Drug misuse

Introduction

The problem of illicit drug use has been one of the key concerns for society during the past 30 years. Many communities across England have experienced the debilitating effects of people using the most destructive substances, heroin and crack – crime, drug litter, the spread of blood-borne viruses, and drug-related deaths.

Statistics show that illicit drug use nationally is falling. For example, the Crime Survey for England and Wales (previously the British Crime Survey), has reported that the overall number of people who use drugs has fallen. While cannabis remains the most popular illicit substance by far, even its popularity has waned: whereas 11% of the population used it in 2001, this was down to just 7% in 2011. More importantly, the most recent prevalence figures estimate that heroin and crack use has fallen significantly in recent years: from a peak of 332,090 users in 2005-06 nationally to 298,752 in 2010-11.

These reductions in drug use are mirrored by a fall in the number of people entering treatment for drug dependency. The number of new treatment starts for heroin and/or crack addiction (i.e. people completely new to treatment or those returning) was 64,288 in 2005-06, but 47,210 in 2011-12.

The number of heroin addicts who start treatment for the very first time has declined even more sharply, from 47,709 in 2005-06 to 9,249 in 2011-12.The 2010 Drug Strategy makes clear the government's aim to create a recovery system that focuses not only on getting people into treatment but into recovery, having overcome their dependence.

The Public Health Outcomes Framework includes two indicators for drug treatment:

1. Proportion of all in treatment who successfully complete and did not represent within 6 months – opiates
2. Proportion of all in treatment who successfully complete and did not represent within 6 months – non-opiates

What do we know?

Facts, Figures, Trends

Prevalence

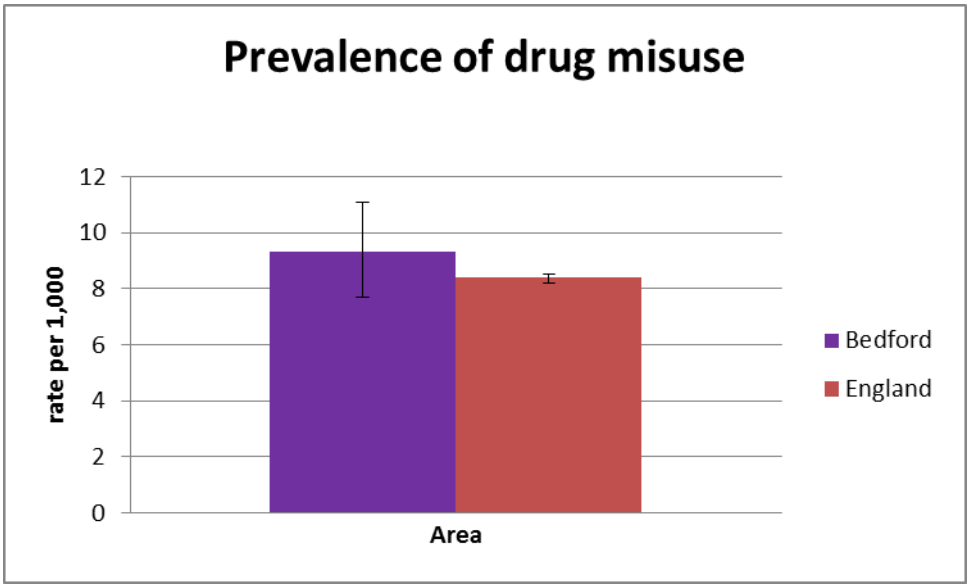
Prevalence estimates are available for Bedford Borough which is shown below (OCU stands for opiate and crack users).

Table 1: Prevalence of drug misuse in Bedford Borough 2011/12

	Bedford		England
	Number	**Rate per 1,000**	**Rate per 1,000**
15-64 population	103,500		
OCU	965	9.3	8.4

Source: National treatment agency (NTA) data sets

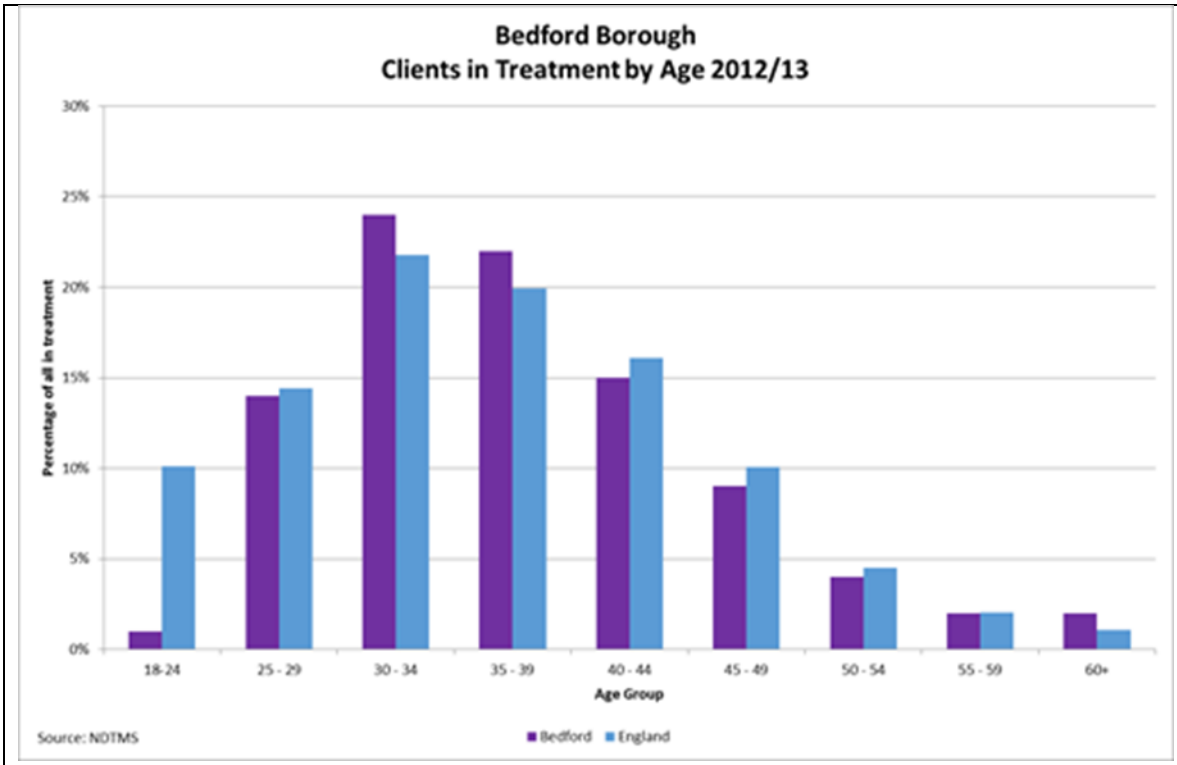
Figure 1: estimated drug misuse prevalence in Bedford Borough 2011/12



Bedford Borough's rate of substance misuse is 9.3 per 1,000 population and is higher than England, but the difference is not significant. This difference could be due to the geographical nature of Bedford Borough - Bedford Borough is a more densely populated urban area and it is well documented that urban areas attract a higher level of drug misuse activity than more rural areas. However, it could also be due to inaccuracy of the prevalence estimates. This group will have significant effects on health, crime and other social needs e.g. housing, unemployment.

Age Group

Figure 2: Age distribution of people in treatment



The majority of the drug misuse population fall in the 30-44 age group, which would correlate with the local anecdotal evidence that there is an ageing opiate population with a new generation of drug users opting to use non opiate drugs. Services need to adapt to support these changes in service user profiles

Table 3: Time in treatment

Average Time in Treatment 2013/14

		Under 2 years	Between 2 and 4 years	Between 4 and 6 years	6 years and over	Average (Years)
Bedford	Opiate	40.5%	18.7%	13.7%	27.1%	3.8
	Non-Opiate	90.3%	6.5%	0.0%	3.2%	1.0

Source: Q4 DOMES

This table illustrates that opiate users typically spend longer in treatment than non-opiate users, and there is a substantial proportion of opiate users who have been in treatment for 6 years and longer. This correlates with the finding that there is an older age group of service users within the treatment system.

Gender

There are more males in treatment in Bedford Borough compared to females, however this is a similar picture to that nationally (28.8% females in Bedford Borough compared to 26.6% nationally). This could indicate that services in Bedford Borough are successful at engaging and retaining females in drug treatment and that interventions are gender sympathetic. It is well documented nationally that women

are more likely to engage in treatment and to stay in treatment longer.

Ethnicity

Bedford has more people living from a non white ethnic group than England based on the 2011 Census data. People in substance misuse treatment from Bedford are more common in the Asian ethnic group compared with England. This is reflective of the local ethnic profile of Bedford Borough.

Table 4: distribution of people in treatment by ethnicity 2012/13

	Bedford Borough	England
White	84.4%	87.3%
Black/Black British	2.0%	3.0%
Asian/Asian British	5.0%	3.9%
Mixed	3.4%	2.6%
Other	0.9%	1.0%
Missing/unknown	4.3%	2.2%

Source: NDTMS

Penetration rate

The following data have been calculated based on the proportions of people by ethnic group from the NDTMS in treatment data compared with the ONS 2011 Census data by ethnic group. A figure greater than 100% means that the population in treatment is greater than that of the population as a whole for that ethnic group. A figure lower than 100% suggests that the service are not treating people from these ethnic groups to the same level, **assuming that drug use is the same across the whole population.**

Table 5: Penetration rate by ethnic group

Penetration rate by Ethnic Group

Ethicity	England	Bedford
White	105%	105%
Black/ Black British	53%	50%
Asian/ Asian British	170%	44%
Mixed	33%	100%
Other	104%	131%
Missing/ Unknown	-	-

Source: PHI

Based on NDTMS and ONS Census

Bedford has a similar penetration rate for the white population and the mixed populations. Bedford is 'under penetrating' the Asian and Black populations, although the proportions of the population are smaller and the numbers of clients smaller. (The key is to consider the penetration rate for Bedford and not compare it with England).

Living with children and Pregnant

The numbers of clients in treatment living with children and/ or pregnant at start of treatment are small and therefore it is difficult to compare with England. In Q2 of 2013/14, 20% (17 individuals) of those beginning a new treatment journey had children, with 1 person being pregnant.

For those drug users in treatment who live with children data has been collected for Bedfordshire prior to April 2013. Therefore it is not possible to show a comparison to previous years or data for a full financial year.

However, the percentages are lower in Bedford Borough for Opiate users and new journeys than nationally and this may indicate that further work needs to take place to review how many opiate users are living with children or pregnant at the start of treatment. This may indicate that assessment and recording of those living with children is being under-reported and this will have an impact on commissioning services in the future, the level of training that is provided to professionals to identify where drugs are an issue for those living with children and how this is disclosed by clients.

Housing

Over 75% of clients in substance misuse treatment have no accommodation needs (new journeys) and this increases to 90% at treatment exit. Less people in Bedford Borough undergoing substance misuse treatment have a housing need when compared with East of England.

This could indicate that there is effective support around housing needs in drug treatment however the fact that there are some who do have a housing need at exit from treatment does need to be scrutinised (even if numbers are low)

Further work needs to take place to ascertain if individuals have the required support to sustain their tenancies/accommodation while in recovery - it is well documented that individuals are more likely to sustain recovery if they have suitable accommodation. This data does not enable us to understand this so data would need to be collected from the local treatment system

Table 6: Accommodation needs of individuals in treatment

	Accommodation needs (new journeys)			No housing needs at exit
	Urgent	Problem	No problem	
Bedford 2013/14	10% 4	10% 4	70% 31	90% 9/10
	12% 4	12% 4	76% 26	91% 10/11
East of England 2013/14	12% 183	15% 233	73% 1,121	
	14% 226	15% 250	73% 1,194	

Source: NDTMS

Prescription or Over the Counter drug use

Table 7: numbers and proportions citing use of prescription/over the counter drugs 2012/13

	All clients in treatment				
	Prescribed/ Over the counter drugs, cited no illicit drug use	Presecribed/ over the counter drugs, cited illicit drug use	Indivduals in treatment	Proportion of all clients citing prescription or over the counter drugs (any use)	Proportion of clients citing prescription or over the counter drugs (no illicit use)
Eastern	379	2,344	16,103	19.6%	2.4%
Bedford	8	57	672	9.7%	1.2%

Source: NDTMS - prescribed and over the counter medication as at 14/11/13

Bedford Borough have a smaller proportion of those in treatment that use prescribed or over the counter medication is less than Eastern England's proportion. However it is recognised nationally that the data collected around the misuse of prescription/over the counter drugs is not necessarily accurate. More work is needed to ascertain realistic levels of misuse, and nationally there is a call for anonymous data to be collected in order to provide an accurate picture of the problem both nationally and locally.

Drug Related Deaths

Bedford Borough has a standardised mortality rate roughly similar to that of the East of England although this is higher than Bedfordshire as a whole.

Progress around the recording and reporting of Drug Related Deaths, protocols pathways and review processes have been greatly improved in 2013/14. A clear multi agency protocol and process has been agreed and quarterly panels will meet to review any cases where there was a drug related death. This will enable professionals to identify if improvements can be made in practice or in service delivery and to enable a coherent review to take place to inform policy and practice locally. Local practice will also be informed by the current PHE consultation taking place around the provision of Naloxone to prevent Drug Related Deaths - results of this consultation are imminent

Table 8: numbers and Standardised mortality rates for drug related deaths 2009-11(Bedford Borough)

Based on EMCDDA definition of a DRD

(Suppressed Data)

Area	Bedfordshire	Bedford	East of England (PHE)
2001	7	4	160
2002	11	6	136
2003	7	5	118
2004	5	3	144
2005	7	3	131
2006	6	5	123
2007	6	3	157
2008	11	6	159
2009	6	3	134
2010	7	6	126
2011	3	<3	117
Deaths 2009-11	16	9	377
Average deaths 2009-11	5.33	3.00	125.67
Population aged 15+ mid 2009-11	1,012,613	388,861	16,633,050
Rate per 100,000 population	1.58	2.31	2.27
Expected deaths	22.95	8.81	377.00
Standardisged mortality ratio	0.70	1.02	1.00

Source: NDTMS team East

Public Health Observatory Mortality Dataset: annual extract of Office of National Statistics mortality

Successful Completions

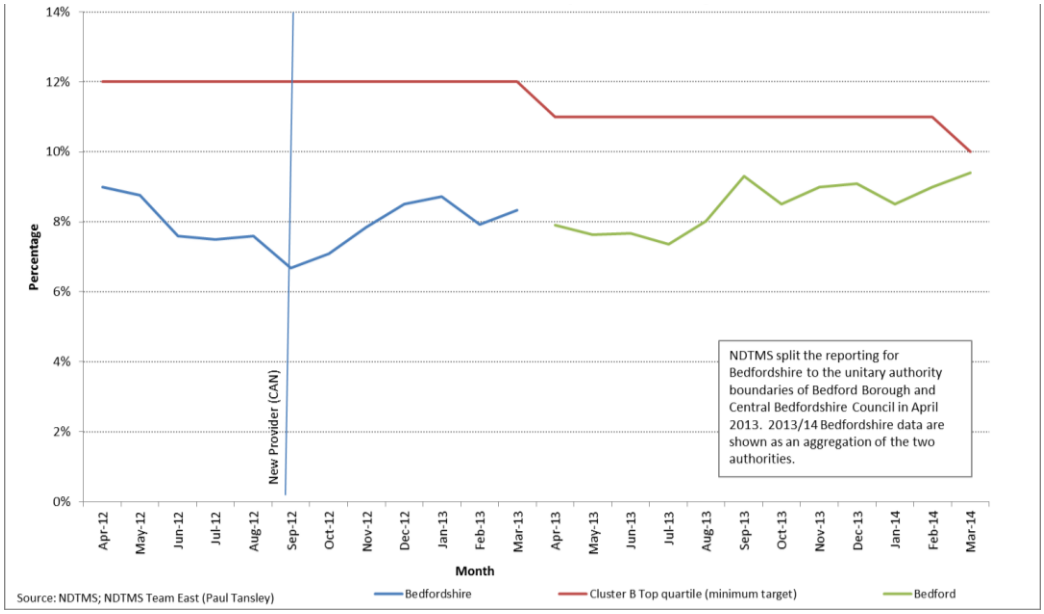
The Successful Completions indicator takes those clients who have completed effective treatment as judged by the professional working with them of those currently in treatment. These data have been charted from April 2012. In this time there has been a change in provider (as marked on the charts) and the method NDTMS employed to present data for Bedfordshire (from April this is as Bedford Borough and Central Bedfordshire rather than Bedfordshire as a whole). NDTMS have their own comparison groups and Bedford Borough is in Cluster B. The target is to have the same rate of successful completions as the top quartile of the cluster.

For opiates there was a dip in successful completions before the beginning of the integrated contract and during the first few months of the new contract from September 2012 This is not unusual in the transition between contracts/providers, and even more typical when the contracting model is so fundamentally altered. However, successful completions has been an improving trend in the 18 month period up to March 2015.

Non-opiate successful treatments in Bedford Borough saw a dip in successful completions around the same time prior and after the new provider. There has been a recent improvement in the proportion of successful completions but this is still some way off the target of the best quartile in the cluster. Again, though the long term trend shows positive development.

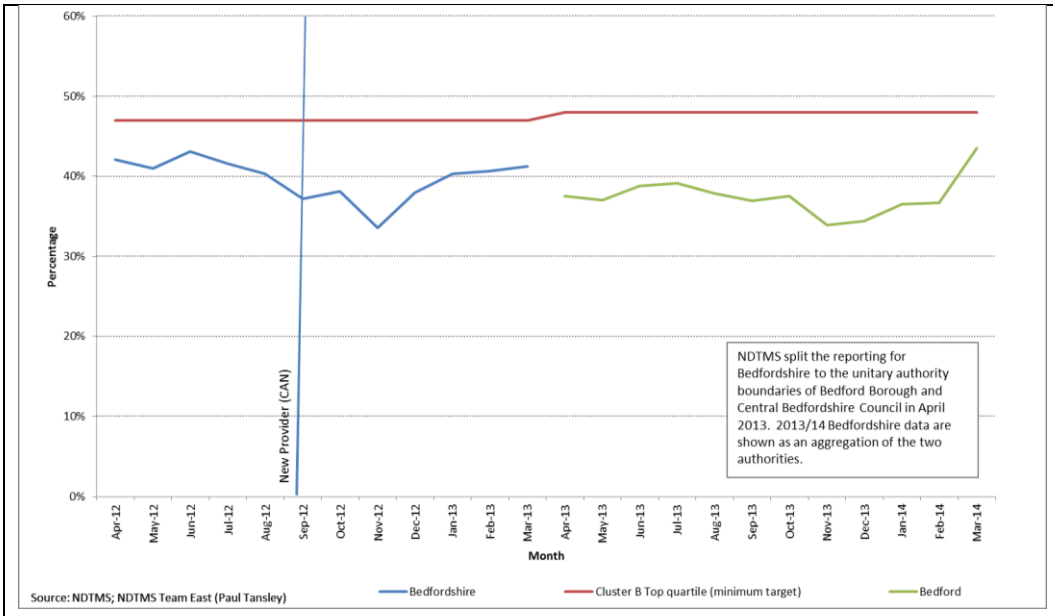
Opiates

Figure 3: Successful treatment completions for opiate users in Bedford Borough



Non Opiates

Figure 4: Successful treatment completions for non-opiate users in Bedford Borough



Successful completions without representing – PHOF Indicators

The Public Health Outcomes Framework (PHOF) includes two indicators related to substance misuse:

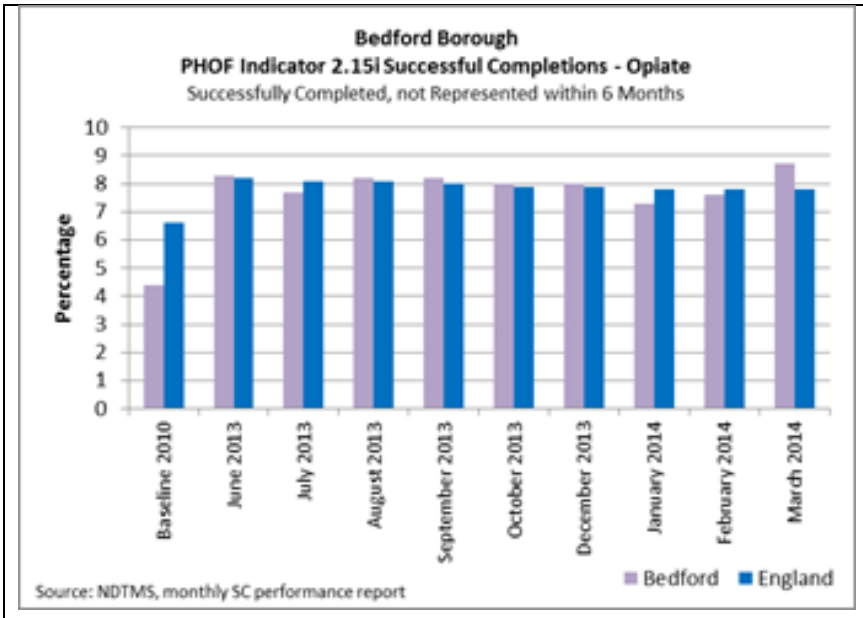
1. Proportion of all in treatment who successfully complete and did not represent within 6 months – Opiates
2. Proportion of all in treatment who successfully complete and did not represent within 6 months – Non-opiates.

This measure differs from Successful completions because it looks at a 6 month time period to see if clients represent (successful completions are just those who completed effective treatment).

For both opiates and non-opiates the trend for a slight increase in opiate successful completions recently and a decrease in non-opiate successful completions. An improvement plan has been in place to ensure the appropriate training, data collection and recovery based interventions are being provided and offered, and it seems that this has had a positive effect on performance.

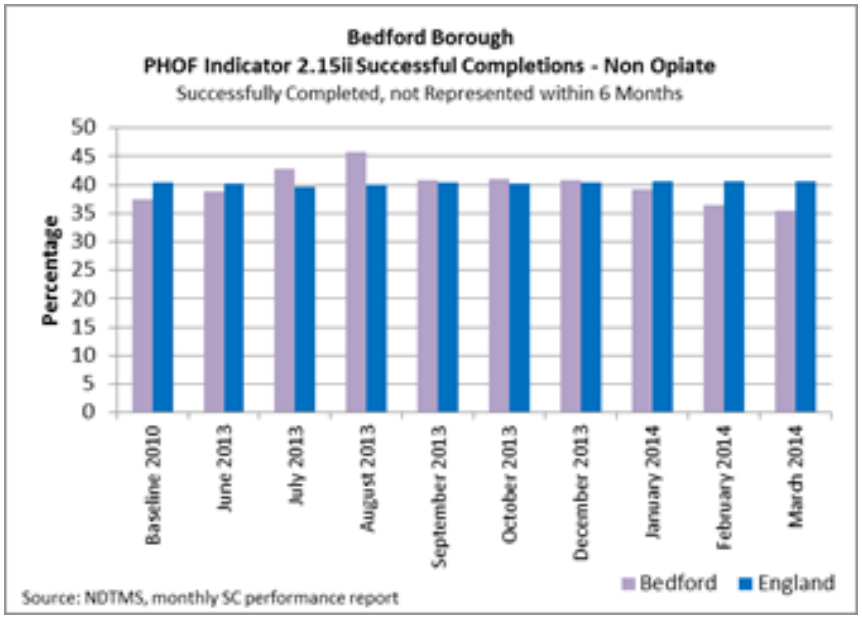
Opiates – Successful completions

Figure 5: Successful completions of treatment without representing – opiate users



Non-Opiates – Successful completions

Figure 6: Successful completions of treatment without representing – non-opiate users



Source: NDTMA data set

Homelessness

Table 9: numbers and rates of homelessness in Bedford Borough 2011/12

Homelessness statistics by Local Authority

Indicator	Year	Bedford		England Rate	East of England Rate
		No.	Rate		
Statutory Homelessness - homelessness acceptances	2012/13	242	3.56	2.37	n/a
Statutory Homelessness - homelessness acceptances	2011/12	211	3.2	2.3	2.2
Statutory Homelessness - in temporary accomodation	2011/12	33	0.5	2.3	1.3
Statutory Homelessness - homelessness acceptances	2010/11	107	1.65	2.03	1.75
Statutory Homelessness - homelessness acceptances	2009/10	141	2.2	1.9	1.5

ONS published statutory homelessness statistics by local authority, table 784
https://www.gov.uk/government/statistical-data-sets/live-tables-on-homelessness
Source: Fingertips indicator 1.15i and 1.15ii
1.15i- Homelessness acceptances per 1,000 households 2011/12
1.15ii- Households in temporary accommodation per 1,000 households 2011/12
http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000041/pat/6/ati/102/page/1/par/E12000006/are/E06000055

Figure 7: percentage of treatment journeys with a dual diagnosis

In Q1 of 2013/14 Bedfordshire data was disaggregated between Bedford Borough and Central Bedfordshire. The data showed that Bedford Borough has a lower proportion of service users with dual diagnosis. This could be a result of disaggregating the data or may be a real decrease in number of individuals with dual diagnosis.

Pathways exist between the community mental health teams and the CAN pathway, however gaps in services exist between:

- Long waiting times for Assessment and Single Point of Access Team

- No clear pathways for those with Autistic spectrum disorders, ADHD or personality disorders
- The crisis team operates predominantly through A&E

Qualitative work in the form of surveys and discussions with stakeholders revealed that there may be concerns regarding referrals for individuals with both mental health and substance misuse issues – they are finding that service users are transferred between substance misuse and community mental health teams with no clear agency taking the lead. There is a dual diagnosis policy written by CAN in place which should be adhered to which details the responsible authority.

More work should be undertaken to build upon the existing examples of very good practice.

Children and Young People

The ChiMat Health Profile 2014 shows that when compared with England, Bedford Borough is either similar to or significantly better for all the indicators used in substance misuse.

Table 10: Child Health Profile

Child Health Profile - Substance Misuse Indicators

Health Profile	Indicator	Bedford	England
2011	23 Hospital admsissions due to alcohol specific conditions <18	40.9	64.5
	24 Hospital admsissions due to substance misuse (15 -24)	27.5	62.8
	25 Children and young people using drugs	3.0	4.0
	26 Children and young people using alcohol	14.0	15.0
	27 First time entrants to the Youth Offending System	1,310.0	1,472.0
	28 Reoffending rates	-	1.1
2012	11 First time entrants to the Youth Offending System	1,090.0	1,160.0
	22 Hospital admsissions due to alcohol specific conditions <18	35.1	61.8
	23 Children and young people using alcohol	14.0	15.0
	24 Hospital admsissions due to substance misuse (15 -24)	33.8	63.5
	25 Children and young people using drugs	3.0	4.0
	26 Children and young people smoking	3.0	4.0
2013	11 First time entrants to the Youth Offending System	975.8	876.4
	23 Hospital admsissions due to alcohol specific conditions <18	37.7	55.8
	24 Hospital admsissions due to substance misuse (15 -24)	39.3	69.4

Red Significantly worse than England average
Amber Not significantly different
Green Significantly better than England average

Source: ChiMat Child Health Profiles

Problem drug users aged 15-24 years

Numbers of young people accessing treatment are in single figures on a monthly basis. In Bedford Borough the predominant drug of choice for this age group is cannabis, and traditionally cannabis users no not access drug treatment, for a number of rreasons.The number of people in treatment traditionally dips in August with a peak in March.

Future trends

'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. These drugs can be harmful and heavy use can develop into a dependency. Data collected since 2005-06 now tells us enough to form an idea of the scale and nature of the problems associated with the more established club drugs – ecstasy, ketamine, methamphetamine, GHB/GBL[1] and mephedrone. What is becoming clear is that despite the widespread use of club drugs, they are currently causing a treatment problem for relatively few people. There is no evidence to suggest they are replacing the most damaging substances, heroin and crack, as drugs of dependency, but they can seriously harm the physical and mental health of the people who use them. Though only a small number of people need treatment for club drugs (just 2 % of over 18s and 10% of under 18s in contact with services), the figure is creeping upwards. There is an inevitable time lag between first use and developing a dependency, so we do not yet know how many more may require treatment in the years to come. But those club drug users who need help tend to respond well. Unlike typical heroin and crack users, they often have the good personal resources – jobs, relationships, accommodation.

Treatment typically involves psychosocial interventions, which address basic motivation and prevent relapse. It also benefits from links with other services, such as urology for ketamine users, sexual health for methamphetamine users and acute medical services as back up for GHB/GBL detox. All the experts say treatment services need to be alert to new trends and to adapt current treatment approaches accordingly. 'There is an argument for promoting services among specific populations where particular drug use is known to be high, such as gay men who use GBL.

A range of New Psychotic Substances (NPS) or 'legal highs' which are widely available both on-line and through specialist outlets are starting to become a concern nationally. There have been a number of high profile incidents where these legal highs have had serious harmful outcomes for those taking them. These substances, usually based around synthetic cannabinoids in a multitiude of variations, brands and

names, are mostly manufactured overseas with little information about their contents

[1] GHB (gammahydroxybutrate) and GBL (gammabutyrolactone), are closely related, dangerous drugs with similar sedative and anaesthetic effects. GBL is converted to GHB shortly after entering the body. Both produce a feeling of euphoria and can reduce inhibitions and cause sleepiness. But both can kill and are particularly dangerous when used with alcohol and other depressant or sedative substances.

or regard for safety.

There is little evidence of 'legal highs' being a specific problem in Bedford, but further work needs to be carried out to identify the scale of use in the Borough. The specification for the new provider, from September 2015, is clear that there needs to be flexibility to respond to the potential issues posed by NPS, and which may not be prevented by planned legislation.

Current programmes/pathways

Table 11: Numbers of drug related hospital admissions

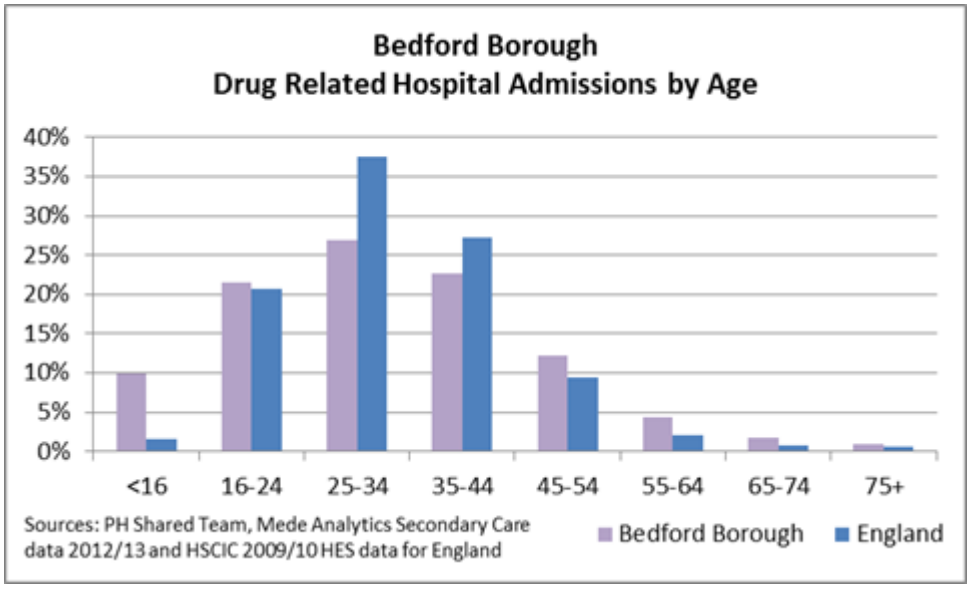
2012/13 Drug Related Hospital Admissions (Spells)

Admission Method Desc	Bedford
Elective: booked	7
Elective: from waiting list	15
Elective: planned	<3
Emergency: other means	3
Emergency: via A&E services	300
Emergency: via consultant OP clinic	<3
Emergency: via GP	7
Maternity: where delivered after mother's admission	10
Maternity: where delivered before mother's admission	<3
Transfer	<3
Grand Total	**345**

Source: PH Shared Team, Mede Analytics Secondary Care data

ICD10 codes F11–F16, F18–F19, X40–X44, X60–X64, X85, Y10–Y14

Figure 8: Drug related hospital admissions by age 2012/13



Residential Rehabilitation (Tier 4)

The trend in those in residential rehab dipped to 2008/09 but then increased again. The data reflects that levels of activity are stable however the numbers are low (average Bedford Borough = 11 and Bedfordshire = 13 per annum). This indicates that there could be an issue with pathways to and availability of resources for individuals who require residential rehabilitation interventions as part of their recovery journey.

Figure 9: percentage of treatment population in residential treatment

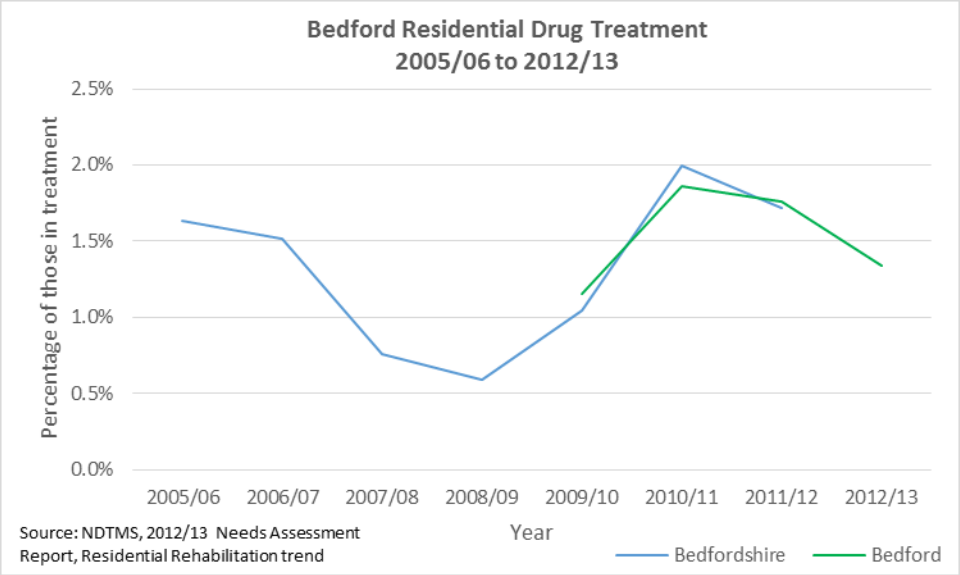


Table 12: proportions in residential treatment

Supplementary residential rehabilitation trend data for 2012/13

Cluster B

Number and proportion of all clients with residential rehabilitation as part of their latest treatment journey, 2005-06 to 2012-13

Partnership	2011/12			2012/13		
	Clients with residential rehabilitation	All clients	%	Clients with residential rehabilitation	All clients	%
Bedford UA **	**13**	**737**	**1.8%**	**9**	**672**	**1.3%**
Cluster B	**564**	**28,793**	**2.0%**	**508**	**28,448**	**1.8%**

Source:

www.ndtms.net

Time series: Annual

Themes: Needs Assessments

Report: Supplementary Residential Rehab trend data

Criminal Justice Clients

Criminal Justice Successful Completion rates

Table 13 Successful completions in criminal justice clients

		Successful completions			**Representations**			**Time in treatment**	
		Opiate	Non-opiate	Alcohol	Opiate	Non-opiate	Alcohol	Drug	alcohol
2013/14	Q1	3% 5/154	26% 7/27	41% 25/61	0% (0/2)	0% 0/5	0% 0/14	25%	15%
	Q2	7% 9/139	30% 7/23	48% 20/42	0% 0/3	0% 0/5	0% 0/9	26%	14%

When Criminal Justice Successful Completion rates are compared within Bedfordshire's cluster group upper quartile range Bedford Borough is performing at less than expected (Q2 2013-14).

Further investigation is required to ascertain the reasons behind this, attrition rates and return to prison rates. It would be advisable also to interrogate community order rates in cluster group areas and correlating successful completion rates. It would be useful also to scope good practice amongst those areas that are performing well within the upper quartile range in the cluster group.

Alcohol and Drug Related Crime and Disorder

Drugs related incidents cost the Bedfordshire Police Force £18 million per year; in response to this Force Drugs Strategy has been published. There continues to be a reduction in heroin use but there are remaining hard core heroin users who are not responding to treatment. Heroin users can be divided into 3 categories: those who have had problematic upbringings and lifestyles, those with mental health issues and those career criminals who make a living out of dealing drugs. It is the career criminals who should be targeted as they take advantage of vulnerable people. There is an appetite amongst ex drug users to support the police in dealing with the 'nastier' side of the drug dealing market.

Young people have moved away from Class A drug use with the exception of some powdered cocaine, and are most commonly using methadone and cannabis. Cannabis use is generally not supported through crime other than supply offences.

A survey suggests that 30% of drug users are buying drugs outside of their home area.

There are increasing problems with users being sold PMA (para-methoxy amphetamine) believing it to be ecstasy. There have been at least 4 deaths in past

12 months. Eastern Europeans are involved in the importation and supply of diazepam. It is possible that in Bedford Borough the tightening of the substitute prescribing of methadone has resulted in increases in serious acquisitive crime, probably being committed by IOM and heroin dependent individuals.

Integrated Offender Management /Drug Interventions Programme

WDP (Westminster Drug Project) currently manage the substance misuse compliment of the established IOM service in Bedford Borough. WDP have recovery practitioners collocated in Probation engaging with other Integrated Offender Management partners, Police, Probation, ETE and Housing providers. WDP also oversee the Drug Intervention Programme services across Bedfordshire, this involves reaching out to clients within the Criminal Justice System and engaging them into structured treatment. The aim of this service is to support changes in offender behaviour and remove issues which influence reoffending. In addition WDP also provide Drug rehabilitation Requirement (DRR)/Alcohol treatment Requirement (ATR) coordination across Bedfordshire and Luton and psychosocial treatment services in HMP Bedford.

Table 15: Caseload and referrals into IOM service 2013/14

		Number
Current caseload		42
Referrals into structured treatment		27
Current caseload	DRR	23
	ATR	18
Referrals into structured treatment	DRR	11
	ATR	6

Not known in treatment Bedford Borough 2012/13

This data has been calculated using the national Treatment Agency prevalence data for Bedford Borough.

Table 16: Numbers of individuals not known to treatment (2011/12 prevalence data)

Not Known drug user estimates

Bedford	Prevalence	In treatment now	In treatment during financial year	Known to treatment but not being treated	Not known to treatment	In treatment now	In treatment during financial year	Known to treatment but not being treated	Not known to treatment
OCU	1,468	423	183	158	704	28.8%	12.5%	10.8%	48.0%
Opiates	1,270	416	175	149	530	32.8%	13.8%	11.7%	41.7%
Crack	638	207	119	78	234	32.4%	18.7%	12.2%	36.7%

Methodology NTA

Prevalence from NTA 2010/11 Prevalence estimates

In treatment data from NDTMS BullsEye report (all in treatment) (2012/13)

'Known to treatment but not being treated' are those clients who were in receipt of tier 3 or 4 treatment the previous year but are not being treated the year for this data (2012/13). 'In treatment during financial year' includes those clients who were in treatment during the financial year but are not currently. This includes those who have completed treatment successfully or left treatment. These figures would suggest that there is a high number of opiate users who are not known to the treatment system across Bedfordshire. By referring to the numbers in treatment and the prevalence figures we can see that potentially there is a significant level of unmet need in Bedford Borough. This needs further investigation and a review of the prevalence figures and a scoping exercise around unmet need across Bedford Borough.

Value for Money

The Value for money toolkit shows the estimated costs of substance misuse in Bedfordshire and shows how much money will have been saved by spending money in this area. The fields that can be changed are limited and only include the activity for numbers in effective treatment and successful completions for opiate or crack users (OCUs) and non-OCUs as well as budget and expenditure information

	Summary for 2012-13	
1	The estimated harm in this area in 2012-13 if no opiate and/or crack cocaine	£18.5m
2	The total estimated spend in this area in 2012-13 in real terms, adjusted for area	£3.4m
3	The total benefits1 accrued2 in 2012-13 are:	£11.6m
	(i) Below are the break downs in terms of crime and health benefits:	
	Estimated crime cost savings and QALY benefits	£7.9m
	Estimated health cost savings and QALY benefits	£3.7m
	(ii) Below are the break downs of cost savings and QALY benefits:	
	Estimated cost savings	£7.9m
	Estimated QALY benefits	£3.7m
	(iii) Below are the break downs of effective treatment and sustaining recovery	
	Estimated benefits in 2012-13 from clients in effective treatment	£8.4m
	Estimated accrued benefits from clients in sustained recovery	£3.2m
4	The accrued estimated number of crimes prevented in Bedfordshire was:	34,294
5	In 2012-13, the accrued net benefit (Net benefit = Total benefit - Cost) was:	£8.2m
6	In 2012-13, the in-year net benefit (Net benefit = Total benefit - Cost) was:	£5m
7	**In 2012-13, drug treatment in you area is estimated to have an accrued benefit-cost ratio (BCR) of:**	**3.40**
8	**In 2012-13, drug treatment in your area is estimated to have an in-year benefit-cost ratio (BCR) of:**	**2.47**

In other words, for every £1.00 spent on the local treatment system in 2012-13 £2.47 was gained in benefits.

Source: NDTMS VFM Tool 2012/13

www.ndtms.net

National & Local Strategies (Current best practices)

The 2010 Drug Strategy

- The 2010 Drug Strategy shifts the focus for substance misuse services towards

recovery, and not just harm-reduction, as was previously the case. It encourages a holistic person-centred approach, which is integrated and provides continuity of case management and support.

- The two overarching aims of the strategy are to:
  - Reduce illicit and other harmful drug use
  - Increase the numbers recovering from dependence

HM Government (2010) Drug Strategy 2010. Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life.[2]

NICE Guidelines

- When designing and commissioning services in line with the new model for treatment services, it remains essential to ensure that these are in line with national guidelines. A number of relevant NICE guidelines exist, as follows:
- NICE Clinical Guideline
  - NICE (2008) CG51 Drug misuse: psychosocial interventions
  - NICE (2007) CG52 Drug misuse: opioid detoxification
  - NICE (2011) CG120 Psychosis with coexisting substance misuse
  - NICE (2011) CG100 Alcohol use disorders: physical complications
  - NICE (2010) CG115 Alcohol dependence and harmful alcohol use
- NICE Public Health Guidance
  - NICE (2007) PH4 Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people
  - NICE (2010) PH24 Alcohol-use disorders: preventing harmful drinking
  - NICE (2014) PH 52 Needle and syringe programmes
  - NICE (2012) PH43 Hepatitis B and C – ways to promote and offer testing
- NICE Technology Appraisal Guidance
  - NICE (2007) TA114 Methadone and buprenorphone for the management of opioid dependence
  - NICE (2010) TA115 Naltrexone for the management of opioid dependence

Cochrane Systematic Evidence Reviews

- **Motivational interviewing for substance abuse:**
  Motivational interviewing is a client-centred semi-directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence. Compared with no treatment, but not other 'usual' treatments or assessment and feedback, motivational interviewing can reduce the extent of substance abuse.

Smedslund G *et al* (2011) Motivational interviewing for substance abuse. The Cochrane Collaboration

- **Case management for persons with substance use disorders:**
  Case management is a strategy for linking patients with alcohol and drug use disorders with relevant services for additional social, physical and mental health treatment needs. A single case manager is responsible for the individual, linking them with multiple relevant services. Evidence supports the fact that case management can enhance linkage with other services; however evidence that the approach reduces drug use or produces other beneficial outcomes was not found to be conclusive.

  Hesse M *et al* (2009) Case management for persons with substance use disorders. The Cochrane Collaboration

- **Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence:**
  Methadone was found to be effective maintenance therapy for treatment of heroin dependence as it retains patients in treatment and decreases heroin use better than treatments not utilising opioid replacement therapy. No statistically significant effect was shown on criminal activity or mortality.
  Mattick RP *et al* (2009) Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. The Cochrane Collaboration

Cost Effectiveness

- Drug addiction leads to significant economic and social costs. Evidence-based drug treatment leads to savings, particularly in crime costs, but also through health improvements, including reductions in drug-related deaths and blood-borne disease transmission rates. A recent report by the National Audit Office notes that the Drug Treatment Outcomes Research Study found a benefit-cost ratio for drug treatment of 2.5 to 1.

http://www.nao.org.uk/publications/0910/problem_drug_use.aspx

Medications in Recovery report

A new guide to best practice in reviewing treatment for drug users has been published by Public Health England, based on supplementary advice provided by the Recovery Orientated Drug Treatment Expert Group.

The Expert Group chaired by Professor John Strang, which produced the Medications in Recovery report in 2013 provided advice to the Chief Medical Officer on the frequency and context of treatment reviews to support recovery. In 2012 the Recovery Orientated Drug Treatment Expert Group published its report "Medications in Recovery :re-orientating drug dependence treatment". The report supports a radical ambition to place prescribing within a fully recovery orientated system of care, with changes at system, service and individual levels. The report makes it clear that this involves treatment services continuing to re-orient their delivery of care to provide active and visible support for recovery from the point of entry to treatment, during treatment and after exit and that successful recovery also

relies on support from others, including mutual aid employment and housing services.

The group's advice makes clear that:

- care planning, with its ongoing and planned reviews of specific goals and actions, should be part of a phased and layered treatment programme
- a strategic review of the client's recovery pathway will normally be necessary within three months (and no later than six months) of treatment entry, and will then usually be repeated at six-monthly intervals
- strategic review should always revisit recovery goals and pathways (to support clients to move towards a drug-free lifestyle)
- drug treatment should be reviewed based on an assessment of improvement (or preservation of benefit) across the core domains of successful recovery.

Preventing drug related deaths and blood borne viruses

There are a number of public health harms associated with drug use, including overdose or unintentional injury, which might lead to premature drug-related death; and the spread of blood-borne viruses via injecting or sexual activity.
We work with partners to provide guidance and materials to help service users, families and treatment commissioners and providers to reduce drug-related deaths and blood-borne viruses.

The 2010 Drug Strategy sets out a fundamentally different approach to tackling drugs and reducing drug use and dependence. It also recognises that previous drug strategies have focused on the harms caused by heroin and crack cocaine, and that tackling these harms remains vitally important.

Key to successful delivery in a recovery-orientated system will be that all services are commissioned with, among others, the Drug Strategy's best practice outcome of preventing drug-related deaths and the spread of blood-borne viruses.

Open access and low threshold services that provide interventions to tackle these public health harms are a vital gateway into treatment. They can act as a platform for people who use drugs to access structured, recovery-focused treatment. Having a sense of control over of their drug use can mean they are more able to later go on and make the more dramatic changes that recovery requires.

Criminal Justice
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.

As a direct consequence of the crime they commit, these problem drug users 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 now compels them to confront their drug problems.

Drug treatment for offenders in the community has improved enormously over the past decade, in terms of availability and quality. Prisons are now catching up, with the introduction of a new treatment regime – the Integrated Drug Treatment System (IDTS).

Former NTA board member, Lord Patel of Bradford OBE was asked to carry out a review of drug treatment and interventions in prisons and for people on release from prisons in England.

He found that there has been an improvement in drug treatment in prisons, but that interventions "are complex and characterised by a multitude of funding streams, commissioning and process targets.(which) resulted in a fragmented system with the risk of a 'one-size-fits-all."

Those drug users having just been released from prison are amongst the most vulnerable and at significant risk of opiate-related death, so it is important that prison and community services provide continuity of care.

(Ref: The Patel report: Reducing drug-related crime and rehabilitating offenders, DH, September 2010)

The current Integrated Drug and Alcohol Services Contract, from 1 September 2012, covers both community and HMP Bedford drug treatment services, delivering the benefits of continuity and consistency of care through a single provider.

Families

Substance misuse is a complex issue. It affects not only individuals but also their families, friends and communities.

Parental or carer drug or alcohol use can reduce the capacity for effective parenting. In particular the children of parents or carers who are dependent on drugs or alcohol are more likely to develop behaviour problems, experience low educational attainment, and be vulnerable to developing substance misuse problems themselves. Some children's health or development may be impaired to the extent that they are suffering or likely to suffer significant harm.

Half of all adults new to treatment for drug dependency are parents, so the NTA is leading initiatives to protect families, and especially children, from the negative impact of drug misuse.

Becoming a parent is the spur for many drug users to seek treatment and stop using drugs. Much of the problem behaviour linked to drug or alcohol use can reduce a person's ability to be an effective parent. For the children involved, having a parent in treatment can be a protective factor.

The aim of all those working with drug users who are parents is to maximise the opportunities for families with multiple problems to get the right sort of support. Treatment provides a platform for drug-dependent parents, or those living with children, to stabilise their lives – which can have a positive impact on their families. Joint guidance on developing local protocols between drug and alcohol treatment services and local safeguarding and family services has been developed by the NTA

and the Department for Education (formerly the Department for Children, Schools and Families).

The NTA is now leading new activity to embed good practice in working with drug-dependent parents within local treatment systems. This will encourage services to be more consistent and collaborative, and to take account of the needs of the whole family, and particularly children.

NTA families manager Anna Hemmings says this work will include assessing the progress made in establishing local protocols among safeguarding and family services in all drug treatment partnerships. "We aim for every local area to have a protocol and accompanying programme of activity in place so that drug services work with other local services and families themselves to ensure they get the help they need," says Anna. "The NTA will support drugs partnerships in determining their local priorities for drug misusing parents, and provide good practice examples on how to improve positive outcomes for families and users."

The recovery-oriented vision to replace the current framework, Models of Care for Treatment of Adult Drug Misusers, which the NTA is developing with its partners, is an opportunity to make sure that drug treatment systems embed at a local level the idea of putting families first.

The children of drug addicts will get special help if they are at risk when their parents are receiving treatment, under a new agreement between the NTA and the Department for Children, Schools and Families (DCSF).

New guidance issued to local social services makes clear that drug and alcohol treatment workers can help children's services identify vulnerable children and families. The document highlights the need for adult drug and alcohol services to work with children's services to ensure children in families affected by drug or alcohol misuse are safe from harm and have the support they need to succeed.
In addition to safeguarding issues the document suggests that commissioners of adult drug treatment services should ensure that services adopt a 'Think Family' approach.

The 'Think Family' approach was developed to improve the support offered to vulnerable children and adults within the same family. 'Think Family' aims to secure better outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children, adult and family services.

Employment and Recovery

Employment and Recovery – a good practice guide has been published to update the NTA's 'Joint-working protocol between Jobcentre Plus and treatment providers' (December 2010).

It reflects the significant changes to the provision of employment support since this date, most notably the introduction of the Work Programme and changes to the way that Jobcentre Plus provide support to drug and alcohol users.
The updated document encourages drug and alcohol treatment providers to work

more closely with Jobcentre Plus and Work Programme providers in order to better support the employment outcomes of people in treatment, and highlights key principles and best practice case studies that demonstrate joint-working arrangements.

What is this telling us?

What are the key inequalities?

- More deprived areas: Whilst deprivation is not related to whether people have ever tried drugs, there is a clear link between problematic drug use and deprivation. In addition, deprivation often means that a user is less likely to get care and treatment, and is less likely to overcome drug problems. Deprived people living in over-crowded and sub-standard accommodation are also more likely to share injecting equipment and more likely to contract hepatitis, HIV and tuberculosis as a result.[i]
- Certain groups are more vulnerable e.g. young people, pregnant and although the number are small the treatment needs of these populations are not fully understood.
- Bedford Borough is 'under-penetrating' the Asian and Black Populations. This may indicate that services need to do more to attract and treat Asian individuals into treatment. However, the numbers are small and further work needs to be done in this area to ascertain the true reasons behind this statistic.

What are the unmet needs/ service gaps?

- Prevalence data suggests there is potentially a large number of people not known to treatment across Bedfordshire. This needs further investigation and a review of the prevalence figures and a scoping exercise around unmet need.

- For Criminal Justice successful completions, performance is less than expected. Further investigations need to take place to ascertain the reasons behind this, attrition rates and return to prison rates. It would be advisable also to interrogate community order rates in cluster group areas and correlating successful completion rates. It would be useful also to scope good practice amongst those areas that are performing well within the upper quartile range in the cluster group. This is an area that will be looked into in the evaluation of the drug and alcohol services that is currently underway

- Numbers of those in residential rehabilitation are stable but low – this could indicate an issue with pathways to and availability of resources for individuals who require residential rehabilitation interventions

- Families especially those with children - the percentages are lower in Bedford Borough for Opiate users and new journeys than nationally and this may indicate that further work needs to take place to review what percentage of those living with children or pregnant at the start of treatment is recorded. This may indicate that assessment and recording of those living with children is being under-

reported and this will have an impact on commissioning services in the future, the level of training that is provided to professionals to identify where drugs are an issue for those living with children and how this is disclosed by clients.

Recommendations

For commissioners:

- CALS workers are thought of highly and are currently working outside their remit on occasion. Commissioners should consider how the CALS practitioners are commissioned, for example to consider extending the role of these practitioners. This could be by extending the number of sessions where necessary, or by expanding their role to cover tier 2, 3, and 4 services
- Commissioners to collect more accurate data from CMHTs and service user pathways to triangulate data to identify those families coming under 'toxic trio' of domestic violence, mental health issues and substance abuse for appropriate support and onward referral where appropriate. This would include joint care plans, ensuring the relevant agencies are engaged and developing a shared approach to the care of these families
- There is a need to address several of the pathways surrounding dual diagnosis of drugs and mental health issues, for example personality disorders, schizophrenia and the crisis team which operates predominantly via A&E
- The numbers accessing residential rehab beds are low, which could reflect an issue with pathways to and availability of resources for individuals who require residential rehabilitation interventions
- Further work needs to take place to ascertain if individuals have the required support to sustain their tenancies/accommodation while in recovery

For providers:

- CAN needs to make itself more attractive to clients and reduce stigma of attending hubs. This could include, for example, holding alcohol and drug related clinics on different days, different hubs for alcohol and drugs services
- Continue to identify accurate number of those using on top of a methadone script and aim to reduce numbers with appropriate clinical interventions. These could include peer mentors, information and guidance, key worker sessions and Psychological Interventions
- For service users with a dual diagnoses of mental health issues and substance misuse, there is a need to identify these individuals better, gain a better understanding of the needs of those clients .services available and awareness of this amongst health care professionals. Mental health teams may see the main issue as substance misuse without addressing mental health issues. There should be better integrated working for these service users, for example joint care plans or mental health workers within drug and alcohol teams
- Outcomes improve when psychosocial work is taken up, including group work and the numbers engaged in group work needs to increase–
- Better integration of treatment of adults and children within families with improvement of pathways of care when wider stakeholders involved
- The provider needs to increase the numbers of peer mentors from the current

4 These are demonstrated to support treatment. The provider should also continue to offer 'meaningful activities' and establish a mentor support group in addition to increasing the accreditation of the peer mentors.

- Bedford is 'under penetrating' the Asian and Black populations, although the proportions of the population are smaller and the numbers of clients smaller. (The key is to consider the penetration rate for Bedford and not compare it with England) Consideration needs to be given to how treatment services can penetrate these populations and ensure that accessible and appropriate services are offered.

Probation

Further work is needed to ascertain the reasons behind the low rates of successful completions, attrition rates, and return to prison rates. It would be advisable to scope good practice amongst those areas that are performing well within the upper quartile range in the cluster group. This is an area that will be looked into in the evaluation of the drug and alcohol services that is currently underway by commissioners.

Further information needed:

OTC drugs: nationally it is recognised that data collection is not always accurate for this, therefore more work is needed to ascertain realistic levels of misuse, for example anonymous data, and establish a reliable baseline

This section links to the following sections in the JSNA:

References

References

1. Home Office, 2013. *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales.* London, Home Office
2. Home office, 2012. *Drugs Strategy 2010: annual review May 2012*. London, Home Office
3. National Treatment Agency for Substance Misuse 2010. *Club Drugs: Emerging trends and risk.* National Treatment Agency
4. Public Health England, 2012. *Alcohol treatment in England 2012-2013*. London, Public Health England.

Appendices

Name and contact details of author:

[i] www.drugscope.org.uk [accessed 2 January 2012]