# Drug Use Disorder

## JSNA Report

This version published in **September 2018**

To be fully reviewed in **September 2020**

**Authorised for publication by Matthew Ashton, Director of Public Health**

# Further Information

For a PDF copy of this report, and other research intelligence products, visit *Knowsley Knowledge* – the website of Knowsley's JSNA.

# Reader Information

| | |
|---|---|
| **Title** | 'Drug Use Disorder JSNA Report' |
| **Author** | C Owens – Public Health Programme Manager |
| **Authorisation for publication** | M Ashton – Director of Public Health |
| **Reviewers** | ***Consultation with:*** |
| **Contributors** | L Dowd – Trainee Public Health Intelligence Analyst<br>M Grace – Senior Intelligence Officer ( Public Health) |
| **Pages** | 37 |
| **Date of Release** | September 2018 |
| **Review Date** | September 2020 |
| **Description** | One of a number of topic based reports contained within the Lifestyles theme of the Joint Strategic Needs Assessment. The report contains latest intelligence about drug use disorder and offenders, the policy context (local and national), local drug use disorder services, evidence of what works and local engagement. |
| **Superseded Documents** | 'Joint Strategic Needs Assessment, 2015' |
| **Contact Details** | matthew.grace@knowsley.gov.uk |
| **Website** | http://knowsleyknowledge.org.uk/substance-misuse-and-offenders/ |
| **Related Information** | JSNA Report – Cannabis:<br>http://knowsleyknowledge.org.uk/cannabis-2/<br>JSNA Report – Alcohol:<br>http://knowsleyknowledge.org.uk/alcohol-2/<br>JSNA Report – Crime:<br>http://knowsleyknowledge.org.uk/crime-2/ |

A number of acronyms have been used throughout this document and are given below:

| | |
|---|---|
| ACMD | Advisory Council on the Misuse of Drugs |
| BBV | Blood Borne Virus |
| BZP | Piperazines |
| CCG | Clinical Commissioning Group |
| CGL | Change, Grow, Live |
| CJS | Criminal Justice System |
| CSEW | Crime Survey for England & Wales |
| DIP | Drug Interventions Programme |
| DsPH | Directors of Public Health |
| DTORS | Drug Treatment Outcomes Research Study |
| GBL | Gamma Butrolactone |
| GHB | Gamma Hydrixybutyrate |
| GP | General Practitioner |
| HBV | Hepatitis B Vaccination |
| HCV | Hepatitis C Virus |
| HIV | Human Immunodeficiency Virus |
| HWB | Health and Wellbeing Board |
| JSNA | Joint Strategic Needs Assessment |
| KIRS | Knowsley Integrated Recovery Service |
| KYM | Knowsley Youth Mutual |
| LDIS | Local Drug Information Systems |
| LINks | Local Involvement Networks |
| MDMA | Ecstasy |
| MSM | Men who have sex with men |
| NEET | Not in Education, Employment or Training |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| NPS | New Psychoactive Substances |
| OCU | Opiate and/or Crack User |
| ONS | Office for National Statistics |
| ORA | Offender Rehabilitation Act |
| OTC | Over The Counter Medicines |
| PHE | Public Health England |
| PHOF | Public Health Outcomes Framework |
| PIN | Professional Information Network |
| POM | Prescription Only Medicines |
| PPG | Patient Participation Group |
| STI | Sexually Transmitted Infection |
| THinK | Teenage Health in Knowsley |
| UN | United Nations |
| UNODC | United Nations Office on Drugs and Crime |
| YOS | Youth Offending Service |

# CONTENTS

## EXECUTIVE SUMMARY

Drug use disorder refers to the continued use of a drug (legal or illicit) by an individual that is consumed in quantities that are harmful to themselves or those around them.

Drug use disorder is a complex issue and has a major impact on the health and wellbeing of individuals, families and communities. Those affected by drugs use them compulsively and the effects of substance misuse are cumulative, significantly contributing to poor health, homelessness, family breakdown and offending.

Drug dependence varies from substance to substance, and from individual to individual. Dose, frequency, the pharmacokinetics of a particular substance, route of administration, and time are critical factors for developing drug dependence.

The annual cost nationally of drug addiction is £15.4bn to society with £488m of this attributed to the NHS cost. The major cost to society from drug addiction is from drug related crime, which is estimated to cost £13.9bn per year nationally.

In 2016/17, the proportion of all opiate users in treatment in Knowsley who had successfully completed treatment and did not return within 6 months was 5.6%, which is lower than England (6.7%). In comparison, the proportion of all non-opiate users in treatment in Knowsley who had successfully completed treatment and did not return within 6 months was 41.5%, which is higher than the national figure of 37.1%.

Drug users in treatment can cite prescription-only medicines (POM) or over-the-counter medicines (OTC) as well as having a problem with illicit drugs. In 2016/17, 4% of drug users in treatment from Knowsley were there for dependence on prescription-only medicines or over-the-counter medicines, slightly higher than the national figure of 3%.

In 2016/17, 75% of adults who were new to treatment were offered and accepted for a HBV vaccination. In comparison, 39% of adults were offered and accepted nationally; meaning uptake of the HBV vaccine for those who are new to treatment is nearly double in Knowsley compared to the national figure. Of those drug users in Knowsley who were previous or current injectors, 78% were offered and received a HCV test, compared to 83% nationally.

10% of all people (adults and young people) in specialist treatment services in Knowsley during 2017/18 were young people, broadly similar to the whole of England.
Of those young people in treatment, 68% were males. Males were substantially more likely than females to be involved in offending or antisocial behaviour as well as citing cannabis as a problematic substance. However, females were substantially more likely to be involved in self-harm, sexual exploitation and to cite alcohol as a problematic substance.

Cannabis was the substance most commonly used by young people in specialist substance misuse services in Knowsley during 2016/17, with 92% doing so (88%

nationally). Alcohol was the next most commonly used substance (5% compared to 49% nationally) with 3% of young people accessing drug use disorder services in Knowsley using stimulants (ecstasy, cocaine, amphetamines), compared to 11% nationally citing problematic ecstasy use, 9% citing problematic cocaine use and 3% citing problematic amphetamine use.

In 2016/17, there were 5,815 drug offences recorded across Merseyside, with offences comprising of possession, production and supply of drugs.

In Knowsley there were 538 drug offences recorded in 2016/17. The rate of offences in Knowsley was 3.6 drug offences per 1,000 population over this period, lower than other areas of Merseyside.

In the three-year period 2014-16, there were 12 deaths in Knowsley relating to drugs, an average of 4 deaths per year and 0.3% of total deaths over that period. This gave an age-standardised rate of 2.8 drug related deaths per 100,000 population in Knowsley, lower than the rate across the whole of England (4.2) and the lowest in the Liverpool City Region. The amount of deaths in Knowsley relating to drugs has increased over time. In the period 2008-10, there were only six deaths in Knowsley relating to drug use, and in the period 2011-13, there were ten deaths in Knowsley relating to drug use. This highlights that, even though Knowsley's rate of drug related deaths is below the rate of England and the other members of the Liverpool City Region, there is a documented increase in the number of drug related deaths in Knowsley, particularly in women.

Evidence shows that people who experience non-fatal overdoses are more likely to experience a future fatal overdose. In Knowsley in 2016/17, the rate of hospital admissions, in which drug poisoning was given as primary or secondary diagnosis, was 109.5 per 100,000 population, over double the rate of England (52.3 per 100,000).

## 1. WHY IS DRUG USE DISORDER IMPORTANT

Drug use disorder refers to the continued use of a drug (legal or illicit) by an individual that is consumed in quantities that are harmful to themselves or those around them.

Drug use disorder is a complex issue and has a major impact on the health and wellbeing of individuals, families and communities. Those affected by drugs use them compulsively and the effects of substance misuse are cumulative, significantly contributing to poor health, homelessness, family breakdown and offending[1].

Drug use is widespread with an estimated 2.8 million adults in England and Wales having used an illegal drug in 2016[2] and 1,200,000[3] affected by drug addiction in their families - mostly in poor communities. However, addiction is rare but concentrated with an estimated 301,000 heroin and crack users in England in 2014/15[4].

Addiction to drugs affects health in a number of ways[5, 6]:

- Lung damage - from drugs and tobacco
- Cardiovascular disease
- Overdose and drug poisoning
- Depression, anxiety, psychosis and personality disorder
- Blood-borne viruses among injectors
- Arthritis and immobility among injectors
- Liver damage from undiagnosed or untreated hepatitis C
- Poor vein health among injectors

Drug dependence varies from substance to substance, and from individual to individual. Dose, frequency, the pharmacokinetics of a particular substance, route of administration, and time are critical factors for developing drug dependence. An article in the Lancet[7] compared the harm and dependence of 20 drugs and showed that the two drugs with the highest harm ratings were heroin and cocaine. Both of these drugs are Class A drugs; however, correlation was poor between a drug's harm score and class according to the Misuse of Drugs Act (see section 2.4).

The annual cost nationally of drug addiction is £15.4bn to society with £488m of this attributed to the NHS cost. The major cost to society from drug addiction is from drug related crime, which is estimated to cost £13.9bn per year nationally[8].

# 2. LINKS TO NATIONAL AND LOCAL DRIVERS

## 2.1 Drug Strategy 2017: Restricting Supply, Reducing Demand, Building Recovery and Global Action

In 2010, the Coalition Government set out their ambitions through the launch of the Drug Strategy[9]. This strategy has been updated[10] to reflect the changes that have occurred and to refresh the ambitions set out in the 2010 report. These ambitions were structured around three themes:

**Reducing demand:** The government is clear that, in order to protect society and individuals from the harms of drug misuse, they must act at the earliest opportunity to prevent people starting to use drugs in the first place and prevent escalation to more harmful use. Public Health England are tasked to provide professional guidance to various sources, such as healthcare workers, local authorities and those who work with youths (school nurses, teachers, youth workers etc.) in order to improve health and wellbeing across the life-course. Dedicated drug resources need to be built on for young people, such as the Talk to FRANK service and the Rise Above digital hub, in order to prevent use at an early stage in the life-course.

It has also been highlighted that a targeted approach is needed for high priority groups. This refers to vulnerable young people, those not in education, employment or training, offenders, families, those who experience/have experienced domestic violence/abuse, those who are sex workers, those who are homeless and veterans. Targeted approaches are also needed on older people, in which the proportion of those reporting drug use disorder issues is increasing.

**Restricting supply:** It is estimated that 95% of the heroin on UK streets originates in Afghanistan, and that the majority of cocaine consumed in the UK comes from Peru, Columbia and Bolivia. Therefore, the main goal with restricting supply is to make the UK an unattractive destination for drug trafficking by attacking profits and driving up risk. Since the 2010 report, various developments have occurred with regards to restricting supply. They are:

- There is now a need to recognise the changing behaviour of criminals and the interconnectivity between the illegal drugs trade and other crime types. Efforts to respond to the threat will continue to evolve accordingly.
- The landmark Psychoactive Substances Act 2016 tackled drugs not already covered by the Misuse of Drugs Act 1971. It removed so-called ‘legal highs’ from open sale on the UK high streets and put an end to the fast paced nature of the market.
- Co-operating with international partners to try to support the fight against narcotics, from anti-corruption work and border checks, through to enhanced investigation and prosecution practices.
- Efforts have been made to tackle specific crime types related to drugs, such as drug driving and anti-social behaviour, as well as offering a smarter approach to drug-related offending.

**Building recovery in communities:** Progress has been made in supporting people to recover their independence on drugs, but further efforts need to be made. The ambition for recovery has been raised by offering to enhance treatment quality and improve outcomes through tailored interventions for different user groups. The government has pledged to support local areas in order to deliver an enhanced, joined-up approach to commissioning and delivery of the wide range of services, in addition to treatment, that are essential to supporting every individual to live a life free from drugs and dependence.

Since the 2010 report, a fourth theme has been listed: Global Action

**Global action:** The United Kingdom is a global leader in tackling drug harms. It has been highlighted that it is in the United Kingdom's best interests to promote a balanced approach internationally; reducing the global supply and demand for drugs helps to minimise drug harms at home. The United Kingdom will strengthen international cooperation, and work with partners to deliver a balanced, evidence-based response. Work with European and other international partners will continue once the United Kingdom leaves the European Union.

## 2.2 NICE Public Health Guidance

Public health guidance makes recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health. The guidance may focus on a particular topic (such as drug use disorder), population or setting. It is aimed at public health professionals, practitioners and others with a direct or indirect role in public health within the NHS, local authorities and the wider public, voluntary, community and private sectors.

With regards to drug use disorder, the following six guidelines are available from NICE[11]:

- Drug misuse in over 16's: psychosocial interventions (CG51)
- Drug misuse in over 16's: opioid detoxification (CG52)
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings (CG120)
- Coexisting severe mental illness and substance misuse: community health and social care services (NG58)
- Drug misuse prevention: targeted interventions (NG64)
- Needle and syringe programmes (PH52)

## 2.3 Public Health Outcomes Framework

The Public Health Outcomes Framework[12] identifies four outcome indicators that directly relate to drug use disorder, however it must be noted that drug use disorder impacts on a much larger number of indicators:

- 2.15i – Successful completion of drug treatment - opiate users
- 2.15ii – Successful completion of drug treatment - non-opiate users

- 2.15iv – Deaths from drug misuse
- 2.16 – Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison.

## 2.4 Misuse of Drugs Act 1971

The Misuse of Drugs Act 1971, with amendments, is the main law regulating drug control in the United Kingdom. Illegal drugs are known in the UK as controlled drugs, and are divided into three classes (A, B, C) based on harm, with Class A being the most harmful. These classes also provide the basis for attributing penalties for offences. Each class attracts different levels of penalties for a range of unlawful activities, including possession, supply and production of a controlled drug. Drugs within each category can be moved by order of the Home Secretary as well as listing new drugs, removing others and delisting previously controlled drugs. Examples of drugs included in the three classes can be found below:

| Class A | Class B | Class C |
|---|---|---|
| Crack cocaine | Amphetamines | Anabolic steroids |
| Cocaine | Barbiturates | Benzodiazepines (diazepam) |
| Ecstasy (MDMA) | Cannabis | Gamma hydroxybutyrate (GHB) |
| Heroin | Codeine | Gamma butyrolactone (GBL) |
| LSD | Ketamine | Khat |
| Magic mushrooms | Methylphenidate (Ritalin) | Piperazines (BZP) |
| Methadone | Synthetic cannabinoids | |
| Methamphetamine (crystal meth) | Synthetic cathinone (mephedrone, methoxetamine) | |

**Table 1: Classification of UK Drugs**

## 2.5 Offender Rehabilitation Act 2014

The Offender Rehabilitation Act[13] (ORA) is the Act of Parliament, which accompanies the Transforming Rehabilitation programme. The Act makes changes to the sentencing and releasing framework to extend probation supervision after release to offenders serving short-term sentences. It came into force on 1st February 2015.

In relation to drug use disorder, the supervision requirement outlined in the ORA may include:

- A drug testing requirement
- A drug appointment requirement

The ORA allowed problematic drug use to be tackled as part of an offender's period of supervision on release. It extended previous provision to impose drug-testing requirements for Class A drugs to also include Class B drugs. In addition, it introduced a new power to require offenders, on release, to attend

an appointment designed to address their dependency on, or propensity to, misuse a controlled drug.

## 2.6 Psychoactive Substances Act 2016

The Psychoactive Substances Act 2016 came into force on 26 May 2016. The act makes it an offence to produce, supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect. The maximum sentence will be 7 years' imprisonment[14].
This covers New Psychoactive Substances (so called 'legal highs') which were not covered by the Misuse of Drugs Act 1971. New Psychoactive Substances (NPS) might be[15,16]:

- Stimulant-type drugs, which mimic substances such as amphetamine, cocaine and ecstasy, and are known by names such as Mephedrone and Benzo Fury.
- Depressant-type drugs, which mimic tranquiliser or anti-anxiety drugs. These include new drugs from the benzodiazepine family and also Etizolam, Pyrazolam and Flubromazepam.
- Hallucinogenic drugs, which mimic substances like LSD. These include substances such as 25i-NBOMe and Bromo-Dragonfly.
- Dissociative drugs, whose main effect is to cause a sense of detachment, as if the mind and body have been separated. These substances mimic substances such as ketamine and PCP (phencyclidine).
- Synthetic Cannabinoids, which mimic the action of the active chemical found in cannabis and are traded under names such as Spice and Black Mamba.

# 3. WHO IS MOST AT RISK?

The sections of the adult population most likely to be at risk of having problematic drug use are given below and are mainly derived from the Crime Survey for England and Wales, 2016/17[17] unless stated otherwise.

**Age:** Young adults in the 20-24 age group are the most likely age group to take illicit drugs. In 2016/17, 21.2% of 20-24 year olds had taken an illicit drug in the previous year compared to 8.5% of the adult population as a whole (those aged 16-59). Indeed, 8.5% of 20-24 year olds had consumed a Class A drug in the previous year.

Young adults are three times as likely to have used new psychoactive substances (NPS) than adults are as a whole. In 2016/17, 1.2% of adults aged 16-24 had used NPS compared to 0.4% of adults aged 16-59. In terms of nitrous oxide use (otherwise known as 'laughing gas') in the younger population is also considerably higher compared to the use in all adults, with the prevalence of nitrous oxide use at 9.3% for 16-24 year olds compared to 2.6% for adults aged 16-59.

Adults aged 20-24 are most likely to use non-prescribed, prescription-only painkillers. In 2016/17, 9.2% of 20-24 year old adults had used non-

prescribed, prescription-only painkillers compared to 7.6% of all adults aged 16-59.

Using NHS Digital's Statistics on Drug Misuse: England, 2018 report, it was found that adults aged 35-44 are most likely to be admitted to hospital due to drug related conditions. In 2016/17, there were 23,952 admissions nationally with a drug related mental health or behavioural disorder as a primary or secondary diagnosis. However, those aged 25 to 34 were not far behind them with 23,255 admissions in the previous year[18].

Adults aged 40-49 are most likely to die of drug related misuse, with 844 deaths in this age group nationally during 2016. However, when comparing sexes, the age group 50-59 was the most likely to die of drug related misuse for females, with 199 deaths in this age group. Since the turn of the century, the average age of drug related deaths has been rising. In the late 1990's, adults aged 20-29 had the highest number of deaths due to drug related misuse[19].

**Gender:** Males are more likely than women to take illicit drugs. In 2016/17, men were more than twice as likely as women to have taken illicit drugs in the previous year, 11.5% compared to 5.5%. Males are twice more likely to have used NPS than females in the previous year. In 2016/17, 0.6% of males and 0.3% of females had taken NPS in the previous year. Males are over twice more likely to die from drug related misuse than females. In 2016, nationally there were 1,896 male deaths compared to 697 female deaths[20].

**Deprivation:** In the previously produced JSNA, it was found that adults living in the most deprived areas were more likely to use illicit drugs than adults living in the least deprived areas. However, according to 2016/17 data, this has changed. Those who are most deprived were found to be least likely to take illicit drugs (8.0%), whereas those living in the middle output areas of deprivation were most likely to take illicit drugs (8.7%). 8.4% of those in the least deprived areas were found to have taken illicit drugs. Note that these percentages are very close, so they should be treated with caution.

In 2016/17, adults living in the most deprived 20% of the country were nearly twice more likely to use non-prescribed, prescription-only painkillers than adults living in the least deprived 20% of areas in England (9.5% for most deprived, 4.9% for least deprived).

**Income:** Adults living in a household where the income is less than £10,000 are nearly twice as likely to take illicit drugs compared to those living in a household with a combined income of over £50,000, at 13.7% vs. 8.0% in 2016/17. This is the same when comparing use of non-prescribed, prescription-only painkillers in 2016/17, with 11.0% of those living in a household with an income of less than £10,000 using compared to 5.9% of those living in a household with an income of more than £50,000.

**Ethnicity:** Adults who are mixed race are most likely to take illicit drugs compared to all other ethnicities, with 19.1% of the mixed ethnic group taking them in 2016/17, compared to 9.0% of white adults, 2.8% Asian adults, 4.7%

black adults and 7.8% Chinese adults. White people are more likely to use non-prescribed, prescription-only drug compared to non-white people (7.9% vs. 6.0% in 2016/17)

**Sexuality:** Adults who are gay or bisexual have been found in previous versions of the CSEW to be significantly more likely to use illicit drugs than adults who are straight or heterosexual. In 2013/14, 28.4% of gay or bisexual adults used illicit drugs compared to 8.1% of heterosexual adults[21]. A trend that has gained popularity, especially with MSM (Men who have sex with men) is Chemsex. Chemsex is when people take drugs that enhance sex and make them feel uninhibited. This can lead to risk of infection from STI's, through the sharing of needles and having unprotected sex. In a survey of over 1,000 gay men, one-fifth had Chemsex in the past five years and one-tenth had done it in the past four weeks[22].

**Offenders / Ex-Offenders:** Drug use is a major problem in the prison system[23], with 70% of offenders report drug use prior to prison, 51% report drug dependency and 35% admit injecting behaviour. Furthermore, a survey by the Prison Reform Trust[24] has found that 19% of prisoners who have ever used heroin reported first using it in prison. It has also been stated that a particular problem in prisoners is the use of new psychoactive substances[25].

**Young People:** Young people who truant or have been excluded from school are more vulnerable to problematic drug use[26].

**Homeless:** Those who have been homeless for a period of at least one month, sleeping either rough or living in a temporary hostel or bed and breakfast accommodation are more susceptible to problematic drug use. In recent years, the use of new psychoactive substances, such as Spice, by homeless people has been found to be on the increase[27].

**Ever in Care:** Those who have spent any time in a foster family, care home, children's home or young people's unit between the ages of 10 and 16 are at increased risk of having a drug misuse problem.

## 4. THE KNOWSLEY PICTURE

### 4.1 Adults

#### 4.1.1 Prevalence

| Substance | Number |
|---|---|
| OCU | 1,090 |
| Opiate | 949 |
| Crack | 664 |

**Table 2: Estimated Number of Drug Users in Knowsley, 2014/15**
**Source: Public Health England**

Table 2 shows the estimated number of opiate and/or crack users (OCU) in Knowsley, as gathered from a study commissioned by Public Health England based on the years 2014 to 2015[28]. OCU refers to the use of opiates and/or

crack cocaine, including those who inject either of those drugs but excludes people who use cocaine in powder form, amphetamine, ecstasy or cannabis, or injecting by people who do not use opiates or crack cocaine. Collectively, they have a significant impact on crime, unemployment, safeguarding children and long-term benefit reliance.

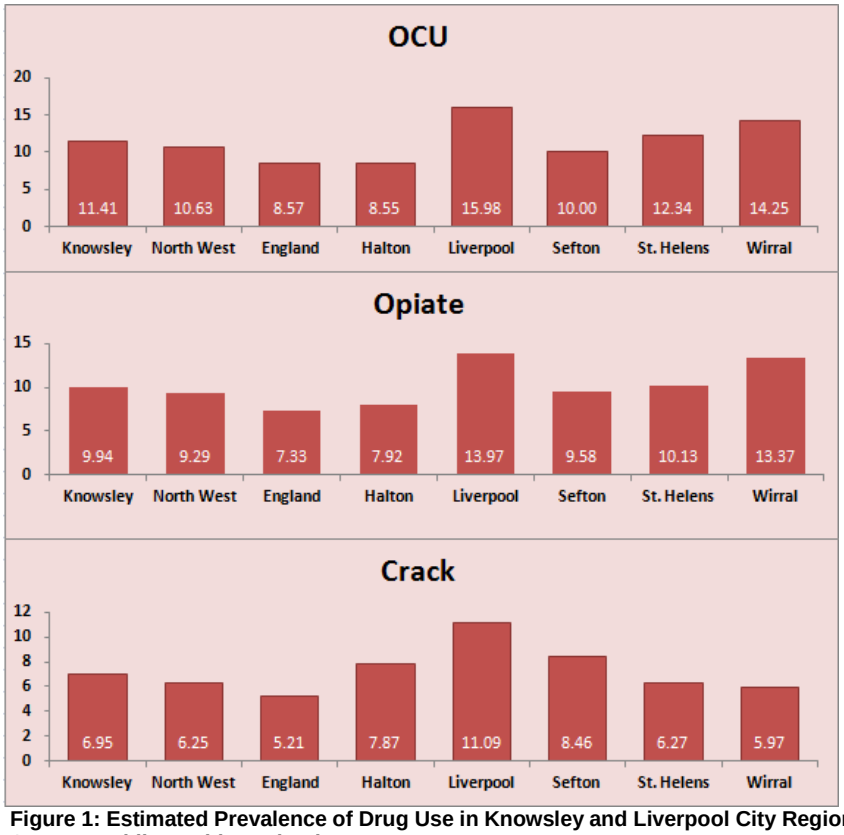


**Figure 1: Estimated Prevalence of Drug Use in Knowsley and Liverpool City Region, 2014/15**
**Source: Public Health England**

The estimated prevalence of OCU in Knowsley was 11.41 per 1,000 adults aged 15-64 in 2014/15, the third lowest rate in the Liverpool City Region. Prevalence was higher than the North West region (10.63) and England as a whole (8.57).

A similar pattern can be seen with the estimated prevalence of opiate users. In 2014/15, the prevalence of opiate users was 9.94 per 1,000 adults aged 15-64, the third lowest rate in the Liverpool City Region. Prevalence was higher than the North West region (9.29) and England as a whole (7.33).

The pattern of crack usage in Knowsley is similar to OCU and opiate use, with Knowsley having the third lowest rate in the Liverpool City Region at 6.95 per 1,000 adults aged 15-64. Prevalence was also higher than the North West region (6.25) and England (5.21).

There has been a significant increase in estimated OCU use between 2011/12 and 2014/15 in Knowsley, from 9.60 per 1,000 adults aged 15-64 to 11.41 per 1,000. Similarly, there has been an increase in opiate use from 8.59 per 1,000 adults in 2011/12 to 9.94 in 2014/15. However, there has been a decrease in the use of crack cocaine, which has fallen from 7.28 per 1,000 in 2011/12 to 6.95 per 1,000 adults in 2014/15.

Analysis by age shows that Knowsley has a higher rate of OCU and opiate users in the 35-64 age group than in any other, 15.29 per 1,000 and 14.02 per 1,000 respectively - higher than England (8.58 and 7.83 respectively). However, prevalence is lower in Knowsley for younger adults aged 15-24 and 25-34 than nationally.

### 4.1.2 Treatment

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better - which also benefits the community. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes.

In 2016/17, there were a total of 891 adults in treatment services in Knowsley. This has reduced by nearly a fifth since the last update of the Joint Strategic Needs Assessment, in which there were 1,090 adults in treatment services in Knowsley.[29]

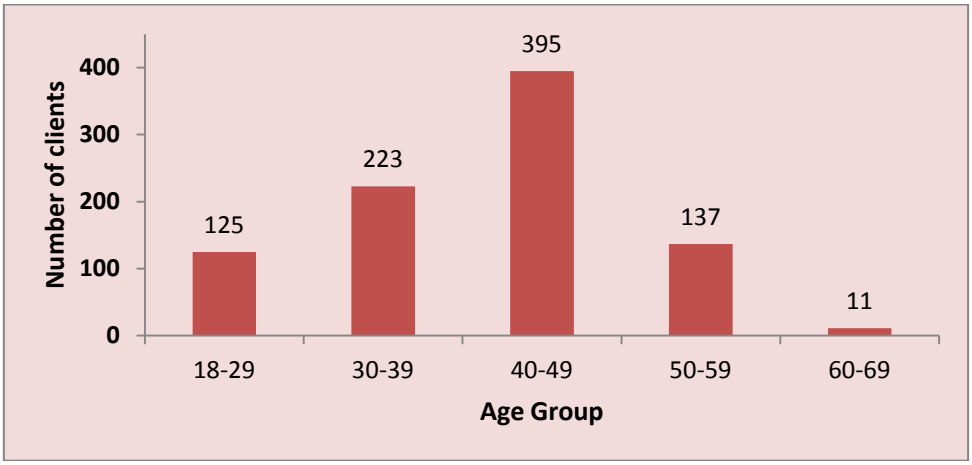


**Figure 2: Number of Clients in Treatment - Knowsley, 2016/17**
**Source: Commissioning Support Pack, Public Health England**

Figure 2 shows the breakdown by age of the number of clients in treatment in Knowsley. Over two-fifths of clients (44%) were aged 40-49, meaning this age group had the highest proportion of the number of clients in treatment. This goes against the national figures, in which people in age band 30-39 were most likely to be in treatment (37%). Three-quarters of clients in treatment were males, compared to a quarter being females.[29]

The proportion of clients in treatment who live with children (either their own or other) is 22%, similar to the proportion for England as a whole (20%). However, when split by gender, the proportion of new presentations that live with children is only 14% in males, lower than the national figure of 17%, yet it is 44% in females, considerably higher than the national figure of 29%. [29]

When looking at employment status at the start of treatment, Knowsley's proportion of people who were deemed 'long term sick or disabled' was 36% in 2016/17, considerably higher than the national average of 28%, with the

proportion of those in regular employment (25%) also higher than the national average (21%)[29].

The measure for effective treatment engagement is defined as those in contact with structured treatment who are recorded as having begun a treatment intervention and either they were retained for 12 weeks or more from their triaged date or they successfully exited from treatment. Of those adults in treatment during 2016/17, 98% were in effective treatment.[29]

| | Number | Change from 2015/16 | % of treatment Population |
|---|---|---|---|
| Opiate | 558 | -3% | 98% |
| Non-opiate | 175 | -27% | 96% |
| Non-opiate and alcohol | 133 | 4% | 96% |
| **All** | **866** | **-8%** | **98%** |

**Table 3: Adults Effectively Engaged in Treatment - Knowsley, 2016/17**
**Source: JSNA Support Pack, Public Health England**

Table 3 shows the number of adults in effective treatment from Knowsley during 2016/17. Opiate users account for 64% of adults in effective treatment, lower than England (75%). In total, 98% of opiate users in treatment are being managed effectively, higher than nationally at 95%. Indeed, the proportion of people from Knowsley who are dependent on opiates and / or crack cocaine and were in treatment during 2016/17 was 53%. This is higher than nationally (49%).

The proportion of non-opiate users in effective treatment as a proportion of the treatment population is lower than it is for opiate users and for across the whole of England. There was an increase of 4% in the number of adults in effective treatment for non-opiates and alcohol combined between 2015/16 and 2016/17.

A quarter of referrals into treatment were via the Criminal Justice System (CJS) in 2016/17, 25% in total. This total was higher for males at 31%, compared to 10% of referrals for females. In comparison, only one-fifth of referrals nationally were via the CJS (20%). A further 58% of adults self-referred into treatment.

| | Number | Proportion Abstinence | National Abstinence |
|---|---|---|---|
| Opiate | 20 | 31% | 39% |
| Crack | 20 | 49% | 42% |
| Cocaine | 58 | 65% | 66% |
| Cannabis | 29 | 38% | 44% |

**Table 4: In Treatment Outcomes in Knowsley (Abstinence), 2016/17**
**Source: Commissioning Support Pack, Public Health England**

Those drug users that are in treatment have their progress checked to see if improvements in outcomes have been made. Table 4 shows the six-month review outcomes for users and shows abstinence amongst cocaine users was 65% during 2016/17, slightly lower than the national figure (66%). A further 18% of cocaine users had a significant reduction in use in 2016/17.

Abstinence was lower for cannabis users in Knowsley than nationally (38% compared to 44%). However, 14% had a significant reduction in cannabis use during 2016/17. The level of abstinence was lower in Knowsley (31%) than nationally (39%) for people in treatment for opiates, with a further 28% having a significant reduction in use after 6 months of treatment. However, for crack cocaine, the level of abstinence in Knowsley (49%) was significantly higher than the national figure (42%), with a further 10% of clients had a significant reduction in the use of crack cocaine after 6 months of treatment.

Those who successfully complete treatment for drugs are free of dependence upon drugs and have not relapsed or re-entered treatment during a set period of time. Although many individuals require a number of separate treatment episodes spread over many years, most individuals who complete treatment successfully do so within two years of treatment entry.

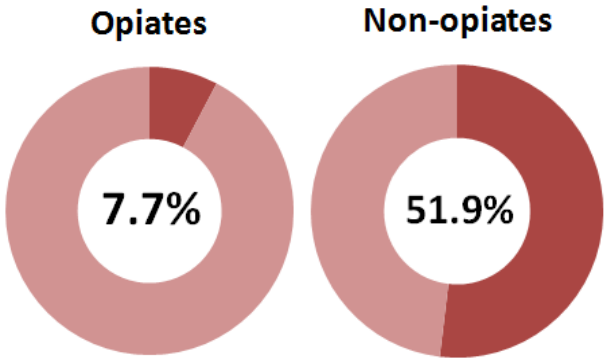


**Figure 3: Successful Completion of Drug Treatment, 2016/17**
**Source: Commissioning Support Pack, Public Health England**

The proportion of drug users who completed their treatment free of dependence on opiates was 7.7% in 2016/17, beating the national figure of 7.1%. The proportion of non-opiate users who complete treatment successfully was much higher than opiates at 51.9% during 2016/17, also higher than that observed nationally (40.9%).

In 2016/17, the proportion of all opiate users in treatment in Knowsley who had successfully completed treatment and did not return within 6 months was 5.6%, which is lower than England (6.7%). In comparison, the proportion of all non-opiate users in treatment in Knowsley who had successfully completed treatment and did not return within 6 months was 41.5%, which is higher than the national figure of 37.1%. These figures directly relate to PHOF 2.15i and 2.15ii.

Drug users in treatment can cite prescription-only medicines (POM) or over-the-counter medicines (OTC) as well as having a problem with illicit drugs. In 2016/17, 4% of drug users in treatment from Knowsley were there for dependence on prescription-only medicines or over-the-counter medicines, slightly higher than the national figure of 3%.

### 4.1.3 Blood-Borne Viruses

A blood-borne virus is one that can spread through contamination by blood or other body fluids. Drug users who share injecting equipment can spread blood-borne viruses. Because of this risk, drug users in treatment who are eligible can have hepatitis B (HBV) vaccination or hepatitis C (HCV) test. Providing methadone and sterile injecting equipment protects them and their communities, and provides long-term health benefits and savings.

In 2016/17, 75% of adults who were new to treatment were offered and accepted for a HBV vaccination. In comparison, 39% of adults were offered and accepted nationally; meaning uptake of the HBV vaccine for those who are new to treatment is nearly double in Knowsley compared to the national figure. Of those in Knowsley who were offered a HBV vaccination, 49% completed a course of the vaccination (21% nationally) and a further 21% started a course of vaccination (17% nationally). Of those drug users in Knowsley who were previous or current injectors, 78% were offered and received a HCV test, compared to 83% nationally.

### 4.1.4 Drug Interventions Programme

Between April 2016 and March 2017, there were a total of 119 DIP contacts recorded by Knowsley Integrated Recovery Service, while the average number of contacts across Merseyside was 496[30]. The number of DIP contacts in Knowsley has reduced by 31% when compared to the previous year (n=172). All Merseyside areas, except Wirral, have seen a reduction in numbers.

The largest proportion of clients was aged 30-34 (19%), followed by clients aged 45-49 (18%) and clients aged 18-24 and 40-44 (17% each). Almost nine in ten (87%) DIP contacts in 2016/17 were male, which is slightly higher than the Merseyside average (83%). The majority (99%) of DIP contacts in Knowsley were of White British ethnicity, which is greater than the Merseyside average (92%).

Cocaine was the most commonly used drug among clients assessed, with over two-fifths (41%) of DIP contacts reporting use. 18% reported use of heroin, followed by 16% who reported use of crack. Comparatively, the average proportion of clients who used heroin and crack across Merseyside was 26% and 23% respectively. When broken down by age, cocaine and cannabis are more likely to have been the main drug used by DIP contacts in Knowsley aged 18-34 whereas heroin and alcohol consumption is more likely in those aged 40+.

It was found that, when looking into the route of administration of clients' main drug, sniffing the drug was done by 58% of the contacts, with 29% smoking their main drug, 11% taking their main drug orally and 3% injecting their main drug. In terms of injecting drugs, 92% of contacts had never injected, 6% had previously injected and 3% were currently injecting. Note that the percentages do not add up to 100% due to rounding.

## 4.2 Young People

### 4.2.1 Prevalence

As part of the 2017 Health Related Behaviour Survey undertaken in Knowsley, 9% of secondary school children said that they had at some point taken an illegal drug in their lifetime. Cannabis was the main drug that had been used by secondary school children and in the month prior to the survey, 4% said that they had taken cannabis.

### 4.2.2 Treatment

In 2017/18, the number of young people aged under-18 from Knowsley in specialist drug use disorder services was 120[31]. This includes specialist services in the community, 'young people only' services in the community or services within the secure estate (e.g. young offenders' institutions, children's homes). Proportionally, 10% of all people (adults and young people) in specialist treatment services in Knowsley during 2017/18 were young people, broadly similar to the whole of England[31].

Of those young people in treatment, 68% were males. Males were substantially more likely than females to be involved in offending or antisocial behaviour as well as citing cannabis as a problematic substance. However, females were substantially more likely to be involved in self-harm, sexual exploitation and to cite alcohol as a problematic substance[31].

Young people come to specialist services from various routes. During 2017/18, 28% of young people were referred via education services, with a further 16% being referred by youth justice and a further 9% via Social Care. The proportion referred via youth justice was substantially lower in Knowsley than across England (25%), those referred via education services was slightly lower than nationally (29%) and those referred via social care services was lower than nationally (15%). Knowsley is lower than England due to other entry routes such as via a housing provider or via services such as CAMHS and Families First being a more popular route of entry to specialist drug services[31].

Many young people receiving specialist interventions for drug use disorder have a range of vulnerabilities. They are half as likely as the general population to be in full-time employment and are more likely to:

- Not be in education, employment or training (NEET).
- Have contracted a sexually transmitted infection (STI).
- Have experienced domestic violence.
- Be in contact with the youth justice system.
- Be receiving benefits by the time they are 18.

In 2017/18, all young people entering services for specialist drug use disorder interventions began using their main problem substance under the age of 15 (this can include alcohol as the main substance). However, less than 1 in 5 (17%) young people accessing services in Knowsley were using two or more substances, substantially lower than nationally (58%).[31]

In terms of wider vulnerabilities, a fifth of young people (20%) in Knowsley had been involved in offending or antisocial behaviour, which is significantly lower than the national figure of 32%, with almost a quarter (24%) affected by domestic abuse (21% nationally). In addition, a fifth of young people entering services in Knowsley were not in education, employment or training compared to 16% across the whole of England.[31]

Cannabis was the substance most commonly used by young people in specialist substance misuse services in Knowsley during 2016/17, with 92% doing so (88% nationally). Alcohol was the next most commonly used substance (5% compared to 49% nationally) with 3% of young people accessing drug use disorder services in Knowsley using stimulants (ecstasy, cocaine, amphetamines), compared to 11% nationally citing problematic ecstasy use, 9% citing problematic cocaine use and 3% citing problematic amphetamine use.[31]

Young people generally spend less time in specialist treatment services than adults because their drug use disorder is not as entrenched. In Knowsley during 2017/18, 63% of young people spent 12 weeks or less in treatment, with a further 18% spending 13 to 26 weeks. In total, 4% spent longer than 52 weeks in treatment.[31]

Psychosocial interventions are a range of talking therapies designed to encourage behaviour change. In 2017/18, 98% of interventions for young people were of this nature.[31]

## 4.3 Crime - Drug Related Offences

In 2016/17, there were 5,815 drug offences recorded across Merseyside, with offences comprising of possession, production and supply of drugs[32]. The number of offences related to a 3.8% fall from the previous year and corresponds to a rate of 4.1 drug offences per 1,000 population, almost twice as high as the North West region (2.1) with the North West rate being similar to the rate of the whole of England (2.3).

In Knowsley alone, there were 538 drug offences recorded in 2016/17. The rate of offences in Knowsley was 3.6 drug offences per 1,000 population over this period, lower than the whole of Merseyside. Drug related offences in Knowsley in 2016/17 ranged from 1.2 offences per 1,000 population in Swanside electoral ward to 6.8 drug offences per 1,000 population in St Michaels electoral ward. In total, there were six electoral wards with a significantly higher rate of drug offences than Knowsley as a whole. These wards were St Michaels, Northwood (6.4), Cherryfield (5.1), Page Moss (4.7), Whitefield (4.5) and Stockbridge (4.2)[33].

## 4.4 Drug Related Mortality

In the three-year period 2015-17, there were 18 deaths in Knowsley relating to drugs[34], an average of 6 deaths per year and 0.4% of total deaths over that period. This gave an age-standardised rate of 4.2 drug related deaths per 100,000 population in Knowsley, slightly lower than the rate across the whole

of England (4.3) and the lowest in the Liverpool City Region. The amount of deaths in Knowsley relating to drugs has increased over time. In the period 2008-10, there were only six deaths in Knowsley relating to drug use, and in the period 2011-13, there were 10 deaths in Knowsley relating to drug use. This highlights that, even though Knowsley's rate of drug related deaths is below the rate of England and the other members of the Liverpool City Region, there is a documented increase in the number of drug related deaths in Knowsley, which may need addressing.

## 4.5 Drug Related Hospital Admissions

In Knowsley in 2016/17, there were 50 NHS hospital finished admission episodes where there was a primary diagnosis of drug related mental health and behavioural disorders, 31 males and 19 females. This gave a rate of 34 admissions per 100,000 population, higher than the North West region (21 per 100,000) and England as a whole (13 per 100,000)[35]. However, this is the lowest rate Knowsley has been at when compared to the time periods starting from 2013/14 onwards.

Evidence shows that people who experience non-fatal overdoses are more likely to experience a future fatal overdose. In Knowsley in 2016/17, the rate of hospital admissions, in which drug poisoning was given as primary or secondary diagnosis, was 109.5 per 100,000 population[36], over double the rate of England (52.3 per 100,000). It has been noted that rates of hospital admission due to drugs strongly correlates with area deprivation. Knowsley is in the most deprived decile, and when compared to other areas in the most deprived decile, Knowsley's rate for hospital admissions for drug poisoning is deemed to be higher.

## 4.6 Addictive Prescription Drugs

The number of prescription items dispensed for addictive drugs does not necessarily give an indication of problems with these drugs in Knowsley. However, there is potential for the development of dependency and misuse.

| Drug Type | Total Items |
|---|---|
| Codeine and codeine based drugs | 131,214 |
| Dihydrocodeine | 11,359 |
| Tramadol | 31,521 |
| Pregabalin | 32,287 |
| Gabapentin | 34,805 |
| Benzodiazepines | 41,719 |
| Z Drugs | 27,926 |
| Substance misuse drugs | 12,270 |
| **Total** | **323,101** |

**Table 5: Addictive Prescription Drugs in Knowsley, 2016/17**
**Source: OpenPrescribing.net, EBM DataLab, University of Oxford 2017**

During 2016/17, there were more than 323,000 items prescribed in Knowsley relating to addictive drugs. Codeine and codeine-based drugs were the most

common prescribed in Knowsley during 2016/17 with 41% of the total items. These include drugs such as Co-codamol and Co-dydramol, with the former accounting for 79% of total Codeine prescriptions.

Benzodiazepine prescriptions accounted for 13% of addictive drugs prescription items dispensed in Knowsley during 2016/17, with just under half of prescriptions being for diazepam. Gabapentin, Pregabalin and Tramamol accounted for ~10% of all addictive drug prescriptions in Knowsley in 2016/17. Methadone was the most commonly prescribed drug use disorder drug in Knowsley during 2016/17 with 8,170 items prescribed.

### 4.7 New Psychoactive Substances

New Psychoactive Substances (NPS) refer to substances, which mimic the effects of illegal drugs. They are not covered by the Misuse of Drugs Act 1971 but are covered by the Psychoactive Substances Act 2016. These substances are legal to possess, except when within a custodial institution or when there is intent to supply. NPS were previously sold in shops, which ended with the introduction of the 2016 act.

New Psychoactive Substances are sometimes known by the misleading term 'legal highs', due to the time period in which these substances were legal to use and supply. Yet, these substances can cause serious health risks, and if used in conjunction with other substances, such as alcohol, the risk is greater.

Although there is little local information pertaining to NPS, across England & Wales there has been an increase in the number of deaths due to NPS since 2010. Latest data from 2016 shows that there were 123 registered deaths in England & Wales where a NPS was mentioned on the death certificate[37]. The Crime Survey for England & Wales 2016/17[38] stated that 1.2% of young adults aged 16-24 had used NPS that year (and 4.2% had used NPS at some point in their life), with males being nearly twice as likely as females to do so.

The use of nitrous oxide (also called 'laughing gas') has also increased in recent years. Whilst nitrous oxide has a number of legitimate uses in the areas of medicine and catering, it is increasingly, being inhaled as a recreational drug using a balloon or a metal canister known as a 'cracker'. Inhaling nitrous oxide can be dangerous with risks including asphyxiation, especially if consumed in a small space, and vitamin deficiency with heavy regular use.

Since nitrous oxide is not a controlled drug, it is not an offence to possess it. It may be an offence to supply it under trading standards legislation and preventative action may be taken under anti-social behaviour legislation (community protection notices, public spaces protection orders).

## 5. LOCAL DRUG USE DISORDER SERVICES

### 5.1 Community Treatment Services

### 5.1.1 Overview

In 2017 the drug services were re-commissioned in line with best practice. Following a full tender exercise Change Grow Live (CGL) formerly Crime Reduction Initiatives (CRI) were awarded the contract. The new contract start date is 1st July 2018. The service continues to have two bases; Kirkby and Huyton. These include adult treatment services, young person's treatment services, needle exchange, Drug Interventions Programme (DIP) and recovery 'hubs'. The young person's service is an outreach service with staff based within the Kirkby hub.

Other services include inpatient detoxification for drugs and alcohol, residential rehabilitation, support with housing and debt issues, supervised consumption and needle exchange through pharmacies.

### 5.1.2 Adult Treatment Services

The adult service known as Knowsley Integrated Recovery Service (KIRS) operate an open access policy, where people can self-refer by presenting at either treatment centre.

KIRS provide the following:

- A fully integrated drug use disorder service including clinical services, recovery support, criminal justice and GP shared care
- A service that is tailored to the clients goals to improve quality of life
- Structured psychosocial interventions including Foundations for Recovery for each stage of the journey
- Prescribing services including drug and/or alcohol detox, completed in a variety of settings
- Dedicated community-based Young Person's service providing age-appropriate interventions and support
- Whole family service including parenting support programmes
- Health screening including vaccination for BBV and coordination of treatment with clients GP for any long term conditions, preventing ill health and promoting the 5 ways to wellbeing
- Training and education for individuals, communities, employers and families, peer led recovery activities, facilitating access to mutual aid, peer mentoring training and building 'recover communities'

### 5.1.3 Shared Care Treatment Service

Service users who are stable and in receipt of low dose methadone prescriptions are able to transfer into GP Shared Care. This involves a worker from the community treatment service and the user's GP working together to support the service user to recover. It allows them to see the recovery worker in their own GP practice and receive regular medical check-ups and assessments from their GP. The GP prescribes the methadone and the recovery worker encourages recovery during their weekly or fortnightly appointments with the service user. If the service user becomes chaotic in their drug use, they are transferred back into the specialist treatment service.

The aim for GP Shared Care is that the drug user can address emotional, social and/or family problems and re-engage with the wider community.

### 5.1.4 Drug Interventions Programme (DIP)

The Drug Interventions Programme (DIP) was initially rolled out in April 2003 to areas of high crime and then to the whole of England in 2005. DIP's aim is to identify and engage with drug using offenders at every stage of the criminal justice system e.g. pre-arrest, arrest, sentencing, prison and post-prison release, in order to reduce crime and to break the cycle of re-offending.

At each stage, the intention is to provide services tailored to clients' specific needs, addressing issues such as housing, education, employment, finance, family relationships and health, as well as offending behaviour and drug use. DIP aims to provide a beginning-to-end support system that can direct drug-using offenders out of crime and into treatment.

DIP as a programme continues to be implemented across Merseyside, with the processes that underpinned it originally still remaining in place at all stages of the criminal justice system in order to engage offenders into drug treatment.

### 5.1.5 Mutual Aid

The Mutual Aid Groups (Alcoholics Anonymous, Cocaine Anonymous and Narcotics Anonymous) make full use of the recovery hubs, with services provided at one of the locations most evenings including Saturdays.

### 5.1.6 Service User Forum

The service has a vibrant Service User Forum, which is run by the service users. One of the service users represents Knowsley at the CGL Regional Service User Forum.

CGL recognises the vital role that service users have as recipients of, and partners in, the programmes they are involved in. By having effective and meaningful service user involvement processes, it means that:

- CGL can ensure the services are accountable to service users
- The service user experience is improved
- They can promote healthier lives, wellbeing and active citizenship
- They can foster positive relationships between staff, volunteers and service users
- They can ensure any changes in service provision are communicated clearly, in a way that makes sense to those affected by them

### 5.1.7 The Young Person's Treatment Service (ENGAGE)

The young person's service, ENGAGE, was named by the service users. This service is also provided by CGL. It operates an outreach service where young people can be seen in a location that is most comfortable for them.

This can be home, school, college, youth club or any other suitable location. They all offer support and advice to parents and families, whilst offering support around related areas such as housing, education/training, employment and finances.

### 5.1.8 Needle Exchange

The needle exchanges operate from the two recovery hubs in Kirkby and Huyton as well as from some pharmacies.

During 2014-15, a needs assessment[39] was carried out for the needles exchange service. The report set out a list of recommendations, which include:

- Looking into the locations and opening hours of the services, in order to reflect the needs of the specific users. For example, offering to accommodate steroid users and psychoactive drug users at their preferred time, with staff that they are familiar with, might encourage increased engagement.
- Providing a large range of equipment that participants can personally choose from is likely to be beneficial. This is due to the fact that there have been concerns highlighted that there is poor availability of some needle lengths and sufficient amounts of citric acid in the Knowsley services. However, some safe injecting equipment may need to be routinely administered by staff, and due to the amount of needle users engaging in risky sexual behaviour, condoms may also need to be routinely provided.
- Training up staff in order to provide comprehensive services without being judgemental. This can be through implementing policy updates on the provision of leaflets to exchange users and encouraging service users to register with the service in order to receive hepatitis B vaccinations, hepatitis C screening, HIV testing, or to attend their GP for these interventions.

Additional pharmacies were approached to express an interest in operating the needle exchange. This was specifically to improve the geographical reach of the service and increase the availability of out of hour's exchanges. This resulted in the recruitment of an additional five pharmacies. Pharmacy needle exchange now operates in Halewood (2), Huyton (2), Kirkby (2), Prescot and Stockbridge Village.

### 5.1.9 Supervised Administration

Supervised administration of methadone is a commissioned pharmaceutical service for drug use disorder clients. It is a fundamental harm reduction service that can only be provided by a pharmacy following dispensing of the diamorphine substitute methadone, or buprenorphine (subutex). It is not part of the essential tier of the pharmacy contract but greatly reduces harm by reducing the diversion of prescribed medicines onto an illicit market and protection of vulnerable individuals from overdose. It is mainly used for service users on high doses of medication who are not considered stable.

The majority of Knowsley's community pharmacies provide supervised administration of prescribed medicines (methadone or buprenorphine (Subutex)) which requires the pharmacist to supervise consumption at the point of dispensing in the pharmacy within a private consultation room, ensuring that the dose is recorded and has been administered to the patient.

## 5.2 Residential Rehabilitation

Residential rehabilitation placements are arranged by the Social Inclusion Team in Knowsley Council Adult Social Care. Clients requiring residential rehabilitation post detox either inpatient or community based are referred to and assessed by the Adult Social Inclusion Team. The request then goes to a panel for approval.

The planning for residential rehabilitation includes pre-work with a number of agencies including CGL to ensure that the client responds to group work. The rehabilitation placements involve many group work activities and post discharge planning to ensure that there is wraparound support when the person leaves the placement.

## 5.3 Inpatient Detoxification Service

Inpatient care should be available to clients at different stages in their treatment journey and not thought of as a last resort. However, it is essential that inpatient detoxification is not offered as a stand-alone treatment for drug use disorder but often as an essential initial intervention within a broader, longer-term care plan including psychosocial or pharmacological therapies to prevent relapse.

There is evidence to show that detoxification in specialist drug use disorder facilities are more effective than in general hospital or psychiatric wards, which are associated with low success rates[40]. Following a tender process in 2016 the inpatient detoxification for Knowsley is now provided by the Chapman Barker clinic based in Prestwich, Manchester.

## 5.4 Housing Support and Debt Advice

This is provided through the Tenants Extra Support Service. The contract for which is currently held by Villages Housing, part of the Forviva Group.

## 5.5 Local Drug Information System (LDIS)

Media reports and other warnings regarding new and/or novel, potent, adulterated or contaminated drugs have increased over the last decade. However, these reports are often inaccurate, rarely confirmed by toxicology tests and may sometimes be counterproductive to public health messages intended to reduce drug-related harms and deaths.

The response to these new or increasing threats is multi-faceted. One aspect recommended by PHE in 2016 is the establishment of Local Drug Information

Systems (LDIS). LDIS would aim to gather information from professionals and relevant parties regarding potential drug related threats, use consistent methods of assessing risk through multi-disciplinary panels, generate appropriate and accurate messaging regarding threats, and decide on the best mechanisms for their dissemination. Over time, LDIS can also act as surveillance systems. They complement existing national systems, which are not necessarily set up to either gather real time information from localities or provide rapid information to the appropriate audiences in those localities about emergency threats.

In response to the guidance, the Cheshire and Merseyside DsPH have agreed to establish an LDIS across Cheshire and Merseyside, drawing on the key principles of the PHE guidance but ensuring that a centralised function for assessing threat and response can provide consistency. Knowsley are currently working to set up the local Professional Information Network (PIN), which will be used to feed into the Cheshire and Merseyside LDIS.

## 5.6 Prevention

### 5.6.1 Knowsley Youth Mutual

As part of their contract Knowsley Youth Mutual (KYM) are commissioned to:

- Support a reduction in the use of illicit drugs and the frequent use of alcohol amongst young people under 25, especially by the most vulnerable young people.
- Increase a population wide approach to increase levels of awareness and support as required to young people in respect of information provision/signposting regarding a range of topics including drugs.
- Increase the uptake of services for access to support relating to substance misuse.
- Support the commissioning of youth services within the Public Health agenda ensuring the voice of the child is heard when commissioning decisions are made.
- Develop and deliver a peer education programme to young people, drugs is one of the subjects to be covered by this work.
- Develop and run a Teenage Health in Knowsley (THinK) campaign working with young people, which includes substance misuse, specifically cannabis and New Psychoactive Substances.
- Develop and host a THinK website where young people can access information about a range of health issues including substance misuse.
- Provide drug use disorder support and education to under 19's in order to prevent escalation of problem behaviours
- Provide targeted support for vulnerable groups of young people including:
  - Young people who are exposed to parental or sibling substance misuse
  - Young people who are experimenting with substance misuse

### 5.6.2 Parenting Skills

A range of parenting skills courses are provided across the Borough including universal provision in Children's Centres and targeted provision by Stronger Families and Early Help.

### 5.6.3 Family Nurse Partnership

Supporting parents to provide the best start in life for their children is important in protecting the children from future risk taking behaviours, making them less vulnerable and improving their life chances. The Family Nurse Partnership is commissioned to provide intensive support to first time mothers under 19 years of age.

### 5.6.4 Knowsley Youth Offending Service (YOS)

Knowsley Youth Offending Service (YOS) provides a service for young people aged 10 to 17 who have been involved in offending behaviour. YOS view the use of cannabis as a significant link to offending. Knowsley YOS, using intelligence collated from internal recording systems, highlighted that the most prolific offenders had been first time entrants due to possession of cannabis. This information was drawn upon to identify any additional corresponding factors and a Cannabis Matrix was formulated. The matrix supports the YOS in targeting young people who may require a specialist drug use disorder intervention and can provide the evidence for a referral into the Criminal Exploitation Group.

YOS offer psychosocial interventions guided by the Good Lives Model. This looks at building on the young people's resilience and reducing any risk factors. Parents and carers are also offered specialist support and the key points such as loss of tenancy are discussed. Parents/carers leaflets have also been produced and YOS Family Link Workers support families not only to address their young people's drug use disorder issues, but also those within the family.

### 5.6.5 School Nursing

As part of the specification for school nursing in Knowsley, the service is contracted to work in partnership with the schools to identify young people who are at risk of poor health outcomes, including drug or alcohol misuse.

In addition, as part of the health promotion specification for children between year 7 and year 11 (secondary school), risk taking behaviour, incorporating drug use disorder, is included.

### 5.6.6 Workplace

Commissioned by Public Health, Working Well engages with businesses across Knowsley in partnership with the Environmental Health and Consumer Protection department, The Chamber of Commerce, Occupational Health and hundreds of local businesses to meet health standards in Knowsley work places. One of the six standards that businesses working with the programme aim to achieve for the health and wellbeing of staff is 'Drugs and Alcohol'. Work includes raising awareness of drug use in and out of work and working with companies to develop policies that support any substance misuse issues in their workforce.

## 6. COMMUNITY, PATIENT & STAKEHOLDER VIEWS

### 6.1 Knowsley Youth Mutual Drugs Strategy Consultation

In 2015, Knowsley Youth Mutual (KYM) was commissioned by Public Health Knowsley to consult young people on their views and opinions on drugs.

Young people said they were knowledgeable in areas of drugs, the law and NPS but when this was investigated further it became apparent that their actual knowledge was limited. The education or sharing of important messages around drug use disorder needs to be delivered by adults who are not only trained in the subject but can 'relate' to young people and use a variety of tools and methods to share the messaging.

One of the messages highlighted by the young people as ineffective was the exaggeration of side effects in order to scare them. The young people felt that the best way would be to inform them of the dangers and consequences of drugs, and allow them to make their own decisions.

### 6.2 Substance Misuse Re-Commission – Stakeholder Engagement

To inform the substance misuse re-commission, different methods of engagement were used in order to find out the views of different stakeholders. This included focus groups, stakeholder engagement events and SurveyMonkey surveys targeted at particular demographics to enhance useful feedback.

Focus groups were chosen as a method of engagement for service users. Feedback from these focus groups showed that service users like having a key worker, having peer mentors and having a routine and purpose. However, service users would like more service user engagement, as there were currently around 700-800 users, yet under 10% were engaging fully. It was found that service users felt the need for the service to be promoted positively on social media, in order to raise awareness of the service and to remove the stigma.

An engagement event was set up for partner organisations. Feedback from the engagement event showed that partners were unsure that the 'drop in' of service is useful for all service users. Feedback they had received indicated from those who are anxious/lacking confidence that they would prefer to have assessment outreach clinics/surgeries as a point of entry. It was agreed that carer and family support is needed and that the first appointment should utilise health centres near to public transport in an attractive site. In addition, partner organisations felt that there needs to be a dual diagnosis worker on site, or some form of mental health support.

SurveyMonkey surveys were used for those who were not targeted by either the focus group or the engagement event. This included the general public, CGL staff members, GP's and Pharmacists. The feedback from the public was that the service was not promoted as much as it should be, and that there was a lot of stigma surrounding the service, re-iterating the point gathered through the focus groups. For CGL staff, they again pointed out the stigma in Knowsley and pointed out that some alcohol/steroid users are not comfortable with the town centre location. They also said that the links to services needs improvement and an increase is needed in education, training and employment support. GP's felt that more education was needed to raise awareness with GP's, and that more support was needed for families and

carers, whilst Pharmacist's thought that improving the links between the service and publicising the service better was needed.

Based on the stakeholder engagement, the following recommendations were made:

- Include a focus on volunteer development and sharing of stories in promotion
- Request that initial assessments are offered in a community/clinical venue away from the hub's as a point of entry for those who are anxious about attending
- Provide a programme that supports carers, family and friends
- Request low level mental health support in house and better links to mental health services
- Sites should be attractive, on transport links, just outside of the town centre
- Further develop education, training and employment focus for service users
- Further develop community education (including GP's) and sharing of information to reduce stigma and promote positive stories
- Develop a wider promotion plan designed to reduce stigma, working with Knowsley Public Health on a possible campaign to reduce the stigma associated with attending drug and alcohol services, which must also target those who are digitally excluded

It was also recommended that Knowsley Public Health could possibly run a Knowsley specific anti-stigma campaign in partnership with CGL. The campaign should focus on promoting positive stories, myth busting and consider that large numbers of individuals who would benefit from support will be digitally excluded. Also recommended was for Knowsley Public Health to work with Adult Social Care to push substance misuse higher up the assessment agenda.

## 7. EVIDENCE OF WHAT WORKS

### 7.1 Treatment Services

Investing in drug treatment cuts crime and saves money. It is estimated that every £1 spent on drug treatment saves £2.50 in costs to society[41]. Drug treatment prevents an estimated 4.9m crimes per year and treatment saves an estimated £960m costs to the public, businesses, criminal justice and the NHS[42].

The Advisory Council on Drug Misuse (ACMD)[43] states that services should be commissioned which include activities that develop all these areas; for example there needs to be the opportunity to access training, volunteer activities and ultimately support to gain employment.

The ACMD recommend that:

- Services segment their service user population to gain a better understanding of the recovery potential of each group and use interventions targeted to specific groups.
- Services should focus on the wider health and wellbeing of those in treatment, not just their addiction
- Local commissioners, providers and other stakeholders encourage the development of mutual aid in the local community.

The ACMD (2013) recognise that there is a need to tackle the stigma around recovery from drug addiction making recovery acceptable and celebrated. This will be done by ensuring that recovery is visible both within the drug service and in the local community.

## 7.2 Preventing Blood-Borne Virus (BBV) Transmission

All services in contact with injecting drug users, including drug treatment services and needle exchange services, should provide testing for hepatitis B/C and HIV plus vaccination for hepatitis B or have pathways in place for treatment or to direct people towards these services[44].

## 7.3 Prevention

The United Nations Office on Drugs and Crime International Standards on Drug Use Prevention states that it is not a lack of knowledge that leads to drug use disorder but a range of life factors including mental health disorders, family neglect and abuse, poor attachment to school and community, drug use being seen as a social norm, environments conducive to drug use disorder and growing up in marginalised and/or deprived communities.

The factors that protect people against drug use disorder are having good psychological and emotional wellbeing, personal and social competence, a strong attachment to caring and effective parents, and to schools and communities.

Interventions and policies that have been found to yield positive results in preventing drug use disorder according to the UN's Group of Experts, based on the strength of evidence available are given in Table 6 (by age and setting for the intervention / policy) [45]:

| Setting | Initiative or Policy |
|---|---|
| ***Family:*** | Parenting skills (middle childhood and early adolescence) |
| ***School:*** | Early childhood education<br>Personal and social skills (middle childhood)<br>Classroom management (middle childhood)<br>Prevention education based on personal and social skills and social influences (adolescence) |
| ***Community:*** | Alcohol and tobacco policies (early adolescence through to adulthood)<br>Community based multi-component initiatives (universal) |
| ***Workplace:*** | Workplace prevention (adolescence to adulthood) |
| ***Health Sector:*** | Brief intervention (early adolescence to adulthood) |

**Table 6: Best Evidence Interventions and Policies for Preventing Substance Misuse**
**Source: United Nations Office on Drugs and Crime**

The evidence base for specific drug prevention programmes is not good. There is little information about what works but there is more evidence of what does not work from the ACMD[46]. Things that do not work include:

- Information provision via the knowledge based school curriculum
- Approaches that use scare tactics
- Standalone mass media campaigns

ACMD also warn commissioners to act with caution when presented with approaches that do not have a clear evidence base because some may be associated with unanticipated harmful outcomes. Any new approaches should only be delivered as part of a research programme.

The report highlighting the lack of evidence states, "prevention actions should be justified on the basis of reducing long-term meaningful and adverse (individual and population) health and social outcomes. In this regard it is important to be realistic about what prevention can achieve, and recognise that abstinence from drug use may not always be necessary to achieve these outcomes".

Programmes in schools, which build knowledge and strengthen the resilience of children are recommended by The Centre for Social Justice in their report Ambitious for Recovery (August 2014)[47].

## 7.4 Needle and Syringe Exchange

Recent NICE Guidance recommends[48]:

- Consultation with and involvement of users, practitioners and the local community about how best to implement or reconfigure needle and syringe exchange programmes.
- Collation and analysis of data on injecting drug use.
- Commissioning of both generic and targeted services to meet local need based on the analysis.
- Monitoring of syringe exchange services.
- Development of a policy for young people who inject drugs.
- Provision of a mix of services ensuring that appropriate equipment and harm reduction information are available at a range of times, and in places that meet the needs of people who inject drugs.
- Ensure pathways are in place for referral to the specialist services to ensure that testing for BBV is offered to all.
- Provision of the right type of equipment for service users and no discouragement of those taking needles for others.
- Advice to be offered about safe injecting.
- Encouragement of people who inject drugs to mark their syringes and other injecting equipment or use easily identifiable equipment in order to prevent accidental sharing.

- Encouragement of injecting drug users to access other services.
- Provision of community pharmacy-based needle and syringe programmes.
- Staff who deliver needle and syringe exchange are competent to deliver the level of service offered including harm reduction advice, preventing and managing overdose, health and safety relating to handling the equipment, knowledge of the services that people can be referred to.
- Provision of specialist needle and syringe programmes.
- Provision of equipment and advice to people who inject image and performance-enhancing drugs. This includes providing exchanges outside normal working hours, and/or the provision of outreach services. Specialist information should be provided to support these users and specific training should be provided to staff.

## 8. FUTURE CHALLENGES

- Funding cuts to public sector organisations will lead to further strains on drug use disorder services. Cuts to services and capacity within these services could have a negative impact on the population of Knowsley, particularly if it is allied with increasing prevalence of people in need of treatment.
- The increasing use of Image and Performance enhancing drugs e.g. steroids necessitates a change to the way in which needle exchange services are delivered and potentially a revised offer of support for people wanting to stop using these drugs.
- Addiction to prescribed and over the counter medicines present additional cohorts of people who need support to recover from their addiction.
- The ageing drug using population means that there is the increasing possibility of service users suffering health problems due to their past poor lifestyle and although these may not be directly related to their drug use, ill health will hamper their recovery. A specialised approach to working with this cohort of service users will be needed and it may be necessary for the care system to adapt to accommodate people on opiate substitute medications.
- There is a lack of clear guidance around education and prevention for young people. How to select programmes and agencies to deliver this education presents difficulties when developing an approach to address prevention among young people. There is a need to ensure consistent messages are provided to young people and that current interventions are at least in line with what evidence is there.
- The on-going issue around cannabis availability in the Borough, the amount of cannabis being grown, the links to organised crime, gang and gun crime and criminal exploitation present a challenge.
- The Psychoactive Substances Bill 2016 made it illegal to distribute NPS in the UK. However, it has already been touched upon that the number of people dying due to use of NPS is increasing year-on-year. This means that further work may be needed to be carried out in order to tackle the problem of NPS, as it may suggest that those using NPS are now in contact with illicit drug dealers.

- The threat of Fentanyls which are causing significant issues in the USA and Canada becoming more prevalent in the UK. Potent opioids such as fentanyl could be sought by people who use drugs, or might be unwittingly added to street heroin.

## REFERENCES

[1] Public Health England. Alcohol and drug prevention, treatment and recovery: why invest? Available online at: https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest (Accessed April 2018).

[2] Drug misuse: findings from the 2016 to 2017 CSEW. Home Office (2017). Available online at: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-csew (Accessed April 2018).

[3] Supporting the Supporters: families of drug misusers. UK Drug Policy Commission (2009). Available online at: http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Supporting%20the%20supporters_%20families%20of%20drug%20misusers%20(policy%20briefing).pdf (Accessed April 2018).

[4]Public Health Institute. Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2014/15: Sweep 11 report. Available online at: https://phi.ljmu.ac.uk/wp-content/uploads/2017/09/Estimates-of-the-Prevalence-of-Opiate-Use-and-crack-cocaine-use-2014-15.pdf (Accessed April 2018).

[5] Liver Damage, Poor vein health, Lung damage, Cardiovascular disease, Arthritis and immobility, Blood borne viruses, Overdose and drug poisoning: Department of Health (England). Drug Misuse and Dependence: UK Guidelines on Clinical Management. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf (Accessed April 2018)

[6] Depression, anxiety, psychosis and personality disorder: Department of Health. A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations. Available online at: http://dmri.lshtm.ac.uk/docs/weaver_es.pdf (Accessed April 2018)

[7] Matt D, King LA, Saulsbury W, Blakemore C (2007). Development of a rational scale to assess the harm of drugs of potential misuse. The Lancet 369(9566): 1047-1053.

[8] Gordon, L., Tinsley, L., Godfrey, C. and Parrott, S. (2006) The economic and social costs of Class A drug use in England and Wales, 2003/04, In Singleton, N., Murray, R. and Tinsley, L. (eds) 'Measuring different aspects of problem drug use: methodological developments.' Home Office Online Report 16/06

[9] Drug Strategy 2010. Home Office (2010). Available online at: https://www.gov.uk/government/publications/drug-strategy-2010--2 (Accessed April 2018).

[10] Drug Strategy 2017. Home Office (2017). Available online at: https://www.gov.uk/government/publications/drug-strategy-2017 (Accessed April 2018).

[11] NICE guidelines on Drug misuse. Available online at: http://www.nice.org.uk/guidance/health-protection/drug-misuse (Accessed April 2018).

[12] Improving outcomes and supporting transparency part 2: Summary technical specifications of public health indicators (2016). Department of Health. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545605/PHOF_Part_2.pdf (Accessed April 2018).

[13] Offender Rehabilitation Act 2014. Parliament UK (2015). Available online at: http://services.parliament.uk/bills/2013-14/offenderrehabilitation.html (Accessed October 2015).

[14] Psychoactive Substances Act 2016. GOV.UK. Available online at: https://www.gov.uk/government/collections/psychoactive-substances-bill-2015 (Accessed April 2018).

[15] Home Office. New Psychoactive Substances (NPS). Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/544030/6_1845_HO_NPS_Resources_Booklet_June16_v10.pdf (Accessed April 2018).

[16] DrugWise. New Psychoactive Substances. Available online at: http://www.drugwise.org.uk/new-psychoactive-substances/ (Accessed April 2018).

[17] Drug misuse: findings from the 2016 to 2017 CSEW. Home Office (2017). Available online at: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-csew (Accessed April 2018).

[18] NHS Digital. Statistics on Drug Misuse: England, 2018. Available online at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-drug-misuse/2018 (Accessed May 2018).

[19] ONS. Deaths Related to Drug Poisoning, England and Wales. Available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsrelatedtodrugpoisoningenglandandwalesreferencetable (Accessed April 2018).

[20] ONS. Deaths Related to Drug Poisoning, England and Wales. Available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsrelatedtodrugpoisoningenglandandwalesreferencetable (Accessed April 2018).

[21] Home Office. Drug misuse: Findings from the 2013/14 Crime Survey for England and Wales. Available online at: https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2013-to-2014-csew/drug-misuse-findings-from-the-201314-crime-survey-for-england-and-wales (Accessed April 2018).

[22] New Scientist. What is chemsex and why is the UK government worried about it? Available online at: https://www.newscientist.com/article/2140756-what-is-chemsex-and-why-is-the-uk-government-worried-about-it/ (Accessed April 2018).

[23] Home Affairs Committee, Drugs: Breaking the Cycle, 3 December 2012. Available online at: http://www.publications.parliament.uk/pa/cm201213/cmselect/cmhaff/184/18402.htm (Accessed April 2018).

[24] Prison Reform Trust. Prison: the facts, Bromley Briefings Summer 2013. Available online at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Prisonthefacts.pdf (Accessed April 2018)

[25] Public Health England. An evidence review of the outcomes that can be expected of drug misuse treatment in England. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/586111/PHE_Evidence_review_of_drug_treatment_outcomes.pdf (Accessed April 2018)

[26] NHS Digital. Smoking, Drinking and Drug Use Among Young People in England – 2016. Available online at: https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016 (Accessed May 2018)

[27] The Guardian. Plague of cheap 'spice' strengthens its grip on homeless and jobless in northern towns. Available online at: https://www.theguardian.com/society/2015/nov/07/cheap-spice-strengthens-grip-northern-towns-blackpool-synthetic-cannabinoid (Accessed April 2018)

[28] Public Health England. Opiate and crack cocaine use: prevalence estimates for local populations. Available online at: https://www.gov.uk/government/publications/opiate-and-crack-cocaine-use-prevalence-estimates-for-local-populations (Accessed April 2018)

[29] Public Health England. Adults – drugs commissioning support pack 2018-19: key data.

[30] Public Health Institute. Criminal Justice Project: Drug Interventions Programme. Available online at: http://www.cph.org.uk/wp-content/uploads/2017/12/Knowsley-DIP-Activity-Profile-1617.pdf (Accessed April 2018)

[31] change, grow, live.

[32] Office for National Statistics. Recorded crime data at Community Safety Partnership/Local Authority level. Available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/recordedcrimedataatcommunitysafetypartnershiplocalauthoritylevel (Accessed May 2018)

[33] Data.Police.UK. Merseyside Police Data. Available online at: https://data.police.uk/ (Accessed May 2018)

[34] ONS. Drug misuse deaths by local authority. Available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/drugmisusedeathsbylocalauthority (Accessed April 2018)

[35] NHS Digital. Statistics on Drug Misuse: England, 2018. Available online at: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-drug-misuse/2018 (Accessed May 2018)

[36] Public Health England. Adults – drugs commissioning support pack 2018-19: key data.

[37] ONS. Deaths related to drug poisoning in England and Wales: 2016 registrations. Available online at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2016registrations (Accessed April 2018)

[38] Drug misuse: findings from the 2016 to 2017 CSEW. Home Office (2017). Available online at: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2016-to-2017-csew (Accessed April 2018).

[39] Bates G, Pendlebury M, Cochrane M, Mackridge A (2015). Needle Exchange Services in Knowsley: An investigation into the needs and experiences of staff and service users (Report). July 2015. Liverpool: Centre for Public Health. Available online at: http://knowsleyknowledge.org.uk/wp-content/uploads/2015/06/Needle-Exchange-Service-in-Knowsley.pdf (Accessed April 2018).

[40] Models of care for treatment of adult drug misusers: Update 2006. National Treatment Agency for Substance Misuse. Available online at: https://www.lewisham.gov.uk/myservices/socialcare/health/Drugs-and-alcohol/Documents/NTAModelsOfCare.pdf (Accessed April 2018).

[41] Home Office. Summary of key findings from the Drug Treatment Outcomes Research Study (DTORS), Research Report 23. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/116599/horr23.pdf (Accessed April 2018)

[42] National Treatment Agency. Estimating the crime reduction benefits of drug treatment and recovery. Available online at: http://webarchive.nationalarchives.gov.uk/20170807160642/http://www.nta.nhs.uk/uploads/vfm2012.pdf (Accessed April 2018)

[43] What recovery outcomes does the evidence tell us we can expect? Second report of the Recovery Committee, November 2013. Advisory Council on the Misuse of Drugs (2013). Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/262629/Second_report_of_the_Recovery_Committee.pdf (Accessed April 2018).

[44] NICE. Drug use disorders in adults. Available online at: https://www.nice.org.uk/guidance/qs23/chapter/quality-statement-4-blood-borne-viruses (Accessed April 2018).

[45] International Standards on Drug Use Prevention. United Nations Office on Drugs and Crime (2003). Available online at: http://www.unodc.org/documents/prevention/UNODC_2013_2015_international_standards_on_drug_use_prevention_E.pdf (Accessed April 2018).

[46] Prevention of drug and alcohol dependence. Briefing by the Recovery Committee, February 2015. Advisory Council on the Misuse of Drugs (2015). Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/406926/ACMD_RC_Prevention_briefing_250215.pdf (Accessed April 2018).

[47] The Centre for Social Justice. Ambitious for Recovery: Tackling drug and alcohol addiction in the UK. Available online at: https://www.centreforsocialjustice.org.uk/library/ambitious-recovery-tackling-drug-alcohol-addiction-uk (Accessed April 2018).

[48] NICE guidelines [PH52]. Needle and syringe programmes (2014). Available online at: http://www.nice.org.uk/guidance/ph52 (Accessed April 2018).