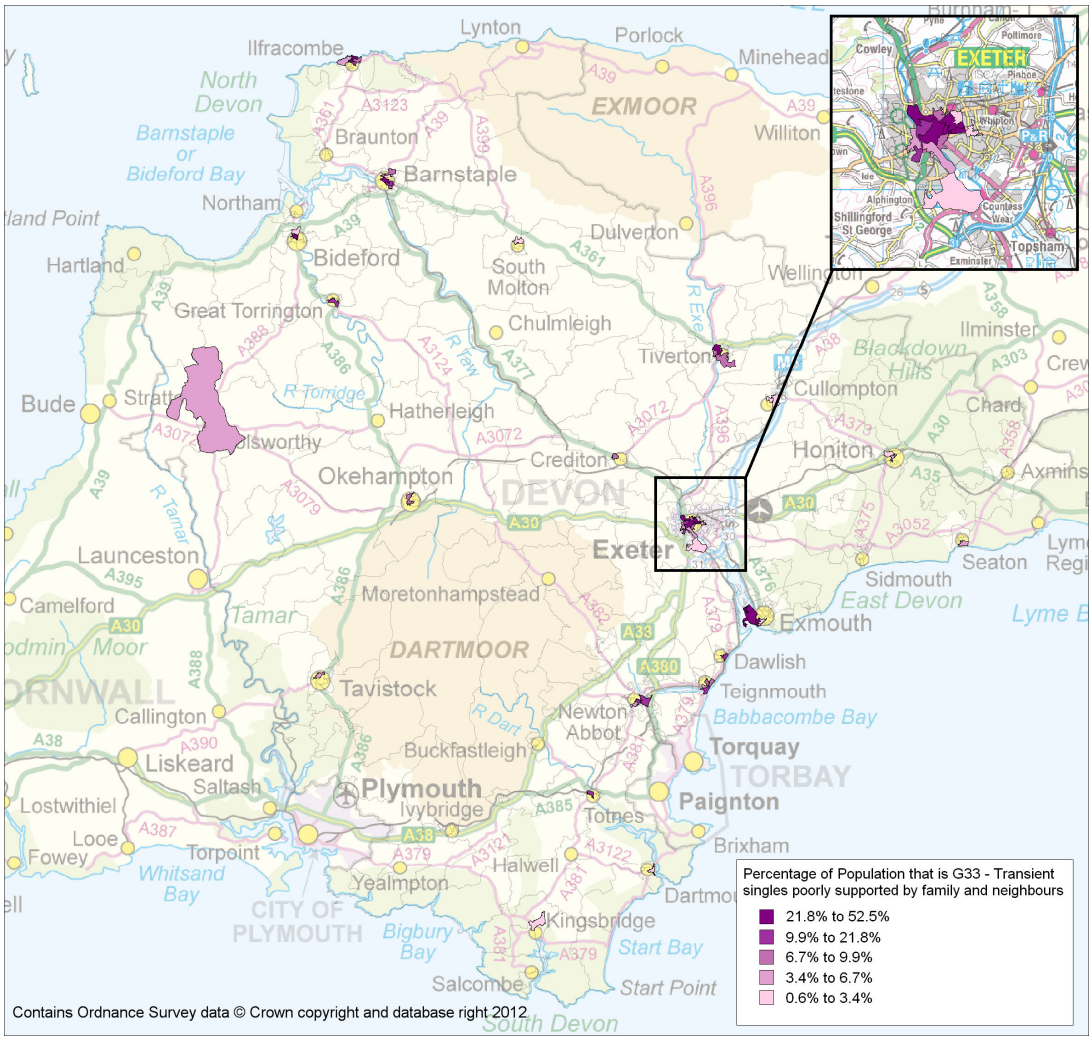
G33s are only 1.5% of the Devon population, but they form 14.4% of the opiate and cocaine users in treatment in the county(344 out of 2,383). They are thus almost ten times over-represented (i.e. the proportion of G33s in the service user group is almost ten times their proportion in the population as a whole).

This emphatically does not suggest that every member of the G33 type is a drug user, but it does indicate that service users can be found in disproportionate numbers in certain neighbourhoods. As well as identifying the G33 type as one of concern in this respect, MOSAIC also locates them within Devon, highlights aspects of their demographics and lifestyles, and gives an indication of the best methods which can be used to communicate with this group. An overview of this group, including the best ways of communicating with them, can be found in Appendix 3.

The population of G33s in Devon has been profiled at the level of Lower layer Super Output Area (LSOA), a unit of census geography with a minimum of 1,000 residents and an average of 1,500. Twenty five LSOAs in Devon (our of 457 in the county) have 100 or more G33 residents, and in two of these (in Exeter St David's and Exmouth Town wards) they represent more than 50% of the population. The first of these, in Exeter St. David's ward, has over 1,200 G33 residents, while the LSOA with the next largest G33 population, in Exmouth Town ward, has over 850.

The locations of these population groups, who are disproportionately heavy users of substance misuse services, should be considered alongside geographic prevalence estimates when it comes to planning service delivery locations.

Figure 25: LSOA areas with a population of G33 - Transient singles, poorly supported by family and neighbours

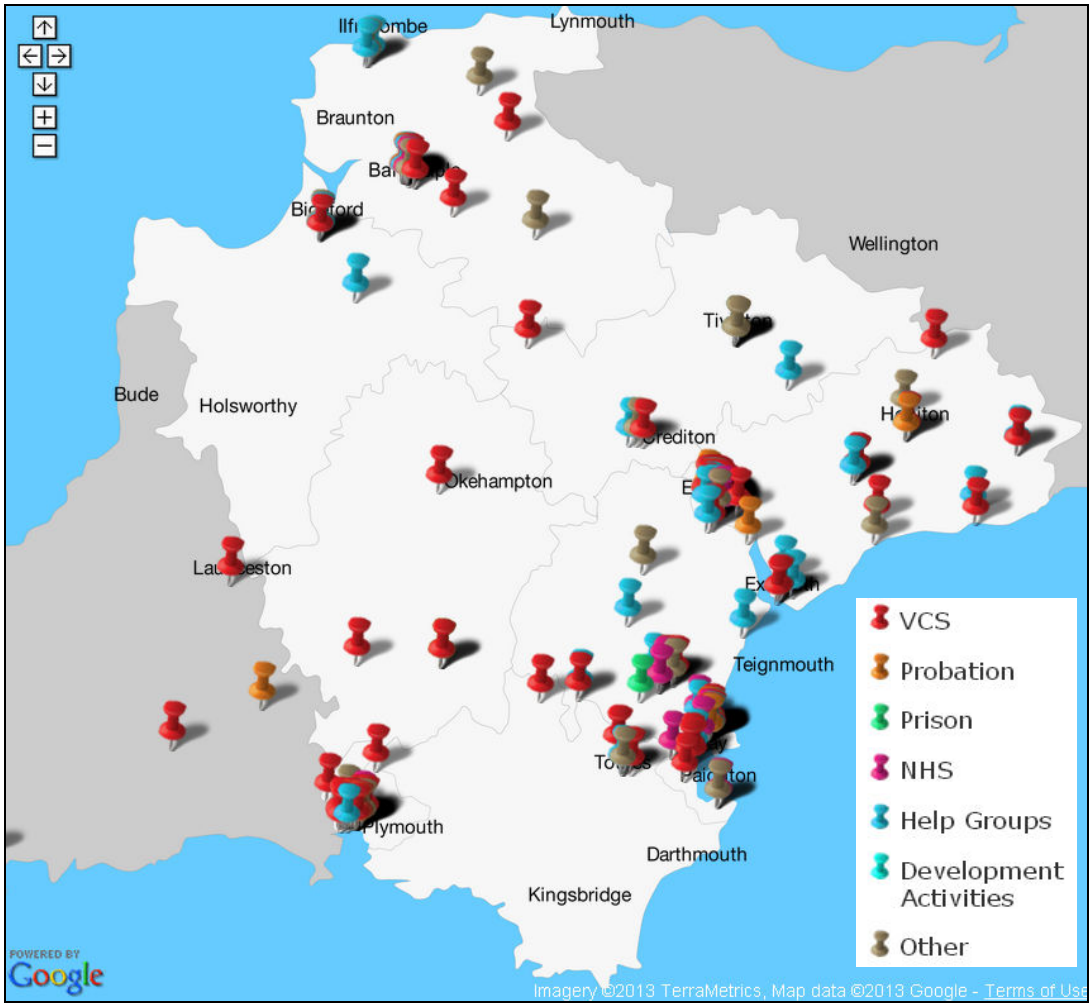


6.3.5 *Location of current service provision*

The Devon Reform provides an interactive map of service locations in the Devon area[12]. Figure 26 shows the location of the different types of service relating to substance misuse. In addition to this, the location of pharmacies participating in needle exchange services and supervised consumption can be seen in Figure 89, and the location of GP practices can be seen in Figure 27.

Figure 26: Location of substance misuse services in Devon (Source: Devon reform website, Feb 2013)

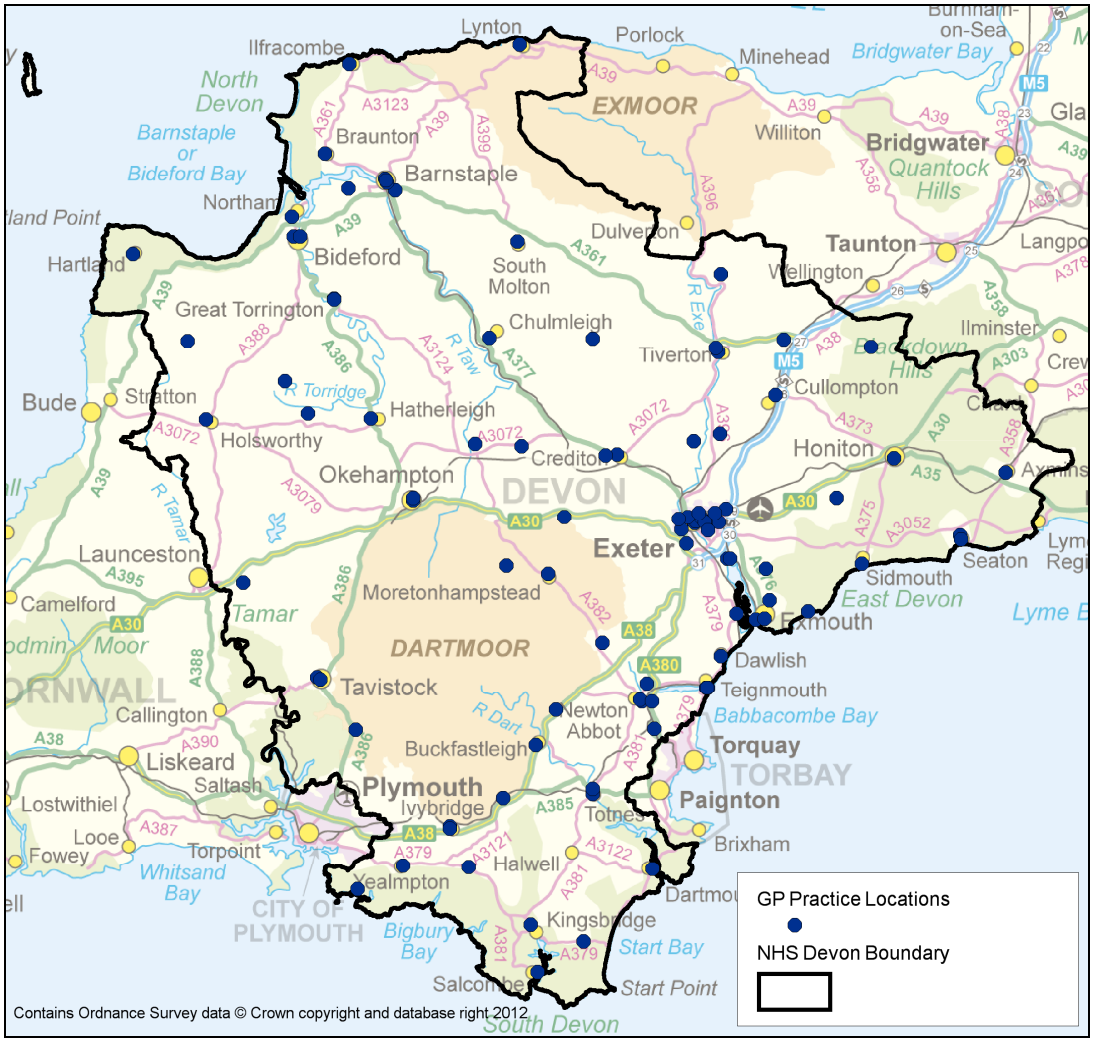
[12] http://www.devonreform.org/Member-Directory



The map shows that there appears to be a higher concentration of services in the South and East of the county. This is predominantly because the South and East of the county are the most populated areas, but given the higher estimated prevalence of drug misuse, and the higher than expected alcohol related admission rates in to the North and West of the county, it is important to ensure that needs in this area are being met. A range of services, including home visits, are already in place, but it is recommended that further investigation is done into the locations of services in North and West Devon and whether drug and alcohol user accessibility to the service is adequate in these areas.

Sometimes substance misuse services use GP practice facilities to hold client meetings. Figure 27 below shows the locations of all the GP practices in Devon. It can be seen that the locations of GP practices offer a good coverage of the general population in Devon, including the North and West of the county, and so offer a good opportunity for improving service accessibility. It is recommended that current use of GP practices is reviewed to identify whether there are more opportunities to improve service accessibility in the more rural areas of Devon, particularly in the North and West of the county.

Figure 27: Location of GP Practices in Devon, February 2013



6.4 Vulnerable children / families

This section contains information on a range of population groups who either are, or have contact with children and young people.

6.4.1 Pregnancy

All psychoactive drugs, including alcohol, tobacco and some prescribed medications, may have adverse effects on the pregnancy, the unborn child and the new-born. Different drugs, however, may act differently (Figure 28). This may be a result of not only to the drug itself, but also the poor overall health and the nutritional status of the drug-using expectant mother. The degree of the impact of drug use during pregnancy largely depends on the intensity of drug use[13].

[13] Pregnancy, Childcare and the Family: Key issues for Europe's Response to Drugs, European Monitoring Centre for Drugs and Drug Addiction, 2012

Figure 28: Health Harms associated with substance misuse in pregnancy (Source: Pregnancy, Childcare and the Family: Key issues for Europe's Response to Drugs, 2012)

Table 1: Health harms associated with substance use during pregnancy

	Alcohol	Tobacco	Cannabis	Amphetamines	Cocaine	Opioids
Low birth weight	+	+	+	+		+
Miscarriage	+	+	+	+	+	
Perinatal mortality	+	+				+ (a)
Developmental problems in childhood	+		+		+	
Foetal morbidity	+		+	+	+	
Premature birth	+			+		+
Decreased foetal growth	+					
Impaired intrauterine growth	+					+
Neonatal withdrawal symptoms	+					+
Premature rupture of membranes, placental abruption				+	+	
Preterm delivery	+					
Respiratory depression						+

(a) Related to withdrawal.
NB: The effect of these drugs may be confounded by polydrug use and/or other health and lifestyle factors associated with drug use.
Source: *A summary of the health harms of drugs,* The Centre for Public Health, Faculty of Health & Applied Social Science, Liverpool John Moore's University, on behalf of the Department of Health and National Treatment Agency for Substance Misuse (2011).

In Devon, between April and December 2012 there were less than five under eighteens with substance misuse issues referred to the RD&E specialist substance misuse Midwife. This low number of referrals suggests that not all young people are disclosing recreational drugs or alcohol to the community midwives. Under reporting of alcohol consumption is thought to be very likely with pregnant women.

6.4.2 Teenage Pregnancy

A report from the British Youth Council[14] outlining the results of a survey of 1083 young people found that two thirds of respondents believed that the link between drinking alcohol/ being drunk and having unprotected sex is strong or very strong. Another finding of the report was that 80% of respondents believed that advice on how to avoid heavy drinking leading to unprotected/ unsafe sex, should definitely be available at sexual health clinics.

A report from the Alcohol and Sexual Health Working Party[15] recommended that:

- Sexual health services should provide information that highlights the link between alcohol consumption and poor sexual health outcomes and signpost sources of useful advice on drinking sensibly. They should provide clear information about self-referral options as additional support for people wishing to reduce their alcohol intake.

- All clinicians providing sexual health services should be trained in asking about drinking habits through use of a recognised screening tool and implementing a

[14] "Sex and drinking – young people's experiences", British Youth Council, September 2009
[15] Alcohol and sex: a cocktail for poor sexual health, Alcohol and Sexual Health Working Party, December 2011.

single brief intervention. This training should be embedded within existing sexual healthcare competency frameworks.

- All sexual health services should develop a robust care pathway to refer patients for further support, including local alcohol services, where and when required.

There is also a strong correlation between STI's, risky sexual behaviour and drug use[16].

A substance misuse service for young people relating to sexual health will:
• Ensure strong working with relationships with sexual health services are in place to ensure referral routes and brief intervention advice is available in both directions

6.4.3 Child protection and Safeguarding

All child safeguarding enquiries in Devon are referred to the Devon Multi-Agency Safeguarding Hub. Robust information from the MASH is only available from November 2011, and between then and August 2012 (inclusive), 8488 enquiries were investigated relating to 6828 children and 3936 adults. The number of enquiries revealing, and children affected by, parental substance misuse is shown in the table below, along with the number of parents this involved.

Figure 29: MASH data relating to parental substance misuse in Devon between November 2011 and August 2012

Risk Factor	When used	Substance	Per Enquiry Form (8488 forms)	Individual Children (6828 children)	Individual Households (3936 households)
Parent	Historical	Drug use	330	267	161
	Historical	Alcohol use	423	343	193
	Current	Drug use	624	510	288
	Current	Alcohol use	793	629	347
Child	Historical	Drug use	31	23	17
	Historical	Alcohol use	32	25	17
	Current	Drug use	97	80	48
	Current	Alcohol use	105	83	51

Following investigation, current alcohol and substance misuse were the third and fourth largest (respectively) risk factors. The two largest risk factors were domestic violence and mental health, both of which are strongly linked to substance misuse. As such substance misuse is a considerable contributor to the risks associated with child protection and safeguarding.

[16] Sex, Drugs, Alcohol and Young People: A review of the impact drugs and alcohol have on young people's sexual behaviour, Independent Advisory Group on Sexual Health and HIV, 2007

6.4.4 Parental Substance Misuse

Children of parents that misuse substances are more likely to experience a range of negative outcomes and potentially face serious harm at every stage of their life from conception through to adulthood. Children of parents or carers who misuse drugs or alcohol are more likely to develop misuse and / or mental health problems themselves (ACMD, 2003[17]).

The Devon family health needs profile conducted in 2012 required health visitors to record if there were substance misuse issues amongst the parents of the families visited. This would have been either, reported by the parent or shared with the Health Visitor on a 'need to know' basis. The survey reached 4,700 households containing 8,238 children (including 48 unborn children). This represents just under 10% of the number of children aged under 5 living in Devon. A total of 341 families (containing 659 children) had 1 or more parents that were recorded as abusing drugs and/or alcohol (Figure 30).

Figure 30: Numbers and percentages of households and children with selected needs (Source: Devon Family Health Needs Survey 2011)

Need	Number of Families	% of Families	Number of Children	% of Children
Parent(s) abuse* alcohol	215	4.57%	439	5.34%
Parent(s) smoke	982	20.89%	1,949	23.69%
Parent(s) abuse drugs	205	4.36%	367	4.46%

*either binge drinking (6+/8+ unites a day) or increasing and higher risk drinking (35+/50+ units per week)

Based on national prevalence rate estimates from PANSI 6% of all adults (aged 18-64) in Devon have alcohol dependency, 8.7% for males and 3.3% for females.

Figure 31: Adults aged 18-64 predicted to have an alcohol problem, by gender, 2010 (Source: www.pansi.org.uk version 4.0, Crown copyright 2010)

Gender	Estimated Number	% of the Population
Males	19,227	8.7%
Females	7,389	3.3%

Addaction South West received 2,500 referrals during 2009-10 of these 205 (8.2%) were living with partner and children, 58 (2.1%) were living alone with children and 7 pregnant women in treatment. It seems likely that this low figure reflects a low rate of disclosure with a far higher proportion of those referred actually being parents.

Based on national prevalence rates[ii] estimates from PANSI 3.4% of all adults aged 18-64 (4.5% of men, 2.3% of women) are predicted to be dependent on drugs. Most dependence was on cannabis only (2.5%), rather than other drugs (0.9%).

[17] ACMD (2003) Hidden Harm: Responding to the Needs of Children of Problem Drug Users, report of an inquiry by the Advisory Council on the Misuse of Drugs (external link).

Figure 32: Adults aged 18-64 predicted to be dependent on drugs, by gender, 2010 (Source: www.pansi.org.uk version 4.0, Crown copyright 2010)

Gender	Estimated Number	% of the Population
Males	9,945	4.5%
Females	5,150	2.3%
Persons	15,095	3.4%

Drug use and parenthood is a very sensitive issue. All drug services should ask about children at assessment (though it is not clear whether this uniformly happens) and not all drug users may be prepared to give information about children, particularly early on in treatment (for example, for fear of official intervention). Consequently, the levels of missing data on the proportion of clients who are parents are considerable.

There were 1,481 adults in effective drug treatment in 2008-09, of which 340 (23%) were parents. This is lower than both the regional (26%) and national average (30%) for the same period (NTA[iii]). However, this only represents those who have received treatment, to measure effectiveness drug use in the general population is estimated.

For 2009-10, the estimates indicate there are 2,197 problem users[18] of opiates and/or crack cocaine in the 15-64 year-old age group in Devon (NHS NTA Smoothed Prevalence Estimates[iv]). If the percentage of problem users who are parents in the wider population reflects that of the in treatment population then based on the previous methodology it could be estimated that around 325 children had a parent who was an opiates and/or crack cocaine problem drug user and not receiving treatment in 2009-10.

A case analysis of adult/carer needs in CAFs, Child Protection Plans and Serious Case Reviews within Devon was conducted in 2010[19]. Parental needs around adult substance misuse, adult mental health needs, domestic violence, adult ill health/disability, single parents and parenting needs were examined. Highlights from the analysis are as follows:

- Of 259 cases analysed where CAFs were undertaken, 14% had parental substance misuse noted, 32% had adult mental health needs and 22% had domestic violence noted.

- In 24% of cases 3 parental vulnerabilities were noted and in 12% of cases 4 parental vulnerabilities were noted.

- Of 101 children with child protection plans analysed, 14% had adult disability/serious illness noted, 43% had adult mental health needs, 22% had adult drugs issues and 36% had adult alcohol issues

[18] Prevalence estimates of problem drug use and injecting drug use for each DAAT were calculated over a three year period up to 2006 by Gordon Hay and colleagues at Glasgow University on behalf of the Home Office these are then smoothed by the NTA to reflect the current population. For these estimates, problem drug use is defined as use of opiates and/or use of crack cocaine. The figures do not include use of powdered cocaine, amphetamine, ecstasy, or cannabis or the injection of drugs aside from opiates or cocaine.

[19] Hobson, G (2010) Analysis of adult/ carer needs for children and young people with social care interventions or subject to a serious case review, Devon County Council (Internal Report)

Of the 5 Serious Case Reviews that have been undertaken in Devon between 2007 and 2010 there was an issue of domestic violence in 3 cases, adult disability/serious illness in 1 case, mental health problems in 4 cases and substance misuse issues in 1 case.

6.4.5 Troubled families (Targeted Family Support)

Research conducted by central government, using health, social care and police data, has estimated that in England and Wales there are around 120,000 "Troubled families" that local government should be working with to:

- Get children back into a classroom
- Get parents (and other adults in the family) back into work
- Reduce Anti-Social Behaviour in targeted families
- Reduce the costs of dealing with troubled families on the public purse

The central government estimate for Devon is 1370 troubled families, though local data suggests that the actual number is lower than this (a first year target was set to identify and work with 300 families in 7 start-up areas).

Defining "family units" for groups of people with complex needs is very challenging, and not an exact science. The definition of a family is most commonly determined based on residential address, though this is by no means the only consideration. In order to identify a local cohort of troubled families, authorities are expected to identify family units who meet three out of four criteria:

1. One family member has a record of anti-social behaviour or a young person has a criminal record
2. A young person in the family is / has been out of education in the last school year due to poor attendance or exclusion
3. No adults in the family are currently working
4. Local discretion

The Local Discretion criteria enable each authority to determine what factors they would like to use to identify troubled families. In Devon, several measures are used to meet the Local Discretion criteria, one of which is whether there is parental or child substance misuse.

Ideally, family units with substance misuse issues would be identified by matching a "family" database with client data from the local drug and alcohol services, but this has proven very difficult, due to differing units, and the often complex family situations that are associated with substance misuse.

However, multi-agency practitioner and manager groups have been established in all 7 of the initial start-up areas and where there is evidence that a family would

benefit from support and intervention around substance and alcohol misuse key partners have been involved in determining and delivering the approach and intervention.

Some of this has meant the engagement of familiar statutory substance misuse services such as Devon Partnership Trust and the Police but the voluntary sector has also been involved via initiatives such as Addaction's 'Breaking the Cycle' scheme. Practitioner groups are also making use school services and expertise in relation to substance abuse.

Whilst the troubled family initiative is still developing in Devon it is planned that further engagement with other providers of substance and alcohol misuse services will develop over time as the multi-agency groups mature in each area.

The troubled families' database does not contain a field specifically indicating substance misuse, and so cannot be used to provide a prevalence estimate for substance misuse among this population. Whilst substance misuse remains a clear contributor to troubled families, intelligence relating to this cohort is too unreliable to draw any meaningful conclusions.

A substance misuse service working with Troubled families will:
• support work undertaken to improve and make better use of current sources of information relating to troubled families, and the way in which they can be integrated.

6.4.6 Child and family poverty (welfare reforms)

The Centre for Social Justice has highlighted alcohol and drug addiction as one of their five "pathways to poverty"[20]. This analysis describes these behaviours both as causes and consequences of poverty, leading to a cumulative cycle of deepening poverty that needs to be broken.

While there are no direct estimates of drug and alcohol misuse among people in poverty, of those that are in receipt of out-of-work benefits, it is estimated[21] that just over ¼ million are problem drug users, and around 160,000 claimants are estimated to be dependent drinkers, equating to 7 per cent and 4 per cent of those claiming benefits respectively.

What is the link between drug and alcohol misuse and poverty? The evidence on drug use and alcohol consumption suggests that both are widespread in society; for the most part, consumption bears little relationship to social class or income. Looking at alcohol consumption, those in work drink more than those who are unemployed and that average consumption rises with income[22]. Marmot (1997)[23]

[20] Centre for Social Justice, 2006
[21] Hay, G. and Bauld, L. (2008) 'Population estimates of problematic drug users who access DWP benefits: A feasibility study', Working paper. Sheffield: Department for Work and Pensions
[22] BMA (2008) Alcohol misuse: Tackling the UK epidemic. London: British Medical Association
[23] Marmot, M. (1997) 'Inequality, deprivation and alcohol use'. Addiction, March, Vol. 92, supplement

presents similar evidence for 'heavy' drinking (those regularly drinking above the recommended daily allowance) which shows lower levels of heavy consumption among unemployed people than among those in work, with the greatest incidence among those in professional and managerial occupations. He concludes that survey evidence does not "lend support to the popular conception that it is the poor and unemployed who are disproportionately represented among heavy drinkers". Similarly, data on drug use shows that, while experimentation with drugs is widespread among young people (one-half of all 16- to 24-year-olds report having used drugs at some time), there is little variation by socio-economic circumstances or correlation with poverty and social exclusion[24]

Overall therefore, general patterns of drug use and alcohol consumption exhibit little correlation with poverty or social class. But these average statistics do not deal with the extremes in the population: alcohol misuse and the incidence of PDUs are much higher among marginal groups such as the prison population, young offenders, and homeless people (Shaw et al., 2007[25]). These groups are often excluded from household survey data. These extreme cases, as Marmot (ibid.) describes them, "may well be unemployed and of lower socio-economic status, perhaps as a consequence of their drinking". But "just as the issue of socio-economic influences on health is not confined to those at the bottom of the distribution, so is the problem of alcohol in society not confined to the relatively small proportion at the extreme of heavy intake. At less extreme levels of consumption, the data does not suggest that there are higher levels of consumption among those in less fortunate socio-economic circumstances."

For those at these "extremes", however, alcohol and drug misuse is undoubtedly a serious problem, which has associations with unemployment and social exclusion. Good quality data on drug and alcohol misuse is sparse. The evidence that does exist, however, notes a relationship between addiction with poverty and social exclusion.

Problematic drug use (PDU) is also correlated with poverty[26], with those at the "margins" of society most at risk, such as those in care, excluded from school and in contact with criminal justice or mental health services, and homeless people. Evidence also suggests that the poorest communities and those with high levels of unemployment are most affected by PDU. Causal effects include poor social capital within communities and weak family networks. Others link PDU to limited opportunities and structural disadvantages: Buchanan (2004, reported in Shaw et al., 2007) argues that PDU may be a "socially constructed phenomenon that has less to do with individual choice or physical dependence, and much more to do with the structural disadvantages, limited opportunities, alternatives and resources". In particular, he suggests that disadvantage and exclusion were major issues preceding a drugs habit for PDUs.

Pudney (2003)[27] reports similar findings, concluding that policies directed at reducing social deprivation may have the most success in reducing the prevalence of the most damaging drugs. Shaw et al. (ibid.) conclude in their review of poverty

[24] The Poverty Site: http://www.poverty.org.uk/38/index.shtml referencing British Crime Survey data
[25] Shaw, A., Egan, J. and Gillespie, M. (2007) Drugs and poverty: A literature review. Scottish Drugs Forum on behalf of Scottish Association of Alcohol and Drug Action Teams
[26] Shaw et al. (2007) report
[27] Pudney, S. (2003) 'The road to ruin? Sequences of initiation into drug use and offending by young people in Britain'. Economic Journal, 113 (486), pp. 182-198

and drug use that: “a central message emerging from this literature review is that, although there appears to be no direct causal link between drug-related problems and poverty per se, the current evidence demonstrates strong associations. Despite these strong associations, over the last 10 years the UK ‘drug problem’ has been increasingly reframed as a ‘crime problem’ – part of a growing trend towards the ‘criminalization’ of a range of policy areas such as youth work and urban regeneration. By prioritizing these policy areas in relation to their crime control potential, a range of inequalities are being exacerbated.”

The Coalition Government has advocated an approach to addressing addiction “rooted in the concept of recovery and reintegration; a process through which an individual is enabled to overcome the symptoms and causes of their dependency and reintegrate back into society” (Hay and Bauld, 2010[28]). However, in the context on employment it has been argued that welfare-to-work programmes may be less suitable for these groups. Kemp and Neale[29] (2005) find that drug users, for example, require other personal, health, lifestyle, and other problems to be addressed prior to participating in welfare-to-work programmes or taking up employment. Such findings are echoed by Bauld et al. (ibid); they recommend a stepwise approach to reintegrating those who misuse alcohol back into employment, with treatment and recovery from alcoholism being a first step.

6.4.7 Educational Issues

The recently published Smoking, drinking and drug use among young people in England in 2010[30] reaffirms the relationship between truancy and exclusion with drug use by young people. The report says:

- Pupils who had truanted or been excluded from school were more likely to report usually taking drugs at least once a month, the measure of frequent drug use, than those who had never truanted nor been excluded (8% and 1% respectively)...

- In 2010, of those pupils who had ever truanted or been excluded, 9% had taken any Class A drugs in the last year, compared with 1% who had never truanted or been excluded from school.

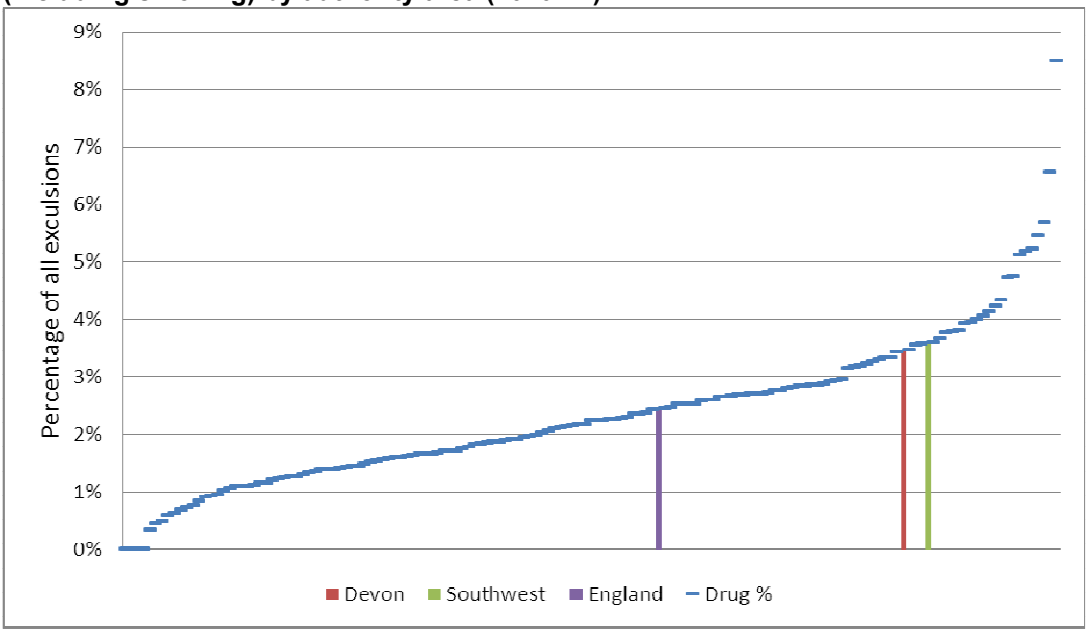
The Department for Education (DfE) “A profile of pupil exclusions in England” for 2010-11 reported a fall in permanent and fixed term exclusions between 2008-09 and 2010-11 (by around 10%), but the number of exclusions for drink and drug issues remained almost static in the same period (showing a slight increase).

An analysis of the 2010-11 DfE pupil exclusion dataset revealed that overall in Devon there were 3,910 exclusions, an average of 4.11 per 100 pupils, which was lower than the Southwest (4.17) and national (4.34) figures. Of these, 135 were due to drugs or alcohol (including smoking), 130 of which occurred in secondary

[28] Hay, G. and Bauld, L. (2010) ‘Population estimates of alcohol misusers who access DWP benefits’, DWP Working Paper 94. London: Department for Work and Pensions
[29] Kemp, P. and Neale, J. (2005) ‘Employability and problem drug users’. Critical Social Policy, February, Vol. 25, No. 1, pp. 28–46
[30] http://data.gov.uk/dataset/smoking-drinking-and-drug-use-among-young-people-in-england-in-2010

schools. This represented 3.5% of all exclusions, which is higher than the national average of 2.4% and lower than the Southwest average of 3.6% (Figure 33).

Figure 33: Percentage of all exclusions occurring as a result of drugs or alcohol (including smoking) by authority area (2010-11)



6.4.8 *Children in Care*

Being in care and previous experience of abuse are risk factors for binge drinking and alcohol and substance misuse. This risk is further increased if the young person's parents or close family have substance misuse issues.

Substance use among young people in care is higher than that of the general youth population. 7.5% of children in care for at least 12 months were recorded as having been identified with a substance misuse problem in 2011-12, increased from 6.3% in 2010-11. In 2011-12 of those identified with a substance misuse problem, 56.3% received an intervention and 40.6% were offered an intervention but refused it. Devon's percentage of children in care identified with a substance misuse problem remains higher than the England average (4.3%, 2010-11).

In future all local authorities with responsibility for children's social care will have the responsibility to collect data on young people's substance misuse at the point of initial assessment, as this will include a much wider number of young people then data quality is likely to improve.

6.4.9 *MISPER*

By the age of 16, one in nine young people has run away from home. Over the course of a year this amounts to around 129,000 overnight runaway incidents in the UK, involving 77,000 under 16-year-olds (Children's Society, Still Running 1999/Social Exclusion Unit, 2002). Of those the peak ages for running away are

between 13 and 16 years old and a quarter are under 11 years old. The risk of harm to a child is increased the younger the child is, and the more frequently they run away. Girls are more likely to run away from home than boys, but boys are likely to first run away at an earlier age and to run away more often. For children who go missing often, there is a progressive risk of detachment from family, carers and school (exclusion or non-attendance) and evidence would suggest that once patterns of school non-attendance and running away become established they are mutually reinforcing. Young people who go missing often are also much more likely to have problems with depression, drugs and alcohol and to have involvement in offending than the general population.

The situation in Devon[31]:

- Total Number of reports (adult and juvenile for 01/04/11 to 31/03/12) 8981 (Devon 4089 taking out Torbay). Juveniles are currently responsible on average for 55% of all missing reports.
- Therefore total missing reports for Juveniles in Devon 01/04/11 to 31/03/12 would be 2249 for this period. Of these it is estimated that 1574 Missing Reports related to children from a care setting and 675 from home. (The local police information system cannot currently separate out children missing from a care setting and those missing from home, hence the estimate.)
- Applying a similar 55% as being juvenile to the total Torbay Missing figures (adult and juvenile) and would leave an estimate of 555 juveniles missing once from Devon and 300 juveniles are responsible for the 1694 repeat missing reports from Devon.

Reasons why young people going missing or the risks they take whilst missing are not recorded comprehensively locally. Missing episodes are only recorded on social care systems where the young person is missing for over 24 hours. Return interviews are carried out largely by their social workers for children who have an allocated worker and on a case by case decision basis for all children who go missing. The Youth Offending Team also operates a case by case decision making process rather than routine return interviews. The majority of police and social care follow up work is focused at present on children who have a history of repeat missing episodes and / or are seen to be at risk of exploitation. This means it is not possible to produce local statistics about why young people go missing. Devon are working to create a team dedicated to work with missing children and those at risk of sexual exploitation. From 1 April 2013 all completed initial assessments (or single assessments) will have to record whether a factor of that assessment is a child going missing from home/care (this will be a new DfE statutory reporting requirement for 2013-14), but this will solely be a yes/no answer so will not provide information about substance misuse.

National research has found that the main causes of running away are family conflicts and personal problems such as relationships, substance misuse, bullying and truancy, with conflict with parents or step-parents being the most common reason by children for running away. The need to escape difficulties between parents – including domestic violence, drug and alcohol problems and persistent arguments – were a major influence for some young people; as were boundary and control issues and feelings of unfair treatment for others. Children who run away

[31] Devon and Cornwall Police MISPER team (2011-2012)

from care are often unhappy with their placement or are influenced by others and do so to 'fit in' with the group. Running away was found to be rarely motivated by boredom or the need for excitement[32].

6.4.9.1 Child Sexual Exploitation

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, attention, gifts, money) as a result of them performing, or others performing on them, a sexual act or activities. Child sexual exploitation grooming can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

There is a need for increased information regarding how many sexually exploited young people there are in the UK: "There is a genuine lack of knowledge and awareness of the nature and scale of sexual exploitation; of the way to respond if the stone is turned and cases are revealed; and a fear of the implications for resource allocation where services are already stretched" (Pearce[33] 2009, p. 30).

Research has also indicated that abusive adults provide young people with substances in order to coerce them into prostitution (Melrose, 2004[34]). Equally, substances are sometimes used as a coping mechanism for sexual abuse.

A nationwide Inquiry by the Office of the Children's Commissioner has found that 2,409 children and young people were confirmed victims of child sexual exploitation in gangs or groups in the 14 month period from August 2010 to October 2011. The Inquiry also identified that between April 2010 and March 2011 there were 16,500 children in England who were at high risk of child sexual exploitation[35].

There is a strong perception in Devon from practitioners working in child safeguarding that the sexual exploitation of young people is increasing; however, it is difficult to identify the numbers involved.

6.4.10 Youth Homelessness

[32] Children's Society, Still Running 1999/Social Exclusion Unit, 2002

[33] Pearce, J. (2009). Young People and Sexual Exploitation. "It's not hidden you just aren't looking". London: Routledge

[34] Melrose, M. (2004). Young People Abused through Prostitution: Some Observation for Practice. Social Work in Action, 16 (1), 17-29.

[35] Office of the Children's Commissioner (2012) Child Sexual Exploitation in Gangs and Groups Inquiry Accelerated Report for the Secretary of State for Education http://www.childrenscommissioner.gov.uk/info/csegg1

There has been an increase in the numbers of youth homeless presentations (people asking to be housed) from 584 in 2010-11 to 704 in 2011-12. Of the 704 homeless presentations by young people (16 and 17 years olds and care leavers 18+ in priority need), in 2011-12, 18% had problem drug and/or alcohol usage[36]. Smoking levels are very high among young people presenting as homeless.

Whilst many took measures to ensure that their substance misuse was as safe as possible, the data gathered suggests evidence of some risky behaviours. These include poly-drug use and unsafe injecting practices. Some of the young people in 2011-12 had lost previous settled accommodation due to problem substance use. A significant minority had needed medical support after accidentally, or intentionally, overdosing on drugs or alcohol.

More accurate data is needed for homeless young people in the county: lack of stable accommodation increases the risk substance misuse amongst vulnerable children and young people. The potential cuts to housing benefits as part of the welfare reform may exacerbate the problems. This is all the more pertinent since the Southwark ruling (the ruling that places the responsibility of supporting and finding suitable accommodation of young people to children and young people's services).

Substance misuse services need to work in partnership with Supported Housing providers to ensure that they have robust drug policies and protocols which keep service users and staff safe and which operate within the law.

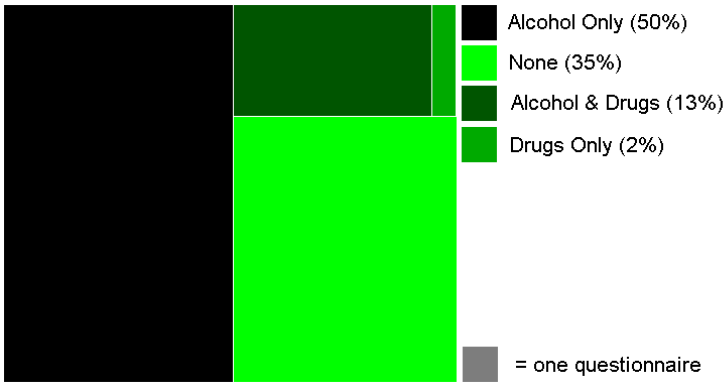
6.5 Substance Misuse and Sexual Health

Substance misusers have an increased likelihood of exhibiting high risk behaviour, which is also reflected in their decisions about sexual health. To try and better understand the link between substance misuse and sexual health in Devon, data was gathered from the sexual health service covering North Devon, East Devon and Exeter, a representative but not complete coverage of sexual health service provision in Devon. Between October 2011 and November 2012 (a 14 month period), 10,463 people accessed the sexual health service and completed a sexual health questionnaire. Of these, 722 (6.8%) were treated for a condition that was obviously linked to drug taking. Over the same timescale, three people were recorded as being treated for a condition that was obviously linked to the consumption of alcohol, though it is though that this is hugely under reported.

During the same time period, 124 people aged under 16 completed a sexual health questionnaire. The questionnaires showed that 65% of young people accessing the sexual health services had used either alcohol, drugs or both at some point in the past (see Figure 34).

Figure 34: Drug and alcohol history of children aged under 16 visiting sexual health services between October 2011 and November 2012.

[36] Devon young people's homelessness presentations monitoring 2011/12



The sexual health questionnaire data was used to identify clients who had a history of intra-venous drug use (IVDU). An analysis comparing the percentage of sexual health clients with and without a history of IVDU who were treated for a blood borne virus was compared. The results of this analysis, summarised in Figure 35 below, showed that those accessing the service that had a history of IVDU were almost three times more likely to be receiving treatment for a BBV.

Figure 35: Proportion of clients receiving treatment for a BBV

IDVU Status	Number receiving treatment for a BBV	Overall number of Questionnaires	% receiving treatment for a BBV	Range
History of IVDU	30	955	3.1%	(2.1% to 4.5%)
No history of IVDU	107	8875	1.2%	(1.0% to 1.5%)

A substance misuse service for young people relating to sexual health will:

- Ensure strong working with relationships with sexual health services are in place to ensure referral routes and brief intervention advice is available in both directions

6.6 Binge drinking

Based on findings from the Health Survey for England, between 2007 and 2009 an estimated 14% of the population of Devon aged 16+ were binge drinking on a weekly basis (more than 8 units for men / six units for women), compared to a national figure of 18.5%. This equates to around 104,000 individuals.

Teenage binge drinking in particular is a growing concern, with adolescents in the United Kingdom (UK) ranked in the top five of thirty countries for measures of

alcohol misuse. A recent report[37] released by the North West Public Health Observatory identified an association between alcohol attributable hospital admissions in both males and females with teenage pregnancy, even after controlling for variations in deprivation. The same was also true for more common sexually transmitted infections.

Regular alcohol consumption and binge drinking are associated with physical problems, anti-social behaviour, violence, an increasing risk of being a victim of crime and assault, injuries and road traffic accidents, with school performance and offending behaviour also implicated. Studies also indicate that people who binge drink in adolescence are more likely to be binge drinkers as adults. Frequent drinking and binge drinking have been shown to increase the risk of developing alcohol dependence in young adulthood.

6.7 Club Drugs

'Club drugs' is a collective term for a number of different substances typically used by young people in bars and nightclubs, at concerts and parties[38]. Although club drug users make up just 2% of over-18s and 10% of under-18s in treatment, unlike overall drug use, the number of people needing treatment for club drugs has risen, and it is thought could grow further. Club drug users generally do well in treatment and last year 61% of over 18 year olds and 74% of under 18 year olds completed treatment successfully. This is thought to be partly due to club drug users usually having good personal resources. Further information can be found on club drugs in the full NTA report:

http://www.nta.nhs.uk/uploads/clubdrugsreport2012[0].pdf

6.8 Offenders

The relationship between problem drug use and crime is complex. Even so, all the evidence indicates that problem drug users are responsible for a large percentage of acquisitive crime, such as shoplifting and burglary[39]. There are also strong links to other types of crime, in particular violent crime.

6.8.1 Young Offenders and Youth Crime

Youth crime in Devon is relatively low. Nonetheless over 700 children and young people enter the youth justice system in Devon each year.

The risk factors for youth offending overlap to a large degree with those for substance misuse, low attainment at school, teenage pregnancy and adolescent mental health problems. A broad-based and multi-agency approach to prevention therefore offers the most opportunity for achieving reductions in offending behaviour.

[37] Contributions of alcohol use to teenage pregnancy and sexually transmitted infection rates, North West Public Health Observatory, 2010
[38] Club Drugs: Emerging Trends and Risks, NTA, 2012
[39] *Breaking the link, National Treatment Agency for Substance Misuse, 2009*

The number of young offender assessment profiles (ASSET assessments) that were completed for the period October 2009 to September 2010 was a significant decrease from previous years. Of the 455 assessments that were completed 184 scored 2 or more within the substance misuse section (40%). The highest score that can be made is 5 and if there is a score of 2 or more the YOT workers are expected to consider making a referral to the young people substance misuse service. In 2007-8 this figure was 42% and in 2008-09 it was 37%.

Research carried out for the Youth Justice Board into alcohol and drug misuse among children and young people in the secure estate (age 12 to 18) found that, in the period before entering custody, over 60 per cent drank alcohol daily or weekly, with 66 per cent reporting binge drinking once a week, and over 25 per cent reporting that their drinking had been out of control.

A referral form has been designed for custody officers to use if young people are arrested and appear to have drug or alcohol problems. This seems to be an very underused resource at the current time.

6.8.2 Acquisitive crime

The National Treatment Agency for Substance Abuse (NTA) has estimated the crime reduction benefits of drug treatment[40], building on research by the Home Office into the cost of offences at 2010-11 prices[41].

In 2011-12 there were 1,419 adults in treatment in Devon. The NTA research estimates that being in treatment reduces each individual's offending by an average of 26 offences per year[42], which in Devon would result in a reduction of 36,894 offences. Using the Home Office estimates for the cost of each type of offence, and the NTA research on the numbers of offences committed by drug users, this amounts to an estimated saving of £5,030 per year per person in treatment, which would equate to a reduction of around £7.1 million per year in the cost of crimes which might have been committed had these individuals not been in treatment.

Figure 36: Estimated reduction in selected crime types in Devon as a result of drug treatment, 2011-12

Offence	Estimated cost per offence	Estimated reduction in offences	Estimated value of reduction in offences
Shoplifting	£124	8,173	£1,013,700
Theft from vehicle	£1,034	411	£424,974
Dwelling burglary	£3,925	127	£498,475
Business burglary	£4,608	368	£1,695,744
Cheque or credit card	£242	454	£109,868

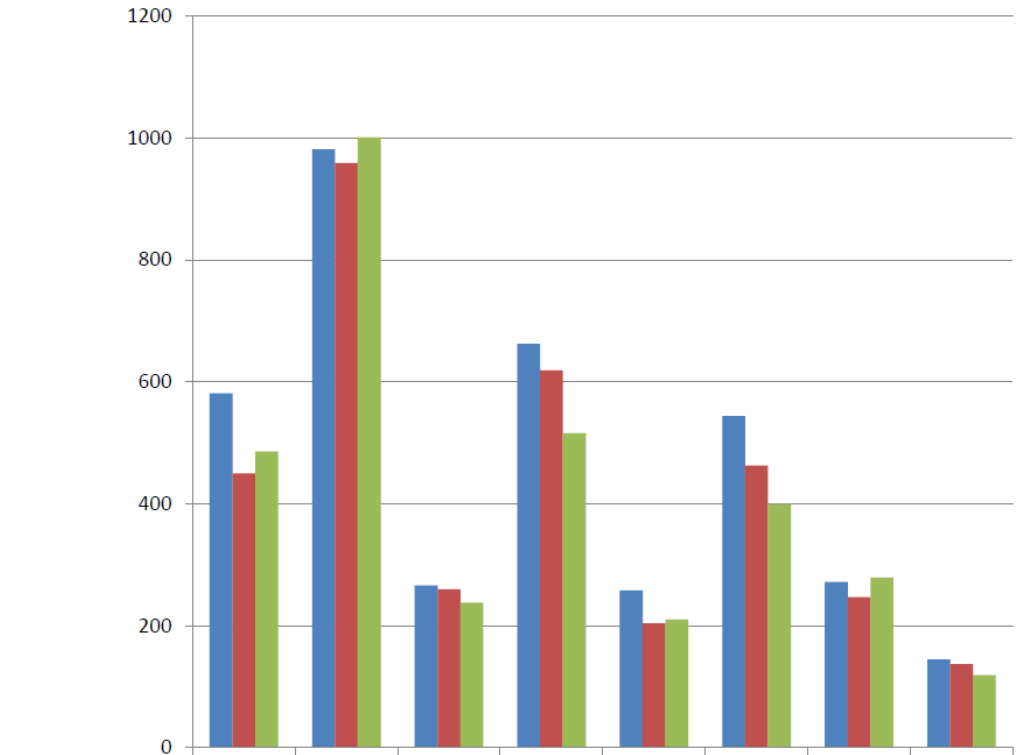
[40] *Estimating the Crime Reduction Benefits of Drug Treatment and Recovery, NTA 2012.*
[41] *The Integrated Offender Management Value for Money Toolkit.*
[42] This is the mid-point estimate. The estimates for the reduction in offending ranged from 19 to 33 offences.

fraud			

6.8.3 Violent crime

Police recording of violent crime includes an indication of those offences in which the offender was thought to be under the influence of alcohol or drugs at the time of the offence. However, no distinction is drawn between the two, although anecdotal evidence indicates that alcohol is the influence in the overwhelming majority of these offences. Figure 37 shows how the number of violent crimes has changed in Devon districts over the past three years.

Figure 37: Number of recorded violent crimes in Devon between Oct 2008 and Sep 2011 (Source: Devon and Cornwall Police Crime Information System)



	East Devon	Exeter	Mid Devon	North Devon	South Hams	Teignbridge	Torridge	West Devon
Oct 08 to Sept 09	581	981	266	662	258	544	272	145
Oct 09 to Sep 10	450	959	260	619	204	463	247	137
Oct 09 to Sep 11	486	1001	238	516	210	400	279	119

It can be seen that over this time period, only Exeter (up by 2%) and Torridge (up by 2.6%) showed any increase in these offences. East Devon saw a 16.3% fall (95 offences), while in North Devon they fell by 22% (146 offences) and in Teignbridge by 26.5% (144 offences). Where the occupation of the offender was recorded, 46.6% of the offences involved an offender who was unemployed.

The Assault-Related Injuries Database (ARID)

The Assault-Related Injuries Database (ARID) was introduced at the North Devon District Hospital in November 2009, and at the Royal Devon and Exeter Hospital in November 2010. It is used by receptionists in Accident and Emergency departments to record anonymous details of patients who attend A&E after being assaulted. The details recorded include the patient's age and gender, the location of the assault, the date and time of attendance, and whether the assault was alcohol-related.

ARID recorded a total of 1,161 assault-related injuries treated in the two A&E departments. As might be expected, alcohol played a part in a large proportion of the assaults. There were slight variations between the two hospitals, Barnstaple's alcohol-related assaults amounting to 60% of the total, while in Exeter this figure was 77%[43], but this means that, across the county, two thirds of the assaults recorded in ARID which resulted in attendance at A&E[44] (784 out of 1,161) were alcohol-related. This figure does not include patients who attended Minor Injuries Units in the smaller hospitals, or those who sought treatment from their GPs.

As the table below shows, almost half (47%) of those who were under the influence of alcohol when assaulted were in the 18 to 24 age group.

Figure 38: Patients attending A&E departments in Barnstaple and Exeter after being assaulted while under the influence of alcohol

Age	Barnstaple Total	Exeter Total	Grand Total
Under 18	33	35	**68**
18-24	160	209	**369**
25-34	95	87	**182**
35-44	63	43	**106**
45-54	25	21	**46**
55 and over	11	0	**11**
No details	1	1	**2**
Grand Total	**388**	**396**	**784**

The information provided by ARID is not available from any other source. Patients cannot be identified, but the details given allow the identification of repeat locations for assaults, such as pubs and clubs, which can then receive attention from police, local authority licensing officers and others, allowing crime reduction measures to be implemented. In Cardiff, this type of information exchange has helped bring about very substantial reductions in violent crime, and a 35% reduction in the number of patients attending A&E with assault-related injuries[45].

[43] Barnstaple figures cover November 2009 to August 2012, while those from Exeter are from November 2010 to August 2012.
[44] 67.5%
[45] http://www.bbc.co.uk/news/health-21266409 31st January 2013

ARID data is particularly important because many of the assaults it records are not reported to the police, and the location data it provides may therefore be the only indication of a developing violent crime hotspot. However, like any such system, ARID is only as good as the data entered, and it is essential that receptionists are encouraged to ensure that the details of all assault patients are recorded. The recent government emphasis placed on the exchange of data from A&E departments makes the successful operation of ARID even more important.

6.8.4 Drug related crime

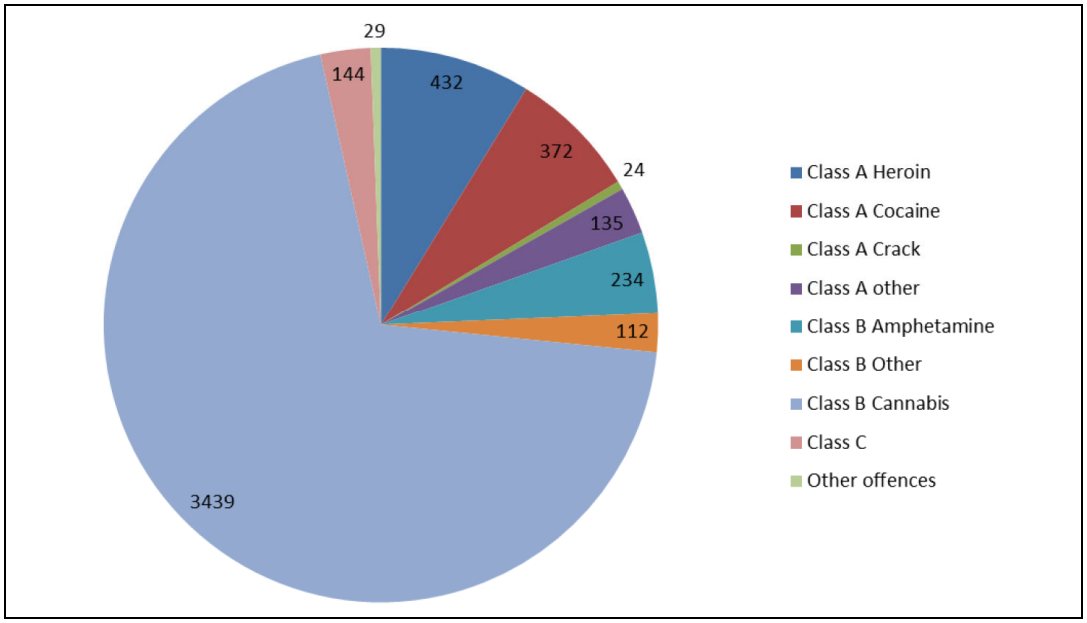
The police data used here were derived from the Devon and Cornwall Police Crime Information System (CIS), and refer to offences committed between 1st October 2008 and 30th September 2011. This three-year period was chosen in order to exclude a period of six months in late 2011 and early 2012 during which a less detailed form of crime recording was adopted, which omitted references to the likely influence of alcohol or drugs.

The volume of drug offences recorded by the police is more of a measure of police activity, rather than of the state of the drug market overall. A police test purchase operation, for example, involving undercover officers posing as users buying illegal drugs, can lead to a considerable number of drug offences within a limited area and over a very short period, but this does not necessarily indicate an equivalent increase in drug activity in general.

However, whilst the sheer volume of drug offences tells us little about the overall level of drug abuse, the police data nevertheless give us valuable information on the individuals involved in committing the offences, particularly as regards age and occupation.

In all, 4,921 drug offences of all types were recorded in Devon in this period, 3,439 (69.9%) of which involved cannabis.

Figure 39: Drug offences in Devon recorded between October 2008 and September 2011 (Source: Devon and Cornwall Police Crime Information System (CIS))



The age profile of those charged with drug offences varied considerably according to the type of drug involved. Out of the 653 offences of possession of a Class A drug, the offender was aged between 18 and 24 in a quarter of the crimes (25.4% or 166), while in just over half (53.1% or 347 crimes) the offender was in the 25 to 39 age group. Offences of 'Supply' and 'Possession with Intent to Supply' Class A drugs showed a similar profile.

6.8.4.1 Handling Stolen Property

The Home Office does not provide an estimate for the cost of offences of handling stolen property, presumably because of the wide range of potential values of the property involved. However, these are estimated to be the most numerous of the offences which service users are likely to have committed if they had not entered treatment (8.4 per person on average, out of the estimated 26 per person per year). Based on the 1,419 adults in treatment in Devon in 2011-12, this would have reduced offending in the county by 11,919 offences, almost a thousand offences per month.

Heroin, cocaine or crack users are believed to commit up to half of all acquisitive crimes – shoplifting, burglary, robbery, car crime, fraud, drug dealing[46] According to the National Treatment Agency, a typical heroin user spends around £1,400 per month on drugs[47], or £16,800 per year. As a result, many turn to crime to pay for their drugs. Given that stolen goods will on average net the offender only about one third of the item's real value, this suggests that it would be necessary to steal goods worth up to approximately £4,200 (£1,400 x 3) every month in order to pay for their drugs. This could result in an annual total of £50,400 in goods being stolen to pay for the heroin of a single user. This means that the estimate of £5,030 quoted above for the annual value of the reduction in offending per person in

[46] Why Invest? How drug treatment and recovery services work for individuals, communities and society. National Treatment Agency for Substance Abuse, 2012.
[47] Ibid

treatment is a very conservative one, and this figure is likely to be exceeded in many cases.

6.8.4.2 Drug Seizures in Devon

The table below shows the drug seizures made by police in Devon in the periods April 2009 to March 2010 and April 2011 to March 2012[48], broken down by drug seized[49]. It must be viewed in the light of the fact that drug seizures, like the number of drug offences themselves, reflect the level of police activity in a given period, rather than the extent of drug use.

As the table shows, seizures of cannabis in various forms (herbal, resin, plants, etc.) dwarf all the rest, and represent 70% of the total of 2,362 seizures. By contrast, those of crack (14) form only 0.6% of the total.

Predictably, seizures of cocaine, amphetamine and heroin were the next largest after those of cannabis, while mephedrone seizures (55) were more frequent than those of ecstasy (39). However Mephedrone was classified as a Class B drug as recently as April 2010, and all the seizures of this drug in this sample were made between April 2011 and March 2012[50], whereas the seizures of ecstasy occurred both in that period and in 2009-10. Mephedrone is thus an example of a substance which was until quite recently a 'legal high', but which now rivals ecstasy in terms of the frequency of seizures[51].

Figure 40: Drug seizures in Devon, 2009-10 to 2011-12

[48] The intervening year's figures are not available, due to staff shortages in the police.
[49] Source: Devon and Cornwall Police
[50] 31 of these seizures were made in Exeter.
[51] More recent figures, for April to December 2012, show 27 seizures of ecstasy compared with 10 of mephedrone.

Cannabis (various forms)	1651
Cocaine	156
Amphetamine	131
Heroin	121
Crack	14
Methylmethcathinone/Mephedrone	55
Diazepam/Nitrazepam/Flunitrazepam/Rohypnol	48
Ecstasy	39
Methadone	24
Other Class B Cathinone derivatives	34
Buprenorphine/Subutex/Temgesic	18
Anabolic/Steroids/and/Androgens	10
Ketamine	10
Morphine	8
Psilocybin/Magic/Mushroom	-*
Substituted Piperazines	6
Dihydrocodeinone/carboxymethyloxime	-*
Temazepam	-*
Not a Controlled Drug/Null	23
Drug not known	6
TOTAL	**2362**

** suppressed*

6.8.5 Drink and drug drivers

As explained elsewhere, the Devon and Cornwall Police Crime Information System (CIS) keeps a record of offences committed under the influence of alcohol or drugs, but does not differentiate between the two. The same applies to the recording of road traffic collisions (RTCs). Although anecdotally the influence of drugs is likely to be the more frequent of the two, the current system of recording renders it impossible to provide evidence for this.

As the table below shows, in the period between October 2008 and September 2011 there were 77 fatal RTCs in Devon, in 10 of which (13%) alcohol or drugs were assessed to have been a contributory factor[52]. In the same period there were 564 RTCs involving serious injuries, 39 of which (6.9%) involved alcohol or drugs. While the annual total of fatal RTCs involving alcohol or drugs fell over this period (from 4 in 2008-09 to 2 in 2010-11), those classified as serious rose considerably, from 6 in 2008-09 to 18 in 2010-11.

Figure 41: Road Traffic Collisions in Devon from October 2008 to September 2011[53]

[52] This assessment is based on the judgement of the reporting officer at the time of the incident, and not necessarily the result of the investigation.
[53] *Source: Devon and Cornwall Police Performance and Analysis Unit*

	Oct 2008 to Sept 2009		Oct 2009 to Sept 2010		Oct 2010 to Sept 2011		Oct 2008 to Sept 2011	
SEVERITY	RTCs	RTCs involving alcohol or drugs	RTCs	RTCs involving alcohol or drugs	RTCs	RTCs involving alcohol or drugs	TOTAL RTCs	Total involving alcohol or drugs
Fatal	35	4	22	4	20	2	**77**	**10**
Serious	143	6	208	15	213	18	**564**	**39**
Slight	1899	97	1653	83	1688	81	**5240**	**261**
Damage only	2065	133	1641	120	1290	116	**4996**	**369**
TOTAL	**4142**	**240**	**3524**	**222**	**3211**	**217**	**10877**	**679**

Between 2009 and 2011, there were 203 collisions involving at least one driver who provided a positive breath test. (Of the 203 collisions, 205 drivers provided positive breath tests). The age range of the drivers providing positive breath tests can be seen in Figure 42 and the ages of the casualties resulting from those collisions can be seen in Figure 43.

Figure 42: Ages of drivers who provided a positive breath test/refused to provide in Devon, 2009-2011 (Source: STATS-19 Data)

Age Group	Number of drivers
0-15	0
16-24	76
25-59	106
60+	15
Unknown	*8*
Total	**205**

Figure 43: Age of casualties resulting from a collision involving a driver refusing or providing a positive breath test, 2009-2011 (Source: STATS-19 Data)

Age Group	Number of drivers
0-15	5
16-24	115
25-59	133
60+	21
Unknown	*10*
Grand Total	**284**

6.8.6 Prisons

This section is predominantly based on information taken from the NHS Devon Prison Needs Assessment 2012-13.

6.8.6.1 Substance Misuse in Prisons – National Context and Guidance

As a consequence of crime often directly or indirectly linked to substance misuse, problematic users of alcohol and/or drugs, are highly likely to end up in the criminal justice system at some point. Some will serve community sentences, others will be sent to prison. In either case, the criminal justice system offers an opportunity to engage with them about their drug or alcohol problem,

The Social Exclusion Unit[54] estimated that the level of substance misuse in the sentenced prison population is 66% of men and 55% of women as compared with the general population levels of 13% of men and 8% of women. Male prisoners are 37 times more likely to die of a drug overdose than other members of the public, due to diminished opioid tolerance. Women are 69 times more likely to do so (Farrell and Marsden 2005).

This increase in substance misuse, is party caused by, and partly the effect of the broader range of complex social and health needs found in the prison population, some of which are outlined in Figure 44 below.

Figure 44 Table comparing complex needs of prisoners with the general population

Characteristics	General population	Sentenced prison population
Suffer from 2 or more mental disorders	5% men, 2% women	72% men, 70% women
Drug use in the previous year	13% men, 8% women	66% men, 55% women
Taken into care as a child	2%	27%
Unemployed before prison	5%	67%
Homeless	0.9%	32%

The Patel report: reducing drug-related crime and rehabilitating offenders (DH, September 2010)[55] looked at reducing drug related crime and the rehabilitation of offenders and is the document which underpins the Governments approach to drug treatment for those in the criminal justice system in England, i.e. those in prison and moving between prison and the community. The recommendations include a more integrated approach within the prisons between substance misuse services and healthcare based on the individual needs of prisoners and with a clear focus on working towards recovery and abstinence from drug and alcohol use.

Substance Misuse Services in Devon Prisons

There are three prisons in Devon, HMP Dartmoor and HMP Channings Wood, which are Category C (Training) prisons and HMP Exeter, which is a Category B (Remand) prison. According to the 2012-13 Prison Needs Assessment[56], the number of prisoners at each of these prisons in December 2011 was:

[54] The Social Exclusion Unit, 2002
[55] The Patel report: reducing drug-related crime and rehabilitating offenders (DH, September 2010)
[56] Prison Needs Assessment, Devon Drug and Alcohol Action Team, 2012

- HMP Dartmoor – 647
- HMP Channings Wood – 725
- HMP Exeter - 530

Due to the fact it is a remand prison, HMS Exeter has a significantly higher throughput of prisoners compared to the other two prisons.

The management of prisoners' drug treatment whist in prison is the responsibility of the Counselling, Assessment, Referral, Advice and Through-care (CARAT) teams. The teams assess the levels of problematic substance misuse (both drugs and alcohol) and provide, or refer individuals to, a range of psychosocial interventions and act as a link to other provision including one-to-one key working sessions, structured psychosocial interventions, group work and specialist programmes such as Prisons Addressing Substance Related Offending (P-ASRO), care planning and review and the Drug Intervention Programme in the community.

At present prisoners are not mandated to engage with the CARAT teams. At the time the prison needs assessment was written, 344 prisoners in total across the three prisons have signed a withdrawal disclaimer, where they have been referred but opted not to engage, although several of these may have engaged later into their sentences.

HMP Dartmoor provides a Prisons Addressing Substance Related Offending (P-ASRO) programme, which is an accredited, medium to high intensity, cognitive behavioural drug treatment programme running for 6 weeks. The programme aims to rehabilitate drug users and is designed to reduce the risk of reoffending by addressing the individuals' substance misuse problems. More detailed information about the P-ARSO programme, including service data, can be found in the NHS Devon Prison Needs Assessment 2012-13.

HMP Channings Wood has a Drug Therapeutic Community (DTC). This is a structured therapeutic community based on hierarchical treatment and aims to teach new behaviours, attitudes and values, reinforced through peer and therapeutic community support over a 10 to 12 month period. This is for adult prisoners with a medium to or high risk of reconviction and high level of dependence on drugs. Increasingly the drug therapeutic community accepts individuals with problematic alcohol use. This is one of four therapeutic communities across the national prison estate. More detailed information about the DTC, including service data, can be found in the NHS Devon Prison Needs Assessment 2012-13.

Substitute Prescriptions in Prisons

The Clinical Management of Drug Dependence in the Adult Prison Setting[57], published by the DH, points out "the correlation between drug withdrawal and self-destructive behaviours" within prisons and that a broader range of treatment

[57] The Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health, 2006

options must be available to manage those with problematic substance misuse on entry to and within the prison setting. The guidance sets out "the model of substance misuse treatment in prison which covers a period from reception into custody, up to and beyond 28 days thereafter" and "seeks to set out the key components for such an approach, which are reception screening, assessment, clinical management and psychosocial interventions".

The Integrated Drug Treatment System (IDTS) for prisons was introduced in 2006 "with the aim of enhancing clinical interventions for drug users in prison, reducing duplication in assessments, improving integration between healthcare and CARAT services, and reinforcing continuity of care between prisons and the community"[58].

All Devon prisons follow the national guidance for opioid maintenance prescribing and so with the exception of some complex cases, all prisoners who require a prescription and have a sentence of six months or more, are put on reduction, rather than maintenance prescriptions. All prisoners on prolonged maintenance prescribing are reviewed at least every three months.

Re-integration into the community

The Drug Intervention Programme (DIP) seeks to engage with prisoners who have a drug problem on release from prison. Drug Intervention Programme workers can assess individuals at any point in the criminal justice system (including custody). The CARAT team liaise with the Drug Intervention Programme team in the area to which the prisoner is being released prior to release from prison to prepare the release plan.

In 2011 the Peninsula Substance Misuse Sub Group commissioned a review of releases of substance misuse clients from the Devon prisons being picked up by the individual's local Treatment Agency. The review found that:

- Of the 92 prisoners with a substance misuse problem who were released, 76 (83%) were referred to treatment agencies (the other 16 either chose not to, or were not suitable for referral).

- Of the 69 prisoners released into a Southwest Treatment Agency, 55 (80%) were referred to their local Criminal Justice Intervention Team (CJIT).

- Of the 55 referrals into CJITs, 23 (42%) did not engage with the service.

Management of Prison Substance Misuse Data

Since April 2011, CARAT teams have been recording their substance misuse data using DIRWeb, the Home Office's data management system, which is used to generate the NDTMS blue reports. Data provided for NDTMS reports prior to this date this was found to be unreliable, and whilst much work has been done to improve this, these reports must be viewed with caution.

[58] The Patel Report, Department of Health, 2010

Not all prisoners in HMP Exeter have a complete reception minimum dataset which would flag up substance misuse for onward referral to Counselling, Assessment, Referral, Advice and Through-care (CARAT). The data for Counselling, Assessment, Referral, Advice and Through-care (CARAT) activity and the Drug Therapeutic Community have come directly from the providers and are deemed more accurate.

Drug Intervention Record Data

Data relating to prisoners choice of drugs was taken from the Drug Intervention Record (DIR) 2009/10 and minimum data set 2010/11, and captures the majority of prisoners associated with substance misuse entering the establishment who engage with the old style carats. The graph below shows the number of prisoners this represents over the past two years for the three Devon prisons.

Prison Transfers

Transfers refer to the movement of prisoners between prisons and information about an individual's treatment should transfer with him in order to ensure continuity of care. There have been instances of vital treatment information not being transferred in a timely manner which has contributed to delays in the continuation of treatment.

The table below shows NDTMS data for treatment exits from the Devon prisons and again there is some uncertainty about its accuracy. The percentage of those leaving treatment in a planned manner, and who are referred by Counselling, Assessment, Referral and Through-care (CARAT) to the Criminal Justice Intervention Team in the receiving area, is low for all three prisons. Each person is asked whether they want to be referred and where the answer is no, an alert form is sent to the local Criminal Justice Intervention Team to inform them of the pending release.

Figure 45: Release Data for the Devon prisons for Integrated Drug Treatment System clients, 2011/2012 (Source: National Drug Treatment Monitoring System Prison Performance Quarter 4 report 2011-2012)

Outcome	HMP Exeter		HMP Dartmoor		HMP Channings Wood	
	Number	%	Number	%	Number	%
Planned exits	441	89%	135	77%	110	74%
Unplanned exits	56	11%	41	23%	39	26%
Transferred to CJIT	191	38%	15	10%	6	6%
Transferred to another prison	188	38%	49	33%	32	34%
Released – no onward transfer	120	24%	81	54%	57	60%
Died	0	0%	0	0%	0	0%
Missing	0	0%	5	3%	0	0%
Total	**497**	**-**	**176**	**-**	**149**	**-**

A substance misuse service for prisoners will:

- Investigate reasons behind lack of engagement when prisoners are referred to CJIT's and not followed up.
-

6.9 Mental Health / Dual Diagnosis

Substance misuse is usual rather than the exception among people with severe mental health problems and the relationship between the two is complex (DoH 2002), and to make things worse, people with mental health problems are usually more sensitive to the effects of modest amounts of substances due to the psychobiological vulnerability that underlies their psychiatric disorder.

The combination of substance misuse and mental health issues in an individual is commonly referred to as "dual diagnosis", though in most circumstances there are more than just these two issues. A comprehensive account of dual diagnosis, which extends beyond the brief of this needs assessment can be found in the "Devon and Torbay Dual Diagnosis Strategy", completed in July.

In 2010-11, there were 6,640 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This is 14.3 per cent more than in 2009-10 when there were 5,809 admissions but 17.3 per cent lower than in 2000-01 when there were 8,027 admissions. More than twice as many males were admitted than females in 2010-11 (4,813 and 1,827 respectively).

Where primary or secondary diagnosis was recorded there were 51,353 admissions in 2010-11 compared with 44,585 admissions in 2009/10, which shows an increase of 15.2 per cent. This is the biggest annual increase for this type of admission in the last ten years. Figures from this type of admission are now nearly twice as high as they were ten years ago at 25,683 admissions in 2000-2001. More than twice as many males were admitted than females in 2010-11 (34,508 and 16,839 respectively).

In addition to these increasing figures, mental health and substance misuse problems are often missed and not recorded or treated because these problems are not fully explored with the individual. As might be expected, lack of recognition and treatment of mental health and substance misuse problems is associated with worse outcomes.

As part of the initial triage, the mental health status of clients entering the substance misuse treatment service is recorded though, the accuracy of this data is open to question as it is not validated to back to mental health service records. It is only recorded when the client is triaged, and so is possibly influenced by the client's willingness to reveal this information at the first appointment.

Alcohol is the most common substance of misuse, cannabis the most common drug of misuse, and poly-substance use frequently occurs. This pattern seems to

be largely unrelated to service users' symptomatology[59] but, rather, is associated with the same demographic correlates as for the general population[60]. This suggests that in a similar way to other people who misuse substances, it is the social context and availability of substances that most often dictates substance choices in people with psychosis[61]. The small literature on reasons for substance use in psychosis also suggests that people with psychosis do not differ from other groups, with reasons including response to negative affective states, interpersonal conflict and social pressure[62].

As many as 80% of alcoholics complain of depressive symptoms, including 30% who fulfill criteria for a major depressive disorder[63]. A lifetime history of depressive disorder has been found in 48% of opiate addicts[64].

A substance misuse service for clients with dual diagnosis will:

- have a shared definition for "Dual Diagnosis" between agencies.
- clarify lead agency and accountability arrangements for all individuals with mental health and substance misuse problems (dual diagnosis)
- implement an integrated and inclusive model of service delivery, in accordance with Department of Health guidelines to meet local prevalence and need.
- ensure greater collaborative and joint working between substance misuse and mental health services
- embed the culture that management of dual diagnosis is everybody's business.
- encourage multi-agency collaborative and appropriate information sharing across all generic providers of care
- ensure all staff across all sectors, who regularly come into contact with this client group, have the appropriate training and support relevant to their needs
- ensure all individuals with a diagnosis of dual diagnosis have a named worker and accountable organisation
- respond to all presenting and on-going needs of the service user irrespective of cultural diversity, age or geographical location within Devon and Torbay
- support and inform both people who use services and carers throughout the treatment/intervention process, aiding recovery.
- ensure joint training in screening and referral for all staff on identification & referral and including joint assessments, joint working and care plans where appropriate.

[59] Brunette *et al.*, 1997
[60] Teeson *et al.*, 2000
[61] Kavanagh *et al.*, 2004; Patkar *et al.*, 1999
[62] Conrod & Stewart, 2005; Gregg *et al.*, 2009
[63] Raimo & Schuckit, 1998
[64] Rounsaville et al, 2001

6.10 Homelessness

There are strong, well established links between homelessness and substance misuse. Among the homeless population there are a group with complex needs who are not benefiting from services because their lives and engagement with services are too chaotic. These adults continue to face poor outcomes in the form of offending, long-term mental and physical health problems, poor family relationships, continuing substance misuse, worklessness and deprivation[65]. Pilots working with rough sleepers have demonstrated the effectiveness of using more proactive, person centred approaches It is also important for the client to be supported to enable them to be part of any support plan or care plan that is drawn up for them, that they are instrumental in their recovery, rather than having things done for them.

A report based on 389 homeless people in London[66] found that two thirds of the sample cited drug and/or alcohol use as the reason for first becoming homeless. There is also evidence that becoming homeless is linked with an increase in drug and alcohol use, and so creating a "feedback loop" with both homelessness and substance misuse making the other more likely. The report also showed that poly-drug use was also extremely common, with almost half of respondents using both heroin and crack cocaine in the past twelve months, and almost three quarters having used cannabis. A separate survey conducted by Homeless Link[67] showed that more than half of hostels reported that the majority of their clients were problem alcohol users.

A local survey of 112 homeless people conducted by NHS Devon[68] supported national findings, with almost half of respondents either currently using or recovering from a drug problem, with many being poly drug users.

From Nicky: 6.9 - I am a bit confused that you put a local survey of 112 homeless people and cite the source as the Devon Health Audit as that had 259 respondents

In addition to increasing the likelihood of substance misuse, being homeless also elevates the risks associated with substance misuse, relating to both the way in which the substances are taken and in accessing services that help support substance misusers.

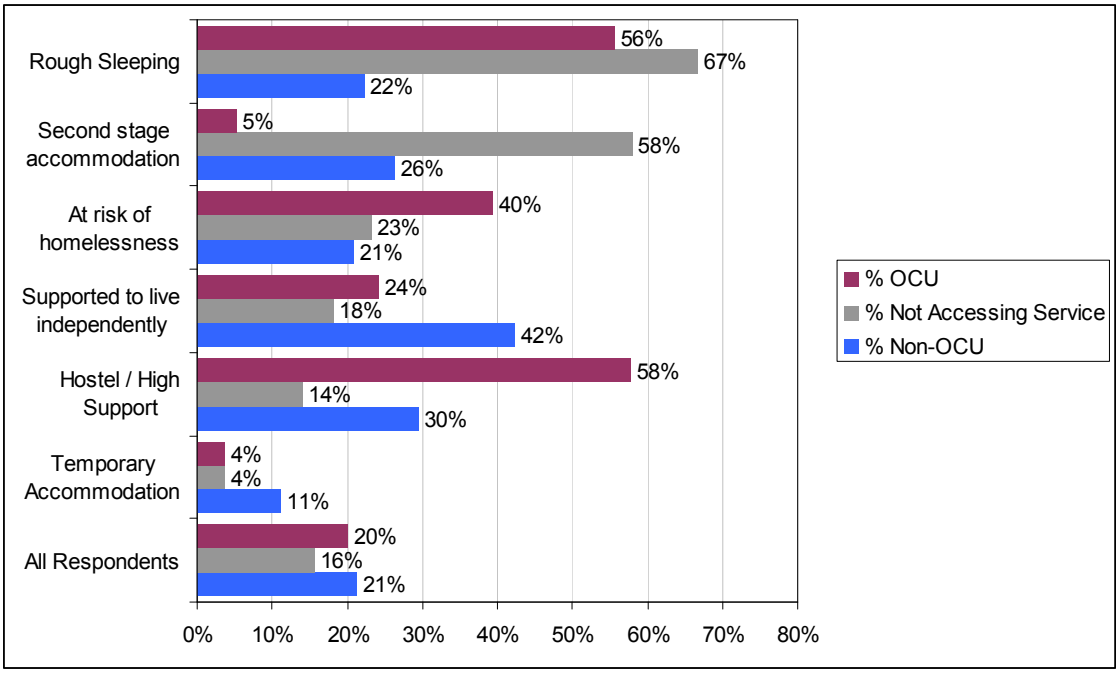
A report into injecting behaviours, published by the HPA[69] showed that 50% of injecting drug users have experienced homelessness in the past twelve months, with this group being 50% more likely to have shared a needle during this time (one in four compared to one in six for those who had not been homeless). In addition to

[65] HM Government (September 2006)
[66] Fountain J. Howes S. (2002) Home and Dry? Homelessness and substance use. London. Crisis
[67] Homeless Link (2011) http://homeless.org.uk/node/655/done#.UKUMZOTgn40
[68] Source: Devon Health Audit. NHS Devon Public Health Intelligence Team 2011
[69] Hope V, et al (2008) Shooting Up: infections among injecting drug users in the United Kingdom 2007. An update: October 2008. United Kingdom. Health Protection Agency.

this it was found that the homeless found it much harder to maintain hygienic injecting practices, injecting in public places and using dirty equipment.

This risky behaviour resulted in an increased risk of developing other health issues such as an abscess, open sore or wound at an injecting site, in addition to an increased risk of contracting a blood borne virus such as hepatitis B or C or HIV.

Figure 46: Results from 2011 NHS Devon Cross Sectional Survey – Percentage of homeless people taking OCU and Non-OCU substances, and the percentage not accessing drug and alcohol services.



Another finding of the Homeless Link survey was that whilst a high number of hostels had access to a range of substance misuse treatment options, 62% of those where services were available reported barriers to access.

The Devon Health Audit showed that one third of respondents had an alcohol problem, of which one third said they were receiving adequate support and half saying they were receiving either inadequate support or no support at all. This suggest that as with homeless drug users, a significant proportion of homeless people with an alcohol problem are not receiving the support they need.

A substance misuse service for the homeless population will:

- make extra efforts engage with the homeless population, and ensure a simple, well supported progression through drug and alcohol services (especially for rough sleepers)
- provide support to improve hygiene standards of injecting equipment
- ensure mental health teams are fully engaged with homeless people accessing the service

- provide comprehensive housing support to break the feedback cycle of drug use and homelessness

A housing service for people with substance misuse issues will

- work in partnership with drug and alcohol services. They will screen and refer all their clients and referral to drug and alcohol services and support from these agencies will be a requirement of them staying at their housing, staff to take part in training.
- A range of accommodation options that meet the service users' needs at different stages of their 'Recovery Journey' should be commissioned
- Housing support workers to receive support and training to work to a Recovery - based model

6.11 Domestic violence

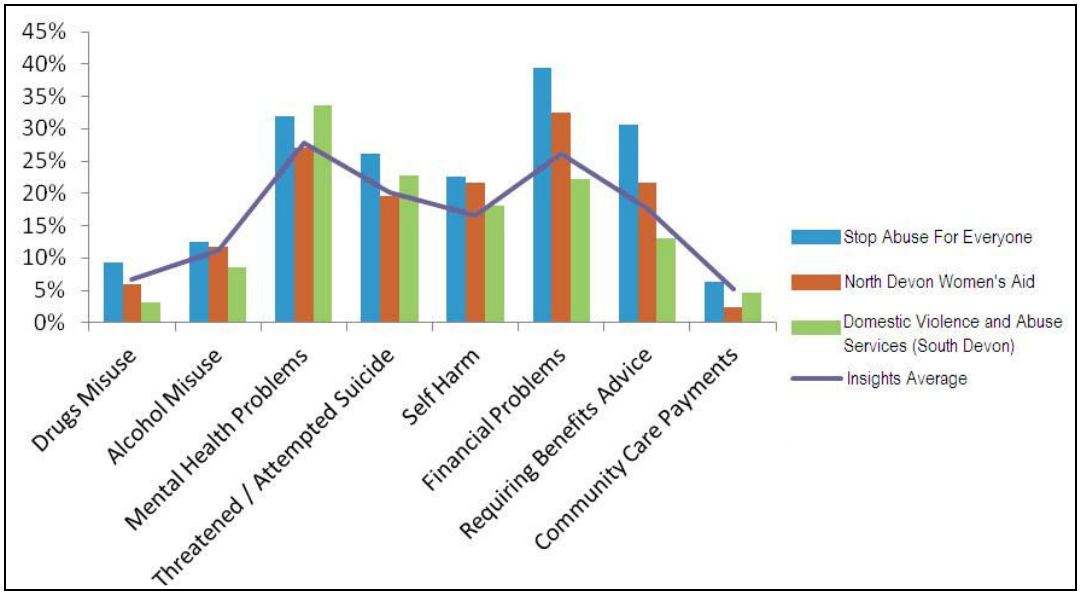
Police in Devon attended an average of one domestic violence incident every hour in (8,798 incidents in 2010-11)[70]. Based on prevalence figures in the British Crime Survey an estimated 7% of women and 4% of men were victims of domestic violence in the last 12 months. This equates to 13,972 women and 8,011 men in Devon.

In line with the proportion for all violent crime, around 50% of domestic violence where children are resident in the household was recorded as linked to alcohol in 2011-12, the trend appears to be slightly rising and this is also in line with the general picture.

North Devon data on referrals to Addaction, the Devon alcohol services provider, suggest that from April to June 2010 perpetrators of domestic abuse made up between 5-8% of referrals and victims of domestic abuse 0-7%. Quarterly reports for the whole of Devon, on the number of referrals who report current or historical domestic violence (victims and perpetrators), will be available for Quarter 3 (July to September 2010) onwards. The number of referrals reporting sexual abuse will be recorded from August 2010 onwards.

Figure 47: Vulnerability issues of clients using specialist domestic violence and abuse services in Devon 2010-2011 (Source: CAADA draft 2 of Best Value Review 2011)

[70] Devon and Cornwall Police



Women who experience domestic violence are up to 15 times more likely[71] to misuse alcohol, which would suggest that a reduction in domestic violence would also result in a reduction in related substance misuse. It is therefore important that domestic violence and substance misuse services work together closely to achieve better results.

6.12 Carers

On 16th November 2012, a consultation was conducted exploring the needs of carers and families of those dependent on alcohol or experiencing problematic drug use. This was followed up with series of one-to-one and group interviews and discussions, which were conducted during November and December 2012. The information in this section is based on the resulting report[72].

Caring for individuals with a substance misuse problem can have a significant effect on the carer. The consultation found that 100% of carers described their experience as isolating. 90% of respondents stated that they experienced a loss of social contact with other people as a result, and talked about a negative impact on their sense of self-esteem. Several said that they had lost friendships because of a lack of understanding of addiction issues, but the majority related the experience of isolating themselves, sometimes unconsciously, because of the stigma and perception of addiction.

The ways in which carers' provide support was wide ranging, but many described commonalities. Over 80% were solely responsible for household tasks such as shopping, cooking, cleaning, laundry, dealing with household bills and finances as well as liaising with schools, colleges, or filling in forms for benefits. 90% said they were responsible for financial matters when faced with financial or housing difficulties, and had to manage and deal with debt (often as a result of the user's

[71] Stark and Flitcroft (1996) Women at Risk: Domestic Violence and Women's Health. London: Sage
[72] Gard and Leyton Plom (2012), Building Resilience and Personal Recovery: A Consultation with Carers of Alcohol and Drug Dependents on current and future support (http://www.recoverylink.org.uk/2013/recoverylink-report-highlights-need-for-greater-support-for-carers-and-families-of-people-with-addiction/)

addiction). Over 75% of respondents said they had had to deal with debt and financial hardship at some point during their caring role.

A support service for carers looking after people with substance misuse issues will:
• provide specialist one-to-one help for carers, including mentoring from those with similar life experiences • Improve the level and quality of support and awareness to reduce perceived barriers to carers of alcohol/drug dependents • Provide more training for staff within relevant services to raise awareness of the challenges of caring for an addicted individual and to make them more inclusive and supportive of carers

6.13 Absenteeism from EET

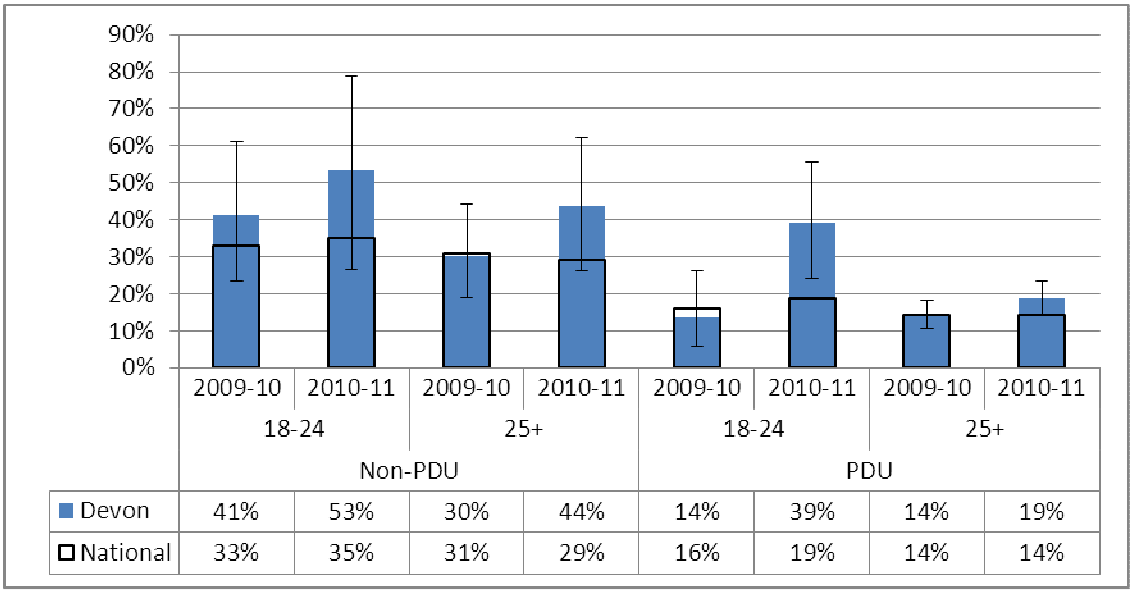
Harmful drinking has been shown to pose significant social and economic costs to the workplace, primarily as a result of lost productivity. The effects of absenteeism, poor job performance, accidents and injuries, and alcohol-related disability and death results in a huge loss in productivity, and is the primary social cost of harmful drinking[73], costing the European Union €59 billion in 2003.

Due to their often chaotic and complex environment, it is common for people with substance misuse problems to not be in full time education or employment. Examining the most recently available (2010-11) NTA Treatment Outcome Baseline Profile (TOP) for new treatment starts to the drug treatment system, it can be seen that nationally only 17.3% of clients were in employment, and only 2.8% were in education. This means that around four in five clients nationally are not in employment. In Devon, the picture was slightly better for employment (23.3%) and the same for education (2.8%).

When looking at the percentage of PDU and non-PDU client base in employment or education over the past couple of years (Figure 48), it can be seen that, as would be expected, a lower percentage of the PDU client base is in employment or education compared to non PDU clients. It can also be seen that generally, Devon has a slightly higher percentage of its client base in employment compared to nationally, though the only group that has a statistically higher percentage is the 18-24 PDU client base for new starters in 2010-11.

Figure 48: Percentage of drug users starting treatment who are in education or employment, 2009-1 to 2010-11 (Source: NTA Treatment Outcome Baseline Profile)

[73] Collins & Lapsley, 2008; Rehm et al., 2006; Saar, 2009



In Devon there are seven Job Centre Plus (JCP) offices, which help to get out of work people back into employment, and enables claimants to collect unemployment benefits. Whilst there is no routine protocol for screening for substance misuse, if an advisor suspects a client may have an issue, they may challenge the claimant, but even if the claimant discloses an issue, unless consent is given a marker cannot be placed on their record in the Labour Market System to indicate a substance misuse problem. If the claimant agrees, the marker is set, and the adviser will suggest to the claimant that they seek support from DDS or Addaction, as appropriate. If the claimant agrees, a formal process involving TPR 1 and 2 referral forms is then taken forward. Figure 49 below is a snapshot of Devon JCP data at end of December 2012.

Figure 49: Number of substance misuse markers set at Job Centre Plus offices, December 2012 (Source: Job Centre Plus)

Office	Total Claimants	Number of substance misuse markers set	%
Barnstaple	1348	13	1.0%
Bideford	959	8	0.8%
Exeter	3111	24	0.8%
Honiton	388	10	2.6%
Newton Abbot	1338	10	0.7%
Tiverton	615	10	1.6%
Totnes	542	4	0.7%
Total	8301	79	1.0%

Nationally, it is estimated that 7% of people on benefits have a substance misuse problem, and 4% are dependent drinkers. Overall, only 1.0% of unemployment benefit claimants are recorded as having a substance misuse problem, but given the limitations on the way these data are

collected, this is likely to be a significant under reporting of the true percentage.

Although the occupation of offenders is not recorded on the Police Crime Information System for all drug offences, where it has been noted it supplies a striking illustration of the prominence of unemployment as a feature of the background of many offenders. During October 2008 to September 2011, for incidents where employment status was recorded, offenders were unemployed in:

- 343 (52%) out of 653 offences of possession of Class A drugs
- 219 (70%) out of 313 offences of supply and possession with intent to supply Class A drugs
- 1,185 (44.8%) out of 2,641 cannabis possession offences (offender occupation was recorded in 2,641 out of 2,993 offences.)
- 230 (55%) out of 417 of offences of cannabis 'supply', 'possession with intent to supply' and 'production' (offender occupation was recorded in 417 out of 459 offences)
- 2,817 (46.6%) out of 6,040 violent offences in which the offender was considered to be under the influence of alcohol or drugs (offender occupation was recorded in 6,040 out of 10,297 offences)

In the supply offences, some of those describing themselves as unemployed may in fact have been full-time dealers, and therefore lacking any legitimate occupation to record. However, the figures for those charged with possession offences provide clear evidence of the large numbers of drug offenders who are unemployed.

As a further indication of this trend, 61% of those entering treatment for alcohol abuse in Devon in 2011-2012 were also unemployed.

6.14 Sex workers

There is not currently any robust local evidence around substance misuse amongst sex workers. Whilst not directly applicable due to its urban setting, qualitative research conducted in south London[74], involving unstructured interviews with twelve female sex workers found that patterns of drug use may be changing among sex workers, with a notable increase in the use of crack cocaine, and that service provision may be failing this group. The conclusions of the study were that the experiences of the women were not new and confirmed existing knowledge and that flexible services are necessary to attract, engage and support this vulnerable group.

[74] Sex work, substance misuse and service provision: The experiences of female sex workers in south London, Mosedale et. al., 2009

6.15 Lesbian, Gay, Bisexual and Transsexual

A report by the UK Drug Policy Commission[75] found that the LGBT community tend to be early users of new drugs and says improving links between such minorities and health officials would identify risks before drug use became widespread. The study finds:

- Illicit drug use among LGBT groups is higher than among their heterosexual counterparts
- LGBT people may also be at risk of misusing other drugs, such as steroids
- Use of some types of drugs may be associated with risky behaviour, including exposure to HIV infection.

In 2008, Stonewall carried out one of the largest surveys of its kind among 6,000 lesbian and bisexual women. The survey found that one in 10 lesbian and bisexual women had taken cocaine, compared with 3% of heterosexual women. Overall, lesbian and bisexual women were five times more likely to have taken drugs than heterosexual women.

The British Crime Survey estimated that 10% of heterosexuals took drugs last year, compared with 33% of gay or bisexual people[76]. Explanations vary as to why these groups appear to be heavier drug users than heterosexuals and relatively little research has been done on this subject. For example: lifestyle choices for LGBT people, with a greater focus around bars and clubs – and clubbers are more likely to take drugs. Additionally LGBT people are more likely to have suffered bullying and abuse and been victims of crime than the heterosexual community, they are also more likely to have mental health needs, all of these could contribute to a greater propensity to use substances as a coping mechanism.

6.16 Serving Armed Forces Personnel and Veterans

Calculating the number of veterans among those who seek treatment for alcohol or drug abuse, or who commit alcohol- or drug-related crime, is made more difficult by the fact that some veterans may simply not reveal their military background, some may manifest problems many years after leaving the Forces, and recording systems are geared to noting *current occupation*, rather than identifying previous employment experience.

Equally, identifying current Armed Forces personnel is hindered by incomplete data on occupation. For example, police crime records contain occupation details for less than 60% of those charged with alcohol- or drug-related violent crime in Devon between October 2008 and September 2011[77].

[75] UK Drug Policy Commission (2010) The Impact of Drugs on Different Minority Groups: A Review of the UK Literature

[76] The British Crime Survey (Year?) Drug Misuse Declared

[77] 6,040 out of 10,297 offences, or 58.6%, based on entries in the Devon and Cornwall Police Crime Information System (CIS).

Analysis by the Ministry of Defence in November 2009 calculated that 3.5% of the prison population in England and Wales at that time were Forces veterans[78], but this is widely believed to be an underestimate. In Devon in 2012 the veteran population of the three Devon prisons ranged from 2.8% in HMP Exeter to 5.3% in Dartmoor[79]. Nationally, a third of the imprisoned veterans had been convicted of violent offences, and 11% had been convicted of drug offences. However, the proportion of veterans imprisoned for all types of offence is significantly smaller than that of the population as a whole.

In Devon, 2.4% of the offenders in alcohol- or drug-related violent offences were serving Armed Forces personnel[80], whereas military personnel overall represent only 0.3% of the UK population.

The Royal British Legion calculates that self-reported mental health problems among veterans aged under 44 are three times the national average[81], while referrals to the Forces mental health charity Combat Stress have increased 72% since 2005. There are no readily available estimates of the number of veterans misusing alcohol or drugs.

None of the above is intended to stigmatise veterans or serving military personnel. On the contrary, it is intended to highlight the needs of a group who are often reluctant to seek help, but whose needs are very significant.
Issues related to veterans will continue to grow. Redundancies will separate an increasing number of personnel from the support of their colleagues, and by the time British forces withdraw from Afghanistan in 2015 there will be more veterans in the UK than at any time since the end of the Second World War.

6.17 Elderly People

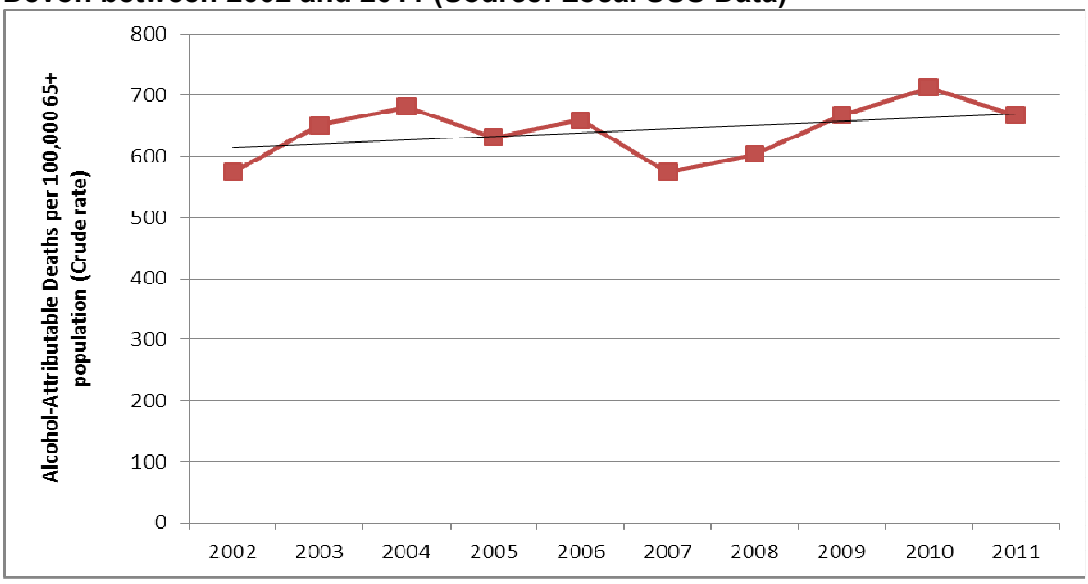
Generally, alcohol consumption declines with age and the proportion of non-drinkers increases, which is thought to be connected to changes in life circumstances and attitudes and, in the later middle aged and older, growing ill health[82]. There is however evidence that consumption of alcohol amongst the older population is increasing.

Alcohol and drug misuse can be a particular problem in the elderly population for a number of reasons, including decreased tolerance, less efficient breakdown of alcohol in the body, pre-existing health conditions (and associated prescription drugs). The accessibility to the service may also be more difficult for the elderly, both from a mobility perspective, particularly in rural areas, and from a communications perspective, as some forms of communication (such as email and the internet) may be less well utilised.

[78] A total of 2,820. *Estimating the proportion of prisoners in England and Wales who are ex-Armed Forces- further analysis,* Defence Analytical Services and Advice, Ministry of Defence, 2012.
[79] The figure for Channings Wood was 5.1%. *Devon Prisons Needs Assessment*, 2012
[80] 112 out of 5,009 offenders between October 2008 and September 2011 whose occupation was recorded on the Devon and Cornwall Police Crime Information System (CIS).
[81] *Profile and Needs of the Ex-Service Community 2005-2020,* Royal British Legion and the Compass Partnership, 2006.
[82] Alcohol & the Elderly Factsheet, Institute of Alcohol Studies, 2010.

Figure 50 below shows the crude alcohol attributable death rate for the over 65 population in Devon over the past ten years. It can be seen that there has been a slight increase in the rate of admissions, a greater increase than has been seen in the general population. This suggests that whilst rates are not increasing rapidly, alcohol consumption in the elderly may be growing slightly more than consumption in the general population.

Figure 50: Crude alcohol-attributable death rate in the 65+ population in Devon between 2002 and 2011 (Source: Local SUS Data)



7. What is currently being done

This section examines how drug and alcohol services in Devon are currently being delivered, who they are being delivered to and how they are performing. The data used in this section is predominantly from reports generated by the National Drug Treatment Monitoring System and the National Alcohol Treatment Monitoring System.

7.1 Overview of service provision

Currently, the drug treatment services for adults and children in Devon are operated and delivered by different providers. The Children's service run an integrated drug and alcohol service, which since 2008 has been managed Devon-wide by a single operator, Y-Smart, who along with their delivery partners, deliver treatment for all tiers of complexity.

The adult service is currently separated into drug and alcohol services. The drug service is managed by Devon Drug Services (DDS), who are now part of Devon Partnership Trust (DPT). DDS provide a service for all levels of client complexity. The alcohol service has a single point of referral for initial assessment with two providers providing a two tier system of treatment, Addaction and Devon Partnership Trust (DPT).

Services offered by Addaction include:

- Triage, initial & comprehensive risk assessment
- Brief interventions
- Structured psychosocial interventions
- relapse prevention and aftercare for recovery maintenance are provided to hazardous or harmful drinkers and those with mild to moderate dependency, mapped to individual need
- Mutual aid groups are also delivered through the volunteering programme.

Addaction's services are delivered by three locality teams in Exeter East & Mid, Northern Devon (including Torridge) and South & West Devon & Teignbridge. These are based in Barnstaple and Exeter but also provide a range of community based services utilising community settings, GPs practices, Community hospitals, mental health services and home visits where appropriate across Devon

DPT provide alcohol services to severely dependent alcohol users and those that that meet the following criteria through the assessment process:

- require a medically assisted detoxification
- have significant mental health problems experiencing chaotic episode and/or requiring detoxification
- Significant poor physical health problems
- Requiring assessment for learning difficulties (Addaction work with those presenting as not severely dependent and mild to moderate learning disabilities)
- Pregnant, and continued use of alcohol (Addaction work with pregnant alcohol misusers who are abstinent)

Figure 51: Configuration of drug and alcohol service provision in Devon, 2012

Service	Stage	Children & Young People	Adults
Alcohol	Triage	Y-Smart	Addaction
	Tier 1 & 2		
	Tier 3		Addaction / DPT
	Tier 4		DPT
Drug	Triage		DDS
	Tier 1 & 2		DDS
	Tier 3 & 4		DDS

The needs of substance misusers are often far more complex than just the substance misuse itself, and the drug and alcohol services for both adults and children work closely with a wide range of partners in order to facilitate the recovery of service users. In addition to the review of core services, information is provided for a number of these partners.

7.2 Young People Substance Misuse Service

This section looks at the referral pathways into Devon's substance misuse service for young people, a range of information about the treatment interventions offered (including length of treatment journey) and also examines the outcomes of those

treatment journeys. Where possible, comparisons are made to national figures, so as to identify where the service in Devon may be under or over performing. The function of some of the supporting agencies is also outlined, as is the process for the transition of young people into adult services.

7.2.1 The referral process

Y-Smart, the provider of Devon's young people's substance misuse service, are an open referral service and so receive referrals from a range of sources. Referrals are received either by post, secure email or fax, or over the phone, where details are transcribed onto a form. In cases where a referral is received from another agency, additional relevant information about the individual's circumstances is also transferred. Once a referral has been received, cases are allocated, based on complexity of need, to either a drug or alcohol practitioner, a member of nurse team (generally mental health trained) or to an educational outreach worker. From the date of the referral, is then the responsibility of the case worker to make initial contact within five days, conduct an initial assessment and create an interim care plan within ten days, and conduct a comprehensive assessment within fifteen days.

The case handler usually contacts the young person using their preferred contact method within 24 hours to arrange an initial meeting, the location of which is, safety permitting, usually chosen by the young person.

At their initial appointment, if the young person is under 16 they are asked to complete an information sharing agreement, stating whether or not they want their parents to know about their engagement with the service. Generally, they are encouraged to involve their parents, but if they don't what their parents to know, an assessment of competency is conducted to see if they are able to declare their own treatment. If it is suspected at this stage that the child may be at risk, referrals are made to the Devon MASH.

At the appointment, an assessment is made as to the severity of the substance misuse problem, which determines the type of treatment the young person receives. Figure 52 shows the four different tiers of treatment that are delivered or supported by Y-Smart. Usually, young people referred into treatment will be classified as Tier Three, with only a handful being requiring a Tier Four treatment for very complex cases. Only Tier Three and Tier Four treatment episodes are reported to the NTA, which places pressures on the additional work done such as providing educational support and support for young people whose parents are the substance misusers, as these are not reportable.

Figure 52: Hierarchy of treatment interventions

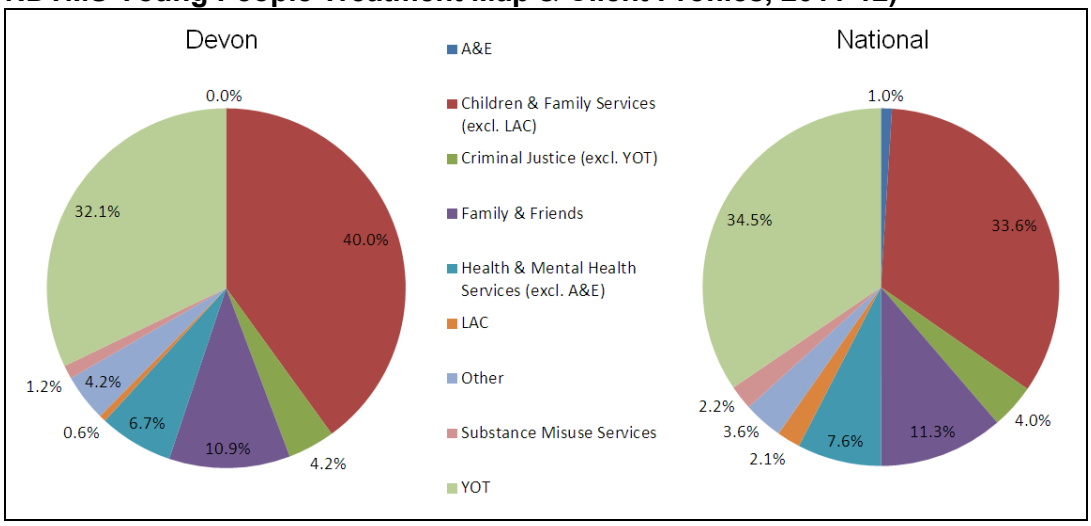
Tier	Details of Intervention
Tier One	General dissemination of information to all young people (e.g. through the national curriculum)
Tier Two	Targeted education and intervention work with vulnerable groups and individual brief interventions
Tier Three	A personal package of care delivered to an individual with an identified substance misuse problem

Tier Four	Residential rehabilitation and/ or detoxification

7.2.2 *Sources of referrals*

During 2011-12, a total of 165 young people were referred into Devon's Substance Misuse Treatment Services. Figure 53 below shows where these referrals came from, and how this compares to the national picture. It can be seen that the overall pattern of referrals in Devon is largely similar to national referral pathways, with the majority (72%) of referrals coming from Children and Family Services and the Youth Offending Team (YOT). During this time period, there were no referrals in Devon from the Accident and Emergency Services.

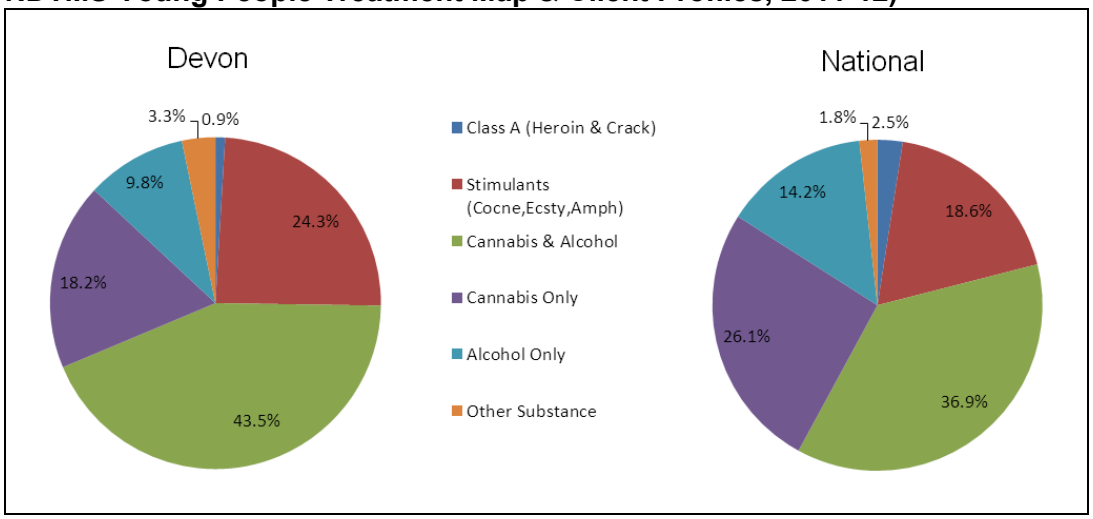
Figure 53: Referrals into Devon's Young Person's substance misuse treatment system by referral source, 2010-11, compared to national (Source: NDTMS Young People Treatment Map & Client Profiles, 2011-12)



7.2.3 *Type of substance*

In Devon during 2011-12, a total of 165 young people aged 12 to 18 (0.27% of the 12-18 population) entered Devon's Young Person's Substance Misuse Services, compared to 164 during the previous year. Figure 54 compares the percentage of people accessing the service for each type of drug in Devon with the national percentages. It can be seen that the profile of substances used in Devon was generally comparable to the national picture. A slightly lower percentage of clients used Class-A substances and alcohol on their own. A Slightly higher percentage of clients used cannabis and alcohol together and Other substances. A statistically lower percentage of clients in Devon were treated for use of cannabis on its own. This suggests that in Devon there is a greater integration between users of cannabis and alcohol. Taken with the trend data showing a decrease in alcohol referrals and increase in cannabis referrals, this could suggest that alcohol use in young people is part of the progression on to using cannabis.

Figure 54: Referrals into Devon's Young Person's substance misuse treatment system by substance type, 2010-11, compared to national (Source: NDTMS Young People Treatment Map & Client Profiles, 2011-12)



Looking back over the past few years, it can be seen that the percentage of young clients who have entered the service for use of cannabis (including those that also use alcohol) has increased steadily from around 45% in 2007-09 to around 65% in 2011-12. Over the same time period, this has been matched by a steady decrease in the percentage of young people accessing the service for use of alcohol (including those that also use cannabis) from 43% to 27%. As such, it would suggest that relatively, cannabis is becoming an increasing issue for young people in Devon.

7.2.4 Cross sectional analysis of referrals

It is possible to cross section the young person's referral data by referral source, substance and age group (see Appendix 4 for more information). A statistical cross sectional analysis has been conducted on the referral data, to identify any differences between Devon and national referral routes. A list of the identified discrepancies can be seen below:

- Compared to national figures, Devon had a statistically lower percentage of young people entering treatment for use of cannabis. This was most notable in the 13-14 year age group, which was also significantly lower compared to national figures.

- Compared to national figures, Devon had a statistically higher percentage of young people entering treatment for use of stimulants

- Compared to national figures, in Devon a statistically lower percentage of young people referred into treatment through Children & Family Services (excl. LAC) were referred for Alcohol only

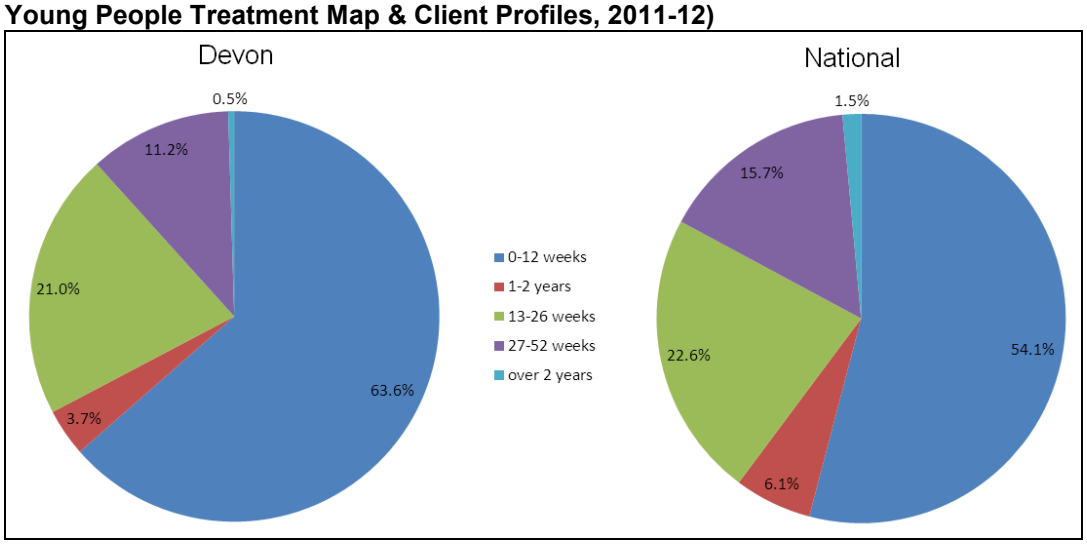
- Compared to national figures, Devon had a statistically lower percentage of young people referred into treatment through Children & Family Services (excl. LAC) who were referred for Cannabis only, and a statistically higher percentage were referred for use of stimulants

- Compared to national figures, in Devon a statistically lower percentage of young people referred into treatment for use of cannabis were referred through Children & Family Services (excl. LAC). This is slightly surprising given that the overall percentage of people who are referred through Children and Family Services (excl. LAC) is higher than the national rate.

7.2.5 Time in treatment

In total, during 2011-12, 214 young people were in treatment in Devon. Of these, almost two thirds (63.6%) were in treatment for twelve weeks or less, which is a statistically higher percentage than nationally (54.1%).

Figure 55: Young people in Devon's Young Person's substance misuse treatment system during 2011-12 by time in treatment, compared to national (Source: NDTMS Young People Treatment Map & Client Profiles, 2011-12)



A statistical cross sectional analysis was conducted on the referral data to identify time in treatment for each type of substance, to identify any differences between length of treatment journeys in Devon compared to nationally. It was found that of the 61 young people being treated for Cannabis and alcohol, 65.6% were in treatment for twelve weeks or less, which was a statistically higher percentage than nationally (53.3%). None of the other drug types were statistically over or under represented in any of the time periods.

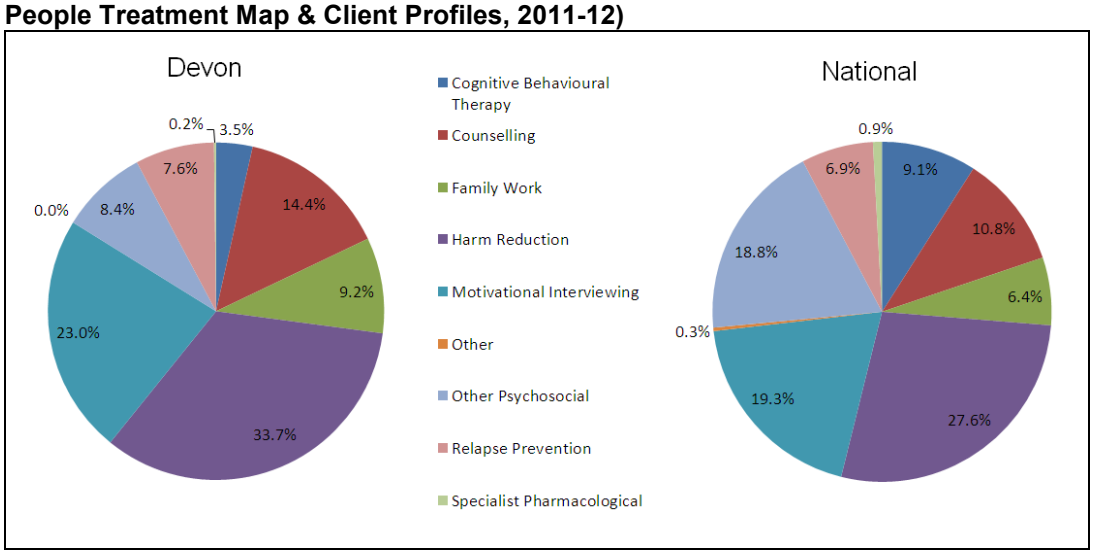
7.2.6 Interventions

From the moment the service is in contact with a young person, interventions are being delivered and risk is being assessed immediately, as it is not guaranteed that their engagement with the service will continue. The care plan that is provided to a young person is based on a comprehensive assessment of need, based on their history and current circumstances, with usually more than one treatment modality being used.

The 214 young people that were in treatment during 2011-12 received a total of 513 interventions. A breakdown of these interventions for Devon and nationally is shown in Figure 56.

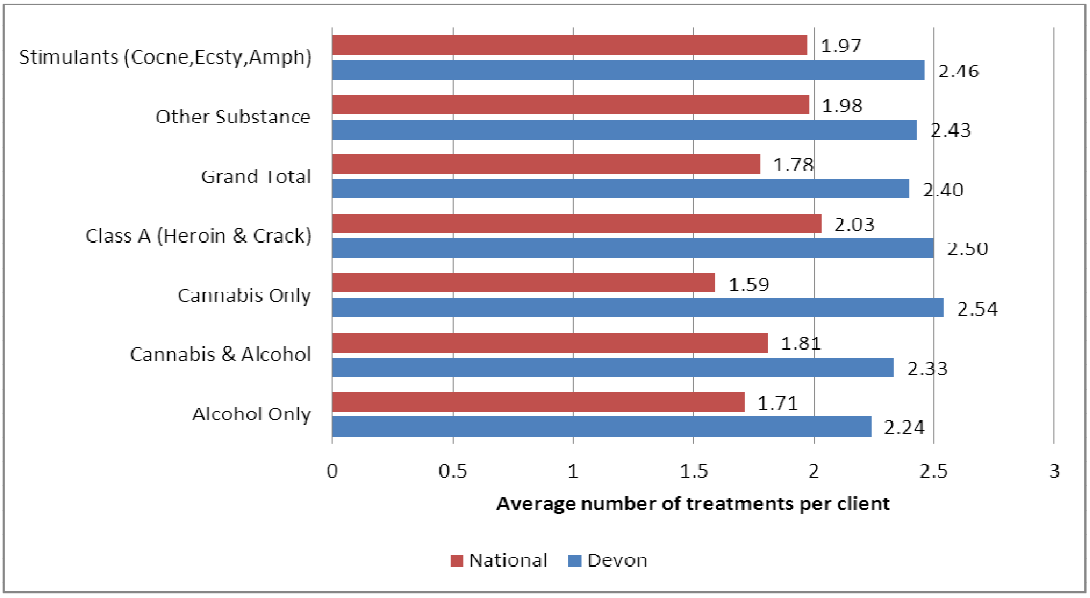
It can be seen that the most commonly offered treatments, both in Devon and nationally, are harm reduction and motivational interviewing. The third most common treatment nationally is “Other Psychological” (18.8% of treatments). In Devon, only 8.4% of treatments are “Other Psychological”. The third most common treatment in Devon is Counselling, which is offered more often that it is nationally (14.4% compared to 10.8%).

Figure 56: Interventions provided by Devon’s Young Person’s substance misuse treatment system during 2011-12, compared to national (Source: NDTMS Young People Treatment Map & Client Profiles, 2011-12)



By combining the number of intervention data with the number of clients in treatment, the average number of treatments per client in Devon was calculated to be 2.40, notably higher than the national figure of 1.78 per client. When broken down further, Devon provides more treatments per client for every drug type compared to the England average.

Figure 57: Average number of interventions per client in treatment 2011-12, Devon compared to national (Source: NDTMS Data)



A statistical cross sectional analysis was conducted on the intervention data to identify interventions used for each type of substance, and to identify any differences between interventions used in Devon compared to nationally.

Of all interventions provided, fewer were for the treatment of alcohol only and Class-A substances, and more were offered for the treatment of stimulants.

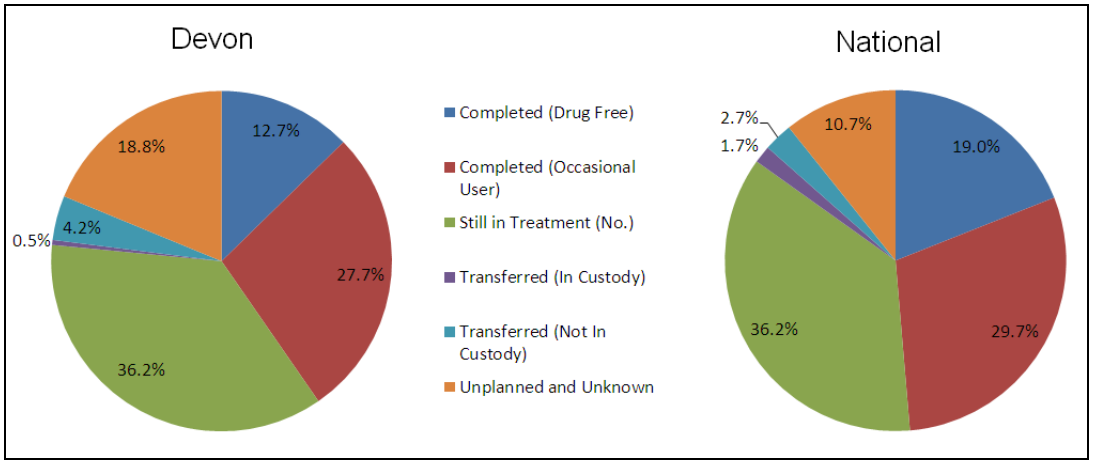
With regards to the type of intervention used, in Devon, fewer were CBT interventions and interventions classed as “Other Psychosocial”, and more were family work and harm reduction interventions. This difference was most pronounced in the treatment of Cannabis and Alcohol, where the same interventions were under / over represented.

The profile of interventions used in the treatment of stimulants was also different in Devon, with less CBT and psychosocial interventions being provided and more harm reduction interventions being provided.

7.2.7 Outcomes

During 2011-12, a total of 136 young people left Devon’s Substance Misuse Treatment Services, with an additional 77 still being in treatment. A breakdown of treatment exits in Devon and nationally is shown in Figure 58. It can be seen that compared Devon has a lower percentage of clients completing drug free or as an occasional user and a slightly higher percentage of unplanned and unknown treatment exits.

Figure 58: Outcomes of young people accessing Devon’s substance misuse treatment system during 2012-13, Devon compared to national (Source: NDTMS)



A statistical cross sectional analysis was conducted on the treatment exit data to identify the types of exit for each type of substance, and to identify any differences between exits in Devon compared to nationally. It can be said that compared to national figures, in Devon:

- Of all people still in treatment, a statistically higher percentage were in treatment for Cannabis & Alcohol and a statistically lower percentage were in treatment for Cannabis only, which reflects the profile of all those seen in treatment during 2011-12.

- Of all people in treatment, a statistically lower percentage completed drug free and a statistically higher percentage were Unplanned & Unknown

- Of all people who received treatment for use of Alcohol & Cannabis, a statistically lower percentage completed drug free and a statistically higher percentage were Unplanned & Unknown

7.2.8 Transition into adult services

Issues around the transitions of young people to adult services needs to be continually monitored to ensure that appropriate interventions are in place within adult services and that the transition process is robust.

The official age cut off between Youth and Adult services is when an individual turns 18 years old. It is common for young people who enter the youth service shortly before their eighteenth birthday to remain in treatment until they have completed their treatment journey. During 2011-12 there were a total of 29 18 year olds and 19 19 year olds in treatment. Over half of the 18 year olds were in treatment in the Youth service, whereas by age 19 only one was a youth service client. Overall there was around a third fewer clients aged 19 than there were aged 18 accessing the service, though based on a single year of data it is not possible to say if this is significant. Further research into the transition of clients from youth to adult services is required.

Figure 59: Number of clients aged 18 and 19 in Devon's Substance Misuse service during 2011-12

Service	Aged 18	Aged 19	Aged 20-24

Adult	14	18	180
Children	15	1	0
Total	29	19	180

In 2009 a protocol was written for the Transition of substance misuse clients from Young People Substance Misuse Agencies to Adult Services. This protocol can be found in Appendix 5.

7.2.9 Other services offered by the Youth Substance Misuse services

Training continues to be an important element of the work that the youth substance misuse agency undertakes. The foundation training for substance misuse and young people, led by the Y-Smart trainer now comes under the DSCB training umbrella and is funded within that umbrella. Funding is now separately raised within the Young People service for a proportion of the cost of the provision of the service. Enhanced training around substance misuse is also covered by Y-Smart and is available on a multi-agency basis.

7.2.10 Support functions and Partner Agencies

In addition to the core of the drug treatment service, a number of other partners are involved in the delivery of both young persons and adult substance misuse services. These include:

- Child and Mental Health Service (CAMHS)
- Multi Agency Safeguarding Hub (MASH)
- Social Services
- Education
- Early Response Service Hubs
- Common assessment framework (CAF)
- Team Around the Child (TAF) / Team Around the Family (TAC) services
- Public health nursing (School nurses)
- Youth Offending Team (YOT)
- Connexions (career southwest)
- District councils (housing)
- Multi-agency panels – homeless prevention panel
- Devon Reform

Further information about some of these services can be found below.

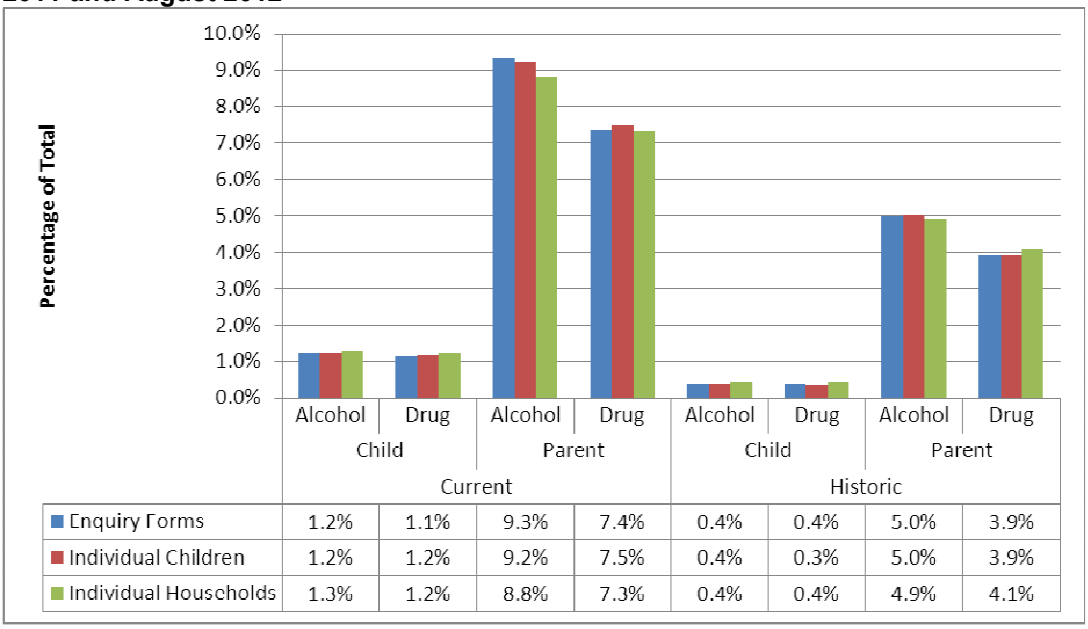
7.2.10.1 Devon Multi-Agency Safeguarding Hub (MASH)

The Devon Multi-Agency Safeguarding Hub (MASH) is the central point of contact for all safeguarding and child protection enquiries within Devon. It is staffed with professionals from a range of agencies including police, probation, fire, ambulance, health, education and social care. These professionals share information to ensure early identification of potential significant harm, and trigger interventions to prevent further harm to children.

When an enquiry is received, if the individual(s) in question have a social worker, the enquiry is discussed with them. If there is no current social worker involvement, MASH staff gather information from every agency and use this to decide the most appropriate intervention to respond to the child's identified needs.

Part of the information gathered identifies whether the parent / carer or child themselves have a history of either alcohol or drug misuse. Between November 2011 and August 2012 (inclusive), 8488 enquiries were investigated relating to 6828 children and 3936 adults. The graphs below shows the number and percentage of enquiries, children and adults that were found to have a history of alcohol or drug misuse.

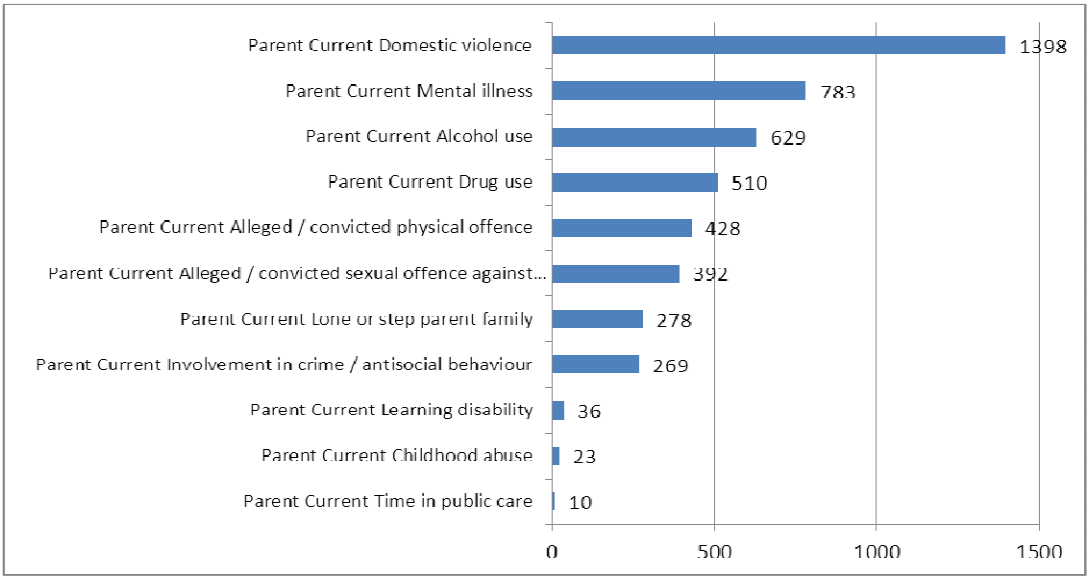
Figure 60 Prevalence of substance misuse in MASH referrals between November 2011 and August 2012



	Alcohol	Drug	Alcohol	Drug	Alcohol	Drug	Alcohol	Drug
	Child		Parent		Child		Parent	
	Current				Historic			
Enquiry Forms	1.2%	1.1%	9.3%	7.4%	0.4%	0.4%	5.0%	3.9%
Individual Children	1.2%	1.2%	9.2%	7.5%	0.4%	0.3%	5.0%	3.9%
Individual Households	1.3%	1.2%	8.8%	7.3%	0.4%	0.4%	4.9%	4.1%

It can be seen that current alcohol and drug misuse by parents is the most commonly found activity relating to substance misuse in MASH referrals. Figure 61 below shows how many children were affected by current parental drug and alcohol misuse (between November 2011 and August 2012), compared to other current behaviours investigated by the MASH. It can be seen that alcohol and drug misuse are the third and fourth largest issues discovered behind domestic violence and mental illness.

Figure 61: Number of children affected by current parental activity between November 2011 and August 2012



When considering the above, it should be noted that, anecdotally, a high number of overall mash referral and enquiries are inappropriate, often due to lack of staff confidence and understanding, so these figures unlikely to show an accurate picture. The robustness of the way in which information relating to substance misuse around children is gathered is currently unclear and required further clarification.

7.2.10.2 Devon Reform

Devon Reform is a collective of Voluntary and Community Sector (VCS) Organisations working with the Criminal Justice System in Devon. It is led by its membership and provides a countywide forum where these groups can support each other, understand each other roles, look for partnership working opportunities and act as a gateway to the statutory agencies.

Devon Reform is developing an interactive web based map of 'recovery assets' available across Devon on behalf of the Devon Recovery Consortium.

The Devon reform website contains a useful geographic directory of recovery organisations:

http://www.devonreform.org/Member-Directory/

The core services and mutual support groups that exist across Devon were mapped in the summer of 2012. This was a direct action that came out of the 'Exploring Recovery' event in May 2012; where workshop participants cited how useful it would be to pool this information into one single point of contact. The map is interactive and organisations can login and update their details, add downloads, project overviews, news and make announcements to other members and statutory affiliates. There is also a recovery section and separate login for recovery members to share news and information that is pertinent to them.

The ambition for the Recovery website is;

- for workers and service users to find out what is available at a very local level across Devon to support people's individual recovery plans.
- to act as a focus to pool community information
- to identify gaps in terms of activity or geography across Devon
- to share ideas and inspire development

Activities will be categorised as:
Sport and Leisure
Health and Well being
Arts Based
Training and Education
Places to go
Family activities

7.3 Adults Alcohol Treatment Service

As previously mentioned, the adult alcohol treatments service in Devon is delivered by two providers, DPT, who provide treatment for the more complex clients and Addaction, who provide treatment for the rest of the client base.

Addaction is a national charity specialising in drug and alcohol treatment. They are currently commissioned by NHS Devon to provide their frontline alcohol treatment service. They work in collaboration with Devon Partnership Trust, who provide a more specialist service for people who have a physical dependence on alcohol and / or have more complex issues such as complex mental health and learning disabilities. Both organisations also have established relationships with other partner organisations including Recovery link, NHS Devon Mental Health, the NHS Devon Prison Service and Children and young people's services probation to name but a few. The intention of this partnership working is to provide a holistic treatment system which caters for all the needs of the people entering the drug treatment process.

7.3.1 Referrals into Treatment

All referrals into the alcohol treatment service and all initial appointments are handled by Addaction. Following the referral, the client will be allocated a case handler, who arranges for an initial assessment to be provided to the client within three weeks of the initial referral, though this is sometimes difficult with the most chaotic clients, who are often difficult to get hold of and frequently do not turn up to appointments. All Addaction staff are FDAP (Federation of Drug & Alcohol Professionals) accredited and qualified to level three in safeguarding.

The initial assessment, which is offered to clients within three weeks of the referral, involves the completion of a SADQ (alcohol dependence) and the gathering of a lot of other information about the client's history and personal circumstances. Based on the initial assessment, the client will be steered towards a care package that they can engage with and that will meet their needs. Depending on the identified needs of the client, they will either enter Addaction's treatment service or be referred on to DPT.

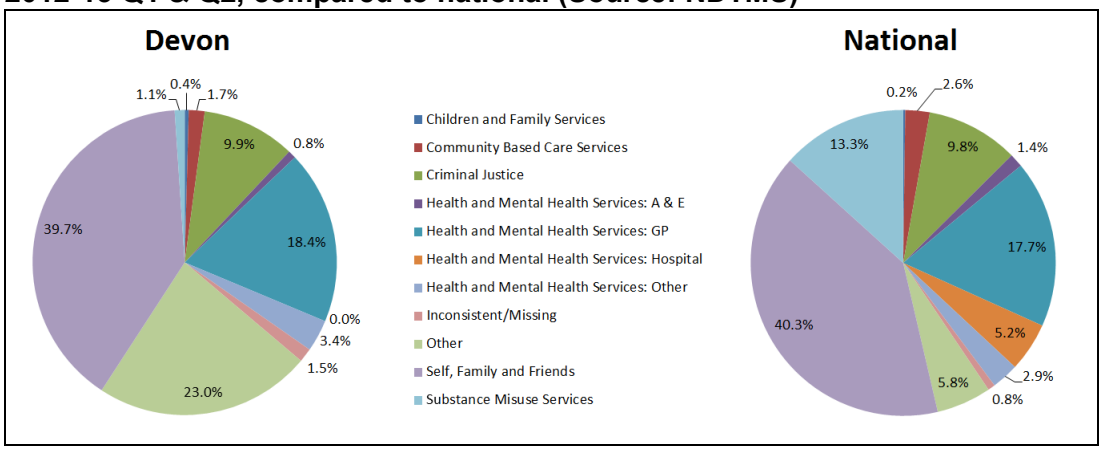
One potential concern with this referral pathway, is that because referrals from Addaction to DPT trigger the start of another wait of up to three weeks for a meeting, the most complex clients can sometimes have to wait for up to six weeks

before they can start fully engaging with the service. A more comprehensive description of Addaction's referral pathway can be found in Appendix 6.

During the first half of 2012-13, Devon received 473 referrals in to its alcohol treatment services. Of this group, 55.2% of them were accessing the service for the first time (statistically fewer than the 61.4% seen nationally).

A breakdown of the sources of these referrals (Figure 62) showed that Devon received a statistically lower percentage of its referrals from Substance Misuse Services (1.1% compared to 13.3% nationally) and from Hospital Health and Mental Health services (0.0% compared to 5.2%. A statistically higher percentage of referrals were received from "Other" referral sources (23.0%), which were around four times higher than the national percentage (5.8%). This suggests that the Other referral sources should be investigated further to see where they are coming from.

Figure 62: Referrals into the alcohol treatment system by referral source, 2012-13 Q1 & Q2, compared to national (Source: NDTMS)



7.3.2 *Waiting times*

During the second quarter of 2012-13, in Devon 199 out of 205 clients were seen within three weeks (97.1%), which was statistically higher than the national average of 89.4%. Looking at the waiting times for different types of treatment, a higher percentage of clients waiting for inpatient treatment were waiting for less than three weeks and no treatments in Devon had significantly more people waiting over three weeks.

7.3.3 *Client profile*

Compared to nationally, for new presentations during the first half of 2012-13 in Devon:

- The percentage of dual diagnosis clients was slightly lower but statistically similar to the national percentage (15.2% compared to 18.9%)

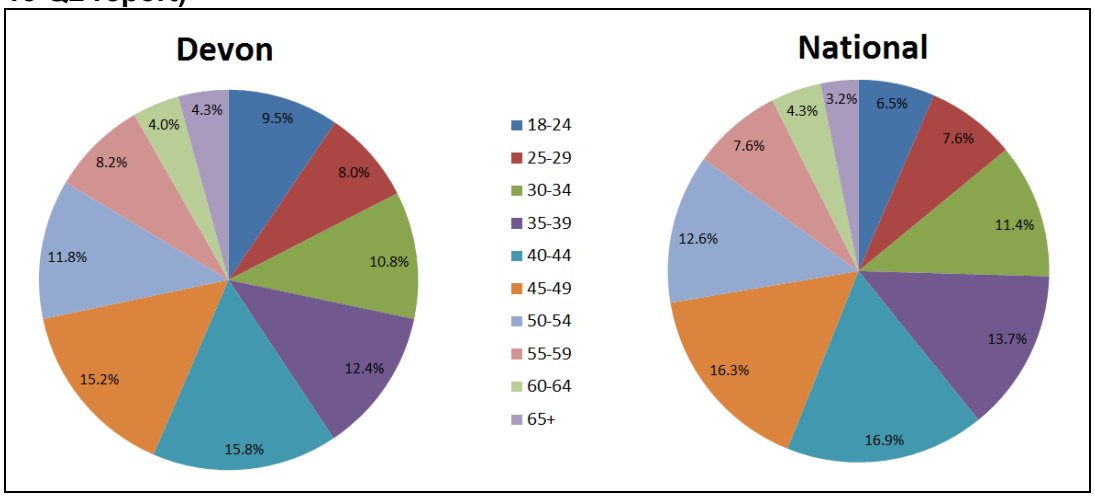
- The percentage of clients with a housing problem or urgent housing problem was slightly higher but statistically similar to the national percentage (15.4% compared to (13.1%)

- The percentage of clients with no child contact was significantly lower than the national percentage (59.2% compared to 44.7%)

- The gender balance was almost exactly the same as nationally (63% males, 37% females)

- The age profile was very similar (Figure 63), with the only significant difference in age bands being the 18-24 year age band, in which Devon had statistically more clients.

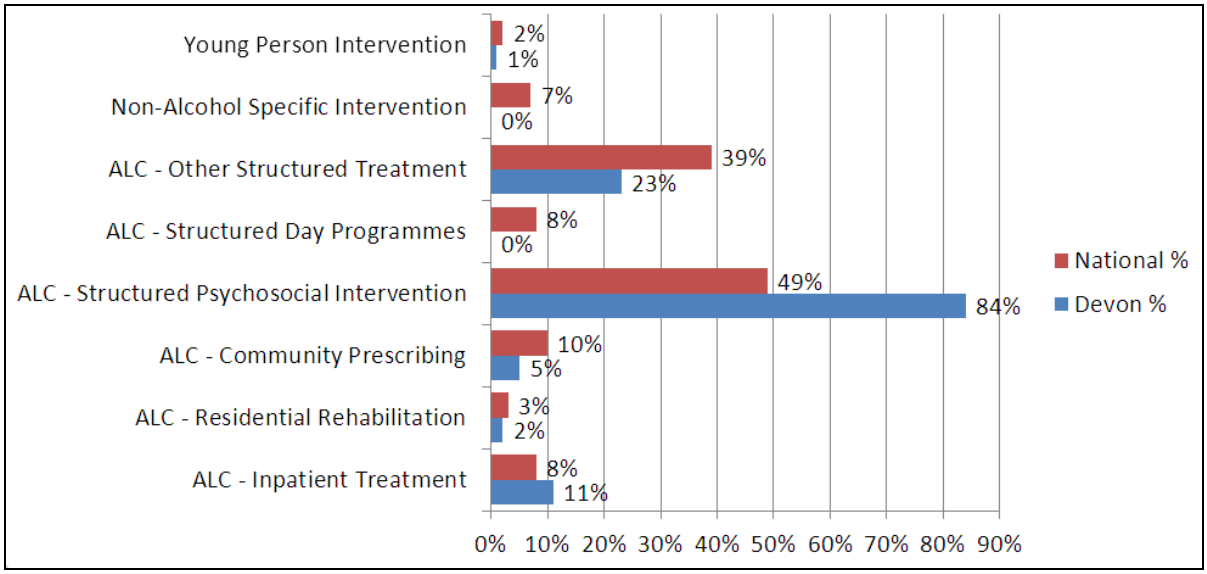
Figure 63: Alcohol age profile for clients in treatment (Source: NDTMS 2012-13 Q2 report)



7.3.4 Treatment data

A comparison of the alcohol service treatment pathways in Devon compared to national figures, for the first half of 2012-13 shows that a huge 84% of Devon's clients were offered a structured psychosocial intervention, compared to only 49% nationally. Other notable differences are that Devon uses around half the amount of community prescribing (5% compared to 10%) and no structured day programmes (0% compared to 7%).

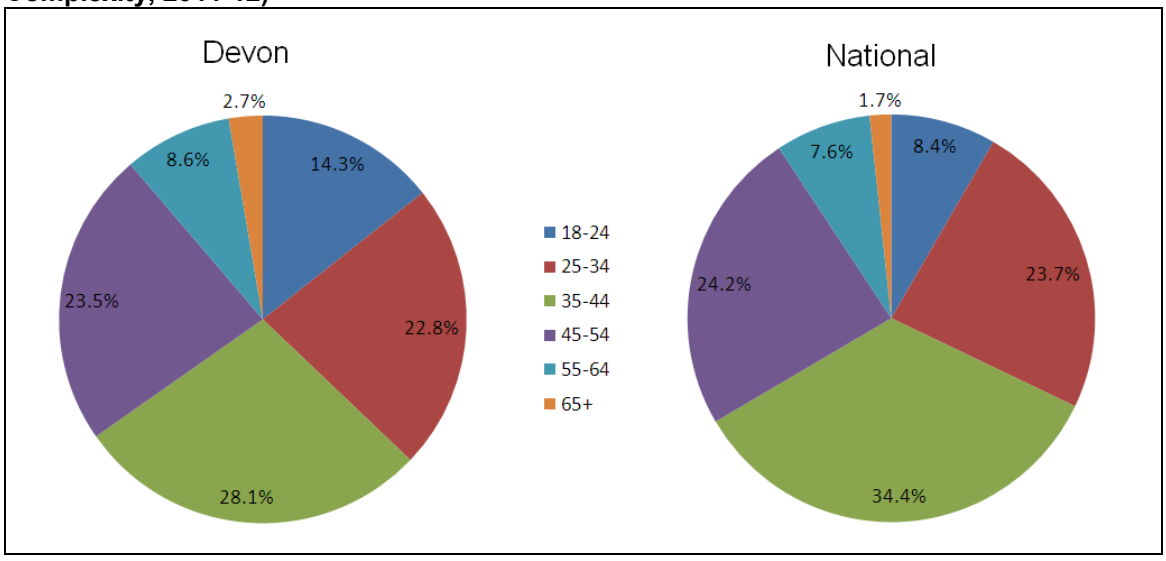
Figure 64: Alcohol service treatment pathway, clients' latest treatment journey 2012-13 Q1 & Q2 (Source: NDTMS 2012-13 Q2 report)



7.3.5 *Client Complexity*

The 1564 adults in alcohol treatment services during 2011-12 had a total of 2274 recorded complexities, equating to an average of 1.5 complexities per client. A breakdown of these complexities by age group shows that in Devon the youngest age group (18 to 24) had the highest number of complexities (2.0 per client), with the number of complexities generally tailing off with age.

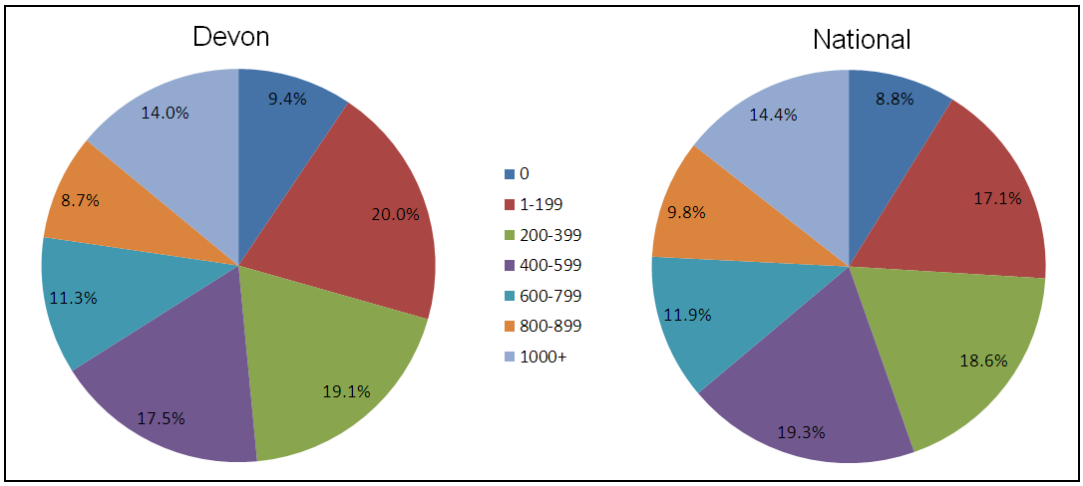
Figure 65: Adult alcohol service client complexities (Source: NDTMS Client Complexity, 2011-12)



7.3.6 *Alcohol Consumption*

Figure 66 shows the percentage of new treatment journeys in 2011-12 (out of a total of 1222) segmented into the number of units consumed during the month (28 days) before initial assessment. It can be seen that Devon has a very similar profile to the national picture. The only significant difference is in the 1-199 units category, where Devon has a higher percentage than nationally (20.0% compared to 17.1%).

Figure 66: Number of Units Consumed per Month (28 days) prior to initial assessment, Devon and National (Source: NDTMS)



The above analysis was conducted for each complexity group. In general the consumption profiles for every group closely matched the national profile. The only complexity group with a profile notably different from national profile was for the 261 clients with dual diagnosis, where there were more clients consumed less alcohol (1-199 units) and fewer consumed more alcohol (800-999 units and 1000+ units).

7.3.7 Poly Drug Use

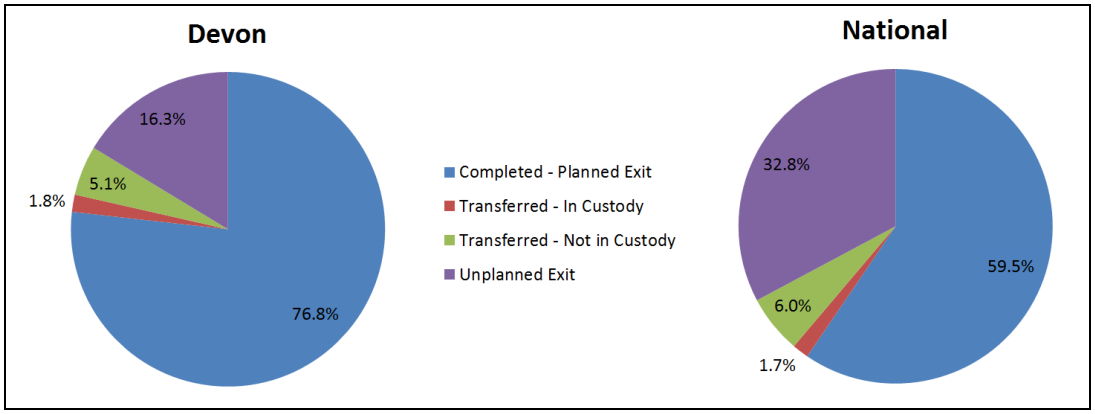
For all clients in treatment during the first half of 2012-13, statistically fewer clients in Devon were recorded as only using alcohol (39.1% compared to 44.0%), although as with nationally, around 40% of clients were missing information on this.

The main reason for the increased poly-drug use in Devon was a higher percentage of clients using cannabis as a second drug, which was 10.3% compared to only 7.5% nationally, a significant difference.

7.3.8 Exits from treatment

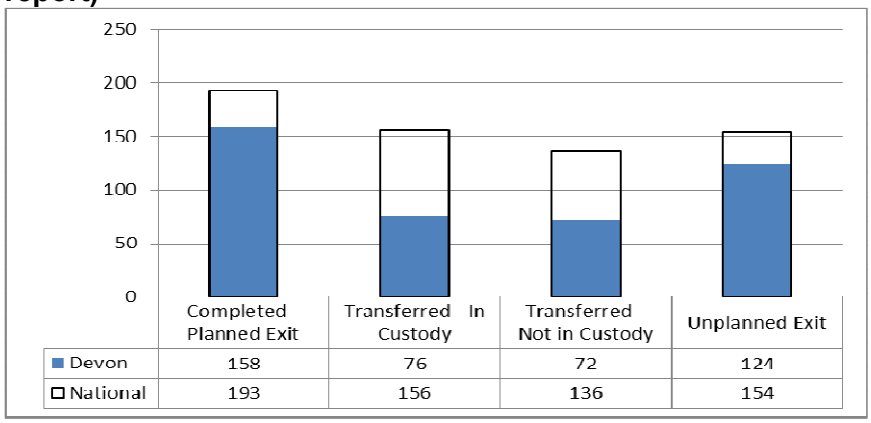
An analysis of treatment exists in Devon and nationally for clients starting their treatment journey during the first half of 2012-13 showed that in Devon 390 out of 508 clients (76.8%) completed with a planned exit, which was statistically higher than the 59.5% seen nationally. There were also around half as many unplanned exits – 16.3% compared to 32.8% nationally.

Figure 67: Alcohol service treatment exits for clients starting treatment during 2012-13 Q1 & Q2 (Source: NDTMS 2012-13 Q2 report)



Looking at the average length of journey (in days) by treatment outcome (Figure 68), it can be seen that as well as having a higher success rate, the average length of journey in Devon is shorter for all treatment outcomes. On average, clients completing a planned exit in Devon was five weeks less than the national average (158 days compared to 193 days). This suggests the service is delivering an effective service to good timescales.

Figure 68: Alcohol journey length (in days) for the alcohol service for clients starting treatment during 2012-13 Q1 & Q2 (Source: NDTMS 2012-13 Q2 report)



	Completed Planned Exit	Transferred In Custody	Transferred Not in Custody	Unplanned Exit
Devon	158	76	72	124
National	193	156	136	154

7.3.9 Assertive outreach alcohol services

Targeted assertive community and hospital based service delivering identification, support and access to appropriate treatment for alcohol related attendees to hospital, through a range of interventions:

- Alcohol Screening, brief intervention and referral in hospital settings, including A&E
- Alcohol nurse specialist available within the hospital
- Alcohol training, advice and information to health professionals in recognition, screening, treatment (including ABI) and management of individuals with alcohol related conditions

- Supported transition to community specialist alcohol treatment
- Assertive Outreach work providing community based support to enable access to a range of community based interventions
- Comprehensive Care planning between hospital and community services.

In North Devon this is delivered by a team of 3 nurses providing 7 day week hospital cover in NDDH and 2 outreach workers providing assertive interventions. In South Devon this is delivered by 1 nurse providing part-time cover in Torbay Hospital and assertive community based interventions. Both services are very new and at present neither has been running long enough to be properly evaluated.

7.4 Adult Drug Treatment Services

The adult drug treatment service in Devon is now delivered by a single provider, Devon Drug Service. Unlike the alcohol service, DDS provide an end to end service for all clients.

DDS is a partnership between Devon Partnership Trust (DPT) and EDP Drug and Alcohol Services. DPT and EDP are fully integrated under a single management structure, enabling frontline services to deliver a holistic package of care based on need and risk. The service has recently completed a transition to locality teams which are able to deliver accessible services into communities in partnership with local agencies and groups. The service is modelled to enable a team around each service user, maximising the range of expertise and interventions available.

DDS has over the past six months been reviewing service design and delivery in terms of maximised recovery orientation. This has led to a number of service improvement initiatives including a strengths-based approach to case management, increased accessibility to psychosocial interventions and a focus on rehabilitation and aftercare. The challenge of engaging service users in recovery oriented interventions and activities whilst effectively managing risk is central to these initiatives. There is also a need to ensure that service users are well equipped to exit our services and maintain their recovery in the longer term.

To support these objectives, DDS is in the process of establishing a dedicated staff team with a focus on partnerships, access to community resources and enhanced access to volunteering, peer mentoring and mutual aid. DDS is also delivering a workforce development programme to support increased recovery orientation within the Service.

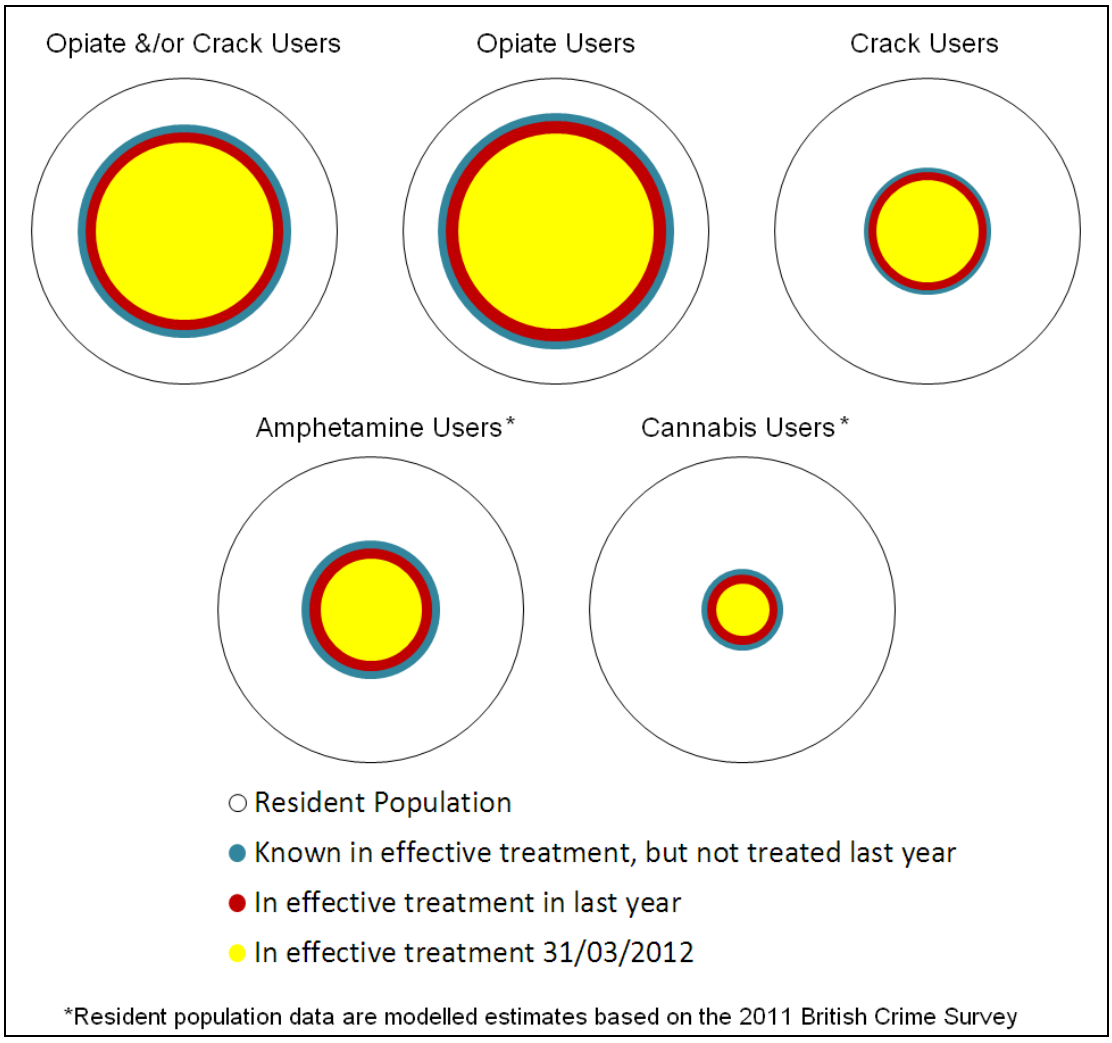
DDS operate in three geographical areas, North Devon, Exeter and South Devon, which between them cover the whole of the NHS Devon area. Each area has a main office, where the majority of clients are seen, but there are a range of other areas where clients can receive treatment, including:

- 3 DDS offices +
- other office locations

- GP surgeries (where rooms are available)
- Mental health services locations
- Hospitals
- Home visits (used occasionally once patient is known and risk assessment conducted)

The penetration of the service can be measured using a combination of NDTMS Bulls eye Data reports and estimates of the number of drug users living in Devon based on the British crime survey and NTA prevalence reports (Figure 69).

Figure 69 & 70: Bulls eye chart and table showing the number of clients in effective treatment compared with drug taking population (Source: NDTMS Bulls eye Data ,2011-12, British Crime Survey, 2011)



Population Group	In effective treatment 31/03/2012	In effective treatment in last year	Known in effective treatment, but not treated last year	Resident Population
Opiate &/or Crack Users	960	250	200	2887

Opiate Users	957	250	198	2340
Crack Users	130	42	24	1143
Cocaine Users	38	49	20	2101
Amphetamine Users	125	60	49	1137*
Cannabis Users	266	209	149	8812*

As would be expected, a far higher percentage of opiate users access the service compared to cannabis, which generally has a less significant impact on the lives of its users. One third (33%) of estimated opiate and crack users (OCU's) in Devon are currently in effective treatment (rising to 34% for all people in treatment). Nationally, approximately 165,000 out of a total of around 300,000 OCU's, around 55%, are currently in treatment, which is notably higher than the Devon percentage. The reasons why the percentage of OCU's in treatment in Devon is lower than nationally are not currently understood. It could possibly be due to an over-estimate in the size of the local OCU population, because the Devon OCU population requires or choses to receive less support from services, or because they are unaware of or unable to engage with services.

7.4.1 Referrals into Treatment

At the initial meeting, a comprehensive assessment is conducted, (for alcohol referrals building on the notes provided by Addaction). This assessment is conducted by suitably trained and qualified, such as psychiatric nurses or drug workers (who are qualified to level three in child and adult safeguarding). During the comprehensive assessment, the client's needs, risks and resources across a range of domains' including mental health, detox and housing requirements are outlined so that a package of care can be agreed with the client.

In Devon during 2011-12, a total of 538 adult drug clients started a total of 609 new treatment journeys with drug providers, of which 262 (43.0%) were entering treatment for the first time. This was slightly higher than the national percentage, where 40% were new to treatment. Compared to national figures, Devon received a statistically higher percentage of self-referrals (which made up almost half of all referrals) and referrals through arrest referrals and DIP. A statistically lower percentage of referrals were received through the drug service, which is thought to be because DDS is an integrated drug service, meaning in Devon "Referrals from the drug service" will be referrals from out of area, rather than through non-integrated low threshold services as found in other areas. Through probation, the CARAT and other criminal justice referrals (excluding arrests), only 11.0% of referrals are received, which is half the national rate of 21.7%.

Figure 71: Referrals into drug treatment system by referral source, 2011-12, compared to national (Source: NDTMS Treatment Map Summary, 2011-12)

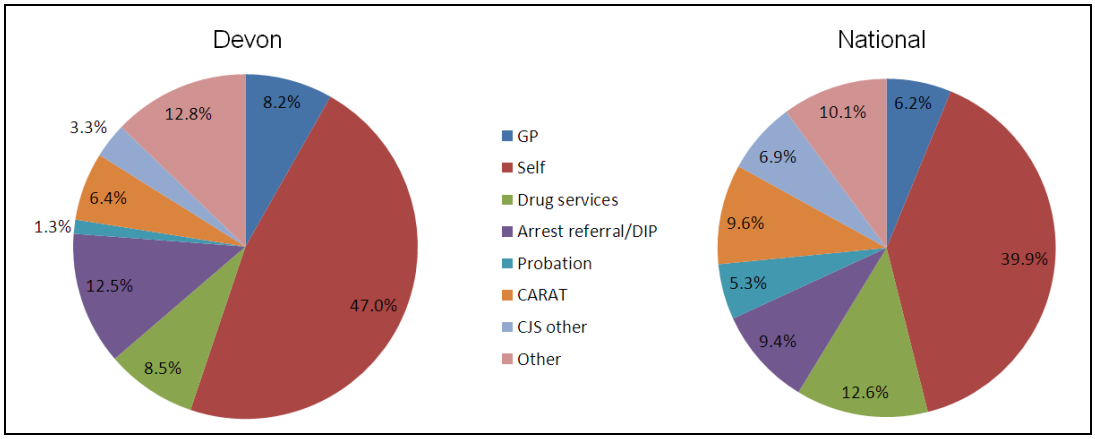
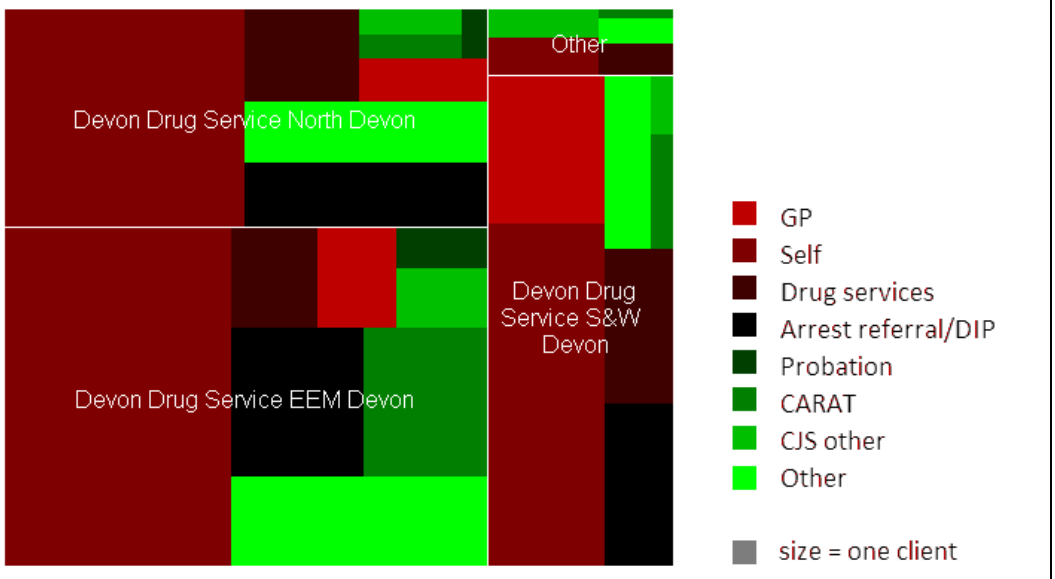


Figure 72 below shows the proportion of clients that were referred into each of the three DDS areas, along with where those referrals came from. The Exeter, East and Mid office (EEM) handled 44% (269) of all referrals, the North office handled 30% (172), and the South and West office handled 23% (148).

It can be seen that self-referral was the biggest source of referrals for all three areas. "Other" referral types were most common in the EEM area, which also received more of its referrals from the CARAT and fewer from Drug services compared to the other two areas. This is likely to be due to HMPS Exeter, which is a remand prison and so has a higher turnover of prisoners. The proportion of referrals that come from GP's appears vary between the areas, with referrals from GP's in South and West Devon being the second largest, whilst in the North and Exeter, East and Mid Devon, it is one of the smallest sources of referrals. The reasons behind this should be investigated to see whether referrals through this route can be increased.

Figure 72: Client referrals by DDS office and referral source (Source: NTA Treatment Map Summary, 2011-12)



Agency	GP	Self	Drug service	Arrest referral/ DIP	Probation	CARAT	CJS other	Other	Total

DDS - EE&M Devon	26%	44%	27%	42%	75%	77%	45%	49%	44%
DDS - North Devon	18%	30%	33%	34%	25%	10%	20%	31%	28%
DDS - S&W Devon	56%	23%	33%	24%	0%	10%	10%	17%	24%
Other	0%	2%	8%	0%	0%	3%	25%	4%	3%

The sections below outline some performance measures for referrals, taken from the 2012-13 Quarter 2 Adult Partnership Performance Report:

Injecting Status
In the first six months of 2012-13 there were a total of 263 new treatment journeys, every one (100%) of which had a recorded injecting status. This is a statistically higher proportion compared to the national rate of 98.1%. When examining the proportion of clients whose injecting status is known, Devon has a statistically higher percentage of clients who have previously injected (but not currently), and a statistically lower percentage of those who have never injected. The proportion of clients who are currently injecting is slightly higher than nationally, (21.3% compared to 17.2%), but this difference is not significant. Overall, this suggests that either a higher percentage of drug users in Devon are, or were, injecting, or that proportionally more injecting drug users in Devon are engaging with the drug treatment service compared to other drug users.

Hepatitis B
The provision of Hepatitis B vaccinations in Devon appears to have a good coverage. During the first half of 2012-13, statistically fewer clients were not offered an intervention (only one out of 263, 0.4%) and statistically fewer were assessed as not appropriate to offer. A statistically higher percentage of clients in Devon have an acquired immunity, and a higher percentage have already been immunised. Devon also has a lower percentage of clients whose status is not recorded (2.3% compared to 4.5% nationally). The percentage of clients offered and accepting an intervention is slightly lower in Devon (28.5%) compared to nationally (33.1%), though this is most likely due to the increased immunity within the cohort. Within this group, there were no notable differences between the proportion of individuals starting (21.3%) and finishing (14.7%) a course compared to the national figures.

It should be noted that data on BBV is largely self-reported and it is likely that some people will say they have been tested when they haven't. Work is needed to develop a system to improve levels of testing and treatment and in data sharing that show these improvements.

Hepatitis C
Every client who has been recorded as either currently or previously injecting (or where route of administration is injecting) should be assessed to see whether they should be offered a Hepatitis C test. Between July 2011 and June 2012 there were 998 such clients in Devon, 768 (77.0%) of which were offered a test. This is significantly higher than nationally (67.9%). Inversely, a statistically lower percentage of clients in Devon were not offered or classed as not appropriate to

offer. Of those that were offered, just over half (51.9%) refused, which is statistically higher than nationally, where one third (33.3%) refused.

General Healthcare Assessments and Care Plans
For new treatment journeys starting within the first six months of 2012-13, a statistically higher percentage of clients received a General Healthcare Assessment in Devon (99.2% compared to 96.9% nationally). All episodes of care (delivered to all clients, not just new referrals) during this time period included a care plan, which was statistically higher than the 98.0% achieved nationally.

Clients with Children
For new treatment journeys starting within the first six months of 2012-13, 66 (25.1%) of clients were parents, which was comparable, but slightly lower than the national rate of 26.7%.

Accommodation Need
For new treatment journeys starting within the first six months of 2012-13, 75 (28.5%) of clients had a housing problem (30 of which were urgent). This is a comparable but higher percentage than nationally (24.4%).

Waiting times
During the first six months of 2012, 0.8% of all clients waiting to receive their first drug intervention in Devon had to wait longer than three weeks, which was lower than the national figure of 2.0% (Figure 73). The percentage of people waiting more than three weeks for their second intervention was also lower; 2.4% compared to 4.8%.

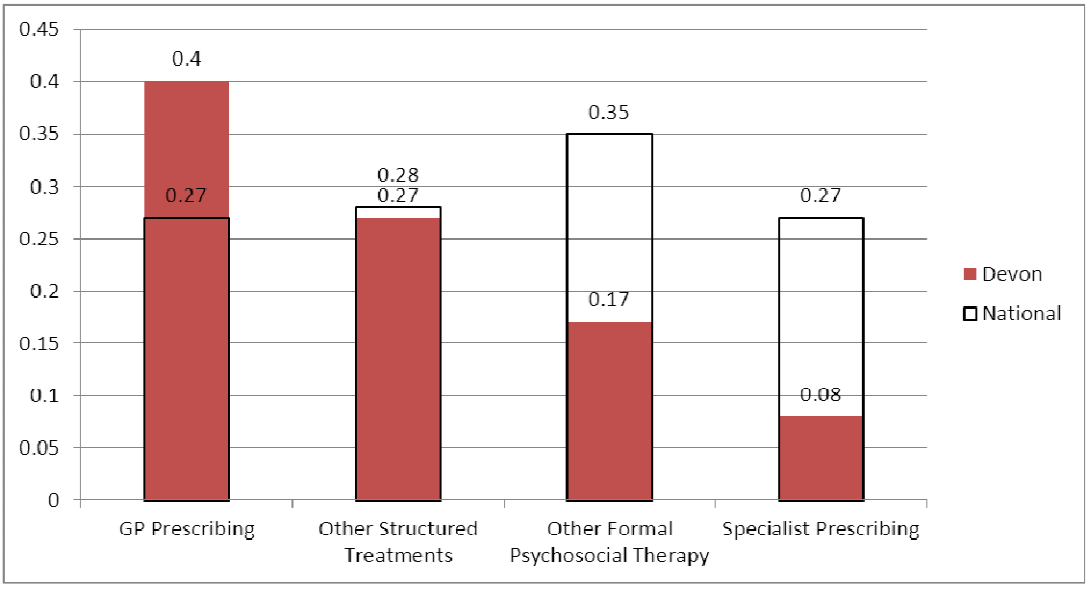
Figure 73: Waiting times for drug treatment services in Devon and nationally

Type of Treatment	Number of Waiting Times - 3 weeks and under	Number of valid waits	Devon Percentage	National Percentage
First treatment intervention	126	127	99.2%	98.0%
Subsequent treatment intervention	41	42	97.6%	95.2%
First treatment intervention - Tier 4	8	10	80.0%	77.2%

Both locally and nationally, the percentage of tier four clients seen within three weeks is lower than for the overall client base. It is well documented that it is generally harder to engage with the more complex clients, and sometimes multiple attempts need to be made to get them to engage with the service, which can take longer than three weeks.

An examination of the average waiting time for the four most common treatment types in Devon during quarter 2 of 2012-13 (see Figure 74) shows that they are generally shorter than the national waiting times, with only GP prescribing, which locally is the least used of the four, being higher than the national average.

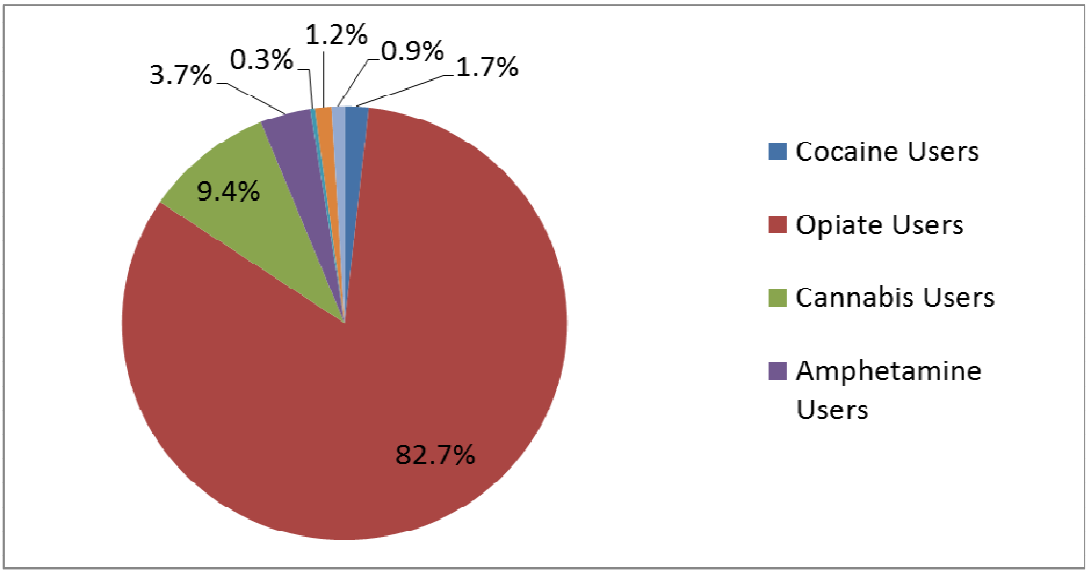
Figure 74: Average waiting time for the four most commonly used treatments in Devon, 2012-13 Q2 (NDTMS)



7.4.2 *Adult clients in treatment*

During 2011 a total of 1,498 adult drug clients received treatment[83]. Figure 75 below shows these clients broken down by primary drug type. It can be seen that the primary drug type for the vast majority of clients receiving treatment was opiates, which reflects what is seen nationally.

Figure 75: Percentage of adult drug clients in treatment during 2011



In the first six months of 2012-13, a total of 1309 adult drug clients were in treatment. An indication of the rate of turnover of the service is the percentage of clients still in treatment on the last day of the period (30th September 2012). In Devon, 1092 clients (83.4%) were still in treatment, which is statistically more than

[83] 2011-12 Q4 Performance Report, NDTMS

the national rate of 81.0%). A higher percentage of clients still in treatment could indicate a number of things, including a higher average complexity of client, a reduced focus on recovery, or a more robust, supportive system that provides more comprehensive support. The sections below outline some demographic information for clients in treatment, taken from the 2012-13 Quarter 2 Adult Partnership Performance Report:

Gender

Of the 1309 clients in treatment during the first six months of 2012-13, 916 (70%) were male and 393 (30%) were female. Nationally, a statistically lower percentage of clients were female (27.2%).

Ethnicity

As might be expected in Devon, 96.5% of clients in treatment were white British, a statistically higher percentage than nationally 83.4%. To account for the lower proportion of Devon's population in minority groups, 2011 census data has been used to calculate the number of clients in treatment as a rate per 100,000 population for each ethnic group for both Devon and England. It was found that there were only two ethnic groups in Devon whose rates are significantly different to the national rates; "white British" and "other white", both of which are statistically lower. The rates for the other ethnic groups vary, but because the size of each of these populations, and the numbers in treatment in Devon are so small, it is not possible to say whether they are under or over represented. The reason for the white British and other white populations being under-represented in Devon is likely to be to a lower prevalence of drug use in Devon compared to nationally, though could also be as a result of the service not being as accessible, either due to the rural nature of the county, or other reasons.

Age Group

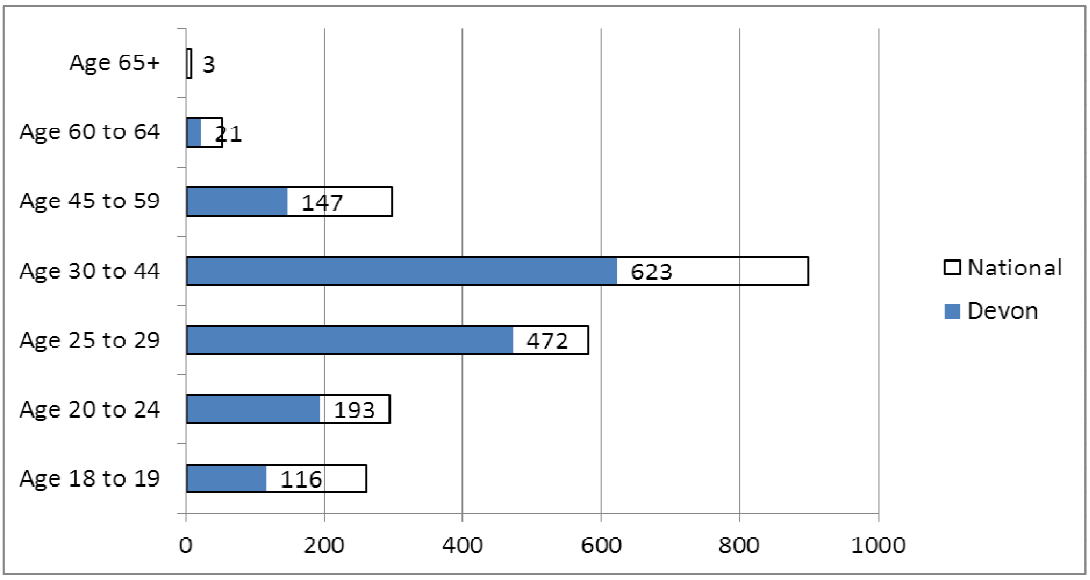
The age profile for all clients in treatment as of 30th September 2012 is very similar in Devon to nationally (see Figure 76). The majority of the clients, over 60%, are in the 30 to 44 year age category.

Figure 76: Age profile of clients in treatment in Devon and nationally on 30th September 2012

Age Group	Devon		National %
	No.	%	
Age 18 to 19	22	1.7%	2.2%
Age 20 to 24	83	6.3%	6.4%
Age 25 to 29	172	13.1%	12.8%
Age 30 to 44	788	60.2%	59.1%
Age 45 to 59	227	17.3%	18.4%
Age 60 to 64	12	0.9%	1.0%
Age 65+	5	0.4%	0.3%
All	1309	100.0%	100.0%

To see how the number of clients in treatment for each age group compares as a rate per 100,000 population, 2011 census data was again used to compare Devon and national rates (Figure 77).

Figure 77; Rate of clients in treatments per 100,000 population, Devon and national



It can be seen that in Devon, the rate per 100,000 population is lower for every age group compared to national figures. In every age group other than the 65+ age group (where the number of clients is very small), this is a statistically significant difference).

7.4.3 Client complexity

Clients usually present to treatment with various needs in addition to treatment for substance misuse, including their employment and housing status, their physical and psychological health, all of which will significantly affect their chances of successfully completing. NDTMS data can be used to group clients into levels of complexity based on their needs, and completion rates vary widely between these groups. Nationally clients with very low needs have a 43% completion rate, whereas those with very high needs have only a 6% completion rate (these are for opiate and non-opiate clients combined). In Devon, a comparable percentage of all with very low needs completed (41%) and a lower percentage of clients with very high needs successfully completed (1%). This is not however true for treatment naïve clients, where the percentage of successfully completions for clients with very complex needs is actually slightly higher than nationally (3% compared to 1%).

7.4.4 Length of time in treatment

The length of time spent in treatment varies hugely between opiate and non-opiate clients. According to the 2012-13 Recovery Diagnostic Report[84], nationally, the proportion of opiate clients who have been in treatment continuously for less than two years has fallen significantly over the past three years, but the proportion that have been in treatment continuously for six years and more has risen, increasing during this time from one in eight clients to nearly one in five now. This pattern is

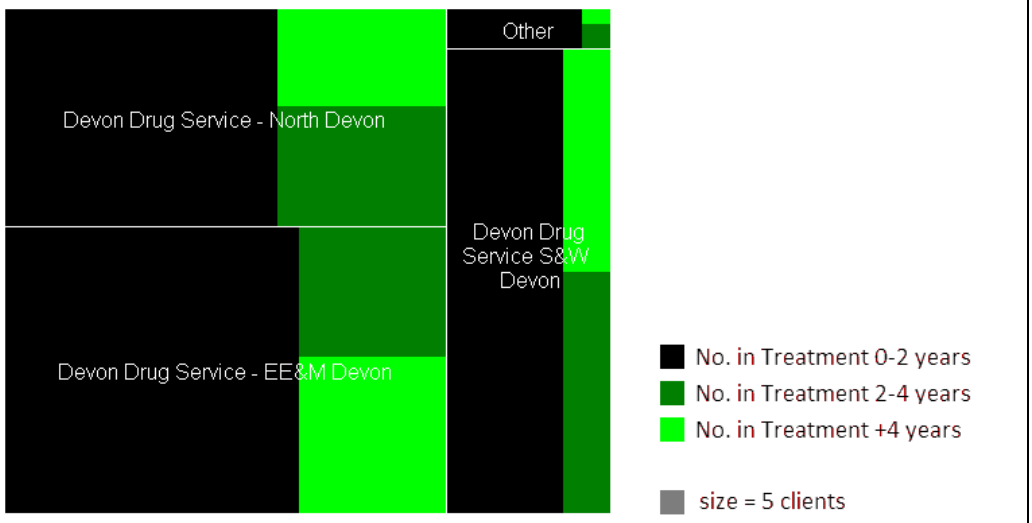
[84] 2012-13 Recovery Diagnostic Report, NTA

also seen in Devon, though the percentage of opiate clients in treatment for over six years is lower (15% compared to 19%).

Over the same time period, the proportion of non-opiate clients in treatment for less than a year has remained very high, fluctuating between 85% and 95% and most recently sat at 90%. This was slightly higher than the value for the comparative cluster (a group of similar PCTs), which was 87%. Overall, 99% of non-opiate clients spend less than two years in treatment.

In addition to the above PCT level data, the NTA also offer a provider level Recovery Diagnostic tool. Whilst there are some issues with changes to coding over time, this diagnostic tool should also be used alongside the information in this needs assessment to evaluate how each provider is performing. Figure 78 below compares the length of time in treatment for Devon clients by geography, defined by Devon Drug Service operational area.

Figure 78: Length of time in treatment by DDS office (Source: NTA Treatment Map Summary, 2011-12)



Agency	No. in treatment 0-2 years	No. in treatment 2-4 years	No. in treatment +4 years	All in Treatment
DDS - EE&M Devon	42%	37%	46%	42%
DDS - North Devon	29%	39%	32%	31%
DDS - S&W Devon	27%	22%	21%	25%
Other	3%	1%	1%	2%

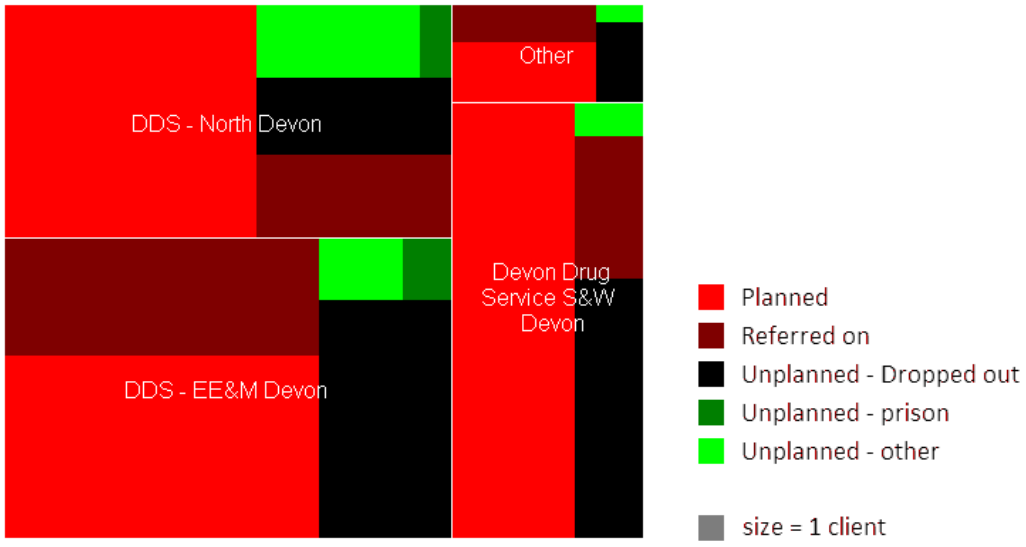
7.4.5 Outcomes

The completion rates for opiate and non-opiate clients vary considerably. According to the 2012-13 Recovery Diagnostic Tool, in October 2012 in Devon, 7% of opiate users and 44% of non-opiate users completed treatment successfully. This

compares to 7% and 37% for the comparable cluster of PCTs, meaning that Devon performs slightly worse for opiate users and better for non-opiate users.

Figure 79 below compares the completion rates of Devon clients by geography, defined by Devon Drug Service operational areas.

Figure 79: Treatment outcomes by DDS office (Source: NTA Treatment Map Summary, 2011-12)



Agency	Planned	Referred on	Unplanned - Dropped out	Unplanned - prison	Unplanned - other	Total
DDS - EE&M Devon	32%	54%	47%	57%	26%	40%
DDS - North Devon	33%	24%	22%	43%	59%	31%
DDS - S&W Devon	30%	14%	26%	0%	11%	24%
Other	5%	8%	5%	0%	4%	5%

The Recovery Diagnostic Tool also provides information on re-presentation rates, which shows that for Devon clients, 22% of opiate clients and 4% of non-opiate clients re-presented within six months following successful completion. This compares to 5% and 21% for the comparative cluster, meaning that Devon is performing slightly better for opiate than non-opiate clients. Completion rates for treatment naïve clients over three years in Devon is also slightly worse for opiate clients (18% compared to 22%) and better for non-opiate clients (55% compared to 51%).

The provider level Recovery Diagnostic Tool provides this information for individual providers, and should be considered alongside this needs assessment.

7.4.6 Treatment effectiveness and outcomes

In the first six months of 2012-13, a total of 217 adult drug clients exited treatment. Compared to national figures during this time, fewer of these exits were completed, planed exits; 94 clients (43.3%) compared to 48.1% nationally. There were also fewer transferred into custody (23, 10.6%) and transferred elsewhere (17, 7.8%). More clients exiting treatment during this time had an unplanned exit (123, 56.7%) compared to national figures (51.9%).

When considering treatment exits by type of treatment, in the first six months of 2012-13, there were 331 individual treatment exists (this is higher than the number of people exiting treatment as some clients were receiving more than one type of treatment).

When looking at each type of treatment individually, compared to national figures, there were no treatments in Devon with a statistically higher or lower percentage of planned exits. The percentage of clients leaving via a planned exit is shown below for the five most commonly used treatments in Devon (making up 90.1% of all treatments) and are compared to the national figures.

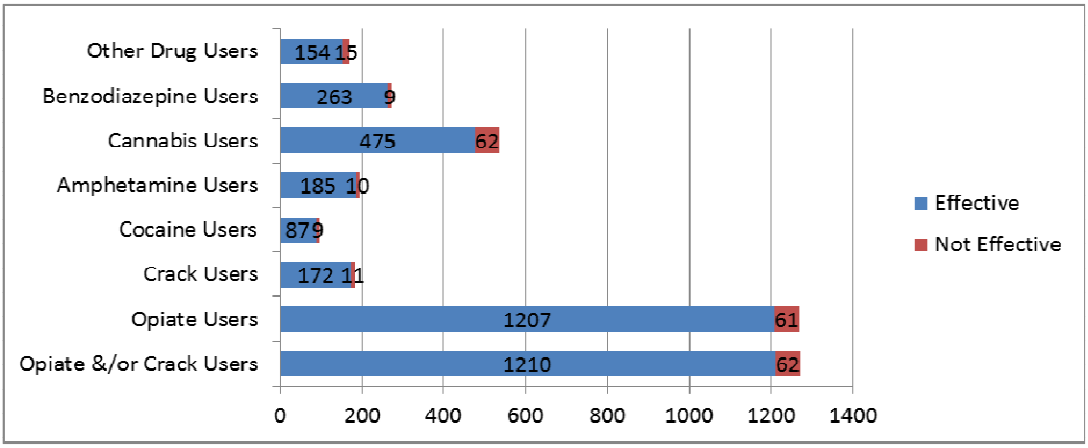
Figure 80: Percentage of clients leaving via planned exists during the first six months of 2012-13

Treatment	Modalities Ending	Devon % planned exits	National % planned exits
Specialist Prescribing	137	74.5%	71.9%
Other Formal Psychosocial Therapy	63	77.8%	74.3%
GP Prescribing	38	76.0%	80.3%
Inpatient Treatment detoxification	17	89.5%	77.1%
Other Structured Treatments	7	50.0%	75.4%

7.4.7 Numbers in effective treatment

In Devon, NDTMS bulls eye data shows the number of drug users who were in effective treatment (those who have exited treatment drug free and did not represent within xx weeks). In 2011-12 there were a total of 1,427 adults in effective treatment. Figure 81 below shows the number of clients being treated for each type of drug (due to poly drug use, the total number adds up to more than 1,427).

Figure 81: Number of clients in effective treatment in Devon by drug type, 2011-12



It can be seen that the most commonly used type of drug within the treatment system is opiates, with cannabis being the second most common, being used by 37.6% of clients.

Numbers in effective treatment is an indicator of the need, capacity and effectiveness of a service. To examine how numbers in effective treatment has changed over the past five years, data from 2007-08 was compared to the 2011-12 data. Figure 82 shows the percentage change in number of people accessing effective treatment by drug type.

Figure 82: Percentage change in number users entering effective treatment from 2007-08 to 2011-12 by drug type

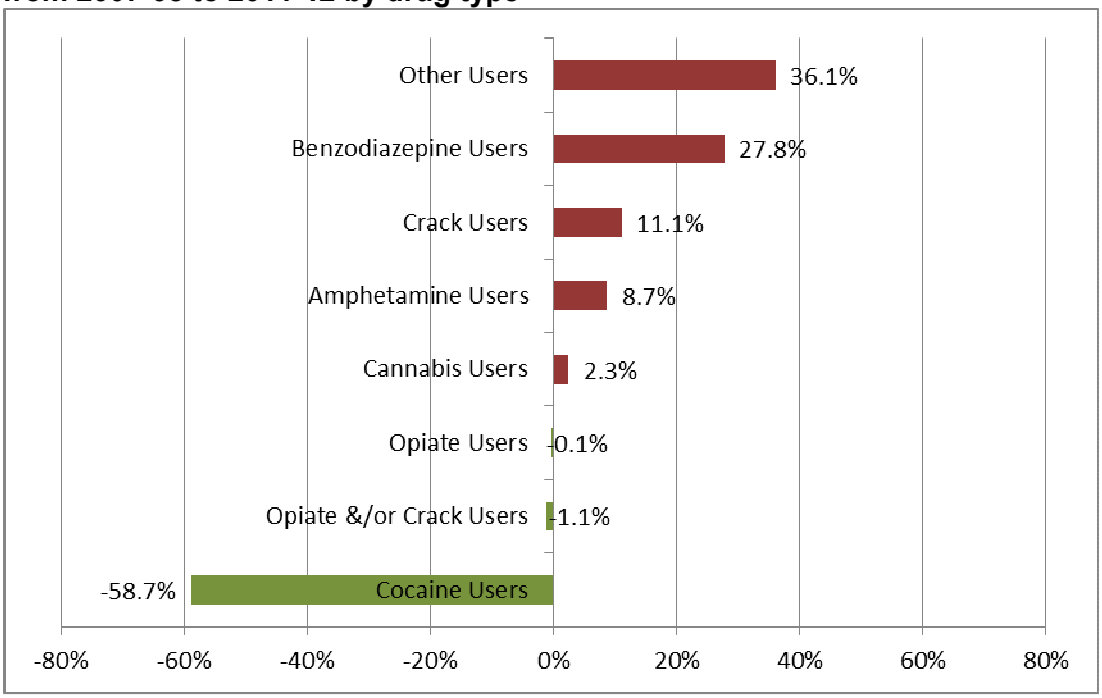


Figure 83: Percentage change in number of users entering effective treatment from 2007-08 to 2011-12 by drug type (Source: NDTMS Bulls eye Data)

Substance	2007-08	2011-12	% change 2007-08 to 2011-12
Opiate &/or Crack Users	971	960	-1.1%
Opiate Users	958	957	-0.1%
Crack Users	117	130	11.1%
Cocaine Users	92	38	-58.7%
Amphetamine Users	115	125	8.7%
Cannabis Users	260	266	2.3%
Benzodiazepine Users	162	207	27.8%
Other Users	61	83	36.1%

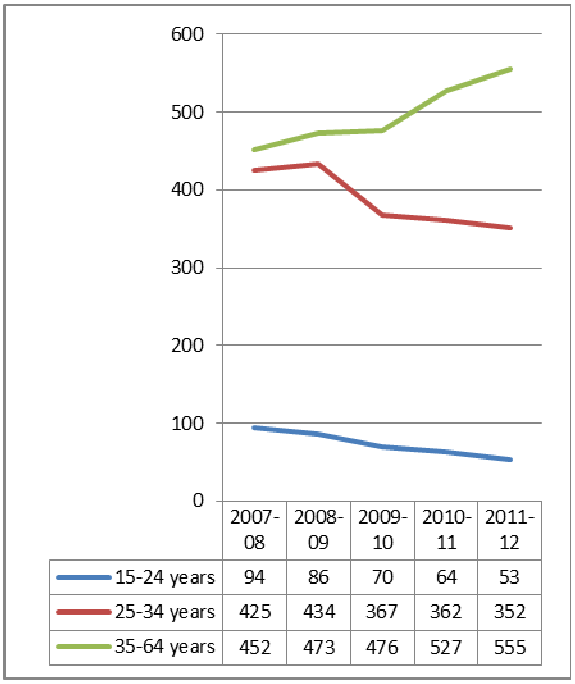
It can be seen that over the five year period, there has been an increase in the number of people in effective treatment for most types of drug. The largest increase was in the "Other users" category, which has seen a 36.1% change. This may be due to the small number of users involved, but is thought to be, in part, due to an increase in the use of New Psychoactive Substances (NPS), which do not fall into any of the other categories.

The only substance where the number of users in effective treatment has appreciably fallen is cocaine, which is perhaps surprising given the national background of increasing use in the 16 to 59 population.

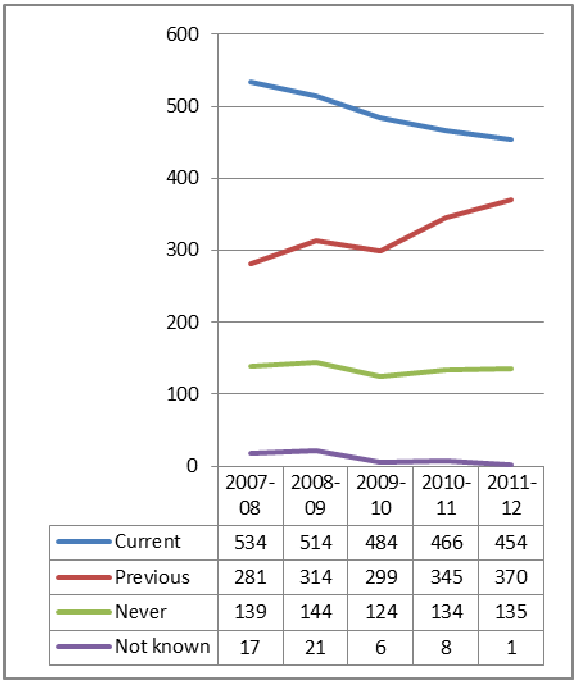
Breaking the effective treatment data for opiate and crack users down by age group and injecting status reveals some noteworthy trends. Over the same five year time period, the number of clients aged 15 to 24 and 25 to 24 has been gradually falling, whilst the number of clients aged 35 to 64 has increased from 452 to 555, an increase of 22.8%. This increase is, however, in keeping with the national trend.

We are aware anecdotally and from entrants into treatment of increased use of Novel Psychoactive Substances, This is an emerging trend that, whilst not independently categorised, may be part of the substantial increase seen in "other drugs". The DAAT is exploring commissioning a piece of work to understand emerging drug trends in Devon in more detail.

Figure 84 and Figure 85: Number of Drug clients in effective Treatment in Devon between 2007-08 and 2011-12 by age group (left) and injecting status (right)



	2007-08	2008-09	2009-10	2010-11	2011-12
15-24 years	94	86	70	64	53
25-34 years	425	434	367	362	352
35-64 years	452	473	476	527	555



	2007-08	2008-09	2009-10	2010-11	2011-12
Current	534	514	484	466	454
Previous	281	314	299	345	370
Never	139	144	124	134	135
Not known	17	21	6	8	1

7.4.8 Cost effectiveness

The 2011-12 Local Cost Effectiveness Tool, produced by the NTA, provides information on the cost effectiveness of different drug partnerships and nationally, based on clients in treatment between April 2010 and March 2012. For all clients in treatment in Devon during this period, the average spend per client was £4,242, which is 16% higher than the national average of £3,660, a statistically significant difference. The spend per client successfully completing and not re-presenting (SCNR) was £22,194, which again was statistically higher than the national spend of £21,811.

In Devon between April 2010 and March 2011 68% (1,186) out of 1,645 care pathways were prescribing only, which was comparable with the national rate of 69%, but well above the top quartile of 49%.

When considering the spend per client for the top six national treatment pathways for all clients, treatment naïve clients and clients previously known to treatment (Figure 86), it can be seen that spend per client on prescribing only is significantly higher in Devon for all three client groups. This is also true for spend per client successfully completing and not re-presenting (Figure 87).

Figure 86: Top six national treatment pathways by client group (Source: NTA Cost Effectiveness Tool, 2011-12)

Client Group	Top six pathways nationally

All Clients	Prescribing only Other structured treatment only Psychosocial only Prescribing, Psychosocial Prescribing, Other Residential rehabilitation pathways
Treatment naïve clients	Prescribing only Other structured treatment only Psychosocial only Structured day programmes only Prescribing, Psychosocial Residential rehabilitation pathways
Clients previously known to treatment	Prescribing only Prescribing, Psychosocial Other structured treatment only Prescribing, Other Psychosocial only Residential rehabilitation pathways

Figure 87: Treatment pathways where Devon spend a significantly different amount than the national average (per patient / per successful completion without re-presentation) (Source: NTA Cost Effectiveness Tool, 2011-12)

Treatment pathway	Client Group	Cost per client			Cost per SCNR		
		Devon	National	% Diff.	Devon	National	% Diff.
Prescribing Only	All clients	£4,488	£3,053	47%	£49,280	£29,873	65%
Prescribing Only	Treatment naïve clients	£2,808	£1,628	72%	£37,385	£12,515	199%
Prescribing Only	Clients previously known to treatment	£4,855	£3,315	46%	£51,348	£34,145	50%
Prescribing, psychosocial	Clients previously known to treatment	£6,721	£7,364	-9%	£38,228	£80,005	-52%
Psychosocial only	Clients previously known to treatment	£1,945	£2,452	-21%	£3,554	£4,751	-25%

Cost per day

For some types of intervention, the NDTMS provide a cost per day estimate. Below are estimates for structured community prescribing, structured psychosocial interventions and inpatient treatment.

Figure 88: Treatment cost per day, Devon compared to national (Source: NTA Cost Effectiveness Tool, 2011-12)

Intervention	Expenditure	Number of Clients	Cost per client per day	% Cost Difference

			Devon	National	
structured community prescribing	£3,352,142	245	£10.28	£6.19	66%
structured psychosocial interventions	£407,575	217	£15.73	£14.57	8%
inpatient treatment	£135,803	13	£256.23	£400.30	-36%

Structured prescribing is the single biggest cost to the Devon Drug and Alcohol Action Team, costing £3,352,142 in 2011-12 making up 57.1% of the overall budget, an increase from 51.0% in 2010-11. Nationally, an average of 30.6% of overall budget is spent on structured community prescribing, meaning in relative terms, overall Devon spends 87% more on structured prescribing. Local prescribing data, which shows the cost of prescriptions issued by GP's and Practice Nurses (which cover the vast majority of prescribing activity), showed that in 2011, a total of around £128,000 was spent on opioid prescribing, meaning that only around 4% of prescribing interventions are related to drug costs.

Psychosocial appears to work well in Devon. The cost per day is 16% higher in Devon compared to nationally (£15.73 compared to £14.57), but due to shorter average treatment journeys (111 days), the cost per client is 19% less. The rate of successful completions achieved through psychosocial intervention is very high in Devon (53% compared to 14% nationally), which makes the cost per successful completion in Devon much lower (£3,296 compared to £15,454).

In contrast, the effectiveness of Prescribing only interventions appears not to be as effective. In Devon the cost per day for prescribing only is 40% higher (£10.28 compared to £6.19), and the rate of successful completions is slightly lower (9% compared to 10%). These two factors result in the average cost per successful completion using prescribing only is £49,280, compared to £29,873 nationally. For new clients receiving prescribing only, the success rate is even worse and the spend per successful client is three times the national average (£37,385 compared to £12,515). Given the extent to which prescribing is used in Devon, the reason behind the increased cost per day requires further investigation.

7.4.9 Dual diagnosis

Anecdotally, most clients seen by DDS suffer with depression or anxiety. NICE guidance says there should be a four week wait post-detox before any mental health intervention, but for some complex mental health cases, substance misuse and mental health interventions are delivered in tandem. DDS staff are trained in dealing with mental health issues, which helps to reduce the number of cases that need to be referred on to a specialist.

7.4.10 Needle Exchange

The needle and syringe provision has four types of outlets in Devon. In each of the areas the North, South and Exeter East and Mid Devon there is:

1. A static Devon Drug Service provision

2. A Devon Drug service mobile provision
3. A number of pharmacy outlets (29)
4. Custody suites (2)

More information on each of these can be found below:

7.4.10.1 Static exchanges

Static exchanges are situated in three locations. In all cases they are separate to, but located within, premises of Devon Drug Service. They are in Newton Abbot for South Devon, Barnstable for the North and Exeter for Exeter, East and Mid.

Static exchanges offer a range of equipment choice. They deliver a pick and mix response. This especially appeals to those with different types of substance use, steroid users and those using private injectable prescriptions. They offer a wide range of harm reduction advice and have time to advise on the correct type of needle for the client's drug use. They also encourage better injecting techniques, therefore decreasing damage. Their ultimate aim is to deter individuals from injecting at all. Advice on sexual health is offered and blood borne virus information, and refer to services for treatment and testing if necessary.

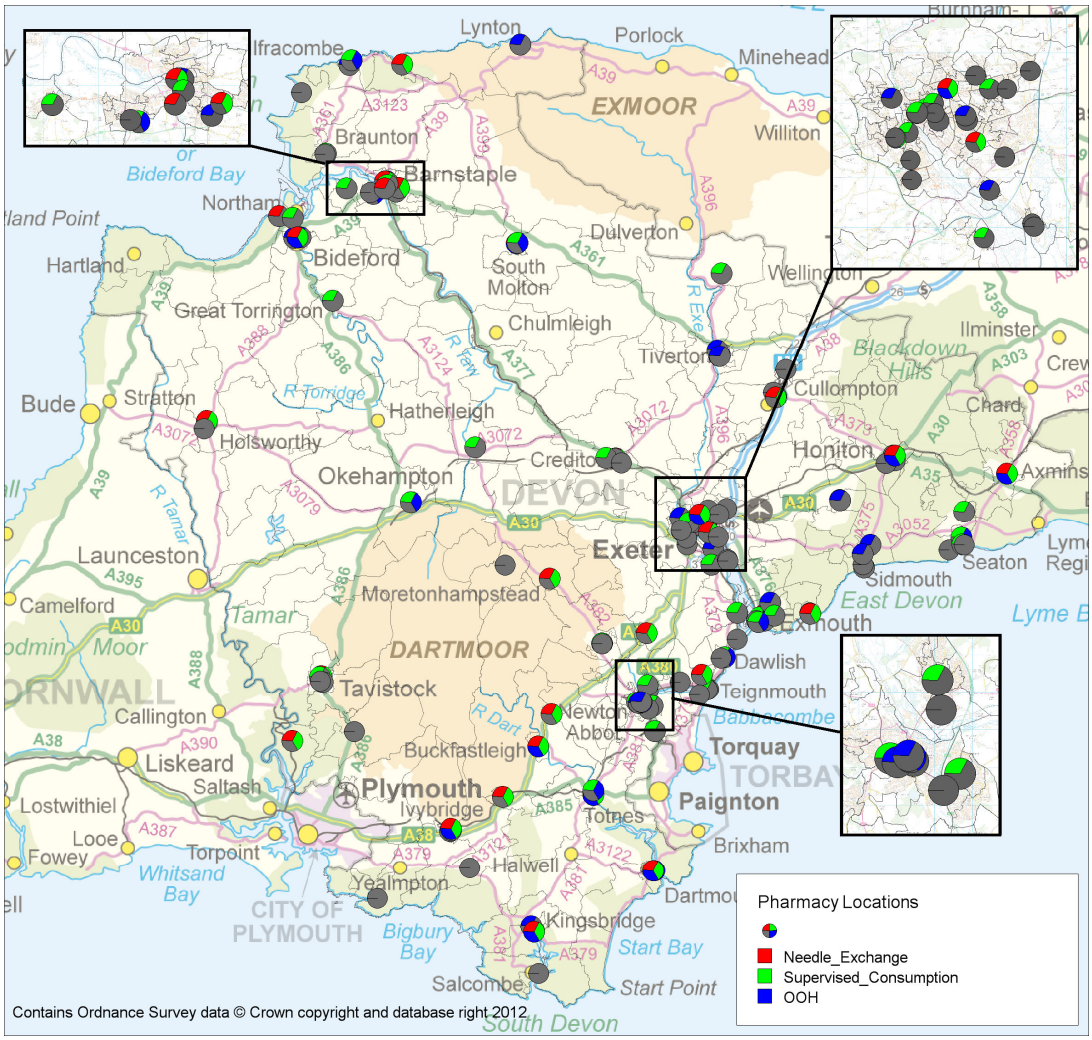
7.4.10.2 Mobile Exchanges

Mobile exchanges offer a limited variation of the static, but again can offer choice and advice that is varied. They offer outreach contact that seems extremely valued by those who use it. Ultimate anonymity is its greatest asset. Times are restrictive as they offer half day sessions once per week in set areas.

7.4.10.3 Pharmacies

Pharmacies offer a more limited range of equipment, partly down to the premises storage space and the time of staff in the pharmacies to sort out requests. Individual packs have been developed that are easy to dispense. There is a small choice in the type of pack so that there is a choice in size of needle. All service users receive written advice with their equipment. Pharmacies have usual shop opening times. Currently there are eight 100 hour pharmacies in Devon who take part in the NSP. Figure 89 shows the distribution of pharmacies in Devon, along with their service provision. Pharmacy needle exchange activity can be seen in Appendix 7.

Figure 89: Pharmacy locations and service provision, December 2012



7.4.10.4 Custody Suites

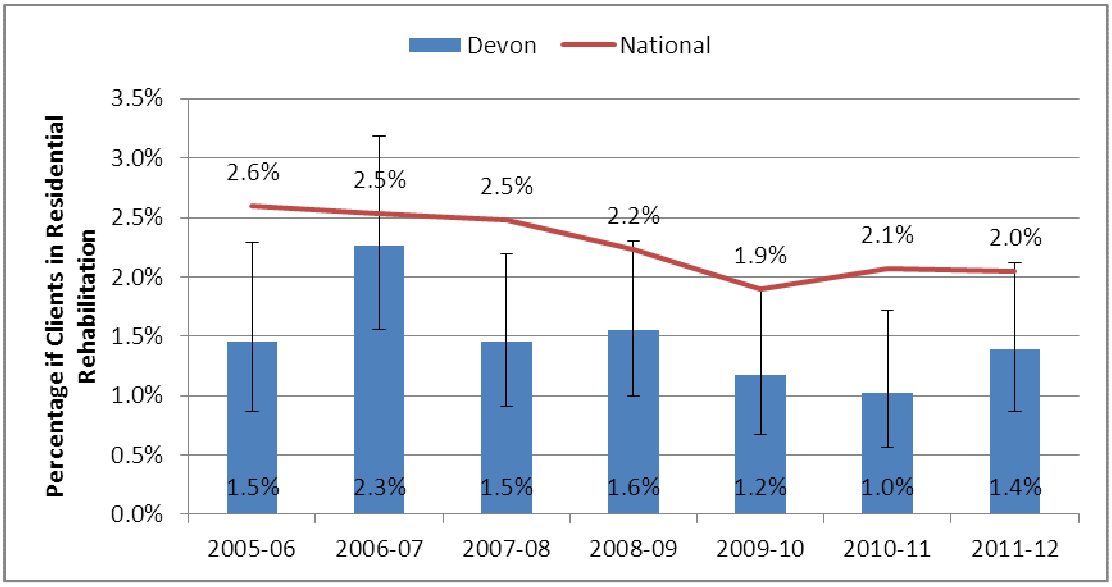
In Devon, NSPs have been established within the two custody suites in Exeter and Barnstable police Stations. It is unlikely that a detailed level of advice and information will be able to given by custody staff, but we hope to develop a referral process and or communication with the drug treatment service (Drug Intervention Programme workers) that enter the custody centres.

7.5 Residential Rehabilitation

Residential Rehabilitation describes a range of treatment interventions for people with an identified addiction or dependency, with abstinence as their end goal. Whilst some provide treatment and accommodation ‘under one roof’, are run as care homes and regulated by the Care Quality Commission, others can provide treatment and accommodation separately, or use different funding streams and are not regulated, these are often referred to as ‘Quasi Residential’.

The National Treatment Agency (2012), states that Residential Rehabilitation is an integral part of any treatment system, a vital option for some people requiring treatment and that it should therefore be easily accessible to anyone who needs it. Figure 90 below shows the proportion of all Devon clients with residential rehabilitation as part of their latest treatment journey, compared to the national average between 2005-06 to 2011-12. It can be seen that Devon has a consistently lower percentage than the national average, with some years being significantly lower. In 2011-12 1.4% of Devon clients had residential rehabilitation form part of their latest treatment journey.

Figure 90: Proportion of all clients with residential rehabilitation as part of their latest treatment journey, Devon compared to National



In 2012, the Devon Drug and Alcohol Team have carried out a review of Residential Rehabilitation as a treatment option in light of the emerging Recovery Agenda, in particular, how it is accessed in the Devon area; ensuring that there is fair a systematic approach that is consistent for drug and alcohol clients across each locality, determining its value for the treatment system as a whole. This would then inform future commissioning. The review was informed by a review of evidence-based literature; an audit of all clients of either Devon Drug Service of Devon Partnership Trust's specialist alcohol service who had applied for residential rehab in the past three years and interviews with service users, clinicians and service providers. The review resulted in a number of findings, the most notable of which are listed below:

- There is a dearth of evidence as to the effectiveness of residential treatment however data available suggests it is beneficial, especially for individuals with more complex needs.

- Conducting the client audit proved difficult as data for alcohol clients was hard to collect, some files were incomplete or poorly completed and outcomes were difficult to ascertain as the was no process or permissions to follow up clients once they had left their placement.

- Administration; There are currently separate panels that meet to consider funding requests; the drugs panel has a finite budget of £100,000 per annum is administered by the DAAT and comprised of clinicians and the Social Care panel which doesn't have a set budget is administered by Devon Partnership Trust and has no substance misuse clinicians on the panel. Each panel has different criteria.

- Commissioning; Residential Rehabilitation costs on average £650.00 per week (more if a detox is needed), the NTA report 'The Role of Residential Rehabilitation in an Integrated Treatment System' (2012), showed that there is a huge discrepancy in outcomes between providers. The choice of Residential Rehabilitation establishments appears to be based upon the workers preference and client choice.

- Access and Treatment Pathways; There is no systematic approach to Residential Rehabilitation for clients of drug services. There are no dedicated posts or specialist workers to carry out assessments. Both the drug and alcohol service do however have processes for preparing people, which service users found useful.

- The role of supported housing; There are a number of supported housing projects that offer a range of services for people with substance misuse issues including a therapeutic community and an 'abstinence based recovery focused resettlement Pathway'. These are not currently well utilised especially by drug services.

The recommendations from the audit were as follows:

Administration

- All Residential rehab applications to be held centrally. Each file to be audited after the treatment episode has ended

- Treatment services to get permission from clients going to rehab to be able to contact them to follow up their progress or to be notified if they present at a different treatment service.

.

- Explore the viability of a single substance misuse panel that focuses upon recovery orientated outcomes. If this is not a viable option then determine whether codes can be applied to cases that differentiate between intended outcomes; Recovery, Respite or 'Needing Social Care'.

- Explore ways of making the panels operate more consistently; Substance misuse clinicians to be on the social care panel, Service user encouraged to attend both panels, Same criteria for both panels

Commissioning

- DAAT Commissioners to explore developing a framework agreement which contains a 'pool' of preferred Residential Rehab providers.

- DAAT commissioners to explore the viability of block booking placements in partnership with the other Peninsula DAAT's (Cornwall, Plymouth and Torbay) to bring prices down and get better value for money.

- Commissioners and treatment providers to work together to ensure a more systematic approach to informing service users of the option of Residential Rehabilitation, clearly stating the eligibility criteria; promoting Recovery and choice

Access and treatment pathways

- Commissioners and treatment providers to review eligibility and ensure that all partner agencies are informed

- A review of initial assessments that are holistic and multi-agency to better determine where the service user would achieve a better outcome; in the community or in a residential setting and to ensure the assessments are service user led.

- To explore with treatment providers pathways for residential rehabilitation including the viability of dedicated workers from each locality (or to work across all three localities) to ensure that there is parity within the system for the service user.

The role of Supported housing

- More creative use of supported housing / Quasi residential;

  - As an environment to carry out a full assessment of needs and identify treatment options.

  - As a local alternative to Residential Rehabilitation.

  - As aftercare for people having an enhanced detox.

  - For people coming to the end of community treatment and in need of a place to adjust to 'life without Methadone'.

- To work with commissioners from Devon County Council, the DAAT, Treatment and Accommodation Providers to explore a more integrated approach of developing services that are recovery focused through the emerging Community Hubs.

- Treatment providers and commissioners to work more closely with quasi residential providers to oversee clinical governance and policies and procedures that ensures the safety of the resident.

- Treatment providers to become members of supported housing management boards.

- To discuss with Devon County Council how Targeted Support funding can better support Substance Misusers in supported accommodation and explore the possibility of more integrated commissioning.

- Carry out a review of the current provision of inpatient and community based alcohol and drug detoxification provision.

7.6 Detox

A comprehensive review of Detox in Devon is being conducted alongside the needs assessment. The findings of this review will not be available in time to be included in a separate document and will form part of a separate report.

7.7 Service Improvement

7.7.1 Personalisation

A working group was commissioned by the DAAT Board during 2011 to consider personalisation in the context of adults with multiple needs who present across a range of services including substance misuse services. The group included representatives of Devon Drug Service, Devon and Cornwall Probation, National Offender Management Service, voluntary sector, Devon County Council and the DAAT. The group was created to consider the use of more personalised approaches to improve outcomes for people with complex or multiple problems, on the basis of that 20% of clients will generate 80% of the work.

The aim of the group was to:

- Inform the development of personalised approaches to commissioning
- Describe personalised approaches to service delivery
- Consider how personalisation can support market development and commissioning approaches
- Support performance frameworks which recognise personalisation
- Support system developments

Figure 91 describes the current commissioning and service delivery landscape and a desired, more personalised commissioning and delivery picture.

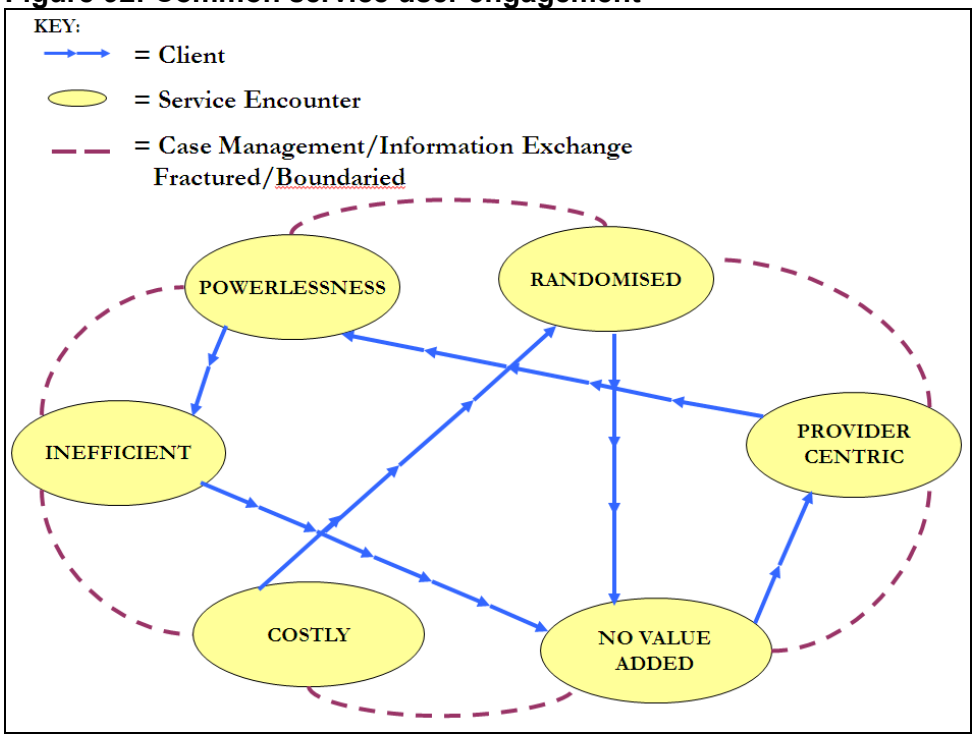
Figure 91: Current commissioning and service delivery – moving from and moving to

Moving from	Moving to
A market shaped by provider interests and historic investment	A market shaped by choice enabling recover

A series of uncoordinated encounters with a myriad of services lacking case managed definition	A commitment to client led recovery journeys which are unique
An offer to clients of generic services, non-sequential and randomised	An integrated multi modal approach where core and specified services can be delivered through multi agency coordination and collaboration
A service user experience in which power and choice are diminished, transferred or absent	A user centric model through which the service user is empowered
Commissioning approaches which lead to measure the wrong things	A commissioning approach which captures key milestones and outcomes in the recovery process
Service and system lack 'organisational memory'. Each encounter starts with a 're telling'	Client's narrative is captured and known and built upon.
Hierarchical and structured accountabilities within a management framework	Dispersed leadership within a reflective and adaptive organisation
Counter intuitive procedures within a target/output driven culture	professional judgement within an outcome orientated culture

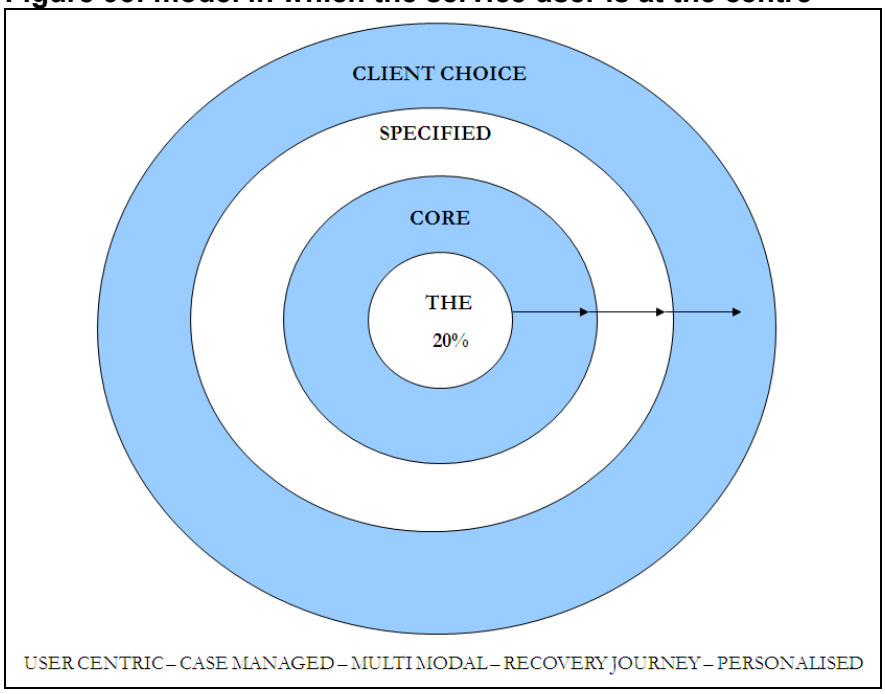
The following illustration describes a common service user engagement with a series of providers working to meet their multiple needs.

Figure 92: Common service user engagement



This illustration describes a model in which the service user is at the centre of a multi-agency approach to addressing their complex and compounding issues.

Figure 93: model in which the service user is at the centre



7.7.2 Feedback from providers

As part of the needs assessment, employees from providers and other stakeholders were given the opportunity to complete an open ended questionnaire relating to current substance misuse services, the responses to which underwent a qualitative analysis. The questions asked were:

1. Within the current system, what works well within the community and / or prison settings?
2. What are the current unmet needs across the system?
3. Where are there gaps for drug users in the wider reintegration and treatment system?
4. Where is the system failing to engage and/or retain people?
5. Who are the hidden populations and what are their risks?
6. What are the enablers and blocks to treatment, reintegration and recovery pathways?
7. What is the name of your organisation or service?
8. Where is your organisation or service based?

The responses received by each of the responding organisations are summarised below. Please note that these summaries are representative of collective views, but based on very small sample sizes and may not necessarily be representative of the entire system.

7.7.2.1 Addaction (eight responses + structured interview)

Service users had a good range of client centred treatment options and were well supported in their decision making. Several mentions were made about group work including relapse prevention, mutual aid, peer support and alcohol education groups. Other treatment options that were thought to work well included Breaking the Cycle, although it was felt that insufficient resources were available to improve the capacity of the service.

The referral system from prisons worked well when it was used, but that not all prison staff were using it consistently. Dual diagnosis clients were often let down by the system as they needed to engage with mental health services before they could overcome their addiction, but were not able to.

Better communication and education about alcohol services is needed in the community and improved use of brief intervention by professionals, particularly for the elderly and the homeless, and people who live in rural areas, as these groups find it difficult to engage with the service. Professionals in families worry about the stigma of using the service.

7.7.2.2 DDS (9 responses + structured interviews)

Use of non-medical prescribers for titration clinics is working well, as is the transfer of staff from IDTS to community services

Whilst staff are generally well skilled, current staffing levels make it difficult to provide the level of support needed by clients, and sometimes mean that care pathways are not always as efficient as they could be. The effectiveness of multi-agency working is variable. Links with probation not as good as they were?

Group work positive but not happening enough

Primary source of referral means sometimes waiting lists are longer than they otherwise could be.

7.7.2.3 DPT Alcohol (5 responses)

Multi-agency working with both statutory and non-statutory organisations works well, though needs to happen more often. Support and education for GP's would be beneficial Relapse prevention work and community / inpatient detox work well (though access needs to be swift).Family work is effective but not able to do as often as needed. Workload often prevents learning from feedback. Accessing the services can be difficult for the elderly in rural areas.

7.7.2.4 Pharmacy (10 responses)

Prescribing and supervised consumption generally works well, though removal of this service in some areas has caused problems and some clients appear to be on a script for a long time. Communication between keyworkers and pharmacies appears to be effective. More training for psychosocial support would be beneficial

7.7.2.5 GP's (9 responses)

Generally receive good support from keyworkers. More advice and training would be good for both GP's and families. Client engagement is sometimes hampered by perceptions of long waiting times / bad previous experiences and is more difficult for clients with mild mental health conditions

7.7.2.6 Other

The below represents responses from a range of other stakeholder organisations, including charities, authorities and NHS organisations, where the number of responses received was less than five.

There is a lack of recovery focussed aftercare for alcohol clients once they have left the system. There is an unmet need for the homeless, the isolated elderly and teenagers. Sometimes tier one and two treatment providers hang on to clients for too long, and when they already have established complex needs.

It is difficult to engage with the homeless and clients with high support needs and chaotic drug misuse and a more flexible approach is needed. More training is required for frontline Support workers working with vulnerable clients. Supported housing needs to be kept up to date with new policies.

The system works best when all agencies are working together. A clear process and pathway needs to be established for people receiving housing support, and particular support is needed for women and people with mental health

There is a lack of join up between partners, especially housing. The system is not truly holistic. There is currently an unmet need around over the counter and prescription medication, new psychoactive substances and elderly people with declining health

Clients referred from prison have too many criteria to meet before they are referred into community services.

7.7.3 Feedback from alcohol consultation event

During the latter part of 2012, measures were put in place to arrange a number of consultation events with service users. Engagement with clients has proven difficult, though at the time of writing the needs assessment, one successful event had taken place involving three current service users and two ex-service users. The process of "journey mapping" was chosen as the most appropriate methodology in the context of "Recovery". This in itself is a subjective concept so no definition was provided, nor was a start point specified or an end or desired state described. Participants were invited to define their own destination or point that had been reached at which they felt they could think of themselves as in beginning the journey, being in Recovery or recovered.

The thoughts and comments of the service users were grouped into a number of themes which were defined by the service users, including Heath Services, Money, Feelings, Quality and Experience of Service, Family and Friends, Recovery Stages, Accommodation, Communications and Information and Groups and Social Support. The comments received were very varied, and whilst a range of interesting observations were shared, there were no clear common themes. The full write up, will be reviewed by the commissioning team and current providers for required actions, can be found on the Devon Health and Wellbeing website.

7.7.4 Feedback from "Exploring Recovery" event

In 2011, a group of people in recovery, supported by workers from a range of agencies, came together to progress the Devon approach to recovery, which included the planning of a recovery event, which took place in May 2012. The event was attended by 165 people from across the county, including workers and managers from a broad range of services, people who were using services and people in recovery. The objectives of the event were to:

- Celebrate recovery and provide real life stories of what helps recovery
- Bring people together to develop relationships and foster a greater dialogue around recovery
- To make things happen that will help spread recovery across Devon

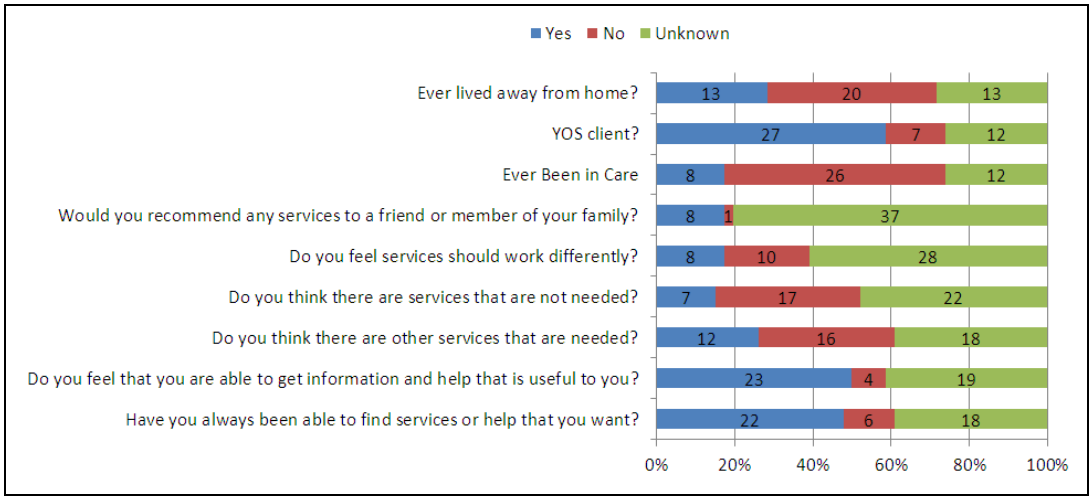
A range of activities were used to collect people's thoughts on recovery, including "Recovery Wall" where people could post their thoughts and a number of workshops. A write up of the findings of the event can be found on the Devon Health and Wellbeing Website:

http://www.devonhealthandwellbeing.org.uk/library/project-reports/

7.7.5 Feedback from youth service clients

During recent focus groups, 46 questionnaires relating to children's services were completed by clients of a number of services, including the YOT, Ysmart, Housing, TRAX, YISP and DPLS. The results to some of the questions can be found in Figure 94.

Figure 94: Young person's questionnaire responses from focus groups, relating to youth services



Whilst a notable proportion of most questions were not answered (unknown), of those that answered, most felt that they were always able to find the services and help that they wanted, and felt that they were able to get the information and help that was useful to them. Almost half of those responding did however feel that services should work differently.

8. What works to address substance misuse

The section summarises and provides reference to some of the key texts in relation to the evidence base and practice guidance for drug and alcohol treatment, covering harm reduction, pharmacological interventions, psychosocial and other forms of recovery support. Further information can be found at http://www.nta.nhs.uk/ and http://www.alcoholconcern.org.uk/

Medications in recovery: re-orientating drug dependence treatment [RODT expert group, 2012] National Treatment Agency

Entering and staying in treatment, coming off opioid substitution treatment (OST) and exiting structured treatment are all important indicators of an individual's recovery progress, but they do not in themselves constitute recovery. Coming off OST or exiting treatment prematurely can harm individuals, especially if it leads to relapse, which is also harmful to society. Recovery is a broader and more complex journey that incorporates overcoming dependence, reducing risk-taking behaviour and offending, improving health, functioning as a productive member of society and becoming personally fulfilled. These recovery outcomes are often mutually reinforcing

Well-delivered OST provides a platform of stability and safety that protects people and creates the time and space for them to move forward in their personal recovery journeys. OST has an important and legitimate place within recovery orientated systems of care. The drug strategy is clear that medication-assisted recovery can and does happen.

They need to approach the change with careful planning and increased support, and include a 'safety-net' in case of relapse. OST will improve as a result of changes at a system, service and individual level. These include:

- treatment systems and services having a clear and coherent vision and framework for recovery that are visible to people in treatment.

- owned by all staff and maintained by strong leadership purposeful treatment interventions that are properly assessed, planned, measured, reviewed and adapted 'phased and layered'.

- interventions that reflect the different needs of people at different times.

- treatment that creates the therapeutic conditions and optimism in which people, and especially those with few internal and external resources, can meet the challenge of initiating and maintaining change.

- OST programmes that optimise the medication according to the evidence and guidance measuring recovery by assessing and tracking improvements in severity, complexity and recovery capital, then using this information to tailor interventions and support that boost an individual's chances of recovering and improve his or her progress towards that goal.

- treatment services that are not expected to deliver recovery on their own but are integrated with, and benefit from, other services such as mutual aid, employment support and housing.

- treatment that works alongside peers and families to give people direct access to, or signposts and facilitated support to opportunities to reduce and stop their drug use, improve their physical and mental health, engage with others in recovery, improve relationships (including with their children), find meaningful work, build key life skills, and secure housing.

Turning evidence into practice: Helping clients to access and engage with mutual aid

According to NICE there is good evidence that 12-step has a positive impact on substance misuse outcomes, so treatment staff should routinely provide people with information about mutual aid groups and facilitate access for those who are interested in attending (NICE, 2007; NICE, 2011; NICE, 2012).

Mutual aid has an extra effect when combined with structured treatment (Fiorentine and Hillhouse, 2000). By providing a continuing support structure, mutual aid can also reduce rates of post-treatment relapse and re-presentation (O'Brien and McClellan, 1996) and help people to sustain their recovery.

However, for people to benefit they need to do more than just show up. A study by Weiss et al. (2005) found that simple attendance did not predict outcomes but that 'active participation' did, with increasing levels of participation producing a significant incremental benefit.

Quality standard for drug use disorders (NICE Quality Standard 23) [NICE, 2012]

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
- Treating and caring for people in a safe environment and protecting them from avoidable harm

The quality standard is also expected to contribute to the following overarching outcomes from the Public Health Outcomes Framework 2013-2016:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

The quality standard is also expected to contribute to the following overarching indicators from the 2011/12 Adult Social Care 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.

Drug misuse and dependence: UK guidelines on clinical management [DH & devolved administrations, 2007] PDF (737kb)

Guidance (based on evidence and professional consensus) on drug treatment in the UK. It looks at clinical governance, treatment provision, psychosocial and pharmacological treatment interventions, and health considerations.

A range of drug misuse treatments have been found to be effective in reducing harm to individual drug misusers, their children and families and local communities. Current levels of mortality and morbidity among drug misusers remain a concern (particularly due to overdose and blood-borne virus infections). _ Substantial numbers are affected by drug misuse across the UK. Many of these could benefit from drug treatment, which has been increased substantially over the last decade.

The effectiveness of well-delivered, evidence based treatment for drug misuse is well established. UK and international evidence consistently show that drug treatment – covering different types of drug problems, using different treatment interventions, and in different treatment settings – impacts positively on levels of drug use, offending, overdose risk and the spread of blood-borne viruses (Hubbard et al., 1989; 1997; Ward et al., 1998; Simpson et al., 1999; Sorensen and Copeland, 2000; Gossop et al., 2003; Hser et al., 2005). The National Treatment Outcomes Research Study (Gossop, 2001) showed that, for a significant proportion of those entering treatment (between a quarter and a third), drug treatment results in long-term sustained abstinence.

Drug misuse: psychosocial interventions (NICE clinical guideline 51) [NICE, 2007] PDF (239kb)

This guideline offers best-practice advice on the care of people who misuse drugs.

Treatment and care should take into account service users' needs and preferences. People who misuse drugs should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If service users do not have the capacity to make decisions, staff should follow the Department of Health guidelines – 'Reference guide to consent for examination or treatment' (2001) (available from www.dh.gov.uk).

Alcohol dependence and harmful alcohol use quality Standard Issued: August 2011 NICE quality standard 11 guidance.nice.org.uk/qs11

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 harmful drinkers and people with alcohol dependence. Alcohol dependence and harmful alcohol use are associated with increased risk of physical and mental health comorbidities including gastrointestinal disorders (in particular liver disease), neurological and cardiovascular disease, depression and anxiety disorders and, ultimately, premature death. 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 harmful drinkers and people with alcohol dependence in the following ways:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long-term conditions.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.
- It is also expected that this quality standard will contribute to reducing alcohol-related hospital admissions and readmissions to hospital.

Models of Care for Alcohol Misusers (MoCAM) (DH, 2006)

Models of care for alcohol misuse Alcohol Misuse Interventions document and NTA effectiveness review provide practical guidance on developing and implementing evidence based programmes that can improve the care of hazardous, harmful and dependent drinkers. Both provide evidence of alcohol related harm to the NHS, individuals, families and communities, and presents powerful economic reasons for taking action.

Duncan Raistrick, Nick Heather and Christine Godfrey - Review of the effectiveness of treatment for alcohol problems, National Treatment Agency, 2006

Provides a comprehensive review of the evidence for alcohol interventions in the treatment of hazardous, harmful and dependent drinking in a number of settings and contexts. It proposes that

- Intervening early before excessive drinking has produced a level of alcohol dependence that makes treatment difficult. Though many alcohol misusers recover without expert help and others move into and out of alcohol problems during their lives (Fillmore, 1988), sufficient numbers do progress to severe dependence to make early intervention advisable

- Preventing medical, psychological and social damage among those who will not necessarily go on to develop severe dependence but who are, by definition, at higher risk of harm through the level or pattern of their drinking

- Reducing the current level of harm from problems such as road traffic and other accidents, violence and public disorder, and loss of industrial productivity. The major contribution to the total cost to society in these areas comes more from the large number of drinkers with less frequent and chronic problems than from the much smaller number of severely dependent drinkers (Kreitman, 1986)

- Identifying alcohol misusers with advanced problems who are not in treatment and persuading them to accept referral to treatment that may be of benefit to them. These aims are clearly consistent with a public health approach to alcohol-related harm and with other measures designed to reduce the harmful effects of alcohol in society (Edwards et al., 1994; Babor et al.,2003) but they are also in the best interests of the individual alcohol misuser. It is essential that treatment services for severely dependent drinkers continue to be made available and, indeed, improved in range and quality. What is being recommended is not a change of direction for alcohol treatment services but an extension of them. There is good evidence that any increased expenditure of resources involved in such an extension of services will be cost-beneficial to society in the long run (see chapter

Working with Troubled Families - A guide to the evidence and good practice – DCLG – December 2012

There is compelling evidence that [family interventions] work dating back to the Dundee Families Project. The Dundee Families project was evaluated by the University of Glasgow in 2001 and this study showed the project to be effective with positive changes for the families. The early evaluation of six family intervention

projects (Action for Children in partnership with local authorities in Blackburn with Darwen, Bolton, Manchester, Oldham and Salford and a sixth project established by Sheffield City Council) in 2006 showed significant successes in reducing anti-social behaviour and preventing eviction:

In more than eight out of ten families (85%) complaints about anti-social behaviour had either ceased or reduced to a level where the tenancy was no longer deemed to be at risk.

In 80% of cases families' tenancies had been successfully stabilised with an associated reduction in the risk of homelessness.

In 88% of cases project workers assessed the risk to local communities had either reduced or ceased completely by the time families left the project. 8

THE IMPACT OF DRUG TREATMENT ON RECONVICTION, National Treatment Agency

Around 200,000 adults get help for drug dependency in England every year. Most are addicted to heroin or crack cocaine, or both, and many commit high-volume acquisitive crime to fund their addiction1. The National Drug Treatment Monitoring System (NDTMS) database was set up in 2004 to record and monitor details of individuals going through the treatment system and the types of treatment received. A new government initiative has enabled NDTMS information to be observed alongside criminal conviction data for the first time.

This study presents analysis of an extract from the DDW provided to the NTA. The extract
consists solely of information from the NDTMS and conviction records from the Police National Computer (PNC). The analysis concentrates on the patterns of convictions observed before and after assessment for drug treatment, for adults who started treatment during the financial year 2006-07

The individuals included in the analysis who are retained in treatment for the entire two-year period observed (4,677) show an average 47% reduction in convictions

- Those who completed treatment successfully after being retained in treatment for six

- months or more show virtually the same average reduction (48%) as those retained in treatment for the full two-year period

- Those who are retained for the full period reduce convictions by more than three times that observed in those who drop out of treatment (15%)

- 41% of all 19,570 individuals in the study show no convictions in the two-year period following initial assessment for treatment

- For all those who both completed treatment successfully and did not return during the period, the observed reduction in convictions is 61%.

- Users of opiates and/or crack cocaine are twice as likely to have one or more convictions pre-treatment than those who use other drugs and they also have a 50% higher average number of convictions per user

- Whether individuals are referred into treatment via the CJS, or present of their own accord or via any other route, appears to make little difference to reductions in convictions.

9. Conclusion and Recommendations

- Areas of Devon with higher rates of alcohol related admissions do not appear to be very consistent with areas expected to have a high prevalence of increasing and higher risk drinking. It is recommended that further work is conducted to better understand the relationship between estimated prevalence and admission rates, particularly with regards to accessibility in rural areas.

- There appears to be a higher concentration of substance misuse services in the South and East of the county. This is predominantly because the South and East of the county are the most populated areas, but given the higher estimated prevalence of drug misuse, and the higher than expected alcohol related admission rates in to the North and West of the county, it is important to ensure that needs in this area are being met. A range of services, including home visits, are already in place, but it is recommended that further investigation is done into the locations of services in North and West Devon and whether drug and alcohol user accessibility to the service is adequate in these areas. It is recommended that current use of GP practices is reviewed to identify whether there are more opportunities to improve service accessibility in the more rural areas of Devon.

9.1 Young people

- Referrals into the Devon youth substance misuse service are broadly comparable to national referral routes, with around 70% of referrals coming from children and family services or the criminal justice system. No referrals into the youth service came from hospitals, which given the high proportion of attendances and admissions are alcohol related, is an area where referral pathways could be developed.

- A number of measures point towards an increasing service use for users of cannabis amongst young people in Devon, which is occurring alongside a decrease in service use for Alcohol. Combined use of cannabis and alcohol is notably higher in Devon than nationally. Further investigation is needed to determine the reasons behind and extent of this pattern.

- Use of stimulants also appears to be higher in Devon than nationally, and accounts for around a quarter of all service activity. This may be in part due to the use of stimulants as “Club drugs”, one of the few areas of substance misuse that has grown over the past few years.

- Compared to national figures, a higher number of treatments per client are used for young people in Devon, with “other psychosocial” interventions being used more than nationally. Despite this, treatment journeys are generally shorter and the percentage of clients with an unplanned and unknown exit is higher. Further investigation should be done into whether the treatments exits are “unplanned” or “unknown”, as this will suggest ways in which the percentage of successful completions could be improved.

- There appears to be a robust process in place for the transition of young people moving from the youth service to adult services, which caters for the needs of the client. Overall, fewer 19 years olds were in treatment (in both youth and adult services) compared to the number of 18 years olds. This could suggest a lack of willingness or ability of young adults to engage with the adult treatment service, but the proportion of clients in the adult treatment service aged 18 to 24 was statistically higher than the national proportion, suggesting this may not be the case. The transition between youth and adult services should continue to be monitored to ensure it is working effectively.

- It appears that effective protocols are in place for working with partners to the youth substance misuse service, and order to better understand how this works a more detailed review of these interactions is required. It is recommended that for both youth and adult services, a rolling programme of reviews is established, that will feed into future service planning and evaluation.

- Better linkage between substance misuse data and other data sets relating to young people would enable the penetration and potential gaps in service provision to be much better understood. Matching of complex and very sensitive datasets, such as MASH data and Troubled Families data, offers both technical and political challenges, but should be considered an important step in better understanding how substance misuse affects young people in Devon.

9.2 Adult Alcohol service

- Compared to nationally, more referrals into the alcohol referral sources were coded as “other”. It would be useful to establish whether this is due to an increased use of uncommon referral routes, or because the main referral routes are not being coded properly. One referral route which appears currently to be under-utilised (both locally and nationally) is hospital referrals. A significant percentage of attendances and admissions are alcohol related, yet only a handful of referrals are receive through this route each year.

- Client waiting times for the alcohol service are generally better than nationally, though the referral process for the most complex clients may currently be longer, and involve more steps than is necessary. Current referral routes and timescales for the most complex clients should be reviewed to identify whether they can be improved.

- In Devon, a higher percentage of clients are in the 18 to 24 age group. These clients generally have more complexities than the same age group nationally. There could be a number of reasons for this increase in the 18 to 24 client base, including an increased need in this age group or an effective transition pathway between young person's and adult services. Some data, such as alcohol related ambulance callouts, where a quarter of all activity was for the 18 to 24 age group, do suggest that there is an increased need compared to other age groups, but it is not clear whether this is a greater over representation than would be seen nationally.

- More adult alcohol service clients also use a second drug, most notably cannabis. This is in keeping with the young person's data, which also showed a large overlap in the number of people both using cannabis and alcohol.

- In Devon, a huge 84% of clients receive structured psychosocial treatment, compared to around only a half of clients nationally. Fewer clients received community prescribing and other structured treatment. The balance of treatment appears to be working well in the adult alcohol service, with over three quarters of clients completing with a planned exit, notably higher than the national percentage of 59.5%.

- According to NDTMS data, fewer clients overall have contact with children. This may be a genuine characteristic of Devon's alcohol service client base (particularly given the increased representation of the 18-24age group), but it is worth checking whether this is due to under-recording as disclosure of parental status is sometimes withheld by clients accessing substance misuse services.

9.3 Adult Drug Service

- It appears that compared to nationally, a lower percentage of OCU's are engaged with or known to the service; around one third compared to 55% nationally. Further investigation should be done to better understand why this may be the case.

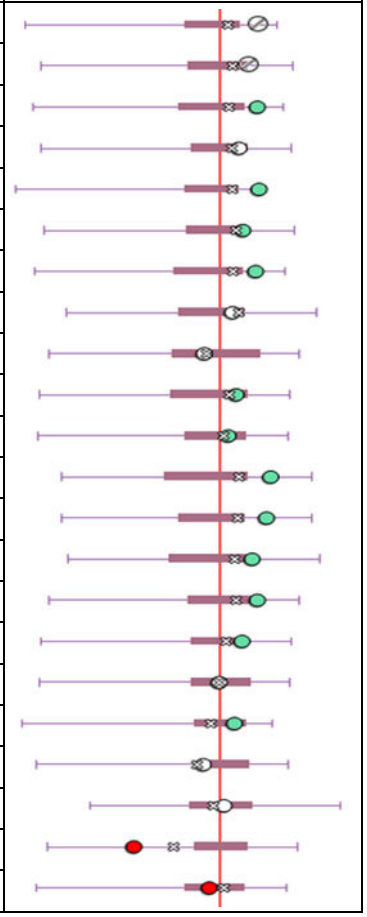
- The cost per adult drug treatment service client is accessing treatment is higher in Devon compared to nationally. A significant contributor to this is higher prescribing costs, which make up 57% of the budget. By focussing on delivering a recovery orientated treatment service, it is anticipated that the proportion of the budget allocated to prescribing will decrease.

- The proportion of referrals that come from GP's appears vary between the areas, with referrals from GP's in South and West Devon being the second largest, whilst in the North and Exeter, East and Mid Devon, it is one of the smallest sources of referrals. The reasons behind this should be investigated to see whether referrals through this route can be increased.

APPENDIX 1: Maps showing estimated drug prevalence

Maps make file size too large for web version of the needs assessment.

APPENDIX 2: Spine chart indicators from the 2012 LAPE Profile for Devon

Indicator	Measure	Spine Chart
Months of life lost - males	7.1	
Months of life lost - females	3.5	
Alcohol-specific mortality - males	8.4	
Alcohol-specific mortality - females	4.9	
Mortality from chronic liver disease - males	7.9	
Mortality from chronic liver disease - females	5.4	
Alcohol-attributable mortality - males	28.8	
Alcohol-attributable mortality - females	13.7	
Alcohol-specific hospital admission - under 18s	63	
Alcohol-specific hospital admission - males	384.6	
Alcohol-specific hospital admission - females	207.4	
Alcohol-attributable hospital admission - males	1161.8	
Alcohol-attributable hospital admission - females	676.3	
Admission episodes for alcohol-attributable conditions	1593.2	
Alcohol-related recorded crimes	5.1	
Alcohol-related violent crimes	4.1	
Alcohol-related sexual offences	0.1	
Claimants of incapacity benefits - working age	72.5	
Mortality from land transport accidents	1.5	
Binge drinking (synthetic estimate)	19.6	
Employees in bars - % of all employees	3.4	
Alcohol treatment - prevalence per 1,000 population	3.3	

APPENDIX 3: Summary of MOSAIC group G33 - Transient singles, poorly supported by family and neighbours

Who are they?

This is a young group, with almost half its members[85] aged between 18 and 35. Ninety per cent live in flats, and more than half[86] live in privately-rented accommodation (nearly four times the national average). Many live in flats above shops or in (often terraced) streets on the fringes of town centres, whose proximity to pubs etc. makes them unattractive to families with children.

This is a highly transient group, with 20% resident in their present neighbourhood for less than a year, while another 40% have been resident for between one and two years.

Unemployment is above average and for many, incomes are low, with almost half[87] of households having a gross annual income of less than £20,000, while more than a third of households[88] have no access to a car.

There are significant mental health problems in this group. Hospital admissions for schizophrenia are four times the national average, while those for bipolar disorder (nearly three times the average) and depression (almost double) are also very high.
It is not clear to what extent high rates of hospital admission reflect the tendency for hostels and refuges to be located in areas of this sort on account of the type and size of the local properties.

In their responses to the British Crime Survey, 41% of this group report using cannabis, while 12% (double the national average) report having used cocaine.

Ten per cent of G33s (nearly double the average) work in the hotel and catering industry, and as a result many may be employed only seasonally, or may be on shortened hours during the winter months.

How do we reach them?

- Cinema attendance among G33s is well above the average, and surveys show that G33s are twice as likely to learn about new products and services through going to the cinema as the average for the population as a whole. As a result, promotional material in cinemas, or adverts before films are likely to be effective methods of reaching this group.
- G33s are above-average users of mobile telephones, and frequent visitors to the smaller, more local branches of some of the leading supermarkets, such as Sainsbury's

[85] 47.7%
[86] 57.5%
[87] 48.8%
[88] 36.2%

Local and Tesco Express and Metro. However large numbers also use the mainstream branches of Tesco (14.5%) and Sainsbury's (10.5%).

- Whilst G33s are above-average television viewers, they make very little use of radio when learning about products and services.
- Eighteen per cent of this group use public transport to travel to work, while a quarter report that they walk to work (both figures obviously influenced by the low level of car ownership, see above).. As a result, advertising on public transport or in public areas accessible to pedestrians is likely to reach a significant proportion of this group.

APPENDIX 4: Cross section the young person's referral data by referral source, substance and age group

Cross Sectional Analysis of NDTMS Referrals Data

Substance categories
Class A (Heroin & Crack)
Stimulants (Cocne,Ecsty,Amph)
Cannabis & Alcohol
Cannabis Only
Alcohol Only
Other Substance

Referral Source Categories
Children & Family Services (excl. LAC)
LAC
Health & MH Services (excl. A&E)
A&E
Substance Misuse Services
Criminal Justice (excl. YOT)
YOT
Family & Friends
Other

Age Group Categories
12 & under
13 - 14
15 & over

Intervention data categories

Substance categories
Class A (Heroin & Crack)
Stimulants (Cocne,Ecsty,Amph)
Cannabis & Alcohol
Cannabis Only
Alcohol Only
Other Substance

Intervention Categories
Counselling
Cognitive Behavioural Therapy
Motivational Interviewing
Relapse Prevention
Family Work
Other Psychosocial
Specialist Pharmacological
Harm Reduction
Other

Treatment Exit data categories

Substance categories
Class A (Heroin & Crack)
Stimulants (Cocne,Ecsty,Amph)
Cannabis & Alcohol
Cannabis Only
Alcohol Only
Other Substance

Treatment Exit Categories
Completed (Drug Free)
Completed (Occasional User)
Transferred (Not In Custody)
Transferred (In Custody)
Unplanned and Unknown

APPENDIX 5: Devon Protocol for managing the Transition of substance misuse clients from Young People Substance Misuse Agencies to Adult Services

1. For those young people who have a current case with young people substance misuse service:

1.1. As a client approaches their 18th birthday a care plan review meeting should be undertaken. If the young person is agreeable this meeting should include the young person, current key worker, worker from adult services felt to be most appropriate and parent/carer if appropriate.

1.2. At this meeting discussions should be held with young person around their current needs and possible future needs.

1.3. Decisions should be recorded as to the wishes of the young person in relation to moving to adult provision.

1.4. If the young person is not agreeable to a meeting with the adult services discussions should still take place with the young person and the young people's service as to transition.

1.5. There is no requirement that the young person should move to adult services on a particular date, however by the age of 181/2 the majority of young people will have been transitioned into adult services. For a young person aged 19 to be in young person services would be exceptional and will only occur after agreement between the Adult Substance Misuse Commissioner and the Young People's Substance Misuse Commissioner.

1.6. If the young person is agreeable to the young people's services and adult services discussing the young person when they are not present this should happen following the care plan review. The young person should be consulted as to what information they are prepared for the young people's service and the adult service to share. Relevant information would include the assessment info, the care plan, reviews, TOPs and risk management plan

1.7. If the young person is not agreeable to the young people's service and the adult service discussing the case this should not happen. Guidance will be given to the young person as to how to access adult services

1.8. If the young person wishes to self-refer to the adult service without the support of the young people's service this must be allowed. The adult service may not be supplied with information on the young person without prior consent from the young person. However, if it is considered that there is a Risk Management issue, in line with existing confidentiality policies, the young people service can breach confidentiality if it is considered that the adult service requires this

information. Guidance will be given to the young person as to how to access adult services

1.9. If it is agreed that the young person should move to adult services a planned transition meeting should take place between young person, young people's substance misuse agency and adult agency. A transitional care plan should be drawn up which will identify what further input young people's services will give, the method and transfer of information to adult services and the responsibilities and actions that each service will undertake during the transition period which could include where appointments will take place. At this time the young people service will report to NDTMS as a successful discharge.

1.10. If the client is not working successfully with adult services further discussions between adult, young person and client should take place. If considered necessary the length of time that the young person remains in contact with young people services can be extended.

1.11. Only in exceptional circumstances will a young person continue to receive treatment in a young people service after the age of 18.5. In the case of exceptional circumstances a case conference will be held to put together a care plan with attached time scales. Exceptional circumstances will only be considered if there is a clinical need. Funding issues will be discussed with the young people commissioner and adult substance misuse commissioner.

2. For young people who seek support from a young person substance misuse service once they are 18:

2.1. If a young person is referred to the young person service the young person service should direct them towards the adult service for a triage assessment.

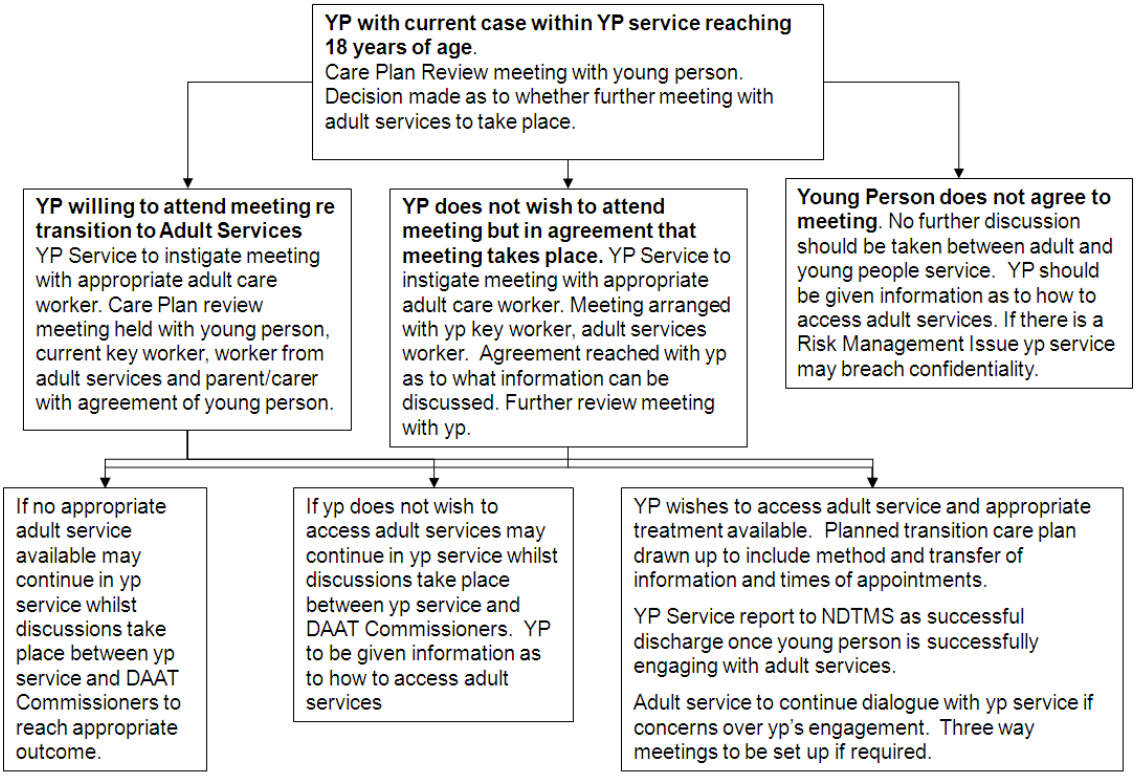
2.2. If after a triage assessment the adult service consider that there is no suitable adult treatment provision this information will be passed to the adult and young people's commissioners for further discussion.

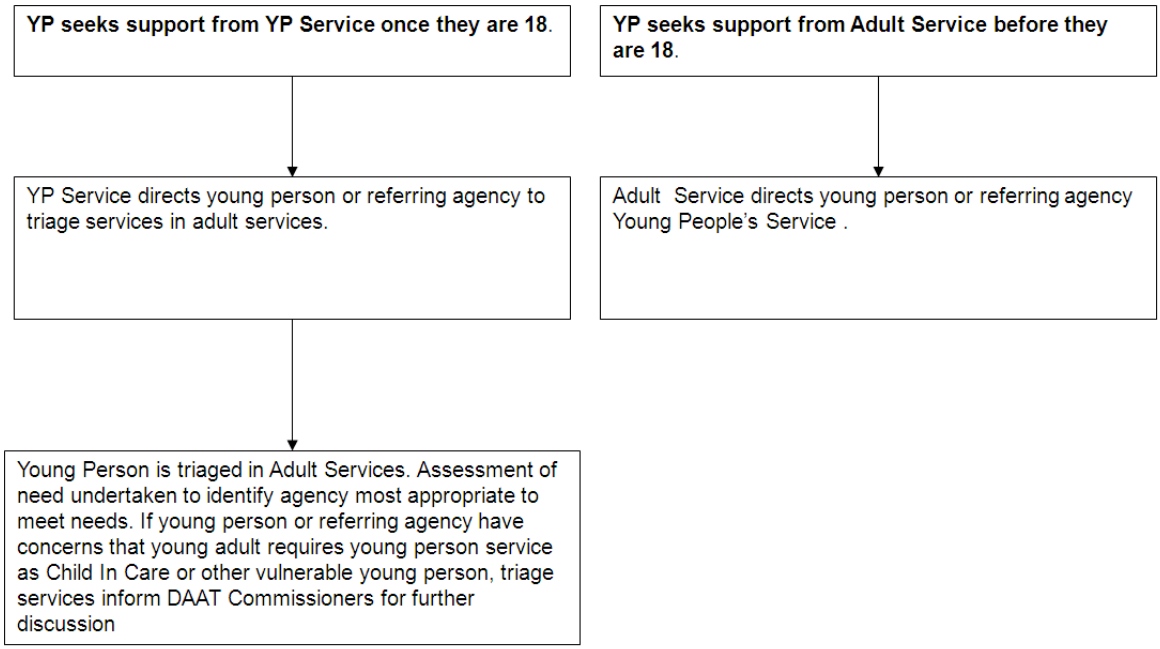
2.3. Only in exceptional circumstances will young people over the age of 18 be accepted onto young people's agency books. These circumstances will need to be discussed with the young people and adult substance misuse commissioners prior to a decision being made.

3. For young people who are referred to adult services in the first place and are under 18:

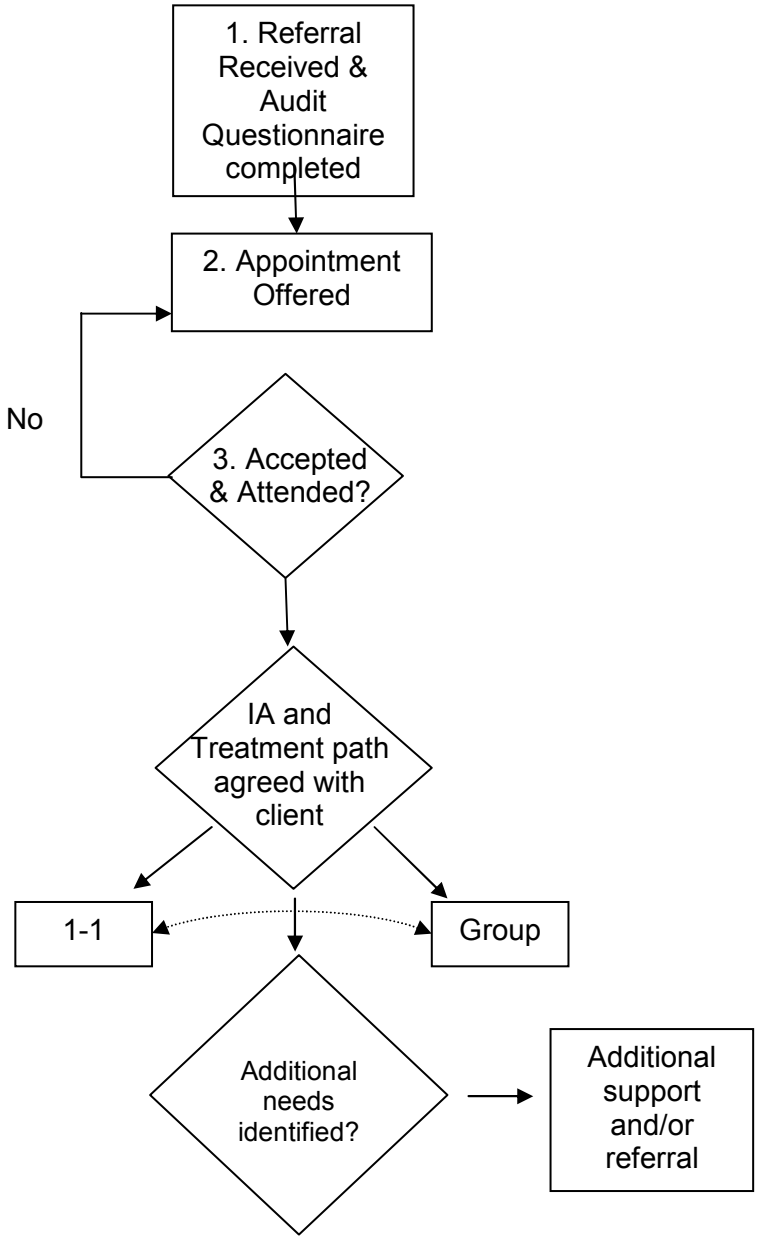
3.1. All young people under the age of 18 are expected to be seen in the young people substance misuse service. Adult services will refer the young person to the appropriate service if a referral is received for triage

March 2009


YP with current case within YP service reaching 18 years of age.
Care Plan Review meeting with young person. Decision made as to whether further meeting with adult services to take place.
YP willing to attend meeting re transition to Adult Services
YP Service to instigate meeting with appropriate adult care worker. Care Plan review meeting held with young person, current key worker, worker from adult services and parent/carer with agreement of young person.
YP does not wish to attend meeting but in agreement that meeting takes place. YP Service to instigate meeting with appropriate adult care worker. Meeting arranged with yp key worker, adult services worker. Agreement reached with yp as to what information can be discussed. Further review meeting with yp.
Young Person does not agree to meeting. No further discussion should be taken between adult and young people service. YP should be given information as to how to access adult services. If there is a Risk Management Issue yp service may breach confidentiality.
If no appropriate adult service available may continue in yp service whilst discussions take place between yp service and DAAT Commissioners to reach appropriate outcome.
If yp does not wish to access adult services may continue in yp service whilst discussions take place between yp service and DAAT Commissioners. YP to be given information as to how to access adult services
YP wishes to access adult service and appropriate treatment available. Planned transition care plan drawn up to include method and transfer of information and times of appointments.
YP Service report to NDTMS as successful discharge once young person is successfully engaging with adult services.
Adult service to continue dialogue with yp service if concerns over yp's engagement. Three way meetings to be set up if required.


YP seeks support from YP Service once they are 18.
YP seeks support from Adult Service before they are 18.
YP Service directs young person or referring agency to triage services in adult services.
Adult Service directs young person or referring agency Young People's Service .
Young Person is triaged in Adult Services. Assessment of need undertaken to identify agency most appropriate to meet needs. If young person or referring agency have concerns that young adult requires young person service as Child In Care or other vulnerable young person, triage services inform DAAT Commissioners for further discussion

APPENDIX 6: Process flow and description of Addaction referral pathway



Pathway description:

1. Referral Received & Audit Questionnaire completed
- Referrals can be received in a range of formats including letter, email, telephone and drop in. - During the referral, an Audit questionnaire and standard questions are completed, which covers a range of information about the client's circumstances. - Once the referral has been logged, the client will be offered an appointment within

three weeks.

2. Appointment Offered

- If a client fails to turn up for an initial appointment, they will be followed up until a second appointment is made, or until communication from them completely ceases.
- The amount of resources that is allocated to chasing up an individual, and the urgency with which appointments are offered, will be dependent on the information that was provided at referral and levels of risk.
- In some cases, where referrals and assessments cause particular cause for concern (for example there are concerns over child safeguarding), investigatory work will be conducted and the case maybe be referred to the MASH team for investigation.

3. Appointment Attended

- At the clients initial appointment, lots more information is collected about the client, including a TOPS questionnaire (tops is completed when they start treatment so first apt after assessment), and a SAD-Q audit to ascertain a physical dependence score.
- Ultimately the client is able to choose the treatment path they use, but the alcohol worker will endeavour to steer the client towards what the most effective option for them
- Clients with a physical dependency and or multiple or very complex needs will be referred on to Devon Partnership Trust, who will continue their treatment
-

4. Receipt of Treatment

The service offered to clients often consists of more than one type of intervention, for example group work and 1-1 sessions. This is flexible depending on the need of the client. Addaction do not do prescribing. The main treatments offered are:

1 -1 Keyworker Sessions

One hour sessions usually held once a week either in an office or surgery environment. An average of six sessions are attended, but this is flexible.

Group Sessions

There are three different types of group sessions, that are attended in a progression of increasing client participation.

Group session 1 – Gateway workshop

The gateway workshop is a three week rolling programme. Sessions are focused facts and information about alcohol and last 90 minutes

Group session 2 – Recovery group

Recovery groups work on a five week rolling programme. Sessions are participatory and last around two hours – process change group

Group session 3 – Relapse Prevention

Relapse prevention group sessions run over eight weeks, lasting 90 minutes. They are sometimes co facilitated by volunteers who have previously been through the service. these groups are for people who are abstinent or drinking within government recommended guidelines
Additional services

In addition to the standard 1-1 and group sessions, if an individual has any “special circumstances”, they may be offered additional support.

Breaking the Cycle (BtC)

If the screening and initial meeting reveals that a child may be being affected by the substance misuse of a parent or carer, they can be entered into the BtC programme. On this programme the client and their family are assigned a case worker, who will look at the overall needs of the family, and see what can be done to meet these needs. This can involve partnership working with housing, social care, mental health and other partners. Any agency or individual can refer into the BtC programme

Homeless

When it is identified that a client has housing problems or are homeless, they will be signposted to the relevant housing support agency

Dual diagnosis (alcohol use and mental health)

Due the effect Alcohol misuse has on the brain, treatment for addiction and mental health is not given in tandem. In most cases this makes sense, but upon occasion, it is felt that support from mental health may be required in order to help someone overcome their addiction. At the moment this is not easy to implement. – however the dual diagnosis strategy may go some way to supporting this work

Learning difficulties

Clients with slight learning difficulties are dealt with by Addaction, more severe cases are sometimes referred through to DPT.

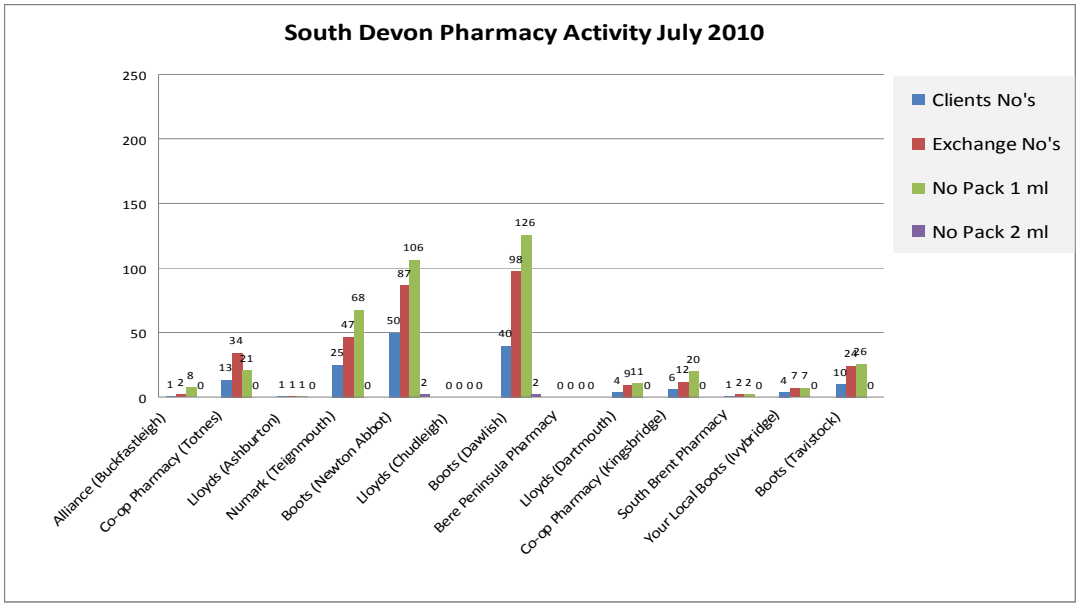
Prisons

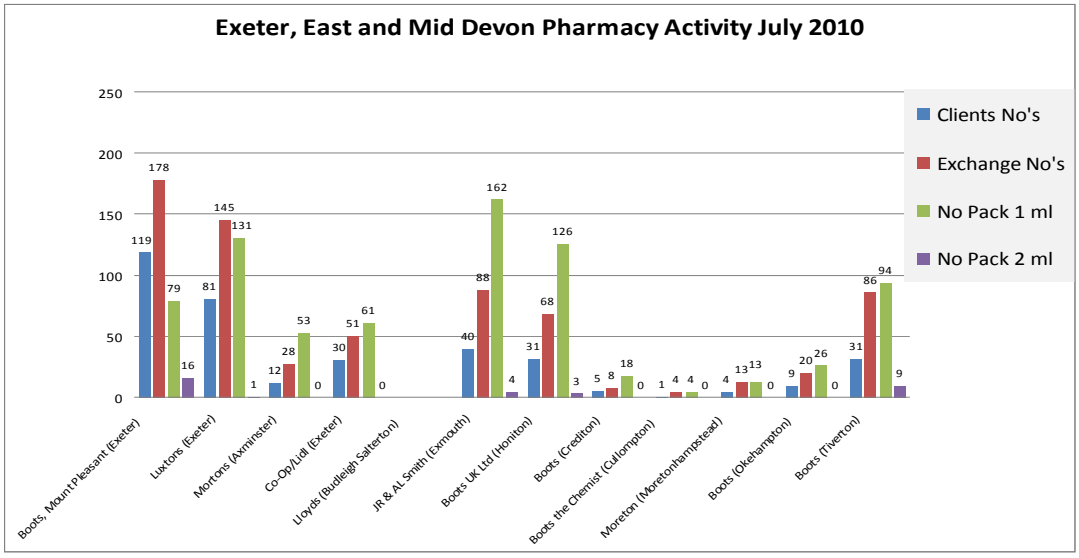
It is not currently clear if CARATS, the prison drug and alcohol service, are routinely arranging appointments for people leaving prison, to ensure continuity of care. Also not clear if case notes are shared? Matt to investigate this.(carats or prison very rarely refer to us) however I am not sure if you can say that or how you say it

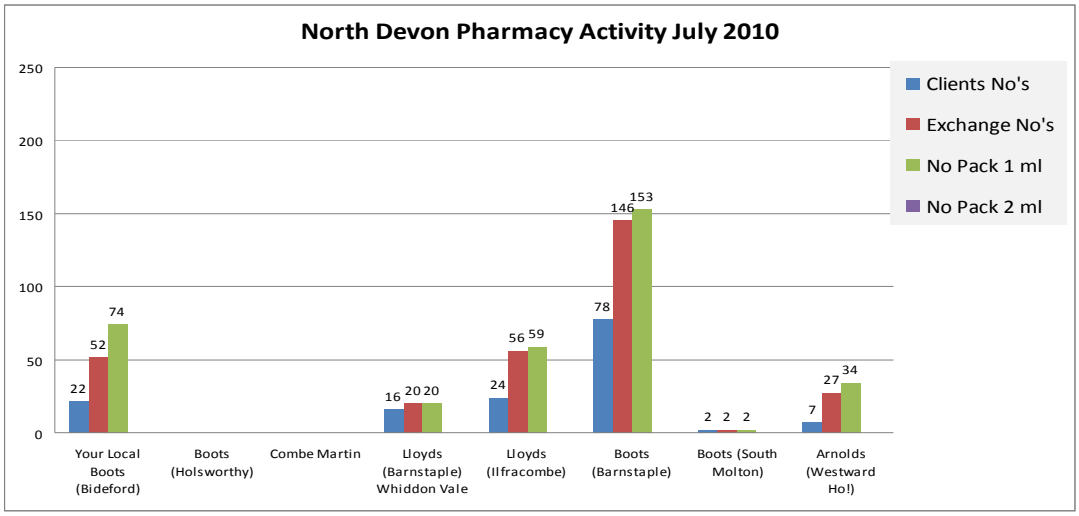
Multiple re-admissions

For “revolving door” clients, Addaction are able to change the service that they offer the client internally, and are able to refer out to other organisations, but the outcomes of those referrals are not always very flexible in “trying something new”. An increased flexibility to move away from “standard procedure” may help end the cycle of re-admission for some clients.

APPENDIX 7: Pharmacy needle exchange activity






North Devon Pharmacy Activity July 2010
250
200
150
100
50
0
Clients No's
Exchange No's
No Pack 1 ml
No Pack 2 ml
22
52
74
16
20
20
24
56
59
78
146
153
2
2
2
7
27
34
Your Local Boots (Bideford)
Boots (Holsworthy)
Combe Martin
Lloyds (Barnstaple) Whiddon Vale
Lloyds (Ilfracombe)
Boots (Barnstaple)
Boots (South Molton)
Arnolds (Westward Ho!)