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Executive Summary
The aim of the Substance Misuse Commissioning Review is to assess the effectiveness of treatment services commissioned by The Crime & Drugs Partnership in the context of Nottingham and its citizens. The Review aims to identify and make recommendations in response to both arising and enduring issues facing Nottingham’s in treatment population and citizens not yet accessing treatment who could benefit from some level of intervention.

The following provides a brief summary of the key findings and recommendations of the Review.

Alcohol
Approximately 12% of the estimated number of people appropriate for some form of treatment actually accessed structured treatment last year. Although many may have accessed unstructured treatment such as brief advice, there remains a considerable amount of unmet need for alcohol treatment.

According to past performance, waiting times for clients accessing structured alcohol treatment are worse in Nottingham compared to the national benchmark. A key priority for the current alcohol treatment provider is to improve client waiting times; thereby reducing attrition and improving treatment penetration.

Nottingham citizens drink to more dangerous levels prior to accessing structured treatment compared to England as a whole. It is recommended that the treatment provider maximises its ability to identify escalating risk drinkers in Nottingham and, where escalating risk drinking is identified, works to encourage those clients into structured treatment before they become at high risk of alcohol-related illness.

The amount of alcohol clients entering treatment through the criminal justice route in Nottingham is less than half that observed at a national level. As a means of improving penetration into the alcohol misusing cohort, it is recommended that the treatment provider works with the criminal justice system to improve the amount of referrals. It is anticipated that criminal justice system referrals will increase as the Transforming Agenda takes effect over the coming year.

Clients accessing structured alcohol treatment in Nottingham are, on average, in treatment for a shorter length of time compared to the average for England. This may be an indication that the treatment provider is not sufficiently retaining clients, particularly considering that the representation rate for alcohol clients is comparatively high and shown to be on the increase. It is recommended that the treatment provider works to reduce representations by ensuring that clients have access to treatment for a sufficient length of time before they are discharged.

Alcohol-related hospital admissions have been identified as a considerable challenge for the city. Nottingham’s direct standardised rate of alcohol-related hospital admissions was 943 in 2013-14, whilst the target rate was considerably lower at 771. In depth analysis of alcohol-related hospital-admission data suggests that the increase is genuine, rather than a result of changes to recording practices. Admissions for females, particularly relating to mental and behavioural disorders, intentional self-poisoning, alcoholic liver disease and breast cancer are shown to be key areas for focused intervention.

Alcohol is a substantial factor in crime, particularly violent crime; in 2012-13, alcohol-related crime and violent crime was above the average for England. There is a significant positive correlation between the rate of licensed premises and the rate of alcohol-related crime by ward when the City Centre is treated as a separate area, which provides evidence for reducing the amount of licensed premises as an intervention to reduce alcohol-related crime.
Drugs
It is estimated that, of those that might require a treatment intervention for drug misuse, 47% are known to treatment. For clients using opiates and crack, the client group most commonly associated with acquisitive crime and also arguably the most complex drug users, the proportion of Nottingham citizens who are known to treatment is much higher at 83%. Encouraging drug misusing individuals into treatment remains a challenge for the city, although to a lesser degree compared to alcohol.

Referrals into drug treatment in Nottingham are dominated by the criminal justice system and this is set to continue in to the future because of the forthcoming effects of the Transforming Rehabilitation agenda under which all prisoners with substance misuse treatment requirements will be ordered to address them through interventions, regardless of sentence length. Although criminal justice referrals have proven to be an effective method of encouraging clients into treatment, providers are urged to improve self-referrals through promotional activity, particularly amongst the male population.

Nottingham has higher rates of planned exits and successful completions compared to the national comparator. In line with this positive performance, representation rates are comparable with national performance and treatment lengths are comparatively shorter. This evidence suggests that Nottingham has struck a balance between achieving positive and lasting outcomes for clients whilst ensuring that clients are not maintained in treatment services for protracted periods of time.

The number of opiate users accessing structured treatment has been increasing since August 2014. Although currently a small increase, this remains a concern because it is the first sustained increase observed in two years and it has taken place within a context of increasing street heroin purity. The Crime & Drugs Partnership is working closely with treatment providers to ensure the needs of these clients are being met and to prepare for the emerging challenges associated with this high-risk group.

New Psychoactive Substances
The use of new psychoactive substances is considered to be a growing threat; however, the impact of these substances is yet to be felt either in national surveys or in Nottingham’s substance misuse treatment system. Additionally the prevalence of new psychoactive substances is not apparent amongst the criminal justice cohort and as such the problem appears to be a public health issue rather than a driver of crime. It must be noted, however, that there is little empirical research in this area.

National and local evidence suggests that the new psychoactive substances presenting the greatest challenge to the city are synthetic cannabinoids. In response, the Crime & Drugs Partnership is facilitating both a New Psychoactive Substances Working Group and a Synthetic Cannabinoids Working Group (a sub-group of the harm reduction meeting) to address this issue and develop appropriate interventions and harm reduction advice.

A significant gap in knowledge exists around the use of new psychoactive substances and criminal behaviour and it is recommended that this information is collected when clients are arrested. There is some evidence to suggest that white powder falsely believed to be cocaine has a role to play in offending, particularly with violence and criminal damage.

Criminal Justice
One in four new receptions to HMP Nottingham commenced substance misuse treatment in 2013-14. This is a reduction of the proportion of receptions accessing treatment over the previous year but a small increase in volume; which could be an indication of service capacity as opposed to treatment need. Opiate and crack users in treatment in HMP Nottingham have reduced and primary alcohol clients have increased which represents a shift in the substance misusing profile of offenders and evidences a need for interventions for alcohol to be completed within the criminal justice pathway. Nottingham is similar to the East Midlands average in terms of identifying substance misuse needs in offenders before they enter...
prison. However, the national average for this measure exceeds Nottingham’s performance, indicating there is further work to be done to ensure substance misuse issues are identified at an earlier stage.

Target testing was introduced in Nottingham City’s custody suite in April 2013. This has led to an increase in positive tests and a reduction in the overall number of tests that have been undertaken. As a result of the changes it has not been possible to compare current performance with historical data on a like-for-like basis. The latest reliable data (based on test on arrest of all trigger offenders as opposed to target testing) highlighted that between 20% and 30% of all offenders tested positive for opiates or cocaine and it is assumed that this is still a fairly accurate assessment of drug-related offending. More than half of all violent crime that was tested under inspector’s authority was shown to be associated with stimulant use.

**Harm Reduction**

Hepatitis C remains the main area of concern in relation to blood borne viruses and 90% of those who acquire the infection do so through injecting drugs. It is estimated that 50% of injecting drug users in the United Kingdom have been infected with the virus and that half of this group remain undiagnosed. Approximately 2,000 Nottingham citizens have a chronic hepatitis C infection and the rate of infection is highest in males and those aged 25-44. Uptake for interventions for both hepatitis B and C has reduced in Nottingham over time in contrast to what has been observed in the Core Cities. It is recommended that drug treatment services work to actively encourage more clients to receive interventions.

There has been an increase over time in the number of needles acquired via specialist needle exchange for femoral (groin) injecting. This information reflects an ageing cohort of opiate users who are partaking in progressively risky behaviours. There has also been an increase in needles traditionally used amongst the ‘club drug’ using population of Nottingham. This might indicate an increasing prevalence in ‘club drug’ use in general, posing a challenge to the city and commissioned services. It is recommended that continued focus is placed on venues frequented in the night time economy in order to counter this issue.

Increasing concern has been expressed by treatment and harm reduction advice providers regarding ‘chemsex’. Chemsex is considered a growing national and local trend which requires targeted harm reduction interventions because it often entails risky sexual behaviour, individuals are often unsure of what substance they are using and the effects it might have and injecting equipment has commonly been used before by someone else. Trend analysis has shown that clients who report sharing injecting equipment at the start of their treatment journey have increased. As a result, it is recommended that harm reduction advice is prioritised when clients start treatment and that this level of intervention is maintained throughout the clients’ treatment journey.

The misuse medications, particularly the misuse of pregabalin and gabapentin, is considered both nationally and locally to be an increasing issue. Pregabalin and gabapentin are anxiolytic sedatives prescribed for pain relief; they are often used by heroin users, can be sold on the street and their use can lead to dependence. In Nottingham, gabapentin and pregabalin prescriptions increased by 15% and 9%, respectively. In response, the Crime & Drugs Partnership set up a working group which produced guidance for GPs and other prescribers regarding the use of these medicines.

In 2014, Nottingham became one of the first cities to distribute naloxone and train clients and practitioners in its use. By November, 132 city drug users had completed training and received a dose of take-home naloxone. Naloxone has been administered on eleven occasions and in all cases the individual was revived. Not only has each administered dose of naloxone saved a life, it has also saved the city approximately £20,000 per individual.

The rate of drug-related deaths in Nottingham is considerably lower compared to other major cities including Manchester and Liverpool. All of the recent female drug-related deaths have been identified as having had previous experience of domestic and sexual violence and, as a consequence, access to harm
reduction advice, overdose training and take-home naloxone should be prioritised for females in treatment where domestic and sexual violence is identified as an issue.

**Mental Health**

It is estimated that 40% (6,687 individuals) of those eligible for drug misuse treatment also have another psychiatric disorder. Mental health amongst the alcohol treatment cohort is also significant, with 37% of clients simultaneously receiving care from mental health services for reasons other than substance misuse.

The Nottingham City and County Dual Diagnosis Needs Assessment 2015-16 identifies the need to improve knowledge in practitioners of both substance use and mental health services, improve data quality, ensure consistent service delivery, improve availability and make appropriate changes to mental health crisis care through the Mental Health Crisis Care Concordat Declaration. The Crime & Drugs Partnership will continue its work to overcome barriers for substance misuse clients, improve pathways between services and more accurately determine the level and range of mental health needs amongst its client base and the wider substance misuse population.

**Young People**

It is accepted that the majority of young people in Nottingham do not use drugs and that those who do are not substance dependent. However, where substance misuse does exist there are considerable risks to an individual’s health, education, relationships and long-term chances in life. Young people in treatment services in Nottingham are more likely (compared to the England standard) to have mental health problems, self-harm, be involved in offending and be out of education, employment and training.

It is estimated that in 2013, 1,333 young people in Nottingham were eligible for substance misuse treatment, which is a 26% reduction on the previous year. Approximately 18% of those eligible for treatment are currently accessing structured treatment which means that the city out-performs the national comparator penetration rate of 7%. Despite this fact, it is important that treatment providers in Nottingham work to encourage more young people into appropriate treatment and thereby improve treatment penetration in the substance misusing population. Opportunities to improve referrals exists in self-referrals and those that are made by families and friends because Nottingham has a much lower level of young people in treatment via this source compared to the England standard.

The proportion of young people who exit treatment services in an agreed and planned way is lower in Nottingham compared to the national rate and has reduced compared to the previous year. It is recommended that young people treatment services work to improve the amount of planned exits from their service.

**Recovery from Substance Use**

One third of substance clients in Nottingham have a child that lives with them. Not only does this evidence underpin the need for family interventions and, where appropriate, involvement in adult substance misuse treatment but it also offers an incentive for clients to address their substance misuse.

Employment and economic activity, recognised as integral to sustained recovery, is low amongst the drug and alcohol treatment cohort in Nottingham compared to the national standard. Although it is recognised that clients may not feel ready for employment whilst undergoing a treatment journey, it is recommended that innovative efforts are made to encourage clients into employment and develop skills for future employment prospects.

Accommodation needs, particularly for clients accessing criminal justice substance misuse treatment, are higher in Nottingham compared to England. It is recommended that treatment services work more closely with housing providers to improve the accommodation status of clients and therefore improve clients’ chances of achieving sustained recovery.
A survey of clients accessing treatment through Recovery in Nottingham, Nottingham’s community drug treatment service, revealed high levels of complexity within its treatment caseload. Of the clients audited nearly half had a mental health issue, over a third had complex physical needs and more than a quarter had safeguarding practices in place. It is recommended that substance misuse providers continue to acknowledge and, where possible, address these issues.
Alcohol
Approximately 9 million people in England drink to levels that put their health at risk. Alcohol misuse covers a wide range of categories of drinking including binge drinking, lower risk drinking\(^1\), increasing risk drinking\(^2\) and higher risk drinking\(^3\).

The prevalence of alcohol use in Nottingham
The prevalence of alcohol use amongst Nottingham’s citizens is reported annually in the Citizens’ Survey. Figure 1 shows the proportion of respondents aged over 16 that drink alcohol. The overall proportion of people that drink alcohol in Nottingham has reduced from 59% to 54% between 2011 and 2014. Males are 1.3 times more likely to drink alcohol compared to females.

**Figure 1: Citizens’ Survey results – proportion of respondents that drink alcohol**

Citizens aged 16-24 years are consistently the age group most likely to drink alcohol, those aged 55-64 are the age group next most likely to drink alcohol; whereas 35-44 year olds have become less likely to drink, as shown in Figure 2.

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\(^1\) Lower risk drinkers (who are at a low risk of alcohol-related illness) are defined as: Men who regularly drink no more than 3 to 4 units a day or women who regularly drink no more than 2 to 3 units a day.

\(^2\) Increasing risk drinkers (who are at an increasing risk of alcohol-related illness) are defined as: Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels or women who regularly drink more than 2 to 3 units a day but less than the higher risk levels.

\(^3\) Higher risk drinkers (who have a high risk of alcohol-related illness) are defined as: Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week or women who regularly drink more than 6 units a day or more than 35 units of alcohol per week.
In 2014, nine out of 10 drinkers in Nottingham are classified as lower risk drinkers. Six percent of drinkers are increasing risk, which is the lowest rate observed in four years of survey data. Higher risk drinkers account for 3% of the drinking population in the city; which is a stable rate. By extrapolating national information on dependent drinking against results on binge and risk drinking from the Nottingham Citizen’s Survey, it is possible to make the estimates for drinking across Nottingham City that are represented in Figure 3.

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4 Alcohol Ready Reckoner Version 5.2 2011.
People profiles
The following variables, measured via the Citizens’ Survey, are shown to be associated with drinking:

- Binge drinkers, increasing risk drinkers and higher risk drinkers are more likely than all respondents to smoke (36%, 37%, 53% and 27%, respectively);

- Higher risk drinkers are more likely than all respondents to be obese (21% compared to 12%);

- Citizens aged 18-24 are overrepresented for problem-drinking behaviour. Citizens aged 18-24 are the most likely to be binge drinkers and account for 31% of all binge drinkers. People within this age group are also more likely to be an increasing risk drinker or higher risk drinker compared to any group (excluding under 18s who were not included in the survey);

- White British citizens accounted for between 91% and 97% of binge drinkers, increasing risk drinkers and higher risk drinkers whereas only 72% of all survey respondents were White British. Whilst this might be an indication that problematic drinking is more common within White British ethnicity, it may also be the case that other ethnicities are less comfortable with self-reporting problem drinking behaviour.

Geographic profiles
Bespoke analysis and national publications have been utilised to assess alcohol-related harm from a geographical approach. Figures 4 and 5 are maps of Nottingham city depicting both binge drinking and harmful drinking segments. Binge drinking is most prevalent in the central locality, the south and Aspley ward. In contrast, harmful drinking segments are most prevalent in the north locality and parts of the south including Dales, Clifton South and Bridge. The geographical distribution of harmful drinking and binge drinking reveals a need for targeted alcohol interventions across the city, although targeted binge drinking interventions should be prioritised within Radford & Park and Dunkirk & Lenton. It should be noted that much of the information used to develop geographical profiles relies on self-report and as such may not be a true indication of need.

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6 Nottingham City PCT. Harmful Drinking Segments.
It is generally accepted that alcohol dependence\textsuperscript{7} is the best indicator for estimating the level of treatment need in an area. Dependent drinkers are a smaller cohort compared to the lower risk, increasing risk and higher risk drinkers that have been focused upon in the Review up until this point. Most dependent drinkers will also meet criteria for higher risk drinking. There are an estimated 10,687 dependent drinkers in Nottingham\textsuperscript{8} which equates to 3.5\% of the population\textsuperscript{9} of Nottingham that might require treatment for alcohol misuse.

**Treatment penetration**

Analysis of treatment penetration into the substance misusing population in Nottingham is a key measure of treatment impact. In the last year, 2,499 adults accessed structured treatment and it is estimated that a further 1,666 accessed unstructured treatment\textsuperscript{10}. Of these clients, 1,232 accessed treatment for alcohol misuse last year, which equates to a penetration rate of 12\%. The alcohol penetration rate is considerably

\textsuperscript{7}According to DSM-IV-TR criteria, alcohol dependence is a maladaptive pattern of alcohol use, leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12 month period: 1) Tolerance 2) Withdrawal 3) Alcohol is often used in larger amounts or over a longer period than was intended 4) There is a persistent desire or unsuccessful efforts to cut down or control alcohol use 5) A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects 6) important social, occupational, or recreational activities are given up or reduced because of alcohol use 7) alcohol use is continued despite knowledge of having a persistent or recurrent physical or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

\textsuperscript{8}Alcohol Ready Reckoner Version 5.2 2011

\textsuperscript{9}Using Census 2011 population figures.

\textsuperscript{10}Approximately 60\% of all treatment is structured according to adult community drug treatment data. This proportion has been used as a proxy measure for the treatment system.
lower than the 47% rate for drugs and the 83% rate for heroin and crack which makes encouraging clients in to treatment a key priority for the city.

**Clients in treatment**

It has been possible to track the number of clients accessing structured alcohol treatment since Public Health England began reporting on alcohol treatment data in June 2013. Since then, the number of clients accessing structured alcohol treatment has been in gradual decline (see Figure 6), which raises concern when considered against the fact that penetration of alcohol treatment into the population is much lower than it is for drugs. However, it must be borne in mind that the data below shows only structured treatment, there is a considerable amount of alcohol dependent clients with a primary drug problem accessing drug treatment and some clients seek to overcome alcohol dependency through different routes such as self-help. Last year, 37% of adults in drug treatment cited problematic alcohol use which is much higher than the 22% cited nationally.

*Figure 6: Number of clients accessing structured treatment (rolling 12 month count) since June 2013*

![](image)

**Treatment profile**

Nationally, women make up 36% of all alcohol clients in treatment which is considerably more than the 27% female cohort in drug treatment, this may be because of a perceived stigma associated with drug use. Of the national female population in alcohol treatment, 54% are mothers and four (1%) were pregnant during their treatment. Many experience poor mental health and domestic and sexual violence.

The profile of clients in treatment is broadly similar to the national picture. However, small differences do exist; females in treatment in Nottingham are more likely to be in their 30s and less likely to be older than 60 years of age. Males are also more likely to be in their 30s compared to the national comparator. The fact that clients in Nottingham present to treatment earlier in life could be a further indication of increased levels of harmful drinking or a reflection of high quality service provision.

Clients of White British ethnicity dominate the alcohol treatment cohort, accounting for 83-84% of all alcohol clients in 2012-13 and 2013-14. This is a higher proportion of White British clients compared to the drug treatment cohort which consists of 78% White British clients. A review of UK literature regarding Ethnicity
and Alcohol concluded that minority ethnic groups are under-represented within treatment cohorts because they can be unsure of how to seek advice. Community engagement is advised in order to prevent the underestimation of need and potential underrepresentation in treatment among minority ethnic groups.

Nottingham has a higher than national level of higher-risk drinking 28 days prior to entering treatment. Nationally, 77% of clients drank to higher-risk levels before commencing treatment whereas in Nottingham this figure is 86%. The fact that Nottingham clients are drinking more prior to entering treatment than the English average is further emphasised in Figure 19, where 46% of clients drank more than 600 units — the equivalent of 60 bottles of wine - in the 28 days prior to treatment commencement. This evidence suggests the need to explore methods of encouraging clients into treatment before their drinking reaches very dangerous levels.

Other substance use in addition to alcohol is lower in Nottingham than it is on average in England. This could be because clients that do use multiple substances tend to have their drug problem dealt with before accessing alcohol treatment. It may also be an indication that clients are developing alcohol dependencies once they are abstinent from drugs. Better mechanisms exist in the criminal justice sector for referring drug users into treatment which may be another reason why primary alcohol clients with secondary drug use are not fully represented here.

**Waiting times**

Maintaining low waiting times for treatment commencement has been identified as a key to keeping attrition rates low, building client faith in services and supporting recovery from alcohol dependency. In 2013-14 84% (458 individuals) of clients waited under three weeks to start treatment which is under the national rate of 93%. Ensuring that clients do not have to wait for protracted periods of time is vital to keeping attrition rates low. Work to reduce waiting times in alcohol treatment should be prioritised.

**Routes into treatment**

Nottingham’s alcohol referrals to treatment are mainly made up of self-referrals and ‘other’ referrals (see Table 1). Self-referrals are common because of the accessibility of the triage alcohol provider, Last Orders. The triage service is part of a walk-in centre situated within the city centre. It is likely, therefore; that many clients were signposted from other agencies but cited ‘self-referral’ at assessment because they went to the triage service independently. The local service performance framework has been redesigned to capture signposting services in 2014-15.

Criminal justice referrals are much less common in Nottingham compared to the England average and also compared to referrals to drug treatment. This is because, unlike heroin and crack consumption, alcohol consumption is not tested for in the custody suite. Furthermore, it is likely that clients referred via the test on arrest scheme are primary drug users with secondary alcohol use and would therefore not be captured in this cohort of primary alcohol clients.

**Table 1: Source of referral into treatment**

<table>
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<th>Referral Source</th>
<th>Nottingham</th>
<th>National</th>
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<tr>
<td></td>
<td>All Female</td>
<td>Male</td>
</tr>
<tr>
<td>Self-referral</td>
<td>39%</td>
<td>36%</td>
</tr>
<tr>
<td>Criminal justice system</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>GP</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Hospital/ A&amp;E</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td>Social Services</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>All other referral sources</td>
<td>46%</td>
<td>45%</td>
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**Length of time in treatment**

By assessing the length of time that clients spend in treatment it is possible to infer whether or not clients are getting all they need from their treatment package. If an area has a high proportion of clients in treatment for over one year it may be that clients are not moving effectively through the system. In contrast, a high rate of clients in treatment for shorter amounts of time might indicate issues with retaining clients. Nottingham has lower levels of clients in treatment for under three months (compared to the national average) and there is a lower than national proportion of clients in Nottingham services for six to 12 months. The length of time in treatment for Nottingham and England are shown below in Figure 7.

**Figure 7: Length of time in treatment for Nottingham and England**

![Chart showing length of time in treatment for Nottingham and England](chart)

**Treatment outcomes**

According to the Government’s alcohol strategy, increasing treatment effectiveness is the quickest way to reduce alcohol-related admissions and costs to the NHS. Successful completions combined with low representations and drop outs are considered the best current measure of alcohol treatment effectiveness. The proportion of clients that exited treatment successfully is under the core cities average (see Figure 8). However, performance has improved continuously, closing the gap between the city’s performance and core cities average, since June 2014. There is a similar amount of disparity in the proportion of clients that exit treatment successfully and did not represent within six months. In Nottingham, 27% of clients were in this cohort last calendar year\(^{12}\) whereas the national figure was 36%. It is anticipated that the number of successful completions with no representation will show improvement in future reports in line with successful completion performance.

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\(^{12}\) In order to allow for a six month representation period the cohort timeframe includes calendar year rather than financial year, thus this measure is less up to date than the successful completion measure.
Alcohol-related hospital admissions

Methodology

The alcohol-related hospital admission calculation

Alcohol-related hospital admissions are calculated using the following two components:

1. **Clinical coding**: For each admission there is one primary code (the ‘main’ reason for the admission) and up to 19 secondary codes (other diagnoses affecting treatment). The secondary codes may include external cause codes such as traffic incident, assault or fall; and

2. **Alcohol-attributable fractions**: A fraction assigned to each and every possible primary code and secondary code (including external cause codes). The fractions differ slightly for men and women.

The alcohol-related hospital admission is a sum of alcohol-attributable fractions.

Broad and narrow measures

There are two types of alcohol-related hospital admission measures:

**The broad measure (original indicator)**
This measure is a sum of all alcohol-attributable fractions including all primary codes and secondary codes. This measure is useful because it provides a full picture of the scale of alcohol-related admissions. However, evidence suggests that this measure is sensitive to recording practices which have added to the acceleration of the overall increase. This measure is best used when estimating the total burden of alcohol-related hospital admissions.

**The narrow measure (new indicator)**
This measure is a sum of the alcohol-attributable fractions of primary codes and, if the primary code for the admission does not have an alcohol-attributable fraction but there is an external cause code as a secondary code that does have an alcohol-attributable fraction, it includes this fraction. This measure is useful because it is less sensitive to changes over time in recording practices. However, it does not
produce a full assessment of alcohol-related admissions. This measure is best used to assess the impact of local action on alcohol. It is the indicator used within the Public Health Outcomes Framework and the indicator against which the city is target monitored within the Nottingham Plan to 2020.

**Performance**

**The broad measure**

Alcohol-related hospital admissions in Nottingham have increased over the previous five years by 28% (2013-14 compared to 2008-09). Despite this increase the rate of hospital admission has remained continuously below the average rate of the core cities (see Figure 9). Between 2008-09 and 2012-13 Nottingham ranked fifth highest rate of alcohol-related hospital admissions out of the eight core cities. Last year, however, Nottingham moved up a place from fifth to fourth highest (see Table 2).

**Figure 9: Performance of alcohol-related hospital admissions - broad measure**

![Graph showing performance of alcohol-related hospital admissions in Nottingham](image)

**Table 2: DSR per 100,000 population and rank by core city - broad measure**

<table>
<thead>
<tr>
<th>Core City</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>1967.27</td>
<td>2145.91</td>
<td>2280.69</td>
<td>2355.83</td>
<td>2314.08</td>
<td>2412.12</td>
</tr>
<tr>
<td>Bristol</td>
<td>2437.99</td>
<td>2507.29</td>
<td>2620.54</td>
<td>2646.13</td>
<td>2480.59</td>
<td>2466.08</td>
</tr>
<tr>
<td>Leeds</td>
<td>1609.69</td>
<td>1841.71</td>
<td>1979.90</td>
<td>2230.40</td>
<td>2053.64</td>
<td>2062.80</td>
</tr>
<tr>
<td>Liverpool</td>
<td>2692.28</td>
<td>2906.70</td>
<td>2934.88</td>
<td>2987.27</td>
<td>2934.89</td>
<td>2912.94</td>
</tr>
<tr>
<td>Manchester</td>
<td>2638.75</td>
<td>3026.75</td>
<td>3382.27</td>
<td>3207.72</td>
<td>3137.29</td>
<td>3308.94</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>2895.23</td>
<td>2742.56</td>
<td>2755.25</td>
<td>3031.93</td>
<td>2916.65</td>
<td>2957.51</td>
</tr>
<tr>
<td>Nottingham</td>
<td>2015.12</td>
<td>2181.63</td>
<td>2440.06</td>
<td>2460.16</td>
<td>2478.26</td>
<td>2577.24</td>
</tr>
<tr>
<td>Sheffield</td>
<td>1586.63</td>
<td>1773.79</td>
<td>1863.85</td>
<td>1834.88</td>
<td>2026.12</td>
<td>2061.53</td>
</tr>
</tbody>
</table>

**The narrow measure**

The rate of alcohol-related hospital admissions in Nottingham has increased by 31% in the last five years (2013-14 compared to 2008-09), which is a greater increase than that observed on the broad measure. The target for Nottingham is to achieve a rate of 771 alcohol-related hospital admissions per 100,000 of
population, which was the core cities average rate in 2012-13. As is shown in Figure 10 below, Nottingham is considerably off target, ending 2013-14 with a rate of 943.49 per 100,000 of the population. This is considerably higher than the core cities average, the East Midlands rate and the England rate. In 2008-09, Nottingham was mid-table in terms of its rank within the core cities, however since 2012-13, Nottingham has moved to the top of the table with the highest level of alcohol-related hospital admissions of the core cities (see Table 3).

**Figure 10: Performance of alcohol-related hospital admissions - narrow measure**

![Performance of alcohol-related hospital admissions - narrow measure](image)

**Table 3: DSR per 100,000 population and rank by core city - narrow measure**

<table>
<thead>
<tr>
<th>Core City</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>685.46</td>
<td>6</td>
<td>720.09</td>
<td>6</td>
<td>742.80</td>
<td>6</td>
</tr>
<tr>
<td>Bristol</td>
<td>777.89</td>
<td>4</td>
<td>802.43</td>
<td>4</td>
<td>803.12</td>
<td>5</td>
</tr>
<tr>
<td>Leeds</td>
<td>649.99</td>
<td>7</td>
<td>714.00</td>
<td>7</td>
<td>728.54</td>
<td>7</td>
</tr>
<tr>
<td>Liverpool</td>
<td>855.94</td>
<td>2</td>
<td>814.46</td>
<td>3</td>
<td>822.91</td>
<td>4</td>
</tr>
<tr>
<td>Manchester</td>
<td>796.24</td>
<td>3</td>
<td>850.06</td>
<td>2</td>
<td>877.45</td>
<td>2</td>
</tr>
<tr>
<td>Newcastle upon tyne</td>
<td>924.29</td>
<td>1</td>
<td>884.94</td>
<td>1</td>
<td>898.08</td>
<td>1</td>
</tr>
<tr>
<td>Nottingham</td>
<td>720.31</td>
<td>5</td>
<td>766.26</td>
<td>5</td>
<td>842.07</td>
<td>3</td>
</tr>
<tr>
<td>Sheffield</td>
<td>620.30</td>
<td>8</td>
<td>650.67</td>
<td>8</td>
<td>698.28</td>
<td>8</td>
</tr>
</tbody>
</table>

**Conclusion**

Whilst the impact of alcohol-related hospital admissions has increased over the last five years, the total burden of the issue remains below average for a core city.

**Other hospital admissions due to alcohol**

Generally, hospital admissions due to alcohol result from alcohol consumers that drink above lower-risk levels. Figure 11 shows the rates (per 100,000 of population) of other admissions related to alcohol for both Nottingham and England. The rate of hospital admissions is higher in Nottingham for alcohol-related conditions and for alcohol-specific conditions in adults (but not under 18s).
Alcohol-Related Hospital Admissions: Areas for Focus

From the information provided on alcohol-related admission so far in this review it is clear that alcohol-related hospital admissions pose a significant challenge to the city of Nottingham. Figures 12 to 14 show admission episodes using the narrow measure (considered less sensitive to recording practices) for all persons and broken down by gender. Considerable percentage increases have been observed between 2008-09 and 2012-13 for all persons (22%) and males (19%), whilst the greatest increase took place in females (26%). Alcohol-related admission episodes using the broad measure support evidence that the female population should be the focus for intervention; whereas the rate of admission episodes increased for all persons and males by 23% and 20% respectively in 2012-13 compared to 2008-09, the rate of admission episodes for females increased by 27%.
Alcohol-related admission episodes under the broad measure (considered more sensitive to changes in recording practices) support evidence that the female population should be the focus for intervention; whereas the rate of admission episodes increased for all persons and males by 23% and 20% respectively in 2012-13 compared to 2008-09, the rate of admission episodes for females increased by 27% (see Figure 15-17).
An exploration of alcohol-related conditions in Nottingham compared to other areas has shown that 1) the substantial increase appears to be reflective of a genuine increase in alcohol-related admissions in that an increase is evident in the narrow measure, which is less susceptible to change due to improvements in recording practices and 2) alcohol-related conditions of females are showing the largest increase in Nottingham.

Figure 18 shows the percentage change (2012-13 compared with 2008-09) in alcohol-related admission episodes for females in Nottingham. Mental and behavioural disorders, intentional self-poisoning, alcoholic liver disease, breast cancer, pneumonia, cardiac arrhythmias and other intentional injuries have all increased in prevalence. The same data for males is shown in Figure 19, as with females; mental and behavioural disorders, alcoholic liver disease, cardiac arrhythmias, pneumonia, intentional self-poisoning and other intentional injuries have increased. However, conversely to the female population; oesophagus alcohol-related admissions have also increased. This information, summarised in Table 4, provides valuable information on the types of issues that are contributing to the increase in alcohol-related hospital admissions in Nottingham.
Figure 18: Percentage change in alcohol-related admission episodes for females in Nottingham (2012-13 compared to 2008-09, narrow measure):

- Mental and behavioural disorders, 67%
- Intentional self-poisoning, 61%
- Alcoholic liver disease, 52%
- Breast, 49%
- Pneumonia, 37%
- Cardiac arrhythmias, 15%
- Other unintentional injuries, 10%
- Colorectal, -4%
- Fall injuries, -20%
- Epilepsy and Status epilepticus, -25%
- Oesophagus, -46%

% Change (2012-13 compared to 2008-09)

Figure 19: Percentage change in alcohol-related admission episodes for males in Nottingham (2012-13 compared to 2008-09, narrow measure):

- Oesophagus, 84%
- Mental and behavioural disorders, 62%
- Alcoholic liver disease, 26%
- Cardiac arrhythmias, 25%
- Colorectal, 22%
- Pneumonia, 15%
- Intentional self-poisoning, 14%
- Other unintentional injuries, 5%
- Fall injuries, -18%
- Epilepsy and Status epilepticus, -32%

% Change (2012-13 compared to 2008-09)
Liver disease

According to the Public Health Outcomes Framework, Nottingham has the highest age standardised rate of under 75 mortality from liver disease (28.6 per 100,000 of population) in the East Midlands (2012-13 data). This rate is also higher than that 17.9 (per 100,000) rate for England as a whole. Nottingham’s age standardised under 75 mortality rate is second highest in the East Midlands for males in Nottingham (37.6) and highest for females (19.4). Whilst this evidence supports evidence for Nottingham as an area of particular concern for alcohol-related hospital admissions and also evidence that the female population in Nottingham is at the greatest level of risk.

Mortality and months of life lost

Information on alcohol-related deaths and lives shortened by alcohol consumption offers insight into the chronic heavy drinking citizens of Nottingham. The majority of these citizens are higher-risk or dependent drinkers. Nottingham has a higher than national level of months of life lost for both males and females (see Figure 20). There is also a slightly higher rate of alcohol-specific mortality and mortality from chronic liver disease. Alcohol-related mortality does not exceed the national level; this measure is related to conditions considered partially due to alcohol such as cardiac arrhythmias and chronic self-harm (see Figure 21).

Table 4: Alcohol-related admission episodes in Nottingham by gender (2008/09 to 2012/13)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Oesophagus</td>
<td>28.18</td>
<td>10.04</td>
<td>27.40</td>
<td>19.21</td>
<td>9.70</td>
<td>-18</td>
<td>-66%</td>
</tr>
<tr>
<td></td>
<td>Epilepsy and Status epilepticus</td>
<td>18.86</td>
<td>17.31</td>
<td>15.91</td>
<td>10.35</td>
<td>14.17</td>
<td>-5</td>
<td>-25%</td>
</tr>
<tr>
<td></td>
<td>Fall injuries</td>
<td>40.15</td>
<td>42.25</td>
<td>46.42</td>
<td>40.79</td>
<td>31.95</td>
<td>-8</td>
<td>-20%</td>
</tr>
<tr>
<td></td>
<td>Colorectal</td>
<td>25.53</td>
<td>21.28</td>
<td>21.22</td>
<td>19.67</td>
<td>24.48</td>
<td>-1</td>
<td>-4%</td>
</tr>
<tr>
<td></td>
<td>Other unintentional injuries</td>
<td>71.98</td>
<td>72.59</td>
<td>70.32</td>
<td>76.96</td>
<td>79.36</td>
<td>7</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Cardiac arrhythmias</td>
<td>22.37</td>
<td>24.31</td>
<td>24.56</td>
<td>20.84</td>
<td>25.81</td>
<td>3</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>19.78</td>
<td>19.51</td>
<td>21.29</td>
<td>21.88</td>
<td>27.12</td>
<td>7</td>
<td>37%</td>
</tr>
<tr>
<td></td>
<td>Breast</td>
<td>69.13</td>
<td>74.35</td>
<td>76.14</td>
<td>86.58</td>
<td>102.96</td>
<td>34</td>
<td>49%</td>
</tr>
<tr>
<td></td>
<td>Alcoholic liver disease</td>
<td>33.00</td>
<td>37.00</td>
<td>37.00</td>
<td>43.00</td>
<td>50.00</td>
<td>17</td>
<td>52%</td>
</tr>
<tr>
<td></td>
<td>Intentional self-poisoning</td>
<td>62.00</td>
<td>97.00</td>
<td>134.00</td>
<td>112.00</td>
<td>100.00</td>
<td>38</td>
<td>61%</td>
</tr>
<tr>
<td></td>
<td>Mental and behavioural disorders</td>
<td>60.00</td>
<td>43.00</td>
<td>63.00</td>
<td>80.00</td>
<td>100.00</td>
<td>40</td>
<td>67%</td>
</tr>
<tr>
<td>Male</td>
<td>Epilepsy and Status epilepticus</td>
<td>43.57</td>
<td>40.63</td>
<td>42.66</td>
<td>36.81</td>
<td>29.79</td>
<td>-14</td>
<td>-32%</td>
</tr>
<tr>
<td></td>
<td>Fall injuries</td>
<td>89.48</td>
<td>93.95</td>
<td>101.66</td>
<td>102.43</td>
<td>73.72</td>
<td>-16</td>
<td>-18%</td>
</tr>
<tr>
<td></td>
<td>Other unintentional injuries</td>
<td>194.71</td>
<td>208.10</td>
<td>208.13</td>
<td>211.10</td>
<td>204.13</td>
<td>9</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Intentional self-poisoning</td>
<td>69.00</td>
<td>81.00</td>
<td>110.00</td>
<td>115.00</td>
<td>79.00</td>
<td>10</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>57.13</td>
<td>53.89</td>
<td>56.25</td>
<td>55.67</td>
<td>65.94</td>
<td>9</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>Colorectal</td>
<td>43.02</td>
<td>49.67</td>
<td>58.83</td>
<td>40.60</td>
<td>52.64</td>
<td>10</td>
<td>22%</td>
</tr>
<tr>
<td></td>
<td>Cardiac arrhythmias</td>
<td>36.88</td>
<td>37.26</td>
<td>38.84</td>
<td>43.34</td>
<td>46.29</td>
<td>9</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Alcoholic liver disease</td>
<td>136.00</td>
<td>164.00</td>
<td>138.00</td>
<td>136.00</td>
<td>172.00</td>
<td>36</td>
<td>26%</td>
</tr>
<tr>
<td></td>
<td>Mental and behavioural disorders</td>
<td>182.00</td>
<td>214.00</td>
<td>243.00</td>
<td>281.00</td>
<td>295.00</td>
<td>113</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td>Oesophagus</td>
<td>30.57</td>
<td>49.10</td>
<td>102.02</td>
<td>74.38</td>
<td>56.09</td>
<td>26</td>
<td>84%</td>
</tr>
</tbody>
</table>
Alcohol-related crime
Crime within the drinking population is most likely to take place within binge, higher-risk and dependent drinking populations. This year to date 15% of the crime that occurred in the city was alcohol-related\textsuperscript{13}. Violence against the person is by far the most prevalent type of alcohol-related crime, accounting for more than a quarter of the year to date total. Having experienced an increase of 23% (226 crimes) this year to date compared to the corresponding period last year, alcohol-related violent crime is on the rise.

Hate crime and sexual offences are also significantly associated with alcohol. In the last year, 23% of hate crime (102 offences) and 14.3% of sexual offences (105) were alcohol related.

Alcohol and crime – national reporting
The link between alcohol and crime is reported at a national level via Public Health England. Figure 22 shows the rate (per 1000 crimes) of recorded crime and violent crime related to alcohol during 2012-13. Both rates are considerably higher in Nottingham compared to the average rate for England. Within its Nearest Neighbour Group\textsuperscript{14}, Nottingham is considered to have the highest levels of alcohol-related crime.

Figure 22: Rate (per 1000 crimes) of alcohol-related crime and violent crime in 2012-13

Geographic profile
Almost half of alcohol-related crime occurs in the City Centre and the north of the city is also over-represented. However, when considering alcohol-related Violence Against the Person only, crimes are much more evenly spread across the four areas.

The highest rate (per 1,000 or population) of licensed premises exists in the city centre and this is also the area with the highest rate of alcohol-related crime. There is a significant positive correlation between rate of licensed premises and rate of alcohol-related crime when the city centre is treated as a separate area ($r=0.975$, $n=21$, $p=0.00$). A slight positive trend also exists between rate of licensed premises and alcohol-related crime.

\textsuperscript{13} A crime is considered alcohol related if it took place during the night time economy (between 6am and 6pm) or was associated with a licensed premises.

\textsuperscript{14} The nearest neighbour group is used by Public Health England as a performance benchmark. The areas identified as the 15 nearest neighbours for Nottingham are Newcastle upon Tyne, Liverpool, Salford, Leicester, Kingston upon Hull, Manchester, Bristol, Sheffield, Wolverhampton, Coventry, Gateshead, Peterborough, Middlesbrough, Derby and Southampton.
related crime in the city wards not including the city centre \((r=0.226, n=20, p=0.169)\). The two wards that do not follow the trend are Wollaton East & Lenton Abbey and Dunkirk & Lenton (Figure 23).

**Figure 23: Wards by alcohol-related crime rate and licensed premises rate**

Offender profile
Males are disproportionately represented as offenders of alcohol-related crime. Over the last 12 months, 82% of alcohol-related crime offenders, where an offender was identified, were male. The most common offender age group is people aged 18-25 years. Of the alcohol-related crime that occurred in the last year, more than a quarter (27%, 433 crimes) were carried out by a male aged between 18 and 25.

Victim profiles
A similar profile for victim age for offenders exists for victims in that the 18-25 year old cohort is considerably overrepresented. However, gender for victims is evenly split, whereas males were much more prevalent offenders.

The fact that the 18-25 year old cohort has emerged as a target group, both for offenders and victims, is in line with the results from the Citizens’ Survey which showed this age group, together with citizens aged 55-64, to be the most overrepresented for problem-drinking behaviour.

Employment
Data showing the employment status of clients at the start of their treatment journey is unreliable because of the considerable amount of missing data in Nottingham. Employment status data is missing for 61% of Nottingham’s alcohol treatment clients (as shown in Figure 24) and as a result, it is not possible to compare Nottingham’s employment profile with the national comparator. Data recording has been highlighted as a key priority for the current alcohol treatment provider, although much of the historic missing data was the responsibility of previous service providers.

Of all clients in alcohol treatment on 31st March 2012, more than half were recorded as receiving benefits of some type. This is a similar proportion to those in treatment and receiving benefits on a national scale. Employment Support Allowance, Disability Living Allowance (DLA) and Incapacity Benefit are the most common types of benefits claimed (see Figure 25). DLA is considerably more common in alcohol clients as...
opposed to drug clients and the median duration of the claim is five years. This might suggest that people claiming DLA are at an increased risk of alcohol dependency.

**Figure 24: Employment status at start of treatment**

**Figure 25: Benefit profile of treatment population**
**Drugs**

**The prevalence of drug use in Nottingham**

The prevalence of substance misuse in Nottingham can be estimated using a number of sources. In most cases it is necessary to calculate estimates using extrapolations from national resources because this information does not exist at a local level. Extrapolations from national datasets are less methodologically robust compared to local surveys, but they do provide a guide in the absence of more detailed information. This section provides estimations of prevalence for drugs and a range of the most prevalent types of drugs.

Substance misuse in Nottingham appears to be relatively high compared to local authorities in the region. However, Nottingham has similar levels of substance misuse compared to other major cities in the country. For example, there are an estimated 2,615 opiate and crack users in Nottingham, the third highest rate in the East Midlands yet mid-table within the eight Core Cities\(^1\)^.

**Cannabis**

Despite an overall increase in the last fifteen years and remaining the most prevalent drug, lifetime cannabis usage has reduced slightly from 31% of 16-59 years olds to 29% in the last two years (Figure 26).

*Figure 26: National proportion of 16 to 59 year olds reporting use of cannabis ever in their lifetime*

![Graph](image)

**Opiates**

Despite an increase in opiate use in 2009-10 to 2010-11, opiate use has reduced by 2.14% in 2011-12 compared to two years previous (see Figure 27). Using the Census 2011 population figure for Nottingham, the proportion of citizens using opiates has reduced from 0.77% in 2009-10 to 0.75% in 2011-12.

---

\(^{1}\) Estimates of the prevalence of opiate use and/or crack cocaine use (2011/12), Liverpool John Moores University.
Figure 28, below, shows the prevalence of opiate use in Nottingham by age group. The use of opiates in 15-24 year olds and 25-34 year olds has reduced in the medium-term, whereas opiate use in 35-64 year olds has consistently increased in the last three years. This shows that Nottingham has a cohort of entrenched and aging opiate users.

Injecting
The level of injecting in the cohort of drug users accessing treatment is stable. In the last three years, 14-15% (97 to 117 clients) of those starting a new treatment journey currently injected, 25-27% (163-189 clients) previously injected and 58-60% (380-454 clients) had never injected. This evidence suggests that
although the number of people presenting to treatment has reduced the level of risk to the treatment cohort has not. A cohort of ageing injecting drug users is associated with increased physical health problems. A considerable number of people continue to access specialist needle exchanges; last year approximately 400 needle exchange clients accessed the Health Shop (local specialist needle exchange provider).

**Cocaine**

**Crack Cocaine**

The number of crack cocaine users in Nottingham has reduced in the short-term (7.4%, see Figure 29, based on data from Glasgow Prevalence Estimates). Using the Census 2011 population figure for Nottingham, the crack using cohort in Nottingham equates to 0.7% of citizens.

*Figure 29: Estimated number of crack users in Nottingham*

![Graph showing estimated number of crack users in Nottingham](image)

Figure 30 below shows crack cocaine prevalence nationally over the last fifteen years, as published in Drug Misuse: Findings from the 2013/14 Crime Survey for England and Wales. In the long-term (previous five years) crack cocaine use has reduced. However it is worth noting that prevalence increased significantly between 1996 and 2014.
Figure 30: National proportion of 16 to 59 year olds reporting use of crack cocaine ever in their lifetime

Long-Term Change

Powder cocaine
The national prevalence of powder cocaine over the last fifteen years is shown below in Figure 31. Overall, powder cocaine use has significantly increased and has consistently accounted for the vast majority of all cocaine use. In the short-term (2013-14 compared to 2012-13) powder cocaine use has increased by 0.6 percentage points.

Figure 31: National proportion of 16 to 59 year olds reporting use of powder or any cocaine ever in their lifetime
**Ecstasy**
In 2013-14, 9.3% of 16-59 year olds reported use of ecstasy. This is a short-term increase, compared to 8.3% in 2012-13. Also over the last five years ecstasy use has increased by one percentage point. These findings are indicative of overall and consistent increase in ecstasy prevalence (see Figure 35).

**Hallucinogens**
The prevalence of hallucinogens has been broadly maintained, as is shown in Figure 35. Approximately 9% of 16-59 year olds are estimated to have used hallucinogens ever in their lifetime.

**Amphetamine**
Amphetamine prevalence in 2013-14 was 11.1% which is a reduction in the long-term (compared to 2009-10, 0.6 percentage points) and the medium-term (compared to 2011-12, 0.5 percentage points), although there has been a small increase in the short-term (compared to 2012-13, 0.5 percentage points, see Figure 32).

*Figure 32: National proportion of 16 to 59 year olds reporting use of Ecstasy, Hallucinogens or Amphetamine ever in their lifetime*

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**Treatment**

**Estimated Treatment Need**
So far within this section, the prevalence of drugs used at any point during an individual’s lifetime has been assessed. This measure is useful in indicating the overall impact of drug use; however some drug use during an individual’s lifetime does not necessarily mean that the individual will require treatment for substance misuse. In order to assess the estimated treatment need for Nottingham, frequent drug use is considered a more indicative representation of those that might require treatment. In 2013-14, 3.1% of 16-59 year olds used drugs on a frequent basis.

The Census 2011 states that Nottingham’s population is 305,680 and that 201,926 citizens (66% of the population) are aged 16-59. If we accept the estimate that 3.1% of 16-59 year olds use drugs on a frequent basis, approximately 6,260 citizens (2% of Nottingham’s population) might require a drug intervention.

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16 Frequent use refers to use of any drug more than once a month in the past year.
Treatment penetration
Analysis of treatment penetration into the substance misusing population in Nottingham is a key measure of treatment impact. In the last year, 2,499 adults accessed structured treatment and it is estimated that a further 1,666 accessed unstructured treatment\(^\text{17}\). Of these clients, 2,933 adults accessed substance misuse treatment for drugs, which equates to a treatment penetration rate of 47%. The penetration rate for opiate and crack use is much higher, at 83%\(^\text{18}\).

Clients in treatment
The number of clients accessing structured treatment has been in general decline since its peak in June 2011 (see Figure 33). However, there has been an increase in clients accessing structured treatment in the last three months. In October 2014 compared to August 2014 there have been an increase in the number of opiate users (2%, 21 clients), alcohol and non-opiate users (6%, 15 clients) and non-opiate users (2%, 4 clients) accessing structured treatment. The increase in alcohol and non-opiate clients is an anticipated effect of the introduction of new reporting methodology from Public Health England, which has enabled the combining of treatment journeys and elimination of client duplicates. The increase observed in opiate clients is of particular concern because it is the first time in two years that this has occurred at a time when street heroin purity is known to have increased.

Figure 33: Number of clients accessing structured treatment for drugs (rolling 12 month count) since April 2011

Treatment profile
Nationally, women make up 24% of the adults in drug treatment (441 of 1809 clients). Women presenting to treatment often experience domestic and sexual violence and poor mental health and most mothers in treatment are lone parents\(^\text{19}\).

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\(^{17}\) Approximately 60% of all treatment is structured according to adult community drug treatment data. This proportion has been used as a proxy measure for the treatment system.

\(^{18}\) Drug Treatment Needs Assessment 2013-14.

Clients of White British ethnicity make up 78% of clients accessing structured treatment in. There has been very little change in the ethnic profile of clients compared to the previous year, as shown in the trend column of Table 5.

**Table 5: Ethnicity of clients in structured treatment during 2012-13 and 2013-14**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>2012-13 No.</th>
<th>2013-14 No.</th>
<th>2012-13 %</th>
<th>2013-14 %</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>1462</td>
<td>1413</td>
<td>78.52%</td>
<td>78.11%</td>
<td></td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>87</td>
<td>77</td>
<td>4.67%</td>
<td>4.26%</td>
<td></td>
</tr>
<tr>
<td>Caribbean</td>
<td>63</td>
<td>68</td>
<td>3.38%</td>
<td>3.76%</td>
<td></td>
</tr>
<tr>
<td>Other White</td>
<td>50</td>
<td>50</td>
<td>2.69%</td>
<td>2.76%</td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>39</td>
<td>37</td>
<td>2.09%</td>
<td>2.05%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>30</td>
<td>1.29%</td>
<td>1.66%</td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td>15</td>
<td>23</td>
<td>0.81%</td>
<td>1.27%</td>
<td></td>
</tr>
<tr>
<td>Other Black</td>
<td>24</td>
<td>23</td>
<td>1.29%</td>
<td>1.27%</td>
<td></td>
</tr>
<tr>
<td>White Irish</td>
<td>13</td>
<td>17</td>
<td>0.70%</td>
<td>0.94%</td>
<td></td>
</tr>
<tr>
<td>Other Mixed</td>
<td>21</td>
<td>14</td>
<td>1.13%</td>
<td>0.77%</td>
<td></td>
</tr>
<tr>
<td>White and Asian</td>
<td>14</td>
<td>13</td>
<td>0.75%</td>
<td>0.72%</td>
<td></td>
</tr>
<tr>
<td>Not stated</td>
<td>20</td>
<td>12</td>
<td>1.07%</td>
<td>0.66%</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>13</td>
<td>11</td>
<td>0.70%</td>
<td>0.61%</td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>10</td>
<td>8</td>
<td>0.54%</td>
<td>0.44%</td>
<td></td>
</tr>
<tr>
<td>Missing / inconsistent ethnicity code</td>
<td>0</td>
<td>6</td>
<td>0.00%</td>
<td>0.33%</td>
<td></td>
</tr>
<tr>
<td>White and Black African</td>
<td>6</td>
<td>5</td>
<td>0.32%</td>
<td>0.28%</td>
<td></td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0</td>
<td>1</td>
<td>0.00%</td>
<td>0.06%</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>1</td>
<td>0.05%</td>
<td>0.06%</td>
<td></td>
</tr>
</tbody>
</table>

Of all clients accessing structured treatment last financial year, 43% (774 clients) were in their thirties. There has been little change in the age profile of clients in 2013-14 compared to the previous year. The small amount of change that has taken place is a slight shift towards an older cohort of clients, which supports evidence of a treatment system dominated by ageing opiate and crack cocaine users. The data featured in this section predates the increase in opiate users that was observed from September 2014. The effects of this increase, including the effect on the age distribution of clients, are explored later within this chapter.

**Waiting times**

Of all clients that started a new treatment journey, 99% (792 of 803 treatment starts) waited less than three weeks to commence treatment. This is better than the 98% national proportion and an improvement on recent years.

**Treatment engagement**

In 2013-14, 93% of all drug treatment clients remained engaged for three months or more. This shows that for the vast majority, the benefits associated with engagement such as reduced crime and health improvement are maximised.

**Routes into treatment**

Nottingham’s referrals into treatment are dominated by the criminal justice system (CJS) which means the client has been referred through an arrest referral scheme (such as test on arrest) or has been subject to a Drug Rehabilitation Requirement (DRR). The level of CJS referrals is almost twice as high in Nottingham compared to the national level and it is expected that Transforming Rehabilitation will lead to even more clients being referred into drug treatment through the DRR route.
There is a much lower proportion of self-referrals to treatment in Nottingham compared to the national level (Table 6). Furthermore, males are much more likely to access treatment via the CJS than they are to self-refer. It is likely that the reduction in crime associated with treatment could be maximised if males were to self-refer prior to involvement of criminal justice services. This evidence highlights an area for consideration.

**Table 6: Source of referral into treatment**

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Nottingham</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>Male</td>
</tr>
<tr>
<td>Self</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td>CJS</td>
<td>61%</td>
<td>65%</td>
</tr>
<tr>
<td>GP</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Hospital/ A&amp;E</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Social services</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>12%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Treatment map summary**

The treatment map summary (published by Public Health England using information on structured treatment services) for structured services commissioned by The Crime & Drugs Partnership and Nottinghamshire Dual Diagnosis Team (included because of the work in this review concerning mental health) is shown in Figure 35.

A third of clients who entered treatment in Nottingham in 2013-14 were treatment naïve 20 (see Figure 34). This proportion is lower than the regional (41%) and national (43%) comparator which indicates that, whilst there is a high penetration rate of treatment interventions within the drug misusing population, there is also a complex cohort of clients who require more than one treatment journey.

**Figure 34: Referral routes – Nottingham compared to the region and England (2013-14)**

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20 A client has been classified as treatment naïve if they have not had any previous contact with the treatment system recorded within the National Drug Treatment Monitoring System.
Within the treatment cohort, seven percent (161 clients) have been in treatment for between two and four years and eight percent (177 clients) have been in treatment for more than four years. This is considerably lower than regional and national comparators (14% and 13% two to four years and 16% and 18% more than four years, respectively). A smaller proportion of clients in treatment for extended lengths of time show that Nottingham has comparatively fewer clients that are stagnant in treatment. It is likely that shorter treatment lengths have an impact on fewer treatment naïve clients presenting to treatment in Nottingham.

Last year in Nottingham, half of treatment exits were planned. Planned exits were higher in Nottingham compared to regional and national comparators (43% and 46%, respectively). Nottingham also had fewer drop outs, which reflects positive performance of the local treatment system. Unplanned exits due to clients entering prison were higher in Nottingham compared to the national and regional comparator (6% compared to 1% and 2%, respectively) which is likely to be due to the large number of clients who access treatment interventions via the criminal justice route.
Figure 35: Treatment Map Summary 2013-14
**Treatment outcomes**

Public Health England analysis shows that clients who stop using illicit opiates in the first six months of commencing treatment are almost five times more likely to successfully complete treatment. Nottingham has an abstinence rate of 42% for opiate clients in treatment which is equal to the national rate. The rate of significant reductions in opiate use is 23% for Nottingham and 25% nationally.

More clients in Nottingham (compared to England) inject at review and this is an issue that is overrepresented in female clients. Nottingham clients are also much less likely to be working when they successfully complete (see Table 7).

**Table 7: Injecting use, housing need and employment**

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Nottingham</th>
<th>Male</th>
<th>National</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults no longer injecting at review</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>49%</td>
<td>63%</td>
<td>46%</td>
<td>57%</td>
<td>55%</td>
<td>57%</td>
</tr>
<tr>
<td>Adults successfully completing treatment no longer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reporting a housing need</td>
<td>93%</td>
<td>100%</td>
<td>91%</td>
<td>88%</td>
<td>88%</td>
<td>88%</td>
</tr>
<tr>
<td>Adults working ten or more days in the month before</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>successfully completing treatment</td>
<td>12%</td>
<td>10%</td>
<td>13%</td>
<td>27%</td>
<td>16%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Clients accessing drug treatment in Nottingham are more likely to successfully complete treatment compared to the national comparator. This is true for all drugs (18% successfully completed in Nottingham in 2013-14 compared to 15% nationally) and also for opiate and non-opiate clients in isolation (10% compared to 8% and 44% compared to 41% respectively).

The vast majority of clients who successfully complete do not return to treatment within six months. This measure helps to estimate the level of sustained recovery. In Nottingham 87% of clients who successfully completed did not return to treatment within six months. At a national level this proportion was 89% which shows that Nottingham is just short of national standards. In Nottingham, men are much more likely than women to return to treatment within six months whereas nationally there is no significant gender difference.

A client’s chances of achieving sustained recovery reduces the longer they remain in treatment over two years. In Nottingham, 39% of clients in the treatment system have been accessing services continuously for two years or more. On a national scale, this figure is 43%.

**Public Health Outcomes Framework**

The Public Health Outcomes Framework reports on two indicators as part of health improvement; successful completion and no representation (within six months) of opiate users (indicator 2.15i) and non-opiate users (indicator 2.15ii).

**2.15i Successful completion and no representation of opiate users**

The proportion of clients who successfully completed and did not represent (within six months) was 10% in Nottingham in 2013. This is the second highest rate in the East Midlands, higher than the average for the East Midlands and higher than the national average (see Figure 36). Performance on this measure has shown improvement over time; albeit there has been a very slight reduction in 2013 compared to 2012 (see Figure 37). Over the previous two years Nottingham’s performance has been significantly better than the national average.
2.15ii Successful completion and no representation of non-opiate users

The proportion of non-opiate clients who successfully completed and did not represent (within six months) was 36.5% in Nottingham in 2013. Nottingham has the fourth highest rate in the East Midlands and under the national average (see Figure 38). In 2013, performance on this measure dropped considerably (see Figure 39). This information identifies a need to improve outcomes from the non-opiate using cohort.

Increase in opiate use

As was identified previously, the number of clients accessing adult substance misuse treatment services in Nottingham has been increasing since August 2014. The increase in numbers is small (21 additional clients in October 2014 compared to August 2014) but remains a concern because 1) this the greatest rate of increase in the last two years (see Figure 40) and 2) the increase comes at a time when heroin purity is known to be on higher than previously.
Drug use and offending
It is estimated that offenders who regularly use heroin or crack cocaine are responsible for approximately 45% of all acquisitive crime\textsuperscript{21}. Research by the Home Office has shown that acquisitive crime reduced by 62% in 2013-14 compared to 1995 and it has been suggested by Public Health England that improving access to and outcomes from drug treatment has played a part in this.

Drug offences
This year to date, drug offences accounted for 6% of the crime that occurred in the city (1,235 of 21,381 crimes, April to November 2014). Possession of Drugs, which made up 80% of offences, dominated the drug offences category and the remainder of the crimes were Trafficking of Drugs.

Geographic profile
The highest rate of Possession of Drugs (per 1,000 of population) exists in the City Centre and there are comparatively lower rates within the three localities (see Figure 44). However, when considering Drugs Trafficking, a very different picture emerges. The highest rates of Drug Trafficking exist in the north and south of the city; in the areas furthest from the city centre (see Figure 45).

\textsuperscript{21} Public Health England, January 2015.
**Offender profile**

Males are disproportionately represented as offenders of drug offences. Over the last 12 months, 88% of drug offence offenders, where an offender was identified, were male. The most common offender age group is people aged 18-25 years. Of the drug offences that occurred in the last year, more than a third (41%, 614 crimes) were carried out by a male aged between 18 and 25.

**Employment**

Evidence suggests that employment is integral to sustained recovery and yet employment outcomes for people exiting the treatment system are low. Nottingham’s drug treatment cohort has greater levels of unemployment, economic inactivity, long term sickness and disability at treatment start compared national comparators (see Figure 46). It is likely that these factors contribute to increasing levels of representations to treatment.

Almost two thirds of people accessing drug treatment on 31st March 2012 received benefits of some kind. This is a greater proportion of clients compared to the national level (64% and 61% respectively). Income Support, Incapacity Benefit and Employment Support Allowance are the three most common types of benefits claimed as shown in Figure 47. Most clients have been accessing benefits for five years or more prior to accessing treatment. A smaller proportion of benefit claimants exists in the successful completion cohort compared to the treatment cohort (53% and 64% respectively). This provides further evidence that unemployment and economic inactivity is not conducive to sustained recovery. Continued multi-agency response is required to improve employment outcomes for clients accessing treatment.
Client Complexity

In December 2014 Recovery in Nottingham completed a snapshot audit of clients in treatment. The audit, designed to demonstrate complexity amongst the treatment cohort, included clients accessing treatment via shared care treatment providers.

Of the clients included within the audit 47% (374 clients) had a mental health issue identified by their practitioner. Personality disorder (91 clients, 11%), anxiety (90 clients, 11%), significant trauma (89 clients, 11%) and depression (70 clients, 9%) were the most prevalent types of mental health issues affecting clients. Prescribed medication (225 clients, 29%), GP support (173 clients, 22%) and anti-depressants (107 clients, 14%) were common means of coping with mental health issues (see Figure 48).

**Figure 48: Recovery in Nottingham audit – mental health**

Complex physical health issues are commonly associated with drug misuse, particularly for opiate and crack users that have a long substance misuse career. Collapsed arteries, respiratory problems and abscesses are common amongst long-term injecting heroin users which lead to reduced quality of life and increased costs to health services. Over a third of clients included in Recovery in Nottingham’s snapshot audit (287 clients, 36%) were identified by a practitioner as having complex physical health needs. Alcohol-related physical needs (79 clients, 10%) hepatitis C virus (72 clients, 9%), issues around intravenous drug use (56 clients, 7%) and pain (40 clients, 5%) were the most common physical health needs cited by practitioners (see Figure 49).

Safeguarding for children in contact with clients was a common factor contributing to client complexity. Of those clients in Nottingham that were audited, 27% (215 clients) had safeguarding practices in place. These included issues relating to domestic and sexual violence (47 clients, 6%), children looked after (42 clients, 5%) and child protection (34 clients, 4%).

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22 National Institute on Drug Abuse
Figure 49: Recovery in Nottingham audit – physical health
New Psychoactive Substances

The prevalence of new psychoactive substance use in Nottingham

The prevalence of new psychoactive substances is largely unknown. Drug Misuse: Findings from the 2013/14 Crime Survey for England and Wales has reported on the last two years of use of ‘emerging legal drugs’ including salvia and nitrous oxide. Prevalence among 16-59 year olds has increased; both for salvia (0.3% in 2013-13 to 0.5% in 2013-14) and nitrous oxide (2% in 2012-13 to 2.3% in 2013-14, see Figure 50). Nitrous oxide is particularly prevalent in the 16-24 year old cohort, in which use increased to 7.6% in 2013-14. The number of mephedrone users also climbed from 161,000 to 205,000 in 2013-14.

Figure 50: National proportion of 16 to 59 year olds reporting use of new psychoactive substances

![Figure 50](image)

A literature review found that, aside from mephedrone, salvia and synthetic cannabinoids (such as Black Mamba); new psychoactive substances do not appear to have had a significant impact of the drugs market. The review does, however, caution that much of the research available uses small convenience samples and that these samples cannot reliably be generalised to wider populations (Sumnall et al., 2013)23.

Synthetic cannabinoids, including Black Mamba (pictured on the right) and Spice, are the types of new psychoactive substances most commonly cited both in Nottingham and the England24. In response, Nottingham Crime & Drugs Partnership is facilitating a synthetic cannabinoids working group. The group’s aim is to collate and synthesise intelligence on the use of synthetic cannabinoids – including partnership data such as police incidents and hospital admissions, establish prevalence of synthetic cannabinoids use and produce harm reduction literature for young people and adults.

In response to the lack of definitive information available of new psychoactive substances, CDMR Research and Consultancy ran a ‘legal high’ national online information gathering exercise during 2014. The organisation produced two surveys;

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one for individuals who had taken a legal high and one for those who had not. The exercise recruited 1,172 participants; 468 ‘ever-takers’ and 704 ‘never-takers’, all aged 18 years and over.

In terms of the effects observed from using new psychoactive substances, 40% cited stimulants, 37% cannabinoids and 30% depressants (see Figure 51). This evidence supports information gleaned locally, which suggests that synthetic cannabinoids are the most commonly used new psychoactive substances in the city.

*Figure 51: ‘Ever-takers’ ever-use of new psychoactive substances by effect category*

![Chart showing the percentage of 'ever-takers' using new psychoactive substances by effect category.](image)

Age of first new psychoactive substance use ranged from 11 years to 51 years amongst ‘ever-takers’; with a modal age of first use of 16.5 years (23% of ‘ever-takers’). Fifty six percent of ‘ever-takers’ had used their first new psychoactive substance by 21 years of age.

By far the most common days for new psychoactive substances to be used were Friday and Saturday; 81% and 91% of respondents cited using substances on these days. A third of participants believed that using their ‘favourite new psychoactive substance’ came with no or low risk (6% and 27%, respectively).

In terms of the effects experienced post new psychoactive substance consumption, 79% (250 respondents) felt relaxed many or some of the time, 65% (207 respondents) had heart palpitations as a consequence of using substances, 60% (189 respondents) felt nauseous at least sometimes, 58% had increased sex drive some or many times and the same proportion of respondents experienced anxiety (186 respondents). All of the effects experienced are shown by category in Figure 52:
Typically, new psychoactive substances were consumed before either a night out or when at home alone. Sixty two percent of ‘ever-takers’ (242 respondents) took new psychoactive substances before a night out and 51% (199 respondents) took new psychoactive substances when home alone. A large amount of clients using substances on their own could increase the health risks they experience.

The three most common sources of new psychoactive substances were via a shop (35%), a friend (30%) and from a website (25%). Action in Nottingham to reduce the number of sales from retailers should, therefore, have a considerable impact on the availability of new psychoactive substances in Nottingham.

Respondents who admitted using new psychoactive substances were most likely to turn to a close friend (81%), a website (59%) or their GP (55%) for advice on drugs.

The role of new psychoactive substances in offending

National information

Information provided by the Centre for Social Justice shows that the number of police incidents involving legal highs has increased within many areas in England. Sixteen forces responded to a freedom of information request by the think-tank, the results of which are shown in Table 9. Lincolnshire has the highest rate of police incidents involving new psychoactive substances. Although Nottinghamshire is not one of the highest ranking police forces, its prevalence of new psychoactive related incidents increased by almost 100% in 2014 compared to the previous year. The process forces follow in regards to identifying and recording the incidents in which new psychoactive substances are associated is likely to vary from force to force and this will have an effect how much of an issue the substance appear to be in that area.
Local information

During 2013-14, the Criminal Justice Intervention Team (one of three community criminal justice treatment providers) conducted a survey on new psychoactive substances use by detainees of Nottingham city centre’s custody suite. Thirty seven per cent of respondents used new psychoactive substances (41 of 110 respondents); evidencing a considerable link between new psychoactive substances use and criminal behaviour. One service user reported being arrested for sexual assault after having used a synthetic cannabinoid and said that he had no memory of the event. By far the most commonly used type of new psychoactive substances was Black Mamba. Thirty six respondents cited use of Black Mamba although it has been suggested anecdotally that many new psychoactive substances users use the name as a catch-all term for synthetic cannabinoids in general. The most prevalent method of administration was smoking, which further supports the evidence that synthetic cannabinoids are the most prevalent type of new psychoactive substances with the cohort.

In terms of the negative effects of new psychoactive substances on the individuals who used them; physical and mental health, finances, housing, relationship breakdown, criminal record and being arrested under the influence of substances were common (see Figure 53).

<table>
<thead>
<tr>
<th>Police Authority</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Yorkshire</td>
<td>6</td>
<td>18</td>
<td>118</td>
<td>465</td>
<td></td>
</tr>
<tr>
<td>Nottinghamshire</td>
<td>1</td>
<td>4</td>
<td>26</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Wiltshire</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Leicestershire</td>
<td>4</td>
<td>10</td>
<td>24</td>
<td>65</td>
<td></td>
</tr>
<tr>
<td>Derbyshire</td>
<td>0</td>
<td>8</td>
<td>27</td>
<td>77</td>
<td></td>
</tr>
<tr>
<td>Cambridgeshire</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>7</td>
<td>57</td>
<td>347</td>
<td>820</td>
<td></td>
</tr>
<tr>
<td>Avon and Somerset</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>Greater Manchester</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>29</td>
<td>104</td>
</tr>
<tr>
<td>Norfolk</td>
<td>2</td>
<td>20</td>
<td>35</td>
<td>93</td>
<td>258</td>
</tr>
<tr>
<td>Hertfordshire</td>
<td>4</td>
<td>6</td>
<td>9</td>
<td>39</td>
<td></td>
</tr>
<tr>
<td>Northumbria</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>24</td>
<td>108</td>
</tr>
<tr>
<td>Devon and Cornwall</td>
<td>2</td>
<td>2</td>
<td>16</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>West Yorkshire</td>
<td>4</td>
<td>13</td>
<td>88</td>
<td>324</td>
<td></td>
</tr>
<tr>
<td>Cheshire</td>
<td>3</td>
<td>3</td>
<td>13</td>
<td>26</td>
<td>63</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>2</td>
<td>9</td>
<td>13</td>
<td>11</td>
<td>22</td>
</tr>
</tbody>
</table>
Direct effects of using new psychoactive substances before, during and after are shown below and in Figure 54:

- Confidence prior to using new psychoactive substances (perhaps due to the perceived legality of the substance),
- Confidence, euphoria, anxiety and paranoia during use; and
- Anxiety, low mood and paranoia following the use of new psychoactive substances.
New psychoactive substance using populations
According to anecdotal frontline reports from Public Health England there are three distinct populations using new psychoactive substances nationally: young people (under 18 and 18 to 24 year olds); heavy ‘club’ drug users (including men who have sex with men, although evidence suggested this group may be concentrated in London), traditional opiate and crack users that supplement use of other drugs with new psychoactive substances and the street homeless. In addition to these three groups of people; prisons and psychiatric inpatient units have also been identified as places of concern for use of new psychoactive substances. In March 2015, the Government launched new powers for prisoners to address the significant threat to keeping order posed by the growing use of new psychoactive substances. Any prisoner suspected of being involved in smuggling new psychoactive substances can be have visitors banned, have up to 42 days added to their sentence and be confined to their cell for up to 21 days.

Young people
A local survey conducted by Framework in 2013 provides valuable insight into the use of new psychoactive substances in vulnerable young people. A total of 101 individuals aged between 17 and 30 years (with a mean age of 23) took part in the survey. The majority of participants felt that new psychoactive substances use was a problem for some people and that the products were easily obtainable. Almost half of respondents did not think information on new psychoactive substances was readily available. The survey results showed that more than half of respondents had used new psychoactive substances (53%). Nearly one in five respondents used them daily (28%). This is considerably more than the amount of respondents that consumed alcohol daily (18%, see Table 10). Six respondents admitted that they were unsure of what a substance was when they took it.

Table 10: Participant responses to Framework survey 4

<table>
<thead>
<tr>
<th>Question</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Yearly</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often have you taken a legal high?</td>
<td>28%</td>
<td>10%</td>
<td>4%</td>
<td>11%</td>
<td>47%</td>
</tr>
<tr>
<td>How often do think friends take legal highs?</td>
<td>29%</td>
<td>24%</td>
<td>4%</td>
<td>10%</td>
<td>33%</td>
</tr>
<tr>
<td>How often do you drink alcohol?</td>
<td>18%</td>
<td>27%</td>
<td>30%</td>
<td>7%</td>
<td>17%</td>
</tr>
<tr>
<td>How often do you smoke?</td>
<td>76%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>23%</td>
</tr>
<tr>
<td>How often do you drink energy drinks?</td>
<td>33%</td>
<td>23%</td>
<td>15%</td>
<td>0%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Treatment

Structured treatment
The number of adults accessing structured drug treatment for primary, secondary or tertiary substance use is low for both new psychoactive substances and ‘other drugs’. In fact, there have been no adults in structured treatment who cite new psychoactive substances as a used substance in Nottingham. There has been an increase of 64% (7 clients) in the number that cite use of ‘other drugs’; however the actual volume of clients remains low (18 clients).

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26 Participants were Framework clients most of whom accessed specialist hostel services.
27 ‘Other drugs’ is a Public Health England drug category and includes ‘other psychoactive drugs unspecified’, ‘other sedatives’, ‘other stimulants’ and ‘sedatives unspecified’ among others. This category may represent a degree of new psychoactive substances use.
At present, new psychoactive substances in structured young people treatment is captured in the ‘other drugs’ category. The level of young people citing other drug use in Nottingham is very low and does not reflect the slight increase that has been observed nationally.

**New psychoactive substances and ‘club’ drugs in structured treatment**

Public Health England has recorded information on new psychoactive substances from April 2013 and will begin to report on these drugs next year. In the meantime information is available on the use of ‘club’ drugs. By nature, many people that use ‘club’ drugs do not present to treatment and, when they do, are less likely than opiate users to require structured treatment. The use of ‘club’ drugs as cited by clients in structured treatment is therefore very low in numbers. Three opiate users and 26 non-opiate users cited ‘club’ drug use in 2013-14. Ecstasy, ketamine and mephedrone were the most prevalent substances.

In February 2014 Public Health England reran the ‘club’ drugs cohort (ecstasy, ketamine, methamphetamine, GHB/GBL and mephedrone) in order that the latest national trends could be observed. Last year saw the highest levels of new presentations in eight years (see Figure 55) and account for more than 5% of treatment starts (see Figure 56).

*Figure 55: New adult ‘club’ drugs treatment presentations*

*Figure 56: New adult ‘club’ drug users as a proportion of all new treatment starts*
As many as one in seven young people in treatment were using ‘club’ drugs (see Figure 57).

**Figure 57: ‘Club’ drugs in young people’s treatment**

Evidence shows that, once people are in treatment for ‘club’ drugs, they are more likely to recover (compared to all clients, see Figure 58). This suggests that focus should be placed on directing people into treatment at the earliest opportunity.

**Figure 58: Successful completions in all clients versus ‘club’ drugs**

**New psychoactive substances in the criminal justice system**

Test on arrest data is currently available via the police database Bridget. At present this data includes whether an individual tested positive for opiates or cocaine and whether they admit use of crack, heroin, cocaine, ecstasy, cannabis and amphetamine. Unfortunately use of new psychoactive substances is not currently available from this data.

Anecdotal local evidence indicates that some people might purchase what they believe to be cocaine but in actual fact this white powder contains other substances including new psychoactive substances.
Monitoring the level of people who admit cocaine use in the custody suite but test negative might provide insight into this area. Figure 59 shows the number of people who admitted but tested negative for cocaine along with this cohort as a proportion of all tests. The number of people that tested negative but admitted cocaine has reduced since April 2012; however it is likely that this is a direct result of the implementation of target testing. In contrast, the proportion of negative testers that admitted cocaine (6% on average) has remained stable. This finding supports the anecdotal evidence that white powder falsely believed to be cocaine is being used and that this is an enduring issue.

*Figure 59: Custody suite negative cocaine tests despite admitting use*

Analysis of the types of offences associated with those who admit use of cocaine but test negative compared to all tests has revealed some interesting differences. Violence against the person, begging, criminal damage and attempted theft rank higher for the cohort that admitted cocaine use but tested negative (see Table 11).

*Table 11: Top 10 ranking offences for those that used white powder falsely believed to be cocaine, cocaine, and all tests*

<table>
<thead>
<tr>
<th>Rank</th>
<th>Offence Type</th>
<th>Rank</th>
<th>Offence Type</th>
<th>Rank</th>
<th>Offence Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Theft</td>
<td>1</td>
<td>Theft</td>
<td>1</td>
<td>Theft</td>
</tr>
<tr>
<td>2</td>
<td>Burglary</td>
<td>2</td>
<td>Possession of specified Class A</td>
<td>2</td>
<td>Burglary</td>
</tr>
<tr>
<td>3</td>
<td>Possession of specified Class A</td>
<td>3</td>
<td>Burglary</td>
<td>3</td>
<td>Possession of specified Class A</td>
</tr>
<tr>
<td>4</td>
<td>Violence against the person</td>
<td>4</td>
<td>Possession w/i to supply Class A</td>
<td>4</td>
<td>Possession w/i to supply Class A</td>
</tr>
<tr>
<td>5</td>
<td>Possession w/i to supply Class A</td>
<td>5</td>
<td>Violence against the person</td>
<td>5</td>
<td>Robbery</td>
</tr>
<tr>
<td>6</td>
<td>Robbery</td>
<td>6</td>
<td>Robbery</td>
<td>6</td>
<td>Violence against the person</td>
</tr>
<tr>
<td>7</td>
<td>Begging</td>
<td>7</td>
<td>Public order</td>
<td>7</td>
<td>Fraud (Section 1)</td>
</tr>
<tr>
<td>8</td>
<td>Criminal Damage</td>
<td>8</td>
<td>Summary Offence - Failure to Attend</td>
<td>8</td>
<td>Public order</td>
</tr>
<tr>
<td>9</td>
<td>Public order</td>
<td>9</td>
<td>Criminal Damage</td>
<td>9</td>
<td>Going Equipped</td>
</tr>
<tr>
<td>10</td>
<td>Attempted Theft</td>
<td>10</td>
<td>Other motoring offences</td>
<td>10</td>
<td>TWOC</td>
</tr>
</tbody>
</table>

*Source: Bridget test on arrest data, C Division, April 2012-January 2014*
During April 2012-January 2014 there were 263 instances in which the individual admitted cocaine use but tested negative for the substance. Almost a third of these instances (76 tests) consisted of individuals who had been tested more than once during that time period. There were 31 individuals who were tested more than once and a range of between 2 and 6 tests per individual, indicating that a considerable proportion might be dependent.

In order to shed more light on the cohort of possible new psychoactive substances users (those that admitted cocaine but tested negative), a random sample of 20 individuals was selected for an in depth examination of offence history. The number of previous offences recorded against the 20 individuals varied widely, from 2 to 169 offences per person, an average of 59 offences per person and 1189 offences in total. Much of the offences were acquisitive crimes and over a third were either shop theft or burglary (35%, 415 offences).

**New psychoactive substances sales**

New psychoactive substances sales, both locally and via the internet, commenced during the 1990s\(^{28}\).

Trading Standards have identified sales from four retailers within Nottingham City. Intelligence has been received on two other retailers, although no sales have been identified. There is no intelligence to suggest that there are any wholesalers within the city area.

Recently 21 seized new psychoactive substances were sent to the laboratory for controlled substances where it was established that three of the seizures contained class B substances. Similar products were sent to the Public Analyst in Staffordshire in order that assessment against safety legislation could be undertaken. All substances failed the assessment because they lacked sufficient labelling and information for the consumer to be able to make an informed choice.

According to information provided by Trading Standards new psychoactive substances are sold for between £10 for 1 gram and £20 to £25 for 3 grams. Between 2010 and 2011 the amount of online sites in the European Union which sold new psychoactive substances increased by 120%\(^{29}\).

**Drug dealers**

Local intelligence suggests that some people that use new psychoactive substances purchase them from a street drug dealer, particularly if they have previous experience of using other drugs such as heroin and crack cocaine. Clients from the Prostitute Outreach Workers service reported clients citing their usual drug dealer as the source for the substances.

**Drug related death**

In 2012 there was a 600% increase in new psychoactive substances related deaths (compared to 2009) in England and nearly a 400% increase (compared to 2010) in Scotland\(^{30}\). One identified new psychoactive substances drug related death has taken place in the city.

**New psychoactive substances related hospital presentations**

Early findings of the Legal High National Online Survey (LHNOS) indicate that people using new psychoactive substances are reluctant to contact health services when they experience a problem. Of 100 respondents, 55 reported that they would be unlikely to call for an ambulance and 45 reported that they

\(^{28}\) Dr Owen Bowden-Jones, Central and North West London NHS Foundation Trust.

\(^{29}\) Source: EMCDDA Annual Report 2012

would be unlikely to visit a hospital A&E department. Results showed that people are much more likely to seek help from a close friend (84%) rather than through health services.

Currently, there is no robust methodology available to determine the level of hospital admissions that are attributable to new psychoactive substances. However, since diagnosis codes for NPS-related admissions were included in data recording during 2014, it has been possible to produce an indication of the effect NPS use is having on emergency services. Between 10th January and 5th March there were 46 admissions with a primary diagnosis of ‘legal high’ to the Queens Medical Centre A&E department. Of the 46 admissions, 70% were male and 30% female. The age of admissions ranged from 16-61, with a median age of 25.

More historical data (April 2010 to March 2013) shows an increase in potentially new psychoactive substance-related hospital admissions31 in Nottingham despite the number of all substance abuse admissions remaining comparatively static. Figure 60 shows potentially new psychoactive substance-related hospital admissions as a proportion of all substance abuse admissions. The figure clearly shows an increase over time, suggesting the new psychoactive substance-related health problems are becoming more of an issue, whilst also highlighting that admissions of this kind peak year on year during summer months.

Figure 60: Potentially new psychoactive substance-related hospital admissions as a proportion of all substance abuse admissions

![Chart showing potentially new psychoactive substance-related hospital admissions as a proportion of all substance abuse admissions.]

**Symptoms and side effects**

Anecdotal evidence suggests that symptoms associated with new psychoactive substances use include heart palpitations and breathlessness. The LHNOS indicates that 65% of respondents experienced heart palpitations after using new psychoactive substances. For 28% of respondents heart palpitations had been experienced many times. A Nottingham drug treatment client was admitted to hospital following a heart

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31 Potentially new psychoactive substance-related hospital admissions include: poisoning: psycho stimulants with abuse potential, poisonings: other synthetic narcotics, poisonings: other psychotropic drugs, not elsewhere classified, poisonings: other and unspecified narcotics and mental and behavioural disorders due to multiple drug use and use of other psychoactive substances.
attack believed to have been caused by new psychoactive substance consumption. This client was known to have ongoing heart-related health problems.

A local citizen and rough sleeper who told his substance misuse treatment practitioner about his experience using Black Mamba said that he ‘had a little to drink and a couple of drags. Fairly quickly I couldn’t stand up or speak and totally tripped out’. Another substance misuse practitioner reported having to call an ambulance for a service user who had used Black Mamba and subsequently had a seizure. In one instance reported by a practitioner, a child was admitted to hospital after having eaten a piece of Black Mamba that had been left by a friend on a table in their home. Other symptoms and side effects reported to substance misuse practitioners include memory loss, black outs and violence (particularly among clients with criminal justice involvement). Compulsive use is also commonly reported.
Criminal Justice

Introduction
This chapter has been designed to supplement The Criminal Justice Substance Misuse Pathway Needs Assessment (CJSMPNA) produced by Ian Bentley (Crime & Drugs Partnership Strategy and Commissioning Manager) and published in January 2014. The CJSMPNA featured a chapter on Transforming Rehabilitation and the effect that implementation of the agenda would have on both clients and treatment providers. At the time of publication it was estimated that Transforming Rehabilitation could lead to a caseload increase of 230% or 971 clients in total. It is anticipated that the increase to clients requiring substance misuse support will be manageable; many clients will require low-level interventions and, in some cases, group sessions as opposed to one to one provision will be appropriate. Effects of Transforming Rehabilitation are expected to manifest in May of this year.

Treatment

Clients in treatment

Community treatment

In 2014-15 The Crime & Drugs Partnership commissioned community justice treatment providers; the Criminal Justice Intervention Team (CJIT), Substance Misuse Team (SMT) and Rapid Access Team (RAT). As shown in Figure 61 below, CJIT (represented by the blue area) has the largest client cohort, followed by the RAT (shown in green) and SMT (in red). The RAT supports CJIT and is designed to provide a quick turnaround for clients requiring a prescribing based drug treatment intervention. Therefore the sum of all clients in the three services does not represent the total number of clients, because some clients will have been counted within more than one of the services. An increase in clients, particularly for the CJIT, has been observed since June 2014.

Figure 61: Volume of clients accessing community criminal justice providers (rolling 12 month count)
Last year, a quarter of new receptions to HMP Nottingham commenced substance misuse treatment during their sentence (1,373 of 5,370 offenders). New receptions accessing substance misuse treatment has experienced a large reduction compared to the previous year, when the proportion was 62% (1,299 of 2,090 offenders). It is important to note that whilst the proportion of offenders accessing treatment has reduced, the actual volume has increased (see Figure 62). Furthermore, the recent inspection of HMP Nottingham found that 50% (89 survey respondents) of prisoners thought that it was easy to get hold of drugs in the prison\textsuperscript{32}, although work to reduce drugs supply was having an impact and substance misuse treatment provision was considered appropriate.

Figure 62: Volume of new receptions and offenders accessing substance misuse treatment in 2012-13 and 2013-14

The substance-type profile of offenders accessing substance misuse in treatment in HMP Nottingham has shifted compared to the previous year. There has been a reduction in opiate users and an increase in clients citing alcohol as their primary problem substance (see Figure 63).

\textsuperscript{32} Report on unannounced inspection of HMP Nottingham. September 2014.
**Treatment profile**

**Community treatment**

Between 79% and 87% of clients in community justice treatment services are male and between 77% and 82% are White British. CJIT, the service with the largest caseload of clients, has the greatest amount of variation in ethnicity with a White British population of 77%. The next most prevalent ethnicity is White and Black Caribbean which has a prevalence rate of between 3% and 8%.

The age range for clients in treatment peaks between 20 and 40 which, as would be expected, is very similar to the profile of substance misuse treatment in prison.

Opiates and crack are the most commonly cited drugs by clients accessing community criminal justice substance misuse treatment (see Figure 64). Heroin has, for some time, been accepted as a driver of acquisitive crime such as shop theft and burglary. Cannabis, alcohol, opiates and cocaine are other substances commonly cited by clients. These substances are most prevalent in CJIT and least prevalent in the RAT which is as to be expected because the RAT is a predominantly prescribing service consisting principally of heroin users. During 2014-15, CJIT carried out a questionnaire within Nottingham city centre’s custody suite of offenders and their use of New Psychoactive Substances and amphetamines. The results of this questionnaire are included in the new psychoactive substances chapter of the document.
**Treatment in HMP Nottingham**

HMP Nottingham is a male-only prison. The ethnic profile of clients is predominantly White British and broadly similar to the community substance misuse treatment ethnic profile. Clients are generally aged 20-39 years of age.

By far the most common main substance used by clients is heroin, followed by alcohol, amphetamines, cocaine and crack (see Figure 65). Cannabis is disproportionately underrepresented as a main substance compared to the community drug treatment profile. This might indicate that the substance is less linked to criminal activity compared to heroin or that the prescription element of heroin treatment plays a key role in incentivising clients into treatment. The second problematic drug profile is dominated by crack use which is traditionally used in conjunction with heroin (see Figure 66). Most clients that use both crack and heroin will cite heroin as their main drug. Whilst clients that use a third drug are less common, the range of substances used is much more diverse (see Figure 67). Alcohol, cannabis and amphetamines are most common.
The amount of units consumed by offenders accessing substance misuse treatment has remained proportionately stable over a two year period. Two in five clients stated that they did not currently drink alcohol, whereas one in four drinks in excess of 25 units – the equivalent of two and a half bottles of wine – per day (see Figure 68).
Waiting times
In community criminal justice treatment services during 2013-14, all but six clients (0.7% of all treatment starts) waited fewer than three weeks for their treatment to commence. All clients that accessed the RAT commenced treatment within three weeks which is particularly important because the service is designed to provide fast access to interventions.

Routes into treatment
As is intended due to the nature of the service, the vast majority of clients accessing community criminal justice treatment are referred via the criminal justice pathway. Other than criminal justice referrals, the only other source was self, family or friend which accounted for just 39 referrals across the three community providers.

Treatment outcomes
Community treatment
The proportion of successful completions (as a proportion of all clients are treatment) are shown below in Figure 69. The CJIT has by far the highest level of successful completions 17.6 in September 2014), followed by SMT (12.8% in September 2014) and the RAT (3% in September 2014). The scope for successful completions from the RAT is slim because the system is designed to provide short-term interventions after which most clients will be transferred to another service provider.
Due to the nature of treatment interventions provided within a secure setting, outcomes for offenders are not focused around successfully completing but rather successful transfer to a community criminal justice treatment provider. Last year, 49% (528 clients) were transferred to the criminal justice intervention team or another community treatment provider upon exit. The remaining 51% (557 clients) were transferred to another prison.

Public Health Outcomes Framework

Since 2012-13, The Public Health Outcomes Framework has reported on the proportion of clients entering prison with substance dependence issues who are not previously known to treatment (indicator 2.16). Although a low level of treatment naïve clients in prison could be considered positive because it means that the treatment system has intervened in an individual’s substance misuse at an earlier stage, it may also be an indication that the earlier interventions have been unsuccessful. Appropriate and effective early interventions have been shown to reduce health harm, improve psychological wellbeing, reduce blood borne virus transmission and improve parenting skills.

The performance of Nottingham, together with other East Midlands Local Authorities (excluding Rutland where data was not available), the East Midlands (40%) and England (50%) is shown below in Figure 70. In Nottingham, three of every five new receptions have already experienced substance misuse treatment intervention at a structured level. Nottingham’s performance is similar to the average for England (shown by the red line) and is mid-table amongst the eight local authorities included in the region.
Figure 70: Percentage of clients entering prison with substance dependence issues who are not previously known to treatment

Drug testing on arrest

Drug testing is undertaken in Nottingham’s Bridewell custody suite. Up until April 2013, two rationales existed for instigating a drug test, either; 1) the detainee was arrested for a trigger offence (acquisitive crimes traditionally associated with opiate use), or 2) the detainee was not arrested for a trigger offence but drug use is suspected and therefore authority to undertake the test was sought from an inspector. The city only has the resources to test for opiates and cocaine, which is problematic because the use of these drugs is reducing, whereas the prevalence of other drugs (including prescription and new psychoactive substances) is increasing. As a result, drug test data might present a deceivingly smaller link between crime and drugs than is actually the case.

From April 1st 2013, the Drugs Intervention Programme (DIP) was discontinued as a national programme and the responsibility of how to run DIP was transferred to local areas to run in accordance to the Police and Crime Commissioner’s guidance. Nottingham has chosen to continue with the DIP ethos with a change in some of the delivery methods. As a result, trigger offence testing has been replaced by target testing. The aim of introducing target testing is to reduce the number of negative tests, give the Criminal Justice Intervention Team more influence in who is tested and plan to increase the number of inspector’s authority tests for other crimes, particularly violence in the night-time economy.

Target testing involves a screening tool which is used for all detainees who are over 18 and not returned to prison. The tool enables the officer to assess the detainee against the following criteria which are designed to identify both existing and new detainees misusing drugs and if the answer to any of the criteria is yes, the detainee will be tested:

1. Has the detainee tested positive in the previous 12 months?
2. Has the detainee admitted to using crack cocaine or heroin?
3. Has the detainee been found in possession of crack cocaine or heroin?
4. Does the detainee have a relevant Police National Computer trigger?

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5. Has the detainee requested medication that suggests they have been using heroin or crack cocaine?
6. Has the criminal justice intervention team specifically requested for the detainee to be tested?
7. Has the sergeant specifically requested for the detainee to be tested?
8. Is this the first time the detainee has been arrested for a trigger offence or an offence that might warrant testing under inspector’s authority?

Due to the introduction of target testing the number of tests has reduced and whilst the proportion of trigger offences has reduced, inspector’s authority testing has remained comparatively static (see Figure 71). Furthermore, the overall number of positive tests has reduced, but the proportion of all tests that were positive has increased (see Figure 72). An unintended consequence of the introduction of target testing is that it is no longer possible to compare current performance with historical figures on a like-for-like basis; which makes it difficult to assess the true level of drug-related offending over time. The last reliable data (based on test on arrest of all trigger offenders as opposed to target testing) highlighted that between 20% and 30% of all offenders were testing positive for opiates or cocaine and it is assumed that this is still a fairly accurate assessment of drug-related offending.

Despite there being an identified increase in the number of opiate clients accessing treatment in quarter 2 of 2014-15, together with evidence of increasing purity of street heroin in the city, the number of positive tests for opiates has not undergone a reflective increase and has instead remained stable (see Figure 73). This finding might reveal the directional relationship of substance misuse and offending in that offending is a symptom of substance misuse that follows later on in an individual’s substance using career. If this inference is correct and if opiate use is increasing, there could be more substance misuse-fuelled offending in the near future and as a result an increase in positive opiate tests on arrest and ultimately more opiate clients accessing treatment via the criminal justice pathway.

The association between the use of stimulants and violent offending remains significant. During April-October 2014 more than half of all violent crime that was tested under inspector’s authority was shown to be associated with stimulant use; either through testing positive for cocaine, admitting use of cocaine (but testing negative) or admitting use of amphetamine (but testing negative for cocaine, see Table 12).
Figure 71: Number of trigger offences, inspector’s authority tests and inspector’s authority tests as a proportion of all tests

Figure 72: Positive tests on arrest and positive tests as a proportion of all tests
Figure 73: Positive opiate tests and positive opiate tests as a proportion of all tests

Table 12: Number of Violence Against the Person tests and the proportion which were stimulant related

<table>
<thead>
<tr>
<th>Violence Against The Person (April 2014-Oct 2013)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All non-trigger offences</td>
<td>126</td>
<td></td>
</tr>
<tr>
<td>Violence Against The Person non-trigger offences</td>
<td>38</td>
<td>30%</td>
</tr>
<tr>
<td>Tested +ive for cocaine</td>
<td>18</td>
<td>47%</td>
</tr>
<tr>
<td>Tested -ive for cocaine but admitted cocaine</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>Tested -ive for cocaine but admitted amphetamine</td>
<td>1</td>
<td>3%</td>
</tr>
<tr>
<td>All cocaine and amphetamine (+ive and admit)</td>
<td>21</td>
<td>55%</td>
</tr>
</tbody>
</table>
Harm Reduction

Introduction
Substance misuse is associated with a wide range of health-related harms. These can affect both physical and mental health and include harms such as blood-borne viruses, vein damage and collapse, bacterial infections, respiratory damage, overdose and death. For those who are unable or unwilling to stop using substances, harm reduction policies, programmes and practice are put in place with the aim of reducing harm to these people and those around them as they continue to use drugs. Reducing and minimising harm whilst people are using drugs helps to ensure that when they do recover, they are able to lead a safe and healthy life.

It is therefore essential that harm reduction information, services and other interventions exist to help keep people healthy and safe. Harm reduction has an important place in the drug treatment system which has seen a recent shift of emphasis on to a recovery focus.

Harm reduction can be delivered via a range of interventions including needle exchange and sexual health services, testing, vaccination and treatment for blood borne viruses and the provision of a range of advice and information.

Blood-Borne Viruses
Blood-borne viruses remain a key threat to health amongst drug users, particularly amongst those who have previously or are currently injecting. Infections such as hepatitis B, C (the two forms of hepatitis that pose the most serious risk to drug users) and the HIV virus can all be transmitted through sharing drug taking equipment. Without treatment, hepatitis B and C infection can result in chronic infection, leading to cirrhosis, liver cancer and death.

There are currently no vaccines available to prevent Hepatitis C or HIV. However treatments are available for hepatitis C that can lead to the body becoming clear of the infection. Treatment for HIV has also improved which means that people living with HIV can expect a near-normal life span if they are diagnosed promptly. People that get a late HIV diagnosis have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed promptly. In 2013, 530 UK residents with HIV infection were reported to have died; the majority of these had a late diagnosis[^34].

Preventing the spread of BBV transmission is achievable through the provision of basic harm reduction equipment and advice. This can include the provision of sterile injecting and drug taking equipment, safer injecting advice and information, distribution of condoms and safe sex advice to service users in addition to BBV testing, vaccination and treatment.

Prevalence

Hepatitis B
It is estimated that around 16% of Injecting drug users have been exposed to the virus. Public Health England estimates that around one in two hundred injecting drug users in England, Wales and Northern Ireland are living with hepatitis B infection.

Around 95% of people who are exposed to the hepatitis B virus clear the infection and attain future immunity. Of the other 5% who continue to have chronic infection, around 20% will progress to cirrhosis of the liver, and of those 10% will go onto to develop liver cancer[^35].

[^35]: Nottingham County Public Health JSNA 2013
A vaccination exists for hepatitis B, consisting of three vaccinations over time and a follow up blood test to determine whether immunity to the virus has been achieved. The availability of the vaccination for hepatitis B has greatly reduced infection rates which have halved over the last 10 years. However, the uptake of hepatitis B vaccination from clients within drug treatment has reduced by 10 percentage points from 2011/12 to 2013/14 (as shown in Figure 74). Similarly, the proportion of those that refuse the intervention has increased by 18 percentage points over the same time period.

Figure 74: Proportion of clients that were offered hepatitis B intervention that accepted or refused over time

Hepatitis C
Hepatitis C remains the main area of concern in relation to BBV’s, due to levels of infection, transmission, the lack of a vaccine, low levels of treatment take up and the serious effects that it has on health. The World Health Organisation estimates that globally between 130 and 150 million people are infected with chronic hepatitis C infection.

Injecting drug use remains the main route of hepatitis C infection in the UK, with 90% of those acquiring the infection having done so through injecting drugs. Public Health England estimates that 50% of injecting drug users in England have been infected with hepatitis C. Around 25% of these will go on to clear their infection naturally, so it is estimated that around two in every five of injecting drug users in the UK currently have hepatitis C infection. Furthermore, they estimate that around half of the injecting drug users in the UK who are infected remain undiagnosed, either because they have not been tested or have been infected since their last negative test.

In England, only 3% of those who have hepatitis C infection are in treatment. It is estimated that in the UK, some 215,000 individuals have a chronic hepatitis C infection and hospital admissions and death as a result of hepatitis C are rising. This equates to approximately 2,000 people within Nottingham City. The rate of infection is highest in those aged 25-44 and is higher in males than in females which mirrors the opiate using population.

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36 Shooting up: Infections among people who inject drugs in the United Kingdom 2013 (Public Health England)
As seen with hepatitis B intervention, the uptake for testing has seen a reduction over time. The proportion of service users that were offered and refused a hepatitis C test increased by 20 percentage points from 2011/12 to 2013/14. Similarly, the proportion of those that accepted the test reduced by 18 percentage points over the same time period (Figure 75).

**Figure 75: Proportion of clients that were offered hepatitis C intervention that accepted or refused over time**

![Graph showing the proportion of clients offered and accepted/refused hepatitis C testing from 2011-12 to 2013-14](image)

**HIV**

HIV (Human Immunodeficiency Virus) is a viral infection that can affect the body’s immune system and its ability to fight infection. Over time this can lead to a condition called AIDS (acquired immune deficiency syndrome). There is currently no vaccine available for the HIV virus.

The number of infections acquired through injecting drug use and through other routes remains low. Data shows that in the UK there were 130 new HIV diagnoses in 2013 where infections were acquired through injecting drug use, of which nearly two-thirds (62%; 80/130) were among people born in the UK. In the past decade, the total number of new HIV diagnoses among PWID reduced from an all-time high in 2006 (200) and has remained stable over the past three years (140 in 2011 and 120 in 2012)\(^\text{37}\).

Infection rates amongst injecting drug user’s remains low and stable in the UK. A Public Health England survey in 2013 found that amongst those surveyed, 6.7 per 1,000 injecting drug users were infected with the HIV virus; 10% of these were undiagnosed. From the prevalence estimate of injecting drug users calculated for this report, there are an estimated 20 HIV+ injecting drugs users in Nottingham with 2 of these with undiagnosed HIV. Information from specialist needle exchange services suggest that this number is slightly higher than the amount currently known to services; 15 injecting drug users with HIV are known to the Health Shop.

\(^{37}\) HIV prevalence
Treatment

Nottingham has invested in ensuring that community based hepatitis treatment is available to those in contact with drug treatment services. These have been available to patients within Recovery in Nottingham and Shared Care drug treatment. Traditionally many service users have been resistant to attending hospital appointments or unable to keep appointments on time. Provision of community based treatment allows service users to be seen in their locality with a greater degree of flexibility.

The historical treatment for hepatitis was for a long time a lengthy process, lasting around a year in total, with a range of very unpleasant side effects and involving biopsy and injection which were both invasive and unpleasant. Because of this, many people could not cope with the treatment regime and take up of treatment was limited. In 2014 NICE approved a range of new hepatitis treatments. The new medicines have few side effects; can be administered by a course of tablets rather than injection, last for only around 12 weeks and have a much higher success rate. It is likely that these will lead to a much higher demand for treatment, and in turn, may lead to greater numbers being willing to find out their infection status by accessing testing.

Take up of treatment in the year running up to the release of the new treatments was very low amongst clients in treatment services as many were deliberately waiting for the new treatments to be given approval.

However, the new medication is very costly and increased demand could also lead to an increase in lab costs for testing. Budget cuts could also have an impact on the future delivery of community based hepatitis treatment.

Needle Exchange

**The Health Shop – specialist needle exchange**

A specialist needle exchange service is provided in Nottingham City by the Health Shop. They give out a range of sterile injecting equipment and deliver a series of harm reduction interventions including the provision of safer injecting and general harm reduction advice, leaflets and information, blood borne virus testing, vaccination and pre and post-test counselling, wound care and a range of sexual health advice and information, including the distribution of condoms. The Health Shop also offers specialist support and advice to a range of commissioned pharmacy needle exchange providers, including training to pharmacy staff. They also deliver overdose prevention training sessions, parenting support sessions for drug users with children and have taken a lead role in the distribution of naloxone within the drug treatment system.

Nottingham City’s drug-using cohort is ageing and partaking in risky injecting behaviours, such as femoral (groin) injecting. In addition to this, the number and type of needles that are given out in the Health Shop has changed dramatically over time.

**Needles**

Figure 76 shows that the most notable changes in needle distribution were seen in short orange (generally used for opiate/crack injection into arms), long orange and long blue (used for femoral injecting). A range of different sized needles and syringes are available within City needle exchange services. The size of equipment chosen by injecting drug users will depend upon the drugs being taken and where in the body they are being injected. Injecting drugs carries with it a wide range of risks, but some sites carry higher levels of risk than others. Most Intravenous drug users will commence injecting in their arms, as a site that offers easier venous access and a lower level of associated risk. Due to the damage that can be inflicted upon veins through the injecting and preparation process, loss of venous access amongst injecting drug users is common and this can lead to drug users being required to switch to other, more high risk sites. It is common for many injectors to switch to femoral injecting, which involves injecting into the vein sited in the groin. This is a high risk site for a number of reasons, including its proximity to the femoral artery and nerve, for the difficulty in accessing the vein and keeping the site clean and free from infection and because of the
increased risk of deep veined thrombosis. Because the femoral vein is located more deeply within the body, a longer length needle is required to reach it. Most commonly, longer orange and blue needles are used for this purpose.

As a proportion of all needles, short orange distribution saw a reduction of 7 percentage points, long orange saw an increase of 4 percentage points and long blue saw an increase of 13 percentage points from 2012/13 to 2014/15. These changes can act as further evidence of the aging cohort of femoral injecting drug-users as longer needles are becoming more popular as a proportion of all needles.

Figure 76: Proportion of type of needle given out over time

[Bar chart showing needle distribution]

Barrels

The largest change in barrel distribution was seen in ‘Nevershare needles’ (barrels of varying colours, which are used to prevent drug users from mixing up their equipment and accidentally sharing, as each injector can use a different coloured barrel) where there was an increase of 7 percentage points from 2012/13 to 2014/15. This is the equivalent to an increase of 1143.43% (n=2870) from Q2 2012/13 to Q2 2014/1538 (shown in Figure 77). Anecdotal evidence suggests that ‘Nevershare needles’ were very popular amongst ‘club’ drug users partaking in chemsex parties. Due to the popularity of these needles, they have become part of the pharmacy needle exchange supply.

38 Data was not released beyond Q2 2014/15
Figure 77: Number and proportion of Nevershare needles distribution

Figure 77 shows the proportion of clients aged 19-24 has reduced by 14 percentage points and those aged 35-44 has increased by 6 percentage points from 2013/14 to 2014/15 (Q1 and 2 only). This is further evidence of our aging cohort of drug-users.

Figure 78 shows the proportion of clients aged 19-24 has reduced by 14 percentage points and those aged 35-44 has increased by 6 percentage points from 2013/14 to 2014/15 (Q1 and 2 only). This is further evidence of our aging cohort of drug-users.

Pharmacy Needle Exchange

In 2014, responsibility for the management of pharmacy needle exchange contracts transferred over to The Crime & Drugs Partnership and with it the collection of associated data. The transfer of responsibility saw with it the initial adoption of paper based recording and monitoring systems that were used by providers under the old contract. These systems proved to be difficult to manage and unreliable in terms of providing quality data. It is therefore proposed that all pharmacy needle exchange providers should transfer to a
computer based recording system. This will lead to the future provision of accurate and reliable data monitoring information. It is hoped that this will commence during 2015.

The only reliable pharmacy needle exchange data available was taken from invoices from the needle supply company so this section will contain information about needles that are ordered, not necessarily distributed. Due to changes in contract management, only data for 2013/14 and 2014/15 are available.

There has been very little change in the proportions of each needle type ordered for pharmacies apart from the introduction of sports packs (shown in Figure 79). The sports pack is aimed at injectors of growth hormones and “body image” drugs, such as melanotan (a hormone that stimulates the body’s production of melanin – a brown pigment responsible for tanning of the skin). Although the numbers have increased, the proportions remain fairly stable; this is due to a higher number of needles being ordered over time. The increase in needles could be a result of the commissioning of pharmacy needle exchange; there is now a better coverage for needle exchange over the city. The consistency of needles ordered could also be due to the nature of the data and services; the pharmacies are likely to order similar numbers every month regardless of need and the clients are likely to collect similar products each time they go to the pharmacy.

Due to the lack of detailed data sets, it is impossible to determine exact drug trends, age trends and ethnicity trends. This has been highlighted as a data gap and it is recommended that pharmacies are given access to a recording system so that data can be monitored to highlight any further need for harm reduction within pharmacies.

Figure 79: Number and proportion of needles ordered for pharmacy needle exchange services

‘Chemsex’
Research over the last 20 years has identified an established link between the use of drugs amongst gay men, particularly so-called party drugs, such as ecstasy, cocaine, ketamine and LSD.

Over the last year, treatment services and providers of harm reduction advice in Nottingham City and throughout the UK, have expressed increasing concern about a growing trend for a practice referred to as
‘chemsex’, which carries high risks of harm and a major need for those participating in ‘chemsex’ to be targeted with harm reduction interventions.

A report into ‘chemsex’ in the London Boroughs of Lambeth, Southwark and Lewisham (entitled “The ‘chemsex’ study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark and Lewisham”) identified ‘chemsex’ as “the practice of sex between men that occurs whilst under the influence of drugs.”

Evidence suggests that certain stimulant drugs are most commonly taken by those engaging in ‘chemsex’ activity, particularly Crystal Meth’, GHB / GBL, Mephedrone and cocaine. These are stimulant drugs which have a range of effects including increasing heart rate and blood pressure and feelings of sexual arousal and euphoria amongst users. These drugs are commonly taken in combination before and during the sessions which often last for many days.

Injecting is a common route of administration and multiple injections may be administered, often by other people who may also have prepared the drugs. It is therefore difficult for a person to know what they are being given and whether the injecting equipment being used is sterile or if it has been used before. Long periods of drug taking may affect a person’s ability to give consent, resist against activity that they do not want to be involved in and to make rational decisions about engagement in risky behaviour.

Furthermore, sex with multiple partners is common at ‘chemsex’ parties and the risk of un-safe sex greatly increases. Because of these risk factors, ‘chemsex’ carries with it a high risk of BBV and STI transmission including Hepatitis A, B and C, HIV, syphilis, Gonorrhoea and Chlamydia.

Concerns have also been raised that engagement in prolonged periods of ‘chemsex’ activity can also result in failure to take prescribed medication, negative effects on mental health and can lead to debt. The Health Shop is undertaking work to target interventions at service users engaged in ‘chemsex’ activity.

Levels of BBV infection amongst this client group remain high, although those involved are more willing to access BBV testing and vaccination.

The ‘chemsex’ service user group should remain a priority target group for the receipt of harm reduction advice, information and interventions in the future.

Table 13 shows the number of clients that attended the Health Shop for needle exchange and cited cocaine, MCAT or ketamine as their primary or secondary drug. These drugs are anecdotally popular with ‘chemsex’ clients. Because of the high degree of peer distribution of injecting equipment at ‘chemsex’ parties, and activity often taking place within social scenes and at private party networks, it is believed that the true extend of numbers involved in ‘chemsex’ activity in the City is underestimated.

**Table 13: Number of clients that cite these drugs as primary and secondary drug**

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<thead>
<tr>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>12</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ketamine</td>
<td>10</td>
<td>7</td>
<td>12</td>
<td>29</td>
<td>29</td>
<td>14</td>
</tr>
<tr>
<td>MCAT</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

**Sharing Equipment**

Treatment Outcome Profiles (TOPs) act as a performance indicator for clients in drug and alcohol treatment. TOPs are completed by drug workers at the start, review (6-monthly) and exit of treatment. Within these assessments, the client is asked about current drug use, offending and wellbeing; part of this is to assess whether they are sharing equipment for drug use. Although clients never report sharing in their
exit TOP, there has been an increase in the proportion of clients reporting sharing upon entering treatment (Figure 80). This increased by 30.6 percentage points from Q2 2013/14 (11.1%; the lowest point) to Q1 2014/15.

Figure 80: Proportion of clients that reported sharing equipment for drug use at the start of treatment, taken from partnership exit TOPs

![Graph showing the proportion of clients sharing equipment at the start of treatment from Q1 2012/13 to Q1 2014/15.]

Although this is an issue within itself, it is ever more worrying that the proportion of treatment naïve clients (those who have had zero previous treatment journeys) is decreasing year-on-year and is much lower than the national (Figure 81) therefore it could be inferred that clients that are reporting sharing in their start TOPs are more likely to have had previous treatment journeys. Anecdotal evidence suggests that regardless of how long a client has been receiving harm reduction, they may still partake in unsafe drug-taking practices. This could suggest that harm reduction messages need to be repeated at every opportunity and clients are, therefore safer when they are in treatment; it also highlights the importance of reiterating harm reduction messages to those exiting treatment.

Furthermore, an increase in clients with 4+ treatment journeys could suggest that clients are often discharged before they are ready; higher levels of representations to treatment could also support this theory. To investigate this, it would be useful to know how long these clients have been in treatment for; this data is unavailable and has highlighted a data gap within Nottingham City drug treatment.
The misuse of medicines

Nationally, there is a gap in data for misused prescribed medications, however, a survey completed by Holloway and Bennett (2011)\(^\text{39}\) in a university concluded that one third (33%) of students and one quarter (24%) of staff members had used prescription drugs that were not prescribed to them. This mainly consisted of pain relievers and sedatives.

Over the last 12 months, a range of providers, including substance misuse treatment services, hostel staff and prison workers have expressed increasing concern about the growing levels of misuse of a range of medicines. The problematic misuse of these substances was frequently highlighted as being an escalating issue and a major area for concern.

By nature, the misuse of medicines is, to a large extent, hidden. In 2013-14 only 130 structured drug treatment clients cited medications as problematic, which equates to 7% of the structured treatment population.

The Crime & Drugs Partnership decided that there was a need to focus on some exploratory work to determine the true extent of the problem. At the same time the City Harm Reduction group and Recovery in Nottingham launched local poster campaigns across Pharmacy providers to raise awareness about the addictive nature of some medicines and the risks of overdose posed by misuse.

The issue was highlighted at The Crime & Drugs Partnership substance misuse Executive Board, during a presentation on “unmet clinical need” which was delivered by Dr. Stephen Willott (The Crime & Drugs Partnership Clinical Lead and a GP with a specialism in substance misuse) and Dr. David Rhinds (a Consultant Addictions Psychiatrist with Nottinghamshire Healthcare Trust). Their presentation led to the

establishment of a clinical working group to examine the extent of the problem and take action where needed.

A multi-agency working group was established which consisted of Dr. Willott and Dr. Rhinds, other GP’s from General Practice and with the CCG, The Woodlands in patient unit, Pharmacists, Public Health England, Nottingham University Hospital pain clinic, the City Medicines Management Group and The Crime & Drugs Partnership.

The group identified that the substances that were of most concern were pregabalin and gabapentin. They looked at data to determine the extent of local prescribing levels and some audits of prescribing levels within local practices were undertaken.

The group decided that there was a key need to produce and disseminate prescribing guidance for local GP’s in relation to these two medicines. This was because it was identified that there was a lack of awareness amongst many GPs about the risks associated with pregabalin and gabapentin misuse, the potential for abuse through the illicit market, it’s unsuitability for those with a history of substance misuse and it’s increasing involvement in overdose and drug related deaths. The group identified that pregabalin in particular, was in danger of becoming “the new Benzodiazepine.”

The group produced the following guidance for dissemination to local GPs:

**Prescribing safety**

1. Prescribe in line with [APC Neuropathic Pain Guidance](#) or licensed indications. Note: Pregabalin for Generalised Anxiety Disorder is designated as specialist initiation only.
2. Agree clear treatment goals and regular review process before prescribing, Document treatment goals and consider them at each review. Stop if not making progress towards goals.
3. Prescribed doses should be within BNF range.
4. Potential for misuse should be discussed with all patients.
5. Use with caution in patients with a history of substance / alcohol misuse or drug alcohol misuse in the family (partner/parents etc.), patients with mental health problems and patients who have experienced a recent life event (including serious injury).
6. If misuse problems identified – prescribing should be managed by a single prescriber AND consider 7 day prescribing with support from community pharmacist.

**Recognising problems**

1. Asking for earlier prescriptions or losing prescriptions
2. Sharing medications with friends relatives
3. Regularly accessing out of hours services
4. Requesting to see different GPs
5. Changes in mood / behaviours of the patient with practice staff

A further action to provide a “less clinical translation” that could provide guidance to non-clinical staff, such as hostel workers has been identified by the City Harm Reduction group and will be delivered in early 2015.

It is well established that gabapentin and pregabalin (pain-killers, anti-epileptic and anti-anxiety medications) prescribing has seen an increase both locally and nationally. Gabapentin prescriptions increased 15% ($n$=32,245) and pregabalin prescriptions increased 9% ($n$=7,457) from September 2013 to August 2014 in Nottingham City. Prisoners are twice as likely to be prescribed these drugs compared to those residing in the community and the drugs have caused a number of deaths in custody in England\(^{40}\). Although the misuse of medicines may not be an issue for the wider population, it has been suggested that drugs such as these may be harmful to those with current or historical substance misuse issues. A working

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\(^{40}\) Down a stony road: The 2014 DrugScope Street Drug Survey.
A group was set up in May 2014 with the aim of creating prescribing guidelines for the prescription of these drugs to this complex cohort.

Although the increase in gabapentin and pregabalin prescribing is large, the number of mirtazapine (an anti-depressant) prescriptions saw a larger increase of 20% (n=8,530) in the same time-frame. Upon consultation with one of Nottingham City’s drug treatment services, it appears that this trend may be mirrored in the drug and alcohol treatment cohort. It was also suggested that this drug is prescribed as a safeguard and a stabiliser for these clients but may actually be inadvertently temporarily masking issues that could be more permanently addressed by the application of psychosocial interventions.

Co-codamol prescriptions have decreased by 2.4% (n=13,137) from September 2013 to August 2014 and 10.8% (n=63,869) from April 2013 to August 2014.

Tramadol (a painkiller) prescriptions have seen a reduction of 4.6% (n=18,116) from September 2013 to August 2014 and 8.1% (n=33,191) from April 2013 to August 2014. Tramadol prescriptions saw the largest reduction in the 16-month time-frame; this could be due to its reclassification in June 2014.

Figure 82 below shows the changing trends of some medications which have been suggested to be problematic for those with current or historical substance misuse issues.

![Figure 82: Change in prescribing](image)

Naloxone

Naloxone is a prescribed medication that can reverse the effects of an opioid overdose. In 2012 the Advisory Council for the Misuse of Drugs said that ‘naloxone provision is an evidence-based intervention, which can save lives. Naloxone provision fits with other measures to promote recovery by encouraging drug users to engage with treatment services, and ultimately, keep them alive until they are in recovery.

In May 2011 a naloxone working group was formed by The Crime & Drugs Partnership. The main aim of the group was to explore the possibility of making take-home naloxone available to drug users in Nottingham City who were deemed to be most at risk of an opioid overdose.
In December 2013 a pilot project was launched that began supplying naloxone to opioid drug users who had completed a course of overdose awareness training. The course gives drug users standard education that includes preventing, identifying and responding to an overdose, how to rescue breathing and the importance of calling the emergency services. At the end of the course, each person deemed to be at risk of overdose is given a supply of naloxone and is taught how to administer the medicine in the event of an emergency situation.

By November 2014, 132 city drug users had undergone the training and had received a dose of take-home naloxone. To date, there have been eleven instances where naloxone has been used in response to an overdose. In all cases the medicine was successfully administered and the person who had overdosed was revived.

This has not only saved the lives of eleven Nottingham Citizens since its launch, but has also saved money in terms of preventing the costs of coroner’s inquests, hospital costs and police time. Each pack of naloxone costs £18.95.

**Drug-related deaths**

A process for recording and investigating drug related deaths within Nottingham City continues to be co-ordinated from within the Partnership. A member of The Crime & Drugs Partnership drug strategy and commissioning team acts as the designated investigator for Nottingham City. The investigator receives reports of potential drug related deaths occurring within the City. They liaise with the Coroner’s office to establish the cause of death, and where a death is found to be drug related; investigate the circumstances and background that led to the death.

All deaths are reported to the Confidential Inquiry Review Group (CIRG); a multi-agency group who receive the investigation reports and identify any learning points that might arise from them. All learning points are widely circulated across a range of treatment services and partner agencies in order to allow them to be implemented and acted upon, in order to prevent further deaths in the future.

A bi-annual report is produced by the Partnership summarising City drug related deaths and identified learning points that arose from the investigations. In the 2011-13 drug-related death report, it was identified that there were ten confirmed drug related deaths in the city, six deaths occurred in 2011-12 and four deaths in occurred in 2012-13.

A comparison to death rates in other areas is available from reports compiled by St. George’s University. St. George’s reports work out where the highest death rates occur by producing figures that show the number of deaths in an area per 100,000 people in the local population. Table 14 shows the highest national drug-related death rates, and also the equivalent drug-related death rate for Nottingham City, which is significantly lower.

<table>
<thead>
<tr>
<th>Area</th>
<th>Drug-Related Death Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Manchester</td>
<td>14.86</td>
</tr>
<tr>
<td>Blackburn, Hyndburn and Ribble Valley</td>
<td>13.35</td>
</tr>
<tr>
<td>Liverpool</td>
<td>11.37</td>
</tr>
<tr>
<td>Nottingham</td>
<td>1.96</td>
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</tbody>
</table>

The highest drug-related death rates for 2012, alongside the equivalent rate for Nottingham, are shown

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41 An estimated £20,000 per life (using NICE QALY guidelines).
below in Table 15. Nottingham’s drug-related death rate has reduced and continues to be significantly below these areas.

**Table 15: Drug-related death rates, 2012**

<table>
<thead>
<tr>
<th>Area</th>
<th>Drug-Related Death Rate (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackburn with Darwen</td>
<td>11.45</td>
</tr>
<tr>
<td>Hammersmith and Fulham</td>
<td>11.34</td>
</tr>
<tr>
<td>Liverpool</td>
<td>12.57</td>
</tr>
<tr>
<td>Nottingham</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Of the ten drug-related deaths in Nottingham, four were female. All of these four women were identified to have previously experienced domestic violence. In response to this finding, the Partnership has instructed all City treatment services to treat female injecting opiate users as high risk in terms of overdose, and to prioritise offering them access to harm reduction advice, overdose training and take home naloxone.

In October 2014, there was a spike in potential drug-related deaths, the reason for which is unknown; however, police intelligence has suggested that there was high purity heroin seized in the city which could be a possible cause of this spike. Furthermore, a recent study found that there are a large number of people in the UK who became drug users in 80s and 90s and are getting older, thereby widening the health gap between this cohort and the general population. In response to this increase, an officer raised a drug alert for distribution around services, to workers and services users describing the situation and giving overdose prevention advice.

Due to the increased volume of drug-related deaths, it was highlighted that the reporting and investigating system needed to be streamlined. Services are now sent electronic questionnaires asking for details about the deceased and their contact with them. If needed, further meetings are held between the lead officer and services. This process saves time for both parties whilst still giving detailed evidence in order to make the investigation as thorough as possible.

In addition to this, non-fatal overdoses are now being reported to the drug-related death investigative lead for monitoring. This process will highlight particular services, drug-types, and ages of these 'near-misses' in order to inform next steps for prevention and harm reduction. It will highlight good practice and learning including how many and which services are referring survivors onto harm-reduction interventions.

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42 These investigations have not yet been concluded.
43 Heroin purity had increased by 19.5% since the last report in August 2014
Mental Health

Introduction

Prevalence

Mental health problems directly affect 25% of the population during any given year\(^45\) which was equivalent to 76,420 Nottingham citizens\(^46\) in 2013-14. For people dependent on drugs or alcohol, the prevalence of mental health problems is significantly increased to 30% and 45%, respectively\(^47\).

By extrapolating national information on frequent drug use\(^48\) and dependent drinking\(^49\) it is estimated that as many as 5.5% of Nottingham’s citizens might be suitable for substance misuse treatment (2% or 6,260 citizens for drug treatment and 3.5% or 10,687 citizens for alcohol treatment). In the last year, 2,499 adults accessed structured treatment and it is estimated that a further 1,666 accessed unstructured treatment\(^50\). This equates to 2,933 adults in drug treatment and 1,232 in alcohol treatment with respective penetration rates of 47% and 12%. By combining mental health prevalence among drug and alcohol dependent individuals with local data on treatment need, it is possible to estimate the number of drug and alcohol dependent citizens - both in and out of treatment - that have another psychiatric disorder. It is estimated that 40% (6,687) of individuals eligible for treatment also have another psychiatric disorder; further details are provided in Table 16.

<table>
<thead>
<tr>
<th></th>
<th>Drugs</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Currently in Treatment</td>
<td>2933</td>
<td>1232</td>
</tr>
<tr>
<td>Those with Another Psychiatric Disorder</td>
<td>880</td>
<td>554</td>
</tr>
<tr>
<td>Not Currently in Treatment</td>
<td>3327</td>
<td>9455</td>
</tr>
<tr>
<td>Those with Another Psychiatric Disorder</td>
<td>998</td>
<td>4255</td>
</tr>
<tr>
<td>Total Estimated Treatment Need</td>
<td>6260</td>
<td>10687</td>
</tr>
<tr>
<td>Those with Another Psychiatric Disorder</td>
<td>1878</td>
<td>4809</td>
</tr>
</tbody>
</table>

Note: Estimations for the number of clients that have another psychiatric disorder have been made using the assumption that 30% of drug clients and 45% of alcohol clients have another psychiatric disorder. Equal weighting across those in treatment and those not in treatment has also been assumed.

Mental health interventions in substance misuse treatment

Psychosocial sub-interventions for mental health

As part of a holistic treatment package, treatment providers deliver a range of interventions which are categorised as pharmacological, psychosocial or recovery. Treatment interventions regarding mental health can be delivered as a psychosocial intervention and are defined as ‘low intensity psychological

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\(^{46}\) Census 2011


\(^{48}\) 3.1% of 16-59 year olds use drugs frequently. This equates to 6,260 of Nottingham’s 16-59 year old population (201,926 according to the 2011 Census) which is equivalent to 2% of the 305,680 population. Extent and trends in illicit drug use among adults – Drug Misuse: Findings from the 2013/14 Crime Survey for England and Wales.

\(^{49}\) Alcohol Ready Reckoner Version 5.2 2011.

\(^{50}\) Approximately 60% of all treatment is structured according to adult community drug treatment data. This proportion has been used as a proxy measure for the treatment system.
intervention for co-existing mental health problems, [interventions] include guided self-help or brief interventions for less severe common mental health problems\textsuperscript{51}.

The number of mental health sub-interventions provided to clients resident to Nottingham are shown in Figure 83 and broken down by the service that delivered the intervention. The marked reduction in the number of mental health sub-interventions delivered since April 2014 are clearly shown to be the result of fewer sub-interventions being provided by Nottinghamshire Dual Diagnosis Team. Conversely, we can see an increase in sub-interventions being delivered by Recovery in Nottingham.

\textbf{Mental health in alcohol treatment}

Last year, 37\% of clients accessing structured alcohol treatment were simultaneously receiving care from mental health services for reasons other than substance misuse. This is more than one and a half times the national level of clients accessing simultaneous mental health and substance misuse treatment, which is 21%.

\textbf{Clients with a dual diagnosis}

While the overall number of mental health sub-interventions being delivered to substance misuse clients is falling, substance misuse services report significant mental health needs amongst their client group. The following trends were reported by service managers during consultation carried out in December 2014:

- There is a significant cohort of clients within the substance misuse services with greater mental health needs than substance misuse needs; this cohort is greater within alcohol services than drug services. In addition to psychiatric disorders, these clients have very complex substance misuse problems;

- Personality disorders are common amongst clients of substance misuse treatment services. These clients are very hard to engage, resource-intensive and unlikely to reach a state of recovery or

\textsuperscript{51} Public Health England (2013). \textit{National Drug Treatment Monitoring System (NDTMS. Business Definition for Adult Drug Treatment Providers NDTMS Data Set L}.  

\hspace{1cm}
successful completion; and

- Psychiatric disorders amongst substance misuse clients are perceived to be increasing.

**Nottinghamshire and Nottingham City Dual Diagnosis Needs Assessment**
The Nottinghamshire and Nottingham City Dual Diagnosis Health Needs Assessment 2015/16 (to be published later this year) has identified a number of gaps in meeting the needs of young people and adults with both a mental health and substance misuse problem, some of which have been outlined below:

1. Knowledge gaps within both substance misuse and mental health services, with a recommendation for further training and support needed for both types of services

2. A lack of readily available information on and a lack of awareness amongst both types of services of each other’s range of services, acceptance criteria and referral processes

3. An improvement in data quality is needed to ascertain prevalence rates, current and projected need

4. Inconsistent delivery of dual diagnosis services across the city and county geographical areas

5. A need to improve appointment availability and waiting times

6. Clearer pathways and better communication are needed between dual diagnosis services, substance misuse services, IAPT services and the police

7. Changes to mental health crisis care are needed.

**Further gaps identified**
In addition to the gaps identified within the Dual Diagnosis Health Needs Assessment, the following issues have been raised by the city’s substance misuse services:

1. Barriers in accessing IAPT services and other mainstream mental health services for substance misuse clients, resulting in many psychiatric disorders being managed in-house;

2. Ineffective and inconsistent pathways between substance misuse and mental health services;

3. Pathways often disappear when services are re-commissioned and new providers are introduced.

A more comprehensive assessment of the mental health needs of clients of the city’s substance misuse services will be carried out during 2015/16 to explore in further depth a number of the issues outlined above. This review will:

1. more accurately determine the level and range of mental health needs amongst this client base and the wider substance misusing population;

2. map the current pathways between substance misuse services and mental health services in the city and assess how effectively these pathways are working; and

3. explore the findings of the Dual Diagnosis Health Needs Assessment and the issues raised by services in conjunction with the Nottingham City clinical commissioning group.
Young People

Introduction
This chapter has been designed to supplement the Young People’s Substance Misuse System Review produced by Kamala Atwal (Substance Misuse Strategy and Commissioning Officer) and published in January 2014.

It is accepted that the majority of young people (under 18 years old) do not use drugs and those that do are not dependent. However, where substance misuse is a factor there are considerable risks of detrimental effects to health, education and relationship and, therefore; long-term chances in life. Drug treatment data provides insight into specialist interventions however, as emphasised within the young people’s strand of the drug strategy (2010), early intervention and prevention is also a major concern. For this reason both treatment information and wider information on health and wellbeing will be considered within this chapter.

Prevalence
There is currently no sophisticated measure in existence for quantifying the number of young people that may require treatment for substance misuse in Nottingham. However, it is possible to estimate prevalence by extrapolating and combining data from Smoking, Drinking and Drugs in Young People (which identifies substance misuse in 11-15 years olds) with the British Crime Survey (which identifies substance misuse in 16-24 years olds); both of which are national surveys. Both surveys show a reduction in the number of young people that use drugs; the proportion of 11-15 year olds that took drugs in the last months reduced from 8% in 2009 to 6% in 2013 and the proportion of 16-24 year olds that are frequent drug users reduced from 8% in 2009 to 5% in 2013.

By extrapolating the survey results using population figures from the 2011 Census, it can be estimated that 1,333 young people might be eligible for treatment in 2013 which, compared to 2009, is a 26% reduction.

The estimated penetration rate for young people in structured treatment as a proportion of all those that might be eligible was 18% in 2013. This is considerably higher than the national comparator which was 7%. Nottingham has a consistently and significantly higher penetration rate compared to England as a whole, as shown in Figure 84.

Value for Money
A cost-benefit analysis conducted by the Department for Education found that for every £1 spent on specialist interventions for young people’s substance misuse £1.93 is saved within two years and up to £8.93 is saved in the long-term. Specialist interventions are deemed to be a cost effective way of improving long-term outcomes for young people that, in turn, reduce future demand other services.

Treatment

Clients in treatment
The number of young people accessing specialist services has declined over the past three years (see Figure 85). Whilst the number of young people accessing secure estate services appears to have increased, it is actually the case that this information has only been fully recorded since April 2013.

The number of people accessing treatment has declined at the same time as the rate of penetration into the substance misusing population. This highlights the need to appropriately encourage more young people into services through outreach.
**Routes into treatment**

The different types of referral routes into treatment are much less evenly distributed in Nottingham compared to England as a whole (see Figure 86). Just like we have seen for adult treatment services, young people are much more likely to come to treatment via the criminal justice sector. Last year 45% of the clients accessed treatment through this route. Referrals via education and youth justice account for 75% of the clients that accessed treatment. This information assists in targeting areas for outreach; self-referrals and those from client family members and friends should be prioritised.

**Figure 86: Referral sources into treatment**
**Treatment profile**

**Vulnerabilities**

Substance misuse has been shown to correlate with other vulnerabilities including sexually transmitted infection, experience of domestic violence, not being in employment, education or training, experience of sexual exploitation, contact with the youth justice system and receiving benefits. Young people receiving specialist interventions are half as likely to be in full-time employment.

One of the key principles of the early intervention agenda is that appropriate substance misuse support should be provided as early as possible, irrespective of whether or not the service in which the client is engaged is a specialist substance misuse agency. Specialist services should be involved if and when substance use is causing harm. Effective pathways must be in place in order for this system to operate effectively.

The substance specific vulnerabilities present in the treatment cohorts in Nottingham compared to England as a whole are shown below in Table 17. Vulnerabilities of all types are more common in England compared to Nottingham. Taken on face value, this could be indicative of less complex substance use among young people.

**Table 17: Substance specific vulnerabilities**

<table>
<thead>
<tr>
<th>Vulnerability</th>
<th>Nottingham</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate and/or crack user</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Alcohol user</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>Using two or more substances including alcohol</td>
<td>51%</td>
<td>61%</td>
</tr>
<tr>
<td>Began using main substance under 15</td>
<td>81%</td>
<td>90%</td>
</tr>
<tr>
<td>Current or previous injector</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The presence of wider vulnerabilities in young people in Nottingham’s and England’s specialist services are shown below in Table 18. Nottingham exceeds the national average for presence of mental health problems and self-harm. Nottingham has twice as many clients involved in offending and one and a half times the national rate of clients who are not in employment, education or training. This is perhaps unsurprising, given three quarters of referrals are made via the youth justice and education sectors.

There are lower levels of domestic abuse and child exploitation in Nottingham compared to England as a whole. Taken to be accurate, this information could be interpreted as a positive finding for the city. Conversely, it might be an indication that local services are less effective at identifying vulnerabilities.

**Table 18: Wider vulnerabilities**

<table>
<thead>
<tr>
<th>Vulnerability</th>
<th>Nottingham</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looked after child</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Child in need</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Affected by domestic abuse</td>
<td>7%</td>
<td>17%</td>
</tr>
<tr>
<td>Identified mental health problem</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Involved in sexual exploitation</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>Involved in self harm</td>
<td>19%</td>
<td>16%</td>
</tr>
<tr>
<td>Not in education, employment or training</td>
<td>26%</td>
<td>17%</td>
</tr>
<tr>
<td>No fixed abode or unsettled housing</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Involved in offending</td>
<td>49%</td>
<td>24%</td>
</tr>
<tr>
<td>Pregnant and/or parent</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Subject to a child protection plan</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>Affected by others' substance misuse</td>
<td>17%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Client age

The profile of clients in young peoples’ treatment services in Nottingham is similar to the national picture (see Figure 87). However, clients accessing services at 18 and over is less common. This could be an indication of smooth pathways for transition to adult services or completion of treatment prior to the client reaching 18.

Figure 87: Age profile of clients in treatment during 2013-14 (Nottingham and England)

![Age profile chart]

Substance

Nottingham’s substance profile is very similar to the national picture (see Figure 88). The types of substances used by young people across England will differ as a mechanism of culture and availability and as such it is unsurprising that Nottingham appears less varied in substance type than the national comparator.
Figure 88: Substance profile of clients in treatment during 2013-14

Gender differences

Last year, the young people treatment cohort was 30% female ($n = 72$) and 70% male ($n = 167$) which is very similar to the gender breakdown across all the services in England as a whole. As is shown in Table 19 below, the needs of males and females differ both nationally and locally.

Females in Nottingham are more likely to have a diagnosed mental health need, to be involved in self-harm, to use alcohol and be 15 or younger. Males, on the other hand, are more likely to have educational, training and/or employment needs, be involved in offending and cite cannabis as a problematic substance. These are key gender differences that enable a better understanding of the profiles of young people accessing substance misuse treatment today.

<table>
<thead>
<tr>
<th>Table 19: Presenting needs by gender for Nottingham and England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local</strong></td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Volume</td>
</tr>
<tr>
<td>Affected by domestic abuse</td>
</tr>
<tr>
<td>Diagnosed mental health problem</td>
</tr>
<tr>
<td>Involved in sexual exploitation</td>
</tr>
<tr>
<td>Involved in self-harm</td>
</tr>
<tr>
<td>Not in education, employment or training</td>
</tr>
<tr>
<td>Involved in offending/antisocial behaviour</td>
</tr>
<tr>
<td>Cited alcohol as a problematic substance</td>
</tr>
<tr>
<td>Cited cannabis as a problematic substance</td>
</tr>
<tr>
<td>Aged 15 or under</td>
</tr>
</tbody>
</table>

Treatment outcomes

The proportion of young people that exited treatment in an agreed and planned way reduced in Nottingham last year compared to the previous two years (see Figure 89). The reduction has placed Nottingham further below the national average for planned exits which has remained stable at 77-79% over the
previous three years. Although planned exits have reduced, only 7% of exits represented to treatment within six months which suggests that when clients are exiting services they are not doing so at the right time.

Figure 89: Planned exits as a proportion of all exits for Nottingham and England

Wider Determinants

Nottingham has been shown to have the following characteristics which interact, either directly or indirectly, with the misuse of drug and alcohol in Nottingham:

- A higher than national proportion of delivery episodes for a mother aged under 18 years (2% compared to 1.3% respectively);
- A much higher than national proportion of children living in poverty (34% compared to 19.2% nationally);
- A higher than national rate (per 100,000 population) of sexually transmitted infections including chlamydia which has increased from 32 in 2011 to 40 in 2012; and
- A significantly higher than national proportion of people aged 16-18 that are not in education, employment or training (6.3% compared to 5.3% respectively).

School absenteeism and exclusions

Nottingham has higher levels of primary and secondary school absenteeism compared to nationally (see Figure 90). Whereas there are similar levels of authorised absences in Nottingham and England (shown in blue in Figure 91), unauthorised absences (shown in red) are comparatively higher.

Since September 2013, the rules for schools on authorised absences have changed. Absences of up to ten days a year can no longer be authorised under ‘special circumstances’ and must instead meet tougher criteria for ‘exceptional circumstances’. The impact of these changes is likely to be a greater amount of unauthorised absences in the future.

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53 Children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% of the median income.
Information on fixed period exclusions from 2012-13, the most recent academic year available, shows that Nottingham has a higher proportion of exclusions (in all schools combined) compared with England as a whole (see Figure 92). As is shown in the chart, in 2008-09 exclusions in Nottingham were similar to England. However, whilst exclusions in England have decreased overall over the last five years, exclusions in Nottingham increased until a peak in 2010-11. Since that point exclusions in Nottingham have reduced although there remains a difference of 4.9 percentage points in Nottingham compared to the lower level of exclusions in England as a whole.

The proportion of all exclusions which were related to drugs and alcohol are shown in Figure 93. In 2012-13, one in 22 exclusions in Nottingham were drug and alcohol related whereas in England the same was true for one in 38 exclusions. During the four years previous to 2012-13, drug and alcohol related exclusions have either been similar or much lower than England yet in the latest year they have increased considerably. Whether this trend continues into 2013-14 remains to be seen but it is likely that school-based interventions may be required to address the increase in drug and alcohol exclusions.

**Figure 90**: Absence (by authorised and unauthorised absence) as a proportion of enrolments (autumn and spring terms only) for Nottingham and England

**Figure 91**: Absenteeism as a proportion of enrolments (autumn and spring terms only) for Nottingham and England

**Figure 92**: Fixed period exclusions as a proportion of number of pupils (all schools combined)

**Figure 93**: Drug and alcohol fixed period exclusions as a proportion of exclusions (all schools combined)
Family Support

Approximately one million children in England are affected by parental alcohol use and up to 350,000 children are affected by parental drug use. In Nottingham, 38% of the drug treatment population live with children whereas this figure for the whole of England is slightly lower at 32%. Over a quarter of the English alcohol treatment population has at least one child living with them some of the time and in Nottingham the same is true for more than a third of the alcohol treatment population.

With high levels of parental substance misuse existing in Nottingham, support for families is high on the agenda. Family support for people with substance dependency, their relatives and carers is a proven method of protecting children whilst improving outcomes for clients of substance misuse treatment.

The range of issues faced by children whose parents are substance misusers can include emotional neglect, limitations in academic attainment and disrupted childhood experiences often leading to substance misuse as a coping mechanism or as a way of connecting and understanding parents. In addition to parental substance misuse affecting children, adult family members are also negatively impacted upon. The spectrum of issues adult family members endure includes financial difficulties, physical health issues such as extreme stress, isolation and stigmatisation. Adult family members of people with substance dependence issues are also often placed at risk of crimes including theft to fund substance misuse and domestic and sexual violence. According to Adfam, 73% of domestic violence offenders consumed alcohol prior to the offence and 48% were considered alcohol dependent.

It has become widely accepted that substance misuse rarely exists in isolation of other problematic factors such as mental ill health, housing instability, employment issues and physical health problems; all of which have been explored within this Review. Furthermore, it is recognised that these myriad challenges are being faced, not solely be the substance misuser, but also by their children, adult family and carers. Families and carers require support to cope with the challenges they are facing and to play that pivotal role in supporting the recovery from substance misuse in their significant other.

In order to improve outcomes for families affected by substance misuse, the Crime & Drugs Partnership commissions Explore Family; a service designed to reduce the impact of substance misuse, support recovery and challenge inequalities linked to drugs and alcohol. The service supports children, young people, adults and whole families and offers the following raft of interventions in order to meet the needs of their clients:

- One to one structured support;
- Advice and information to service users and professionals including harm reduction;
- Self-help resources;
- IMPACT – five step group;
- Family group conferencing for the whole family;
- Adult peer support group (five ways of wellbeing);
- Volunteer, advocacy, mentoring and buddies services;
- Mindfulness sessions;
- Through Our Eyes young people group;
- Neuro-Linguistic Programming;
- Holistic Therapies including massage, reiki and emotional freedom techniques;
- Whole family, adult, children and young people activities including mediation, relaxation sessions and days out;
- Community reinforcement and family training;
- First aid training;

54 Support for families and carers affected by someone else’s drug or alcohol use: why invest? Adfam.
56 Drugs: Protecting families and communities, 2008
• Legal advice drop ins;
• Open door professionals sessions;
• Out of hours telephone and internet support;
• Training, education and information events; and
• Crisis intervention and signposting or referrals to appropriate agencies.

During 2013-14, Explore Family engaged 343 individuals; half of whom were aged 17 and younger. The service also recruited a total of 21 volunteers who contributed 1,287 hours of support. Some of the outcomes achieved through family support are reflected in Explore Family’s case studies below.

**Case Study One: P and M**

P attended three structured one to one sessions by himself, providing an opportunity to explore current concerns and acknowledge the impact his wife’s drinking was having. Information was given regarding alcohol recovery and withdrawal after P identified a need for this in terms of safety and confidence in responding to his wife’s alcohol use. A joint meeting was arranged involving P and his wife M, his wife’s keyworker and myself as P’s keyworker. The meeting was agreed in order to support an open and informed approach to M’s treatment plan and how P would be able to support her with this plan. M was also able to find out more information about Explore Family and our approach and interventions in supporting them both.

M subsequently completed community detoxification with support from P. P was able to offer practical and emotional support to M during this time and accessed some brief telephone support with myself for additional support at this time. A joint session with P and M completed February 2015 with reports of maintained progress with abstinence. M was engaging with treatment and there was far less impact of stress on P than was previously the case. M and P also started to identify things that remained a challenge for them at this session and we agreed that further support was to be focussed on maintaining a positive approach to M’s recovery and ways in which the challenges could be addressed. This included social planning without alcohol, continued communication with M’s treatment keyworker and discussions around trust with support from myself. The review revealed noticeable improvements in relationships, psychological and physical wellbeing.

**Case Study Two: N, E and F**

Family group conferencing was initiated by a teenage son N whose mother F had been dependent on alcohol and was attending treatment regularly. The son lived with his father and his younger brother E (also a teenager) lived with his mother.

N felt there was a lot of tension within the family and he often argued with E about his relationship with his girlfriend who N and F did get on with. He was very protective of F as he felt that any tension may make her want to drink again. He didn’t want E’s girlfriend to be there when he visited F and E at home. He believed that the families’ strengths were that F was in a really good place and he was very proud of her.

During the family group conference the family were all very receptive and keen to move together. F was happily surprised when she realised that the family was on the same page and keen to spend more time together. The family had some great ideas to put down on their plan, including the boys offering to cook Sunday dinner and make Sunday their ‘family day’ where they would eat together at the table and watch a film or play a game, occasionally going out to bowling or something. The family agreed for their first review to be after their family holiday abroad which they had planned.
Case Study Three: H, S and T

Family group conferencing was initiated by moth H and her two daughters S and T who were all clients of Explore Family. H's father had been the substance user and was now in prison serving a short sentence. H wanted the family to come together to discuss the impact of her now ex-husband's drug use and violent behaviour. H felt that there was a breakdown in communication with the girls, she also felt over protective because of the circumstances and wanted to establish new boundaries and routines.

During the family group conference it was clear to see that all three family members were craving boundaries since the shift in control since father left, as he was extremely dominant. The family plan was predominantly around spending individual alone time with H which seemed to stem from H and her new relationship and the girls craving alone time with her. The girls planned to take it in turns fortnightly to spend a Saturday afternoon with H. The family plan also stated that H would speak to her new boyfriend about not sharing his own personal view or opinions about the girls' father as the youngest was particularly upset about this. The girls asked not to be protected or kept in the dark around new information about their father; they wanted H to share updates with them about the court and other processes. When the family discussed rules and boundaries they spoke about the girls having a social life and what time they could be in at night, this was greed by the whole family, they spoke about being clear when they communicated and for them to say exactly what they mean but for each person to be respectful.

Case Study Four: K, M and F

K was a self-referral who had to wait until he reached his thirteenth birthday because the family did not want him to engage with the service. This was because the family felt they could manage the issues between themselves and, on occasion, K would come home from school and find his mother unconscious from alcohol. Mother M was alcohol dependent and K and his father F were her carers. F and K were also caring for F's elderly mother. M started to drink excessively when she lost her daughter to cancer, lost her father and her grandson was no longer living at the family home. K's school attempted to initiate social care involvement but F refused to engage.

Explore Family managed to engage the family and assessed both F and M, encouraging them to be involved in a family care plan. Quite soon after the service started working with the family M took her car out on numerous occasions whilst under the influence of alcohol and, as a consequence of this, was caught for drink driving. As a result of this social care instigated a child protection plan and K had to stay with his grandmother. M committed a further drink driving offence involving a two year old child and was arrested for child neglect. She was sentenced to two weeks in prison.

M was released from custody with a twelve months suspended sentence providing she accessed an alcohol treatment order. Upon release M relapsed on the first day and our service initiated a meeting with our local treatment provider to encourage further support.

M is now engaging well on her treatment order and F is able to go back to work. K is feeling a lot better about M's wellbeing because when he sees her he is able to engage her like he was able to do before she started drinking.
Substance Misuse Treatment: The Impact on Nottingham and its Citizens

Objective One: Family

Affected Citizens

It is estimated that there are between four and six people affected by every drug user\(^\text{57}\). This is equivalent to 1 in every 10 citizens.

Parents in Treatment

One in three drug treatment clients\(^\text{58}\) has children and one in three alcohol treatment clients\(^\text{59}\) lives with children.

Children in Care

One in five Children in Care cases was associated with parent or guardian drug misuse. The same was true for parent or guardian alcohol misuse.

\(^{57}\) Nottingham JSNA 2013.
\(^{58}\) New treatment presentations 2013-14.
\(^{59}\) New treatment presentations 2013-14.
Effects on Children and Young People

Approximately 2-3% of children are affected by parental drug use (heroin/crack cocaine). In Nottingham City, this equates to approximately 973 children of school age. This does not include alcohol or other drugs which makes it a very conservative estimate.

Children whose parents had substance misuse issues are more likely to use substances themselves and participate in risky behaviour such as unprotected sex. There was also a higher prevalence of teenage pregnancy, eating disorders in adolescence and hospital admissions.

According to a survey undertaken by the Crime & Drugs Partnership, 53.9% (48 respondents) said that when they drank alcohol they got it from their parents.

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60 Advisory Council on the Misuse of Drugs – Hidden Harm.

One in three young people received family work interventions whilst they were in treatment for drugs and/or alcohol (Source: NDTMS).
For one in every twenty five benefit claimants the main disabling condition is drug or alcohol misuse. For alcohol this figure is increasing year on year.

**Objective Two: Working**

**Benefit Claimants**

Benefit claimants with a primary disabling condition of drug or alcohol misuse

On average, employment increased by 37% from start of drug treatment to exit.

288 interventions were recorded in 2013-14 in drug and alcohol services across Nottingham City.
In response to NTA guidance\(^6\), the Crime & Drugs Partnership set up an ‘Employment Pathways Working Group’ in order to create stronger links between the Department of Work and Pensions (DWP), Job Centre Plus (JCP) and Recovery in Nottingham (RiN).

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\(^6\) Joint-Working Protocol with JCP.
According to the most recent data available, drug and alcohol related fixed term school exclusions in Nottingham City are at their highest for at least three years\textsuperscript{63}, indicating that the impact of substance misuse on educational attainment is far from diminishing.

Last year 267 criminal justice substance misuse treatment clients took part in the Fit for Work scheme. Many attendees left with references and qualifications.

\textsuperscript{63} Permanent and Fixed Period Exclusions from Schools in England 2011/12. Department for Education.
A survey was completed to see how the welfare reform had affected service users. There were 65 responses (in July 2014) and the responses showed increased substance use and contact with services; including A&E, GP, walk-in centres and substance misuse services. This increased contact with substance misuse services has meant that changes to benefits have been explained to service users. Without treatment services, service users may find it more difficult to adapt to future changes to benefits.

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64 Anecdotal evidence from welfare reform survey
Take-home naloxone (a substance that reverses the effects of opioids) is being given out by services across Nottingham City. The packs cost only £18.95 each and the scheme has already saved one citizen’s life. For every life saved with naloxone, £2,000 is saved in costs for a coroner’s inquest.

For every £1 spent on substance misuse services, at least £4.70 is gained in health and crime benefits. It was estimated that the accrued benefits in 2012/13 equated to £23.9m whereas the estimated spending for this period was only £5m.

65 Source: NDTMS.
The number of drug-related deaths has decreased by two thirds over 6 years. Nottingham City’s Confidential Inquiry Review Group is responsible for looking at reports and distributing learning points. Without this group highlighting good and bad practice, we would expect to see these numbers increase.

Drug-related Offending

Drug fuelled offending has reduced as a function of drug treatment provision.

Less than half the amount of people test positive when they are when arrested (2012-13 compared to 2007-08).

The proportion of people who test positive after being arrested has reduced by almost two thirds.
Drug treatment reduces crime by at least 50%.\textsuperscript{66}

\textsuperscript{66} Source: NDTMS Treatment Outcome Profiles, crimes admitted by clients at treatment start and exit
As part of an assessment of treatment clients at the start and exit of treatment, quality of life and physical and psychological wellbeing levels increase. Low levels of these indicators can increase the risk of further substance misuse, suicide and increased offending as a result\(^67\).

41% of suicides in the UK in 2003 were attributable to alcohol\(^68\) and each suicide costs society an estimated £1.7m\(^69\). With cuts to treatment, there will be fewer interventions to improve psychological wellbeing, physical wellbeing and quality of life and the number of suicides may increase as a result.

\(^{67}\) Anecdotes from welfare reform survey (SEA)
\(^{68}\) NICE guidelines, alcohol use disorders 2011
Using figures published by Public Health England (May 2014) extrapolated for Nottingham, it is estimated every £1 spent on needle and syringe programmes leads to a saving of £417.50 (in societal and treatment for HIV and hepatitis C) costs. This equates to a saving of just over £467,000 in 2013-14.

69 ‘No health without mental health: A cross-government mental health outcomes strategy for people of all ages’ (www.gov.uk)