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<th>Frances Howie</th>
</tr>
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<td>Strategic priority</td>
<td>Alcohol Plan 2013</td>
</tr>
<tr>
<td>Care pathway</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>February 2014 (draft)</td>
</tr>
<tr>
<td>Clinical lead</td>
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**Statement of the Problem**

<table>
<thead>
<tr>
<th>Scope</th>
<th>The objectives of this project are:</th>
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<tbody>
<tr>
<td></td>
<td>1. To review and evaluate the current service</td>
</tr>
<tr>
<td></td>
<td>2. To develop a comprehensive needs assessment to commission a service that meets the needs of the local population</td>
</tr>
<tr>
<td></td>
<td>3. To ensure that key partners and stakeholders can contribute to the needs assessment process</td>
</tr>
<tr>
<td></td>
<td>4. To ensure the needs assessment links with other health improvement services and the wider determinants of health</td>
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<table>
<thead>
<tr>
<th>Population group(s) of interest.</th>
<th>Adults and young people in treatment for drug and alcohol abuse, at risk groups, and those suffering from the effects of substance misuse i.e. liver disease</th>
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</table>

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<tr>
<th>Key risks for group(s)</th>
<th>There are a number of 'at risk' or vulnerable groups, including young adults older adults; people with learning disabilities, victims of domestic abuse, people who have experienced poor parenting or have spent time in care. Multiple co-morbidities including long term conditions, liver disease, mental health issues and the conditions disproportionately affecting disadvantaged communities.</th>
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<thead>
<tr>
<th>Sub-categories</th>
<th>The needs assessment aims to identify at risk groups where prevention is key to reducing future demand for substance misuse services. Such 'at risk' groups, might include prisoners, older people, young people, people with mental health issues, troubled families, pregnant women. Wider determinants of health as identified by Marmot (2010) are key for consideration when developing the substance misuse service, these include access to recovery communities, mutual aid and factors such as meaningful employment, housing and access to green space and leisure activities</th>
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Substance Misuse Needs Assessment

Process

<table>
<thead>
<tr>
<th>Public, service user, patient and carer involvement</th>
<th>The process has involved a wide range of stakeholders including: local authority, children’s services, colleges, services users, young people, at risk groups, hidden populations, treatment services, mutual aid, related services i.e. domestic abuse services, police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timescale</td>
<td>The need assessment project plan was designed to fit into the timetable for strategy development and service re-tendering. The new service specification will be on the commissioning portal in June 2014</td>
</tr>
<tr>
<td>Clinical/professional engagement</td>
<td>Stakeholder events held to develop the needs assessment and inform the service specification include representatives from CCG, Pharmacies, clinical staff, GP’s</td>
</tr>
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</table>

Needs Assessment Group Members

Frances Howie, Head of Health and Wellbeing, Consultant in Public Health
Tim Rice, Health and Wellbeing Manager
Anne McKay, Commissioning Manager Substance Misuse
Mark Sheldon, JSNA Officer
Kathryn Cobain, Specialty Registrar in Public Health
Deborah Tillsley, Strategy Development Officer
Ruth Pawsey, Strategy Development Officer
Sue Davidson, Commissioning Support Officer
Kam Everton, Commissioning Support Officer

Summary of key issues for Worcestershire

Key issues for adult drug treatment;

- The number of opiate users in treatment has remained fairly stable, whilst the number of non-opiate users has fallen significantly since 2010-11.
- The percentage of clients referred into treatment from the Criminal Justice System is significantly lower than national average.
- There is an ageing population of drug users in treatment, with those from the 30-49 age groups accounting for over 70% of the treatment population in 2012/13 compared to around 45% in 2005/06.
- The percentage of opiate clients successfully completing treatment and not re-presenting is falling, and is now below national average and comparators.
- The percentage of non-opiate clients successfully completing treatment and not re-presenting has fallen significantly since 2010. It is now around half the national average and below that of Worcestershire’s comparators.
- For both sets of clients it is the actual number of clients successfully completing treatment that has fallen, whilst the number of re-presentations has not significantly increased.

Key issues for adult alcohol treatment;

- There are an estimated 84,562 increasing risk drinkers and 23,379 higher risk drinkers in Worcestershire.
- Of these 91,823 are classed as binge drinkers and 14,623 as dependent drinkers.
Substance Misuse Needs Assessment

- Rates of alcohol related mortality and months of life lost related to alcohol vary across the Worcestershire districts.
- Months of life lost to liver disease is increasing for both genders in some districts
- From 2008-09 to 2011-12 there was a 55% reduction in the number of adults engaged in structured alcohol treatment in Worcestershire. This compares to an increase of around 10% nationally.
- The rate of successful completion for Alcohol clients in Worcestershire has been in steady decline since 2012/13, whilst the National average has remained stable.

Young People in treatment;
- Just 27% of clients in Worcestershire’s young persons’ substance misuse treatment cited Alcohol as an issue compared to 56% nationally and 53% on the Child Wellbeing index.
- 12% of clients in Worcestershire cited 'Other' as an issue, compared to 6% nationally and 9% on the Child Wellbeing Index. This could indicate increased use of NPS 'Legal Highs' but needs to be explored further.

Conclusions and Recommendations

Recommendations will be taken into account when drafting the revised specification for drug and alcohol services from April 2015

<table>
<thead>
<tr>
<th>Conclusions</th>
<th>Recommendations</th>
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| **1.** Worcestershire has a large static opiate and/or cocaine (OCU) using population in treatment and low levels of planned completion particularly for those aged 35-64 | 1.1 Develop tailored effective recovery mechanisms to move people out of treatment and into recovery  
1.2 Where appropriate, explore alternative models of recovery such as mutual aid, community prescribing, counselling and psychological support, detox and rehabilitation |
| **2.** The number of people coming into treatment for substance misuse has fallen across most age groups, but it has been rising for people aged 40 and over since 2005–2006 | 2.1 Awareness raising campaign aimed at older people  
2.2 Link to Worcestershire Ageing Well Strategy |
| **3.** Children of problem substance misusers are at risk from harm both as a result of their parents using and in future a higher risk of using themselves. | 3.1 Link to the work of Worcestershire Stronger Families Programme and Early Help Programme to support pathways  
3.2 Ensure that the 'Think Family' approach is embedded in local strategies and substance misuse service specifications, so that the needs of families, and their influence on recovery, are both addressed |
| **4.** Qualitative consultation with service users highlighted that treatment service opening times are not flexible, meaning that people who work, or who require immediate appointments are not receiving care when it's needed | 4.1 The service specification for treatment should include a requirement to provide flexible opening hours, in order to cater for people who need immediate services or who are restricted by the times they can attend. |
### 5. Consultation highlighted the issue of dual diagnosis, mental health services and treatment providers are not seen to be liaising effectively, clients feel that they are passed from 'pillar to post'

**5.1** Dual diagnosis should be considered in all substance misuse policies – as a key metric for progress, economic and otherwise. There is clear resonance between these two areas of work; with dual diagnosis (co-morbid substance misuse and mental ill health) being a common theme in both needs assessments. (See Worcs. substance misuse and mental health pathways)

### 6. Liver disease is a growing problem and the age of alcohol related liver disease deaths is falling. In some areas of Worcestershire, months of lives lost for males and females under 75 years is rising as is liver mortality for all genders

**6.1** Awareness raising campaigns with key messages on the harm caused by excessive alcohol usage should be implemented

**6.2** An increased focus on preventative measures and early help to intervene before alcohol related problems escalate to the point where treatment is needed

**6.3** Recommendations from the Alcohol Liaison Nurse evaluation be considered and a robust alcohol liaison role included in the service specification for commissioning services in April 2015 (Review of the Alcohol Liaison Nurse Service, Dr Kathryn Cobain, report available on request)

**6.4** Deliver the Health & Wellbeing Board Alcohol Plan

### 7. In terms of recovery services, consultation revealed that there was a lack of services to tackle wider issues such as access to training, education and employment services

**7.1** Treatment services should strengthen links with wider agencies in order to offer a bespoke recovery programme.

**7.2** Links to services providing education, employment and employability are some of the key areas that help to ensure recovery is maintained.

### 8. Communication with service users and professionals highlighted that communication is poor regarding the range, availability and access to leisure activities, social networks and those interventions that build social capital such as recovery networks.

**8.1** Develop a website giving information to professionals that can be passed onto service users could address this issue

**8.2** Explore the possibility of establishing a Service User Involvement team in Worcestershire. These are used successfully in other areas to engage both current and former service users, and provide a variety of help and support.

### 9. Although alcohol related hospital admissions have fallen in Redditch, it's rates are still higher than the national average

**9.1** Identify cause and develop measures to mitigate, working in partnership with Health Improvement Co-ordinator’s, hospitals, school nurses and district council

### 10. Novel psychoactive substances (NPS) are a growing issue nationally but there is little local knowledge on the subject

**10.1** Develop mechanisms for collecting information on local prevalence of NPS that will inform action

**10.2** Awareness raising initiatives highlighting the harms caused by NPS
<table>
<thead>
<tr>
<th>11. Consultation with substance users in recovery highlights the need for them to access communities that provide ongoing support and interventions such as education and information for people so that they do not return to their previous destructive networks</th>
<th>11.1 The benefits of community assets need to be maximised, reducing the need for more expensive central services.</th>
</tr>
</thead>
</table>
| 12. Referrals from Arrest referral/DIP only 1.8% in Worcestershire compared to just over 9% both regionally and nationally. Similarly, referrals from Probation 2.6% in Worcestershire compared to around 9% in the West Midlands and over 5% for the whole of England. | 12.1 Explore the reasons behind lack of referrals, and ensure the revised service specification included a clear mechanism for change.  
12.2 Review criminal justice pathways, in partnership with police and other key agencies.  
12.3 Link to domestic Abuse Strategy |
| 13 The Governments Drug Strategy (2010) covers “dependence on all drugs, including prescription and over-the-counter medicines,” and local responses to drug misuse and dependence are also expected to cover dependence and other problems with medicines. At present there has been little research into this area in Worcestershire. | 13.1 Further research is needed into the local picture with regard to misuse of over the counter and prescription drugs.  
13.2 Work in partnership with primary care services to develop responses that identify, prevent and treat evidenced need. |
| 14 Cannabis is seen as a low risk drug by many young people. Consultation with young people highlighted a lack of accurate knowledge and information about the potential harms caused by Cannabis usage. | 14.1 Good quality preventative information and educational resources available for targeted groups.  
14.2 Health campaigns targeting young people. |
| 15 The number of clients entering adult drug treatment, adult alcohol treatment and young persons’ substance misuse treatment has fallen over time. | 15.1 Continue to explore the reasons behind this by establishing any patterns or trends that may exist around the types of clients that are no longer entering treatment. This information could then be used to target those demographic groups, referral pathways, or geographical areas that appear to be under-represented in the treatment population and amend the current treatment model as appropriate.  
15.2 Examine the impact that prevention campaigns and brief interventions may be having on reducing the number of people with drug and/or alcohol problems that require structured treatment.  
15.3 Undertake an audit of current data to ensure that all clients in structured substance misuse treatment are correctly captured on NDTMS. |
Legislation and policy

The following section covers some of the key legislation and policy that directly or indirectly impact on substance misuse. The aim is to highlight the importance of interdependency between substance misuse and other policy areas such as mental health, housing and children’s services. The key message is that no issue can be tackled in isolation, and partnership working is key to effective intervention.

National

Health and Social Care Act 2012
In April 2013, the National Treatment Agency for Substance Misuse was abolished and its key functions transferred into Public Health England. Most of the current budget for drug and alcohol services was transferred to Directors of Public Health employed by Local Authorities.

http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Care Act 2014
Councils now have a duty to consider the physical, mental and emotional wellbeing of the individual needing care. They will also have a new duty to provide preventative services to maintain people’s health. Under the Act, carers of drug and alcohol users will have the same rights to a needs-assessment and access to support (if appropriate) as, for example, carers for those with mental illnesses, disabilities and the elderly.

Police Reform and Social Responsibility Act 2011
Under the Police Reform and Social Responsibility Act (2011), the Government amended licensing legislation to give health authorities a statutory role in the licensing process.


Section 17 Crime and Disorder Act 1998 (amended 2006)
A duty is placed on the local authority to exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all it reasonably can prevent, including the misuse of drugs, alcohol and other substances in its area.


National Schools Policy 2012
In January 2012, the Department for Education published reduced and succinct guidance on drugs (including alcohol) in schools. As part of the statutory duty on schools to promote students’ wellbeing, schools have a clear role to play in preventing drug misuse as part of their pastoral responsibilities.


Government Alcohol Strategy 2012
The alcohol strategy 2012 sets out proposals to crackdown on our ‘binge drinking’ culture, cut fuelled violence and disorder, and slash the number of people drinking to damaging levels.

**Substance Misuse Needs Assessment**

**Government Drug Strategy 2010**

The drug strategy expresses the government’s ambition to help individuals to achieve freedom from dependence on drugs or alcohol. In particular, the aim of ‘harm reduction’ was superseded by a focus on full recovery. It also places an emphasis on increasing the number of people successfully leaving treatment having overcome dependency.


**Novel Psychoactive Substances (NPS)**

As part of the Government’s 2010 Drug Strategy, the NPS action plan sets out the direction of new and on-going work to deliver policy objectives in tackling NPS on all fronts.


**Equalities Act (2010)**

People with drug and alcohol problems are not directly protected by the Equalities Act (although they may be protected on other grounds, for example if they are also experiencing mental health problems). A substance misuse impact assessment will be carried out at the service planning stage of the substance misuse commissioning process.


**Local**

**Worcestershire Joint Health and Wellbeing Strategy 2013-16**

Alcohol is one of the four priorities of Worcestershire Joint Health & Wellbeing Strategy.


**Worcestershire Mental Wellbeing and Suicide Plan 2014-17**

There is clear resonance between these two areas of work; with dual diagnosis (co-morbid substance misuse and mental ill health) being a common theme in both needs assessments. The evidence clearly points to an enduring stigma attached to both that is seriously compromising the effective treatment of either. Please refer to the Worcestershire Mental Health Needs Assessment for more information.

**Worcestershire Alcohol Plan 2013-16**

Alcohol is one of the priorities of the Joint Worcestershire Health & Wellbeing Strategy


**Worcestershire Obesity Plan 2013-16**

There are associations between alcohol and obesity and these are heavily influenced by lifestyle, genetic and social factors.

**Worcestershire Joint Strategic Needs Assessment 2013**

Alcohol misuse is one of the main wider determinants of health, and is one of the cross cutting issues that the multi-agency nature of the Health and Wellbeing Boards are best placed to tackle.

Worcestershire Children and Young People’s Plan 2011-2014
Priority: Make sure children and young people feel safe
Supporting families who are at risk of:
- Abuse in the homes (through words and hands)
- Using drugs and alcohol
- Suffering from mental health problems
- Improving protection for everyone, especially for those who need it most
- Children and young people feeling safe from bullying wherever they are.


Worcestershire Sustainable Community Strategy 2011-21
Priority outcomes:
- To reduce the harm caused by illegal drugs and alcohol
- To improve mental health and well-being
- To support children, young people and families to lead healthy lifestyles
- To support adults to lead healthy lifestyles


- Protect communities through robust enforcement to tackle drug supply, drug related crime and anti-social behaviour
- Prevent harm to children, young people and families affected by drug misuse
- Deliver new approaches to drug treatment and social re-integration
- Public information campaigns, communications and community engagement


The Police and Crime Plan for West Mercia 2013-17
The PCC plan aims to, reduce the volume of violent crime with an emphasis on addressing the harm caused by alcohol through partnership working and reduce the harm caused by drugs with a focus on treatment, and targeting those that cause the most harm.


Policy scope and context

Introduction
The UK has a higher prevalence of drug misuse than any other country in Europe. The problem use of drugs carries many serious health risks, and street drugs are often mixed with many other substances, which can be more harmful than the drugs themselves. As well as having immediate health risks, some drugs can cause physical or psychological dependency, with the result that larger amounts are needed to get the same effect often leading to long-term damage to the body.

In terms of alcohol, the UK is one of the few European countries whose consumption has increased over the last fifty years, and over the last decade we have seen a culture grow where it has become
acceptable to be excessively drunk in public and cause nuisance and harm to ourselves and others. In moderation, alcohol consumption can have a positive impact on adults’ wellbeing, especially where this encourages sociability and the majority of people who drink do so in an entirely responsible way, but too many people still drink alcohol to excess. The effects of such excess on crime and health; and on communities, children and young people are clear (Gvt. Alcohol Strategy 2012)

**Alcohol**

Alcohol misuse is the third largest cause of avoidable ill health. It’s not only binge drinking or dependent drinking that cause harm. Around nine million (one in five) adults in England are drinking at a level that significantly increases their risk of diseases such as high blood pressure, diabetes, some cancers and depression.

Binge drinking causes acute harms such as injuries from accidents and assaults, and causes anti-social behaviour which impacts on the wellbeing of wider communities. It places an unnecessary burden on the NHS and the police, and impacts on families and workplace productivity.

It is estimated that 9 million adults drink at levels that increase the risk of harm to their health, with 1.6 million adults in England have some degree of alcohol dependence. Of these some 250,000 are believed to be moderately or severely dependent and may benefit from intensive specialist treatment (Gvt. Alcohol Strategy 2012).

In 2010 to 2011 there were 1.2 million alcohol-related hospital admissions and around 15,000 deaths caused by alcohol. This isn’t only a burden on individuals and families but also a drain on hospital resources and public money: every year, alcohol-related harm costs society £21 billion (Gvt. Alcohol Strategy 2012).

**Liver disease**

The Chief Medical Officer’s report highlights the need for comprehensive action to address the rising rate of liver disease. Liver disease is the only major cause of mortality and morbidity that is on the increase in England while it is decreasing among our European peers. Between 2000 and 2009, deaths from chronic liver disease and cirrhosis in the under 65s increased by around 20% while they fell by the same amount in most EU countries. And all 3 major causes of liver disease - obesity, undiagnosed infection, and, increasingly, harmful drinking - are preventable (CMO 2012).

The National Confidential Enquiry into Patient Outcomes and Death (2013) states that ‘alcohol related liver disease is a disease of the young’, the average age of alcohol related liver disease death is 59 and is falling. The recent Atlas of Liver Care for England tells us that there is: “An 88% rise in age-standardised mortality from chronic liver disease, the only one of the major diseases which is still increasing, of which alcohol-related liver disease is one of the primary causes, along with viral hepatitis.

**Obesity and alcohol**

There is no clear causal relationship between alcohol consumption and obesity (National Obesity Observatory 2012). However, there are associations between alcohol and obesity and these are heavily influenced by lifestyle, genetic and social factors. Many people are not aware of the calories contained in alcoholic drinks. The effects of alcohol on body weight may be more pronounced in overweight and obese people and alcohol consumption can lead to an increase in food intake Heavy, but less frequent drinkers seem to be at higher risk of obesity than moderate, frequent drinkers, the relationships between obesity and alcohol consumption differ between men and women Excess body weight and alcohol consumption appear to act together to increase the risk of liver cirrhosis and there is emerging evidence of a link between familial risk of alcohol dependency and obesity in women (NOO 2012).
Cannabis

In spite of government warnings about health risks, many people see Cannabis as a harmless substance that helps you to relax and ‘chill’ – it is sometimes perceived as a drug that unlike alcohol and cigarettes might even be good for your physical and mental health. However, recent research has suggested that Cannabis can be a major cause of psychotic illnesses in those who are genetically vulnerable i.e. those who have a family background of mental illness (RCP 2009). The Royal College of Psychiatrists cite a study of 1600 Australian school-children, aged 14 to 15 which ran for seven years. It found that while children who use cannabis regularly have a significantly higher risk of depression, the opposite was not the case - children who already suffered from depression were not more likely than anyone else to use cannabis. However, adolescents who used cannabis daily were five times more likely to develop depression and anxiety in later life (RCP 2012). The RCP also point to research from Denmark highlighting a short lived psychotic disorder which subsides once use has stopped, but also that three quarters of those studied had a different psychotic disorder diagnosed within the next year and nearly half still had a psychotic disorder 3 years later. It also seems probable that nearly half of those diagnosed as having cannabis psychosis are actually showing the first signs of a more long-lasting psychotic disorder, such as schizophrenia. It may be this group of people who are particularly vulnerable to the effects of cannabis, and so should probably avoid it in the future. (RCP 2012).

Novel Psychoactive Substances (NPS)

It has been identified that establishing national prevalence of NPS is difficult. The book Novel Psychoactive Substances: Classification, Pharmacology & Toxicology (Harry Sumnall, James McVeigh and Michael J. Evans-Brown 2013) concludes that: Most data on NPS epidemiology comes from (small) convenience samples, and although the results of such studies are frequently cited and often receive national media attention, it is important to prominently acknowledge their limitations – such data can only reveal drug use behaviours in the respondents surveyed, and cannot easily be generalised beyond the study.

However, despite the difficulties in establishing prevalence, the number of people needing treatment for 'club drugs' has risen. 'Club drug' users make up just 2% of over-18s and 10% of under-18s in treatment. (NTA 2012). According to data published in the National Programme on Substance Abuse Deaths (NPSAD) report, compiled by experts at St George’s, University of London, NPS are now linked to more drug-related deaths than ever before, The number of cases where NPS were identified as the cause of death rose by almost 600% during the same period – from 10 deaths in 2009 to 68 in 2012 (NPSAD 2104).

Pregnancy

Alcohol is a teratogenic compound that readily crosses the placenta. In the absence of a developed blood filtration system, the foetus is totally unprotected from alcohol circulating in the blood system. Prenatal alcohol exposure can affect the foetus in a number of ways. The most devastating effects are the intellectual disabilities associated with the adverse impact of alcohol on foetal brain development and the central nervous system (BMA 2007).

A recent study by The Royal College of Gynaecologists (2013) found that drinking not more than one or two units of alcohol per week during pregnancy is not linked to developmental problems in early-mid childhood, which is consistent with current UK Department of Health guidelines. However, it remains unclear as to what level of alcohol consumption may have adverse outcomes and if women are worried about consumption levels the safest option would be to abstain from drinking during pregnancy. NICE guidelines CG62 recommend that pregnant women and women planning a pregnancy should be advised to avoid drinking alcohol in the first 3 months of pregnancy if possible because it may be associated with an increased risk of miscarriage. If women choose to drink alcohol during pregnancy they should be advised to drink no more than 1 to 2 UK units once or twice a week (1 unit equals half a pint of ordinary strength lager or beer, or one shot [25 ml] of spirits. One small
[125 ml] glass of wine is equal to 1.5 UK units). Although there is uncertainty regarding a safe level of alcohol consumption in pregnancy, at this low level there is no evidence of harm to the unborn baby. Women should be informed that getting drunk or binge drinking during pregnancy (defined as more than 5 standard drinks or 7.5 UK units on a single occasion) may be harmful to the unborn baby (NICE CG62 2013).

Different studies have raised concerns about a variety of pregnancy outcomes which may be affected by alcohol intake during pregnancy, including growth before and after birth, miscarriage, stillbirth and preterm birth. A pregnancy outcome which has been linked to heavy alcohol intake during pregnancy is foetal alcohol syndrome, which is characterised by reduced birth weight and length, including small head size, congenital and intellectual abnormalities and certain facial features. However, not all babies of women who drink heavily during pregnancy have foetal alcohol syndrome and diagnosing the syndrome can be difficult as it requires a reliable measure of maternal alcohol intake throughout pregnancy, as well as the exclusion of other congenital syndromes with similar features (NICE CG62 2008).

Families

NICE public health guidance (2007) asserts that more emphasis be placed on reducing rates of alcohol misuse through health education and promotion. Adopting a family oriented approach, to primary prevention is supported by evidence; a Cochrane systematic review found that the 'Strengthening Families Programme' which is based on social learning theory and uses interactive learning methods to assist families with children aged 10-14 in need or 'at risk', showed long-term efficacy for the prevention of alcohol misuse (Foxcroft et al 2008). Practitioners and others who work with vulnerable and disadvantaged children and young people have a key role to play in offering structured family based support to vulnerable children and families.

The ACMD 'Hidden Harm' enquiry (2011) highlights the importance of the child protection system, and the current initiatives such as the Troubled Families Programme, which is designed to support disadvantaged children in general. Effective treatment of the parents’ drug problems is one of the most likely ways to enhance their parenting capacity, but substance misuse services in partnership with other agencies must see the child behind the client, and recognise their responsibility for ensuring the child’s well-being. The children must be seen and listened to; their needs assessed and responded to. Substance misuse services must therefore become family focused and child friendly. Health services, social services, education services and the criminal justice system should share information and work together more effectively, and assisting the voluntary sector to develop and expand is a way that could be useful in providing services to ‘at risk’ families. Behavioural and cognitive behavioural therapies, motivational enhancement therapy, contingency management and 12-step approaches (based on the principles of Alcoholics Anonymous). Family based interventions such as Multi Systemic Therapy and Multi-Dimensional Family Therapy are recommended by NICE for alcohol misusing adolescents with more complex needs (NICE, 2011).

One example of effective intervention is the Triple P programme, which has a significant evidence base mainly from the USA of controlled evaluations (Prinz et al, 2009). There is systematic review evidence that supports universal parenting programmes (Barlow et al, 2010; Barlow et al 2012). Targeted programmes have a mixed evidence base. Parenting programmes for teenage parents and their children are effective according to a recent systematic review, the Family Nurse Partnership (FNP) is an example of this type of intervention, FNP is an intensive health visiting approach targeted at young mothers (Barlow et al, 2011). We are still awaiting the reporting of a recent multi centre Randomised Controlled Trial in UK as most of the research is American.

Young People

Very few young people develop dependency. Those who use drugs or alcohol problematically are likely to be vulnerable and experiencing a range of problems, of which substance misuse is one. This
means that the commissioning and delivery of specialist drug and alcohol interventions for young 
people should take place within the wider children and young people’s agenda. The aim is that all 
needs are met, rather than addressing substance misuse in isolation; and that intervention is 
successful before problematic use becomes entrenched (Gov. Drug Strategy 2012).

Young people and their needs differ from adults:

- The majority of young people accessing specialist drug and alcohol interventions have 
  problems with alcohol (37%) and cannabis (53%), requiring psychosocial, harm reduction and 
  family interventions, rather than treatment for addiction, which most adults but only a small 
  minority of young people require.
- Most young people need to engage with specialist drug and alcohol interventions for a short 
  period of time, often weeks, before continuing with further support elsewhere, within an 
  integrated young people’s care plan.

The annual statistics for young people’s substance misuse interventions have been published by 
Public Health England. The total number of young people seeing specialist substance misuse services 
fell for the fourth year running, to 20,032 in 2012-13 from a peak of 24,053 in 2008-9. This reflects 
the overall decline in alcohol and drug use by young people over recent years (PHE 2103)

A number of recent reviews on effective interventions for adolescents identified as being in need of 
help or advice about their drinking have now been published; the most recent of these have focused 
upon the use of internet, computer and mobile phone technologies, collectively referred to as 
electronic brief interventions (e-BIs). These reviews present limited evidence that e-BI significantly 
reduces alcohol consumption compared with minimal or no intervention controls (Champion et al., 
2013; Mitchell et al., 2013; Newton et al., 2013). However caution should be exercised when 
interpreting these, as earlier studies conclude that face to face intervention is superior. e-BI based 
on motivational interviewing is also seen to be effective in reducing alcohol consumption in 
adolescents when carried out over a series of sessions.

The Home Office Affairs select committee (2012) on drugs policy highlighted the importance of 
educating all young people about the harmful effects of all drugs, legal and illegal, it recommends a 
whole life approach to preventing and reducing the demand for drugs that will: provide good quality 
education and advice so that young people and their parents are provided with credible information 
to actively resist substance misuse; use the creation of Public Health England (PHE) to encourage 
individuals to take responsibility for their own health; intervene early with young people and young 
adults; consistently enforce effective criminal sanctions to deter drug use; and support people to 
recover.

Older People

The number of people coming into treatment for drugs has fallen across most age groups, but it has 
been rising for people aged 40 and over since 2005–2006 (National Treatment Agency for Substance 
Misuse 2010). The main issue for this age group is heroin abuse, either alone or in combination with 
crack cocaine (RCP 2011). A high percentage of Worcestershire’s treatment population is in this age 
group, consequently, there is likely to be an increased demand in the county for specialist drug 
treatment services to cater for the needs of these patients as they age.

Our Hidden Addicts (RCP 2011) states that Both alcohol and illicit drugs are among the top ten risk 
factors for mortality and morbidity in Europe and substance misuse by older people is now a growing 
public health problem. Between 2001 and 2031, there is projected to be a 50% increase in the 
dnumber of older people in the UK. The percentage of men and women drinking more than the 
weekly recommended limits has also risen, by 60% in men and 100% in women between 1990 and 
2006 (NHS Information Centre, 2009a). Given the likely impact of these two factors on health and 
social care services, there is now a pressing need to address substance misuse in older people.
Substance Misuse Needs Assessment

Signs and symptoms of substance misuse may be mistakenly attributed to other physical or mental health conditions, or may be masked by the presence of other illnesses. Thus, an underlying substance use disorder may be missed unless a high degree of clinical suspicion is maintained. The Royal College of Psychiatrists (2011) recommend that general practitioners should screen every person over 65 years of age for substance misuse as part of a routine health check, using specific tools such as the Short Michigan Alcohol Screening Test – Geriatric version (SMAST-G); screening should also incorporate cognitive testing using tools such as the Mini-Mental State Examination (MMSE). The RCP is also concerned that current recommended ‘safe limits’ for alcohol consumption are based on work in younger adults (21 Units for Men and 14 for women per week). Because of physiological and metabolic changes associated with ageing, these ‘safe limits’ are considered too high for older people; recent literature suggests that the upper ‘safe limit’ for older people is 1.5 units per day or 11 units per week (RCP 2011).

Offenders

Lord Bradley’s review of people with mental health problems or learning disabilities in the criminal justice system (2009) shows that, over 90% of prisoners had one or more of the five psychiatric disorders (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence); remand prisoners had higher rates of mental disorder than sentenced prisoners; and rates of neurotic disorder in remand and sentenced prisoners were much higher in women than in men.

Research by the Ministry of Justice (2012) which was carried out using self-assessment and included prisoners with both physical and mental disability, showed that disabled and non-disabled prisoners particularly those with mental health issues exhibited a number of differences. For example, disabled prisoners were more likely to report: having used drugs and needing treatment and support for a drug or alcohol problem; having experienced abuse or observed violence as a child; being homeless before custody; and needing help in finding a job when released. The numbers of the prison population likely to be disabled (34% MOJ 2010) has implications for prison policies, including prisoner and ex-prisoner employment and other programmes. The MOJ highlights the importance of examining how disability is classified and identified in prisons, to ensure that programmes are being effectively targeted and delivered.

Prison-based drug and alcohol services are an essential part of the substance misuse treatment system. All prisons in England currently provide specialist drug and alcohol recovery services as part of the government’s Integrated Drug Treatment System (IDTS). Departments such as Education, Resettlement and Reducing Reoffending are integrated into the recovery plans, providing interventions to address the prisoner’s needs. The aim of these interventions is to break the link between drug use and criminal behaviour, so that individuals don’t reoffend on release and have the opportunity to recover and reintegrate with society. In this way, effective treatment can protect them, their families, and their communities from the harms they suffer as a result of drug-related crime. Effective resettlement of any drug misuser requires the development of a holistic package of support. A package of holistic support needs to be in place when a drug misuser leaves custody, involving access to additional support with a range of issues that may include housing, managing finance, rebuilding family relationships, learning new skills and employment. Early planning pre-release will enable continuity of care and access to wraparound support to be provided at the time when it is needed (DOH 2006).

Mental Health

There is a clear association between having a mental illness and alcohol dependence – if you drink too much, you put your mental health at risk (DOH 2013). Many people with substance misuse problems have existing ‘multiple needs’, including experience of trauma and abuse, homelessness, lack of meaningful activity, and a history of offending. Psychiatric conditions such as anxiety, depression, post-traumatic stress disorder, drug-induced psychosis, schizophrenia, delirium and
dementia may lead to, be a consequence of, or coincide with drug misuse. Alcohol misuse can also be a cause of dementia (Wernicke–Korsakoff syndrome), which may be put down to 'old age' instead of the effects of alcohol (RCP 2102).

The Self-Medication Hypothesis, introduced by a group of scientists that included Harvard Medical School's Edward J. Kantzian (1974), is a theory that states alcohol and drug abuse is often an attempt at self-medication for a variety of mental health conditions, including depression. Sometimes those suffering from depression will turn to psychostimulants, such as cocaine and amphetamines, for the temporary feeling of euphoria. However, cocaine can also cause depression.

For many people, mental ill health and substance misuse combine with a range of other needs including poor physical health, insecure housing and offending.

The 2002 Co-morbidity of Substance Misuse and Mental Illness Collaborative study or COSMIC concluded that:

- 75 per cent of users of drug services and 85 per cent of users of alcohol services were experiencing mental health problems;
- 30 per cent of the drug treatment population and over 50 per cent of those in treatment for alcohol problems had 'multiple morbidity';
- 38 per cent of drug users with a psychiatric disorder were receiving no treatment for their mental health problem;
- 44 per cent of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year (COSMIC 2002).

**Wider determinants of health**

Recovery today is about so much more than a narrow traditional view of treatment - it's about jobs, education, housing, peer support and families; building recovery capital. The Marmot Review 'Fair Society, Healthy Lives' (Marmot 2010) highlights the significant positive correlation between the prevalence of problematic drug users aged 15–64 years and the deprivation indices of a local authority, and the positive association between the number of individuals in contact with structured drug treatment services per 1,000 population and the level of deprivation of each local authority. An inverse social gradient exists with regard to alcohol. In particular, as the level of gross weekly household income rises, so does consumption. However, if people from a lower socio economic position do consume alcohol, they are more likely to have problematic drinking patterns and dependence than people higher up the scale (Marmot 2010).

Marmot recommends proportionate universalism in developing policies to reduce the steepness of the social gradient in health and implementing evidence-based programmes of ill-health prevention that are effective across the social gradient and the life-course. Public health interventions such as alcohol reduction and drug treatment programmes should focus on reducing the social gradient as well as health intervention and diverting problem users away from the criminal justice system.

Active travel (for example walking or cycling), better public transport, energy-efficient houses, availability of green space, healthy eating and building social capital are recommended contributors to sustainable prevention and reduction of substance misuse and dependency. The UK Recovery Foundation believes that we need to focus on the assets that support the '5 Ways to Wellbeing' (NEF 2010) for individuals, groups and communities and challenge our current deficit/needs-based culture. 'In identifying and supporting the assets within our communities that support the ‘5 ways’ we will support new and diverse forms of mutual aid and make recovery visible and accessible for all and ensure that Recovery Networks are there for all that are recovering (UKRF 2010)'.

**Employment**

Substance use may affect an individual’s ability to participate in the labour market, whether through intermittent, regular or long term absences, the loss of work or negative effects on the capacity to
secure work. However, getting people into work is of critical importance for reducing health inequalities. Marmot (2011) states that jobs need to be sustainable and offer a minimum level of quality. Marmot recommends active labour market intervention encouraging, incentivising and, where appropriate, enforcing the implementation of measures to improve the quality of work across the social gradient by for example, employers creating or adapting jobs that are suitable for lone parents, carers and people with mental and physical health problems (Marmot 2011).

The Government’s 2010 Drug Strategy places a significant emphasis on the role that employment can play in supporting and sustaining recovery from substance misuse. Being in work or undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training. However, the majority of people in drug and alcohol treatment will require significant support to address their education, training and employment needs and to get them job ready.

**Housing**

Housing and support can play a key role in helping people to tackle their substance misuse, and a lack of housing and support can at best render treatment ineffective and at worst unusable or inaccessible. Housing with support can provide a stable base for people leaving rehabilitation or prison, or for substance misusers wanting to stabilise their lives in order to progress into detoxification or rehabilitation. However, there are strong links between substance misuse and homelessness. Drug users are seven times more likely to be homeless than the general population, and research suggests that two thirds of individuals report increasing problems with substance misuse after becoming homeless. Homeless people using drugs may face a range of problems in accessing appropriate support to address their substance misuse. Reducing tenancy support for substance misusers and benefit changes including the Spare Room Subsidy and Universal Credit, could all have a profound effect on substance misusers ability to retain tenancies.
Population Trends and Needs

Groups of Interest

National Overview

Alcohol
Data from the National Drug Treatment Monitoring System (NDTMS) on the number of adults (18 and over) in contact with alcohol treatment providers and general practitioners in England in 2012-13 shows that:

- 109,683 clients aged 18 and over in contact with structured treatment cited alcohol as their primary problematic substance in 2012-13.
- A further 33,814 clients aged 18 and over cited alcohol misuse as an adjunctive problem to a range of other primary problematic substances.
- Clients’ median age at their first point of contact with treatment in 2012-13 was 42; 64% in treatment were male.
- Where reported, most clients were white British (87%), while other ethnic groups each accounted for no more than 3% of clients in treatment.
- Where reported, 40% of clients starting treatment were self-referrals and 18% were referrals from general practitioners (GPs). Onward referrals from other substance misuse services accounted for 8%.
- 89% of all clients waited under three weeks to start treatment.
- Where reported, 4% of clients had an urgent housing problem (no fixed abode) on presenting for treatment. A further 10% had other housing problems.
- Of the 70,194 clients exiting treatment in 2012-13, 40,908 (58%) were no longer dependent on alcohol (had completed treatment successfully). A further 5,109 (7%) were transferred for further treatment within the community, while 913 (1%) were transferred into appropriate treatment while in custody.
- The overall number of clients in treatment in 2012-13 increased by 1% (777) from 108,906 in 2011-12. The number of new treatment journeys starting increased by 2% (1,420) from 74,353 clients in 2011-12 to 75,773 in 2012-13. The number and proportion of successful completions also increased from 38,174 (57% of all 66,894 exits) in 2011-12 to 40,908 (58% of all 70,194 exits) in 2012-13.

It should be noted that these figures report data that was collected on adults whose treatment falls within the definition of structured alcohol treatment as defined by the National Treatment Agency for Substance Misuse’s (NTA) Models of Care as “treatment following assessment and delivered according to a care plan, with clear goals, which is regularly reviewed with the client”.

Drugs

Opiate and/or Crack Cocaine Users (OCU)
The number of estimated OCUs has fallen steadily since 2005-06, with a 10% fall in since 2004/05 from a total of 327,662 to 298,752 in 2010/11. This can partly be attributed to the success of treatment interventions. It should also be noted that the age profile of estimated OCUs shows a growing number of those in the 35-64 age bracket, and those estimated to be aged 15-24 now make up only half the number estimated in 2004-05.
• Of the 193,575 clients aged 18 and over in treatment during 2012-13, 181,994 were in for 12 weeks or more or completed free of dependency before 12 weeks (94%).
• 29,025 (47%) of clients exiting treatment in 2012-13 completed, defined as having overcome their dependency.
• A further 8,019 (13%) were transferred for treatment within the community, while 6,602 (11%) were transferred into structured treatment while in custody.
• Of those heroin-only clients with a six-month review in 2012-13, 49% were abstinent from heroin and 23% were classified as reliably improved. 3% had deteriorated.
• 58% of crack-only clients with a six-month review in 2012-13 were abstinent from crack cocaine and a further 7% were classified as reliably improved. 2% had deteriorated.
• Clients’ median age at their first point of contact in their latest treatment journey in 2012-13 was 35.
• 73% of clients in treatment were male.
• Most clients were white British (83%); the next most common ethnicity was ‘white – other’ (4%). No other ethnic groups accounted for more than 2%.
• Most clients in treatment were using heroin (80%). Cannabis was the primary drug for 8%, and powder cocaine for 5%.
• The most common routes into treatment for clients starting in 2012-13 were self-referrals (42%) and referrals from the criminal justice system (28%). Onward referrals from other drug services together accounted for 12%.
• Nearly all clients waited under three weeks to commence treatment (98%).
• Of the clients starting treatment (and where reported) just over half (56%) have never injected while 17% were injecting at the time of presentation.
• Where reported, 9% of clients starting new journeys had no fixed abode on presenting for treatment, and a further 15% had other housing problems.

It should be noted that these figures report data collected on adults whose treatment falls within the definition of structured drug treatment as defined by the National Treatment Agency for Substance Misuse’s (NTA) Models of Care: “treatment following assessment and delivered according to a care plan, with clear goals, which is regularly reviewed with the client”(NDTMS 2102-13)

Overview of the Worcestershire Population

According to the 2011 Census, the total population of Worcestershire is 566,169, an increase of 4.4% since the 2001 census. Approximately 49.2% of Worcestershire residents are male, which is in line with the England average.

Table 1 below shows the populations of both Worcestershire and each district in 2011 and 2001.

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<tr>
<td>Bromsgrove</td>
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<td>+5.65%</td>
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<td>+3.69%</td>
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<td>1,148</td>
<td>+1.18%</td>
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<td><strong>Worcestershire</strong></td>
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<td><strong>566,577</strong></td>
<td><strong>24,477</strong></td>
<td><strong>+4.51%</strong></td>
</tr>
</tbody>
</table>

*Source: 2011 Census, 2001 Mid-Year Population Estimates*

As expected, all districts within Worcestershire have experienced an increase in population across the ten year intercensus period. However, three areas have seen an increase greater than the
county average of 4.5%; namely Redditch, Bromsgrove and Worcester City all with increases of over 5% since the 2001 census.

Worcestershire's population is generally older than that of England as a whole, with a noticeably higher percentage of the population aged between 60 and 70. Since 2001, it appears that the population of Worcestershire has experienced a greater fall in the percentage of both men and women in the 25-40 age range compared to England. Conversely, Worcestershire has experienced a greater increase in the percentage of both males and females aged 60 and above during the same period when compared to England.

**Age of the Population**

Figure 1 below shows the percentage of the population by broad age group for Worcestershire at both the County level and for each District compared with that of the West Midlands and England.

![Figure 1 - Percentage of Population by Broad Age Groups in 2011](chart.png)

**Source:** Office for National Statistics, 2011 Census data

It can be seen from the chart that Worcestershire has a higher than average proportion of people in the older age groups than both England and the West Midlands. Approximately 19% of persons in the county are estimated to be aged 65 and over, compared to around 16% nationally.

At the District level, Redditch has a younger population than the other areas in Worcestershire, though the percentage of those in the 0-15 ad 16-29 age groups in Redditch are actually very similar to those in the West Midlands.

Malvern Hills has the oldest population out of the six District areas, with almost 55% of residents aged 45 and over. Over half the population of Wychavon are also estimated to be in this age group.

**Ethnicity**

Figure 2 below shows the percentage of the population by broad ethnic group for Worcestershire at both the County level and for each District compared with that of the West Midlands and England.
Information from the 2011 Census show that almost 96% of the population of Worcestershire are from White ethnic groups, compared to around 83% in the West Midlands and 85% in England.

The ethnic make-up of the population differs in each Worcestershire District, with Redditch having the lowest percentage of people from all White ethnic groups, at 92%, and Wychavon the highest at almost 98%.

**Population Living in Deprivation**

The Index of Multiple Deprivation 2010 (IMD) is a measure of multiple deprivation at small area level namely LSOA (lower super output area – average population of 1,500). The IMD is made up of 38 indicators covering seven domains and the result is a single score for an LSOA which is then ranked (1 = most deprived area in England and 32,482 = least deprived), these can be then grouped into deciles and quintiles. There are thirteen LSOA areas in Worcestershire which fall within the top 10% most deprived areas for the whole of England; 6 in Worcester City, 4 in Redditch, 2 in Wyre Forest, and 1 in Malvern Hills.

Out of the six districts of Worcestershire, Redditch has the largest percentage of its population in the most deprived quintile at 24.9%. Not only is this significantly greater than the National average of 20.3%, but it is more than twice the figure for the whole of Worcestershire, at just 10.0%. It should be noted that 0% of the populations of both Bromsgrove and Wychavon live in the most deprived quintile.

Using these percentages, along with population estimates, we can approximate the number of adults in each district that live in the two most deprived quintiles. This is shown in table 2 below;
Table 2 – Calculated Populations of Adults Living in the Two Most Deprived Quintiles by Worcestershire District

<table>
<thead>
<tr>
<th>Worcestershire</th>
<th>ONS 2012 Mid-Year Population Estimates Aged 16+</th>
<th>Estimated Population Living in the Two Most Deprived Quintiles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage</td>
<td>Number</td>
</tr>
<tr>
<td>Bromsgrove</td>
<td>77,784</td>
<td>7.1%</td>
</tr>
<tr>
<td>Malvern Hills</td>
<td>62,708</td>
<td>10.9%</td>
</tr>
<tr>
<td>Redditch</td>
<td>67,675</td>
<td>41.1%</td>
</tr>
<tr>
<td>Worcester</td>
<td>80,972</td>
<td>31.8%</td>
</tr>
<tr>
<td>Wychavon</td>
<td>97,870</td>
<td>10.7%</td>
</tr>
<tr>
<td>Wyre Forest</td>
<td>81,295</td>
<td>36.3%</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>468,304</td>
<td>22.8%</td>
</tr>
</tbody>
</table>


Health Hotspots

Deprivation is lower than the England average in Worcestershire, however about 15,800 children live in poverty. Life expectancy in Worcestershire is higher for both men and women than the England average; however life expectancy is 7.8 years lower for men and 5.4 years lower for women in the most deprived areas of Worcestershire than in the least deprived areas.

Figure 3 below shows the difference in life expectancy for the most deprived 20% of the Worcestershire population compared to the remaining 80%.


It can be seen that although life expectancy has been increasing for both groups over time, the life expectancy for the most deprived remains around 4 years lower than the rest of the population.

Figure 4 below shows the difference in the mortality rates from all causes and for all ages, for the most deprived 20% of the Worcestershire population compared to the remaining 80%.
Again it can be seen that although mortality rates for the whole population are gradually falling over time, those for the most deprived 20% of the population are consistently higher than the other 80%.

**Unemployment**

The unemployment benefit claimant rate in the county is relatively low at 2.3%, which is below the West Midlands (3.9%) and the national (3.0%) rates. However, as this represents only those actively claiming benefit it is most likely an underestimate of the scale of the problem. The rate varies between the county districts as depicted in the graph below which compares rates in October 2013 with October 2012. All areas have seen a decrease compared with Same Period Last Year (SPLY); in fact since the beginning of 2013 the unemployment proportions have begun to decrease and are now at their lowest levels since November 2008.
Figure 5 - Unemployment Benefit Proportion % of the population (aged 16-64) Oct 2013

Source: WCC Monthly Economic Summary December 2013 (RIU) using ONS 2013 downloaded from NOMIS

Table 3 - Top 10 wards for unemployment proportion\(^1\) in Worcestershire November 2013

<table>
<thead>
<tr>
<th>Rank (2012)</th>
<th>Ward</th>
<th>District</th>
<th>% Claimants 16-64</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (1)</td>
<td>Oldington &amp; Foley Hill</td>
<td>Wyre Forest</td>
<td>6.6%</td>
</tr>
<tr>
<td>2 (3)</td>
<td>Warndon</td>
<td>Worcester City</td>
<td>5.4%</td>
</tr>
<tr>
<td>3 (2)</td>
<td>Gorse Hill</td>
<td>Worcester City</td>
<td>5.3%</td>
</tr>
<tr>
<td>4</td>
<td>Cathedral</td>
<td>Worcester City</td>
<td>4.9%</td>
</tr>
<tr>
<td>5 (6)</td>
<td>Broadwaters</td>
<td>Wyre Forest</td>
<td>4.6%</td>
</tr>
<tr>
<td>6</td>
<td>Pickersleigh</td>
<td>Malvern Hills</td>
<td>4.4%</td>
</tr>
<tr>
<td>=6 (5)</td>
<td>Rainbow Hill</td>
<td>Worcester City</td>
<td>4.4%</td>
</tr>
<tr>
<td>7 (8)</td>
<td>Charford</td>
<td>Bromsgrove</td>
<td>4.0%</td>
</tr>
<tr>
<td>8 (-)</td>
<td>Areley Kings</td>
<td>Wyre Forest</td>
<td>3.8%</td>
</tr>
<tr>
<td>9 (-)</td>
<td>Sidemoor</td>
<td>Bromsgrove</td>
<td>3.7%</td>
</tr>
<tr>
<td>10 (-)</td>
<td>Central</td>
<td>Redditch</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Source: WCC Monthly Economic Summary November 2013 (RIU) using ONS 2013 downloaded from NOMIS

The unemployment benefit claimant proportion in many of the top ten wards is higher than the West Midlands (3.9%) and England (3.0%) rate, and all but Wychavon district are represented. However, there are more wards from Worcester City District represented in this top 10 list than any other area of Worcestershire. This year, however, it is closely followed by Wyre Forest with 3 areas in the top 10. There is also some resonance as expected, with the areas of higher deprivation (and the lowest life expectancy) in the county, including Oldington & Foley, Warndon, Gorse Hill and Rainbow Hill and Broadwaters.

There are also three brand new wards that have entered the top ten; these are worthy of close monitoring to assess the potential impact, particularly considering the enduring trend of people spending more time in unemployment. Anecdotally, the longer people spend unemployed, the more difficult it is to get back into the work marketplace, and the more vulnerable people are to common mental disorders such as depression and anxiety. There is an increasing trend of long term

\(^1\) Unemployment proportion for wards expresses the number of claimants resident in an area as a % of the Mid-2010 population aged 16-64 in that area.
unemployment in Worcestershire, which is now running at a higher rate than shorter term unemployment and is still increasing.

Some figures about *employment* in the county will provide an additional perspective, using some of the questions in the 2011 census. Figure 6 below summarizes some key features of economic activity in Worcestershire districts.

Figure 6 below shows the percentage of 16-18 year olds Not in Education, Employment or Training (NEET) in each Worcestershire district over a three year period compared to the national average rate for each year.

**Figure 6 - Percentage of 16-18 year olds classified as 'NEET' in each Worcestershire District compared with the National average over three years**

Source: Data for the Worcestershire Districts is taken from the Worcestershire County Council Instant Atlas Toolkit. National data is taken from CHIMAT.

It can be seen that the rate of 'NEETs' in Worcester is just above the national average for all three years, with Wyre Forest experiencing a significantly higher rate of NEETs in 2009 and 2010, but not 2011. Indeed, all of the Worcestershire district areas have a lower percentage of 16-18 year olds classified as 'NEET' in 2011 compared to 2009 with the exception of Bromsgrove which experienced a 0.6% increase.

Table 4 below shows those ward areas that are classified in the highest (i.e. worst) quintile for the percentage of 16-18 year olds that are ‘NEETs’ in the whole of Worcestershire. Oldington and Foley Park has a significantly higher rate of ‘NEETs’ than any other ward.
Table 4 – Wards with the Highest Percentage of 16-18 year olds classified as ‘NEET’ in 2011

<table>
<thead>
<tr>
<th>Ward</th>
<th>District</th>
<th>NEET 16-18 %(2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oldington and Foley Park</td>
<td>Wyre Forest</td>
<td>14.6</td>
</tr>
<tr>
<td>Charford</td>
<td>Bromsgrove</td>
<td>10.9</td>
</tr>
<tr>
<td>St John</td>
<td>Bromsgrove</td>
<td>10.8</td>
</tr>
<tr>
<td>Gorse Hill</td>
<td>Worcester</td>
<td>10.5</td>
</tr>
<tr>
<td>Church Hill</td>
<td>Redditch</td>
<td>10.3</td>
</tr>
<tr>
<td>Cathedral</td>
<td>Worcester</td>
<td>10.2</td>
</tr>
<tr>
<td>Sidemoor</td>
<td>Bromsgrove</td>
<td>10.1</td>
</tr>
<tr>
<td>Warndon</td>
<td>Worcester</td>
<td>9.6</td>
</tr>
<tr>
<td>Greenhill</td>
<td>Wyre Forest</td>
<td>9.5</td>
</tr>
<tr>
<td>Areley Kings</td>
<td>Wyre Forest</td>
<td>9.3</td>
</tr>
<tr>
<td>Arboretum</td>
<td>Worcester</td>
<td>9.2</td>
</tr>
<tr>
<td>Pickersleigh</td>
<td>Malvern Hills</td>
<td>8.9</td>
</tr>
<tr>
<td>Priory</td>
<td>Malvern Hills</td>
<td>8.8</td>
</tr>
<tr>
<td>Harvington and Norton</td>
<td>Wychavon</td>
<td>8.8</td>
</tr>
<tr>
<td>Ripple</td>
<td>Malvern Hills</td>
<td>8.6</td>
</tr>
<tr>
<td>Great Hampton</td>
<td>Wychavon</td>
<td>8.0</td>
</tr>
<tr>
<td>Rainbow Hill</td>
<td>Worcester</td>
<td>7.9</td>
</tr>
<tr>
<td>St Johns</td>
<td>Worcester</td>
<td>7.9</td>
</tr>
<tr>
<td>Nunnery</td>
<td>Worcester</td>
<td>7.6</td>
</tr>
<tr>
<td>Broadwaters</td>
<td>Wyre Forest</td>
<td>7.5</td>
</tr>
<tr>
<td>Sutton Park</td>
<td>Wyre Forest</td>
<td>7.4</td>
</tr>
<tr>
<td>Droitwich West</td>
<td>Wychavon</td>
<td>7.2</td>
</tr>
</tbody>
</table>

Source: Worcestershire County Council Instant Atlas Toolkit

7 of these wards are in the District of Worcester, 5 in Wyre Forest, 3 in each of Bromsgrove, Malvern Hills and Wychavon, with only one in Redditch.

Homelessness

It is difficult to know exactly how many rough sleepers there are in the county. The most recent estimate of rough sleepers came to 46 people across Worcestershire in 2013. Rough sleeping counts and estimates are single night snapshots of the number of people sleeping rough in local authority areas. Local authorities decide whether to carry out a count or an estimate based upon their assessment of whether the local rough sleeping problem justifies counting. The latest estimates were carried out by local authorities between 1 October and 30 November 2013.

In 2010/11 110 people entering services listed their previous accommodation as rough sleeping, whilst 175 people accessed the Night Assessment Centre (NAC) at some point in the same year. More recent figures shows that the NAC accommodated 145 people during the period November 2013 to March 2014. Although many of the latter are not entrenched rough sleepers, many are likely to be single homeless people who unfortunately have experienced a period of rough sleeping.

There is an inward migration of rough sleepers into Worcester City from the surrounding districts and to a degree from outside the county. There is also likely to be a migration out of Worcestershire for example to Birmingham. In terms of migration to Worcester, this is likely to be because of the services offered, such as the direct access hostel and day centre which make it attractive. 97% of new single homeless clients who were previously rough sleeping were living in Worcester City prior to entering services.
The Night Assessment Centre found that 43% of their clients had mental health problems, 34% had alcohol problems and 26% had drug problems. These were also the 3 most common secondary needs of people entering single homeless SP services in general in 2010/11.

Changes in levels of homelessness in the county can be made by looking at the number of people approaching district housing teams and being accepted as homeless. However this only includes those who approach the district councils as homeless. There is also a large number of ‘hidden homeless’ who do not approach for help including those who are sofa surfing and sleeping rough. There are also people who have accommodation but are at risk of losing it i.e. where there is a threat of homelessness.

Figure 7 below shows the number of households who approached district housing teams for whom decisions were made. The chart shows there was downward trend in the number of decisions being made countywide, with a drop of over 600 people between 2005/06 and 2009/10. However, from 2009/10 to 2011/12 there was a gradual increase in the number of decisions being made, with figures from 2011/12 onwards remaining fairly stable. It is not possible to breakdown the data to show how many of these decisions were about single homeless households.

Of these decisions, it is possible to identify how many of these households were subsequently accepted as ‘eligible, unintentionally homeless and in priority need’, which are also shown in the chart. Between 2005/06 and 2009/10 the number of household acceptances in the county was falling broadly in line with the number of decisions made. This is a picture which is also mirrored nationally with the number of household acceptances in England falling by 51% between 2003 and 2008. This decrease is thought to be a result of the Homelessness Act of 2002, which placed the duty on local authorities to formulate homelessness strategies, the prime aim of which was to work on homelessness prevention.

However, between 2009/10 and 2011/12 there has been an increase in the number of acceptances. A number of districts have commented that the economic downturn has led to a greater volume of homeless households needing assessment and accommodation as increasing numbers of people face
unemployment or a reducing income. As the repercussions of the economic crisis continue, it is possible that these numbers may rise further.

Figure 8 below shows there is no coherent pattern across the districts for the number of homelessness acceptances. The rate of homeless acceptances per 1,000 households fell in most of the districts from 2005/06 to 2009/10, with Redditch experiencing the most dramatic fall from 8.5 in 2005/06 to 0.5 in 2009/10, though this has increased since then to 2.1 per 1,000 households. The rate in Bromsgrove has also fallen significantly over the period, showing only a very small increase recently.

Overall Worcester has experienced a fairly stable rate of homelessness acceptances over the period 2005/06 to 2013/14 at around 4 to 5 per 1,000 households. Wychavon is the only district that had a higher rate of homelessness acceptances in 2013/14 compared to 2005/06.

The work being done by district housing teams around homeless preventions is considered to be an important factor in the decline in the number of people presenting as homeless and the number of homeless acceptances. The teams work with clients where they can to sort any issues which are putting their current accommodation at risk such as giving debt advice, resolving housing benefit issues, arranging family mediation or offering the sanctuary scheme, etc.

Client records also tell us about any additional secondary needs which clients have. By far the most commonly identified secondary need is around substance misuse. 24% of clients reporting alcohol problems and 19% of clients having drug problems (12% of clients had both a drug and alcohol problem). 14% of clients also have a mental health issue. All other needs are reported in much lower levels than these top 3 of homelessness, substance misuse and mental health which can often present together. 11 clients (4%) reported a secondary need around offending.

Outcomes data is collected to show the progress service users have made in gaining independence in certain support areas important for maintaining an independent tenancy.
In 2010/11 3,406 positive outcomes were achieved by clients in single homeless services. These included:

- 926 Economic Success outcomes achieved. This includes 189 people who can now successfully budget and reduce their debt and 59 people who have successfully accessed employment.
- 977 Health and Wellbeing outcomes achieved. This includes 229 people who were supported to access a GP and 96 people who were able to successfully access or continue to access drug and alcohol services.
- 621 Community Safety outcomes achieved such as addressing self-harm, a history of abuse or anti-social behaviour.
- 800 Stronger Communities outcomes achieved. This includes 199 people who were successfully able to establish appropriate networks, such as family, social or community networks.
- 63 Better Environment outcomes achieved such as recycling within the household.
- 19 Children and Young People outcomes achieved such as accessing a stable education for children.

**Domestic Violence**

The Worcestershire Forum against Domestic Abuse (WFADA) produced a Worcestershire Domestic abuse profile to inform strategic planning in 2013/14. In relation to alcohol, the research found that;

- Domestic abuse calls are twice as likely to be violent when alcohol is involved. 26.2% of all calls for service for which alcohol is involved are assaults compared with 13.2% when alcohol is not involved.
- The proportion of alcohol related calls for service shows a noticeable peak during December; however, the total number of calls in December is not higher than other months. This indicates a possible link to increased levels of drinking over Christmas and the festive period changing the proportion of calls which are alcohol related rather than increasing the total number of calls.
- Alcohol related calls for services are low on a Monday to Thursday but begin to rise on Friday to a peak on Saturday coinciding with weekend drinking behaviour. Non-alcohol related call levels remain stable throughout the week.
- Alcohol related calls are highest in the evening, showing steady increase from around 3pm to peak at midnight. This would coincide with evening drinking behaviour. In comparison non-alcohol related calls are highest during the day and drop off into the evening.
- There was a higher percentage of alcohol related incidents occurring in town centres than non-alcohol related incidents.

**Mental Health**

Estimates for prevalence of mental ill health in the Worcestershire population are indicated in the table below; these estimates are based around the cluster groupings and also provide projections to the year 2030. It is clear from the data that anxiety and depressive disorders represent the largest group; and also predicted to increase most noticeably across the reporting period.

**Projected local demand based on 2007 Psychiatric Morbidity Survey for ages 16 and over**

<table>
<thead>
<tr>
<th>Table 5 - Cluster 1 to 8: Non-Psychotic (Mild/Moderate/Severe/Very Severe/Complex)</th>
<th>2012</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
<th>2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety and depressive disorder</td>
<td>39,578</td>
<td>40,191</td>
<td>41,051</td>
<td>41,527</td>
<td>42,062</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>19,472</td>
<td>19,708</td>
<td>20,015</td>
<td>20,216</td>
<td>20,497</td>
</tr>
<tr>
<td>Depressive episode</td>
<td>10,338</td>
<td>10,432</td>
<td>10,536</td>
<td>10,602</td>
<td>10,730</td>
</tr>
</tbody>
</table>
These figures demonstrate the higher prevalence of the 'non-psychotic' cluster of common mental disorders such as depression and anxiety, and the relatively higher rate of increase projected for these disorders.

In comparison, the prevalence of other 'non-psychotic' illnesses such as obsessive compulsive disorder and panic disorder is predicted to remain fairly steady over the next 15 years.

The 'psychosis' cluster of disorders represents one of the smallest proportions of mental ill-health and in Worcestershire the prevalence is projected to decrease over the next few years.

In comparison, however, the prevalence of the organic cluster of mental ill health disorders (which includes dementia) is predicted to increase quite rapidly to 2020, from around 8,000 cases in Worcestershire, up to over 10,000 by 2020. And this is almost certainly a considerable underestimate with the acknowledged 'diagnosis gap' for dementia. This represents a considerable challenge for health and social care services. (Worcestershire Mental Health Needs Assessment 2013)

The most frequent diagnoses for mental health admissions in Worcestershire 2008/09 to 2012/13 as a rate per 1,000 population are:

- Mental and behavioural disorders due to psychoactive substances at a rate of 0.7 per thousand population.
- Mood disorders at a rate of 0.6 per thousand population.

**Admissions by District**

Figure 9 below shows the rate of Mental Health hospital admissions where the Primary Diagnosis is in the group of Mental and behavioural disorders due to psychoactive substance use (F10-F19) by district.
It can be seen from the chart that:

- The admission rate for males is higher than for females in every district, although this difference is quite small in Malvern Hills.
- Worcester City has the highest admission rates for males, followed by Redditch, with Malvern Hills experiencing the lowest rate.
- Redditch has the highest admission rates for females, closely followed by Worcester City with Malvern Hills again experiencing the lowest rate; however Wychavon is not far behind.

This analysis shows that the rate of mental health diagnoses varies between the different districts of Worcestershire.
**Alcohol Misuse**

The prevalence of alcohol misuse in the adult population is normally presented as the proportion of individuals reporting, or estimated to be consuming, alcohol at levels of lower, increasing or higher risk, and those binge drinking. These are set out below;

**Lower risk** - A level of alcohol consumption that is within current recommended guidelines (2-3 units daily for females and 3-4 units daily for males).

**Increasing risk** - A level of alcohol consumption that is above recommended levels, and that carries a risk of physical or psychological harm. This is defined as the consumption of between 15 and 35 units per week for females, and 22 to 50 units per week for males.

**Higher risk** - Consumption of alcohol at levels which are likely to cause physical or psychological harm. This is defined as the consumption of over 35 units per week for females and over 50 units per week for males.

**Dependent drinker** - A sub-set of higher risk drinking, defined as an individual that feels unable to function without alcohol. The consumption of alcohol becomes an important, sometimes the most important, factor in their life. Often experiences physical or psychological withdrawal symptoms if their supply of alcohol is suddenly stopped.

**Binge drinking** - Defined as drinking more than two times the recommended daily level in one session. For females this means drinking 6 or more units, and for men, 8 or more units.

In Worcestershire;

- There are an estimated 84,562 increasing risk drinkers (i.e. consume alcohol at a level that is above recommended levels, and that carries a risk of physical or psychological harm) and 23,379 higher risk drinkers (i.e. consume alcohol at levels which are likely to cause physical or psychological harm).
- Of these 91,823 are classed as binge drinkers (i.e. drinking more than two times the recommended daily level in one session) and 14,623 as dependent drinkers (a sub-set of higher risk drinkers, defined as an individuals that feel unable to function without alcohol).
- Out of the six districts of Worcestershire, Worcester City has the greatest estimated prevalence of higher risk drinkers, with Wychavon and Malvern Hills also having higher rates than the National average. Worcester City also has the highest estimated proportion of binge drinkers in the County.
- Wychavon has the largest estimated proportion of increasing risk drinkers in Worcestershire.

**Estimated Drinking Population**

Figure 10 below shows the estimated number of the drinking population in Worcestershire that is aged 16 and over.
Comparing the six Worcestershire District areas, Worcester City has the largest proportion of estimated higher risk drinkers out of all adults that drink alcohol. Both Wychavon and Malvern Hills have a higher rate than the National average, as shown in figure 11 below.

Figure 11 - Mid-2009 Estimated Percentage of Drinking Population (not including abstainers) aged 16 years and over reported as Lower, Increasing and Higher Risk Drinkers by Worcestershire District and National average

Source: Local Alcohol Profiles for England
Figure 12 below shows similar estimates for the percentage of each Worcestershire district’s population aged 16 and over that engage in ‘binge drinking’. Binge drinking in adults is defined separately for men and women. Men are defined as having indulged in binge drinking if they had consumed 8 or more units of alcohol on the heaviest drinking day in the previous seven days; for women the cut-off was 6 or more units of alcohol.

It can be seen from the chart that Worcester has the highest estimated rate of ‘binge drinking’ out of the six Worcestershire district areas. It should be noted, however, that none of the six districts have a significantly higher rate of binge drinking than the National average.

**Figure 12 – Estimated Percentage of Adults (aged 16 and over) who report engaging in Binge Drinking (2007-2008)**

Using these estimates and population data from the based on the 2011 census, we can calculate the approximate drinking populations in each of the Worcestershire districts. This can be seen in table 8 below.

**Table 8 – Estimated Adult Drinking Population in Worcestershire by District**

<table>
<thead>
<tr>
<th>Area</th>
<th>Abstain</th>
<th>Lower</th>
<th>Increasing</th>
<th>Higher</th>
<th>Binge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromsgrove</td>
<td>9,022</td>
<td>47,652</td>
<td>14,188</td>
<td>6,246</td>
<td>14,496</td>
</tr>
<tr>
<td>Malvern Hills</td>
<td>7,155</td>
<td>40,318</td>
<td>11,324</td>
<td>3,422</td>
<td>11,262</td>
</tr>
<tr>
<td>Redditch</td>
<td>10,351</td>
<td>44,585</td>
<td>10,419</td>
<td>2,368</td>
<td>13,599</td>
</tr>
<tr>
<td>Worcester</td>
<td>10,759</td>
<td>50,824</td>
<td>15,576</td>
<td>3,131</td>
<td>17,905</td>
</tr>
<tr>
<td>Wychavon</td>
<td>12,324</td>
<td>62,105</td>
<td>17,467</td>
<td>5,046</td>
<td>18,729</td>
</tr>
<tr>
<td>Wyre Forest</td>
<td>10,961</td>
<td>51,556</td>
<td>15,588</td>
<td>3,166</td>
<td>15,832</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>60,572</td>
<td>297,040</td>
<td>84,562</td>
<td>23,379</td>
<td>91,823</td>
</tr>
</tbody>
</table>

**Source:** Local Alcohol Profiles for England

**Source:** Topography of Drinking Behaviour 2011, 2011 Census & Association of Public Health Observatories 2007/08 revised and published 2011
Mortality and Months of Life Lost

Table 9 below shows the alcohol related mortality rates and months of life lost related for each Worcestershire district and how this compares to its ‘nearest neighbours’. The nearest neighbour approach groups each local area with 15 other areas that are similar across a range of demographic, socio-economic and geographic variables. Utilising a nearest neighbour approach allows for like-for-like comparisons of areas and can reveal patterns in the data that would not otherwise be seen when only making comparisons against a national benchmark.

All data has been divided in to four equal groups (quartiles) in order to allocate levels of harm. Quartile one, shown in dark green, is indicative of lower levels of alcohol related harm compared to the benchmark. Groups two and three indicate increasing levels of harm respectively, and areas in quartile four (shown in red) suggest areas have the highest levels of harm compared to the benchmark.

The data reflects the level of chronic heavy drinking in the population and is most likely to be found in higher-risk drinkers and dependent drinkers. It can be seen from the data that Malvern Hills is ranked as amongst those Local Authorities with the most amount of harm when compared to its ‘nearest neighbours’ for every indicator. Although it should also be pointed out that the district has seen levels of harm generally decreasing since 2004/06 in each of these indicators, with the exception of alcohol attributable mortality.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromsgrove</td>
<td>5.79 ↓</td>
<td>4.17 ↓</td>
<td>0.07 ↓</td>
<td>0.07 ↓</td>
<td>0.27 ↓</td>
<td></td>
</tr>
<tr>
<td>Malvern Hills</td>
<td>11.07 ↓</td>
<td>5.26 ↓</td>
<td>0.13 ↓</td>
<td>0.17 ↓</td>
<td>0.38 ↑</td>
<td></td>
</tr>
<tr>
<td>Redditch</td>
<td>9.76 ↑</td>
<td>4.87 ↓</td>
<td>0.08 ↑</td>
<td>0.10 ↑</td>
<td>0.26 ↓</td>
<td></td>
</tr>
<tr>
<td>Worcester</td>
<td>11.05 ↑</td>
<td>6.50 ↑</td>
<td>0.13 ↑</td>
<td>0.15 ↑</td>
<td>0.30 ↑</td>
<td></td>
</tr>
<tr>
<td>Wychavon</td>
<td>7.66 ↓</td>
<td>3.92 ↑</td>
<td>0.07 ↑</td>
<td>0.10 ↑</td>
<td>0.27 ↑</td>
<td></td>
</tr>
<tr>
<td>Wyre Forest</td>
<td>12.51 ↑</td>
<td>5.11 ↓</td>
<td>0.16 ↑</td>
<td>0.18 ↑</td>
<td>0.41 ↑</td>
<td></td>
</tr>
</tbody>
</table>

High rates of alcohol specific mortality and mortality from chronic liver disease are likely to indicate a significant population who have been drinking heavily and persistently over the past 10 – 30 years.

Whilst alcohol misuse is the primary cause of liver disease, obesity is a growing significant causal factor.

Broadly speaking alcohol attributable deaths make up around 3% of all deaths. Of these, about a third are alcohol specific deaths – e.g. from alcohol poisoning, alcoholic liver disease, alcoholic pancreatitis.

The remaining alcohol-attributable deaths are from conditions partially attributed to alcohol, roughly two thirds of which are from chronic conditions – e.g. haemorrhagic stroke, Cardiac arrhythmias, malignant neoplasm of oesophagus, with the remainder caused by acute consequences such as road traffic accidents or intentional self-harm.

Source: Alcohol and drugs: JSNA support pack Key data to support planning for effective alcohol prevention, treatment and recovery
Hospital Admissions

The rate of alcohol-specific hospital admissions in Worcestershire has increased for both Males and Females. This increase has occurred at a greater rate than the National average over the five year period. Indeed, it can be seen from figure 13 below, that the rate for Females is now higher than the National rate.

In contrast the rate of alcohol-specific hospital admissions for Under-18 year olds in Worcestershire has decreased slightly over the same time period. However, this remains above the national average, which has experienced a greater rate of decline.

**Figure 13 - Worcestershire and England Rate of Alcohol-Specific Hospital Admissions 2006/07 to 2010/11**

It should be noted that there are significant differences in these rates for the six district areas of Worcestershire. Figure 14 below shows the rate of Alcohol-Specific Hospital Admissions for all people and all ages in 2006/07 and 2010/11 for each district compared to the National average. It can be clearly seen that the rate of alcohol-related hospital stays is significantly higher than the National average in the Redditch district. It is also worth noting that in 2006/07, the rate for Wyre Forest was actually below the National average, but this has increased at much greater pace.
Figure 14 - Rate of Alcohol-Specific Hospital Stays for All Ages in Worcestershire Districts compared to the National average 2006/07 and 2010/11

Source: Local Alcohol Profiles for England

Figure 15 below shows the rate of alcohol-specific hospital stays for Males across the six Worcestershire districts in 2006/07 and 2010/11. It can be seen that this is significantly higher in the districts of Redditch, Worcester and Wyre Forest than the National average and, indeed, the other three districts of Worcestershire. It is worth noting that for Wyre Forest the rate in 2006/07 was lower than that of both Redditch and Worcester, and just below the National average.

Figure 15 - Rate of Alcohol-Specific Hospital Stays for Males in Worcestershire Districts compared to the National average 2010/11

Source: Local Alcohol Profiles for England
In contrast, in figure 16 it can be seen that, when taking into account the confidence intervals, only Bromsgrove has a significantly different (i.e. lower) rate of alcohol-specific hospital stays for Females than the National average. It is worth noting, however, that both Malvern Hills and Redditch had rates that were below the National average in 2006/07, but have seen a greater degree of increase since then.

**Figure 16 - Rate of Alcohol-Specific Hospital Stays for Females in Worcestershire Districts compared to the National average 2010/11**

[Diagram showing rates of alcohol-specific hospital stays for females in Worcestershire districts compared to the National average for 2006/07 and 2010/11.]

**Source:** Local Alcohol Profiles for England

Figure 17 below shows a map of alcohol-related hospital admissions for all persons and all ages in Worcestershire by ward area.
It can be seen from the map that Redditch has seven wards with rates of alcohol-related hospital admissions in the highest quintile for the whole of Worcestershire, with having Worcester has six wards in the highest quintile, Wychavon five, Wyre Forest three, Bromsgrove two, and Malvern one. These are listed in table 10 below.

Table 10 – Ward Areas in the Highest Quintile for Alcohol-related Hospital Stays in Worcestershire All Persons, All Ages 2006-10

<table>
<thead>
<tr>
<th>District</th>
<th>Wards in Highest Quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromsgrove</td>
<td>Charford, St John</td>
</tr>
<tr>
<td>Malvern Hills</td>
<td>Pickersleigh</td>
</tr>
<tr>
<td>Redditch</td>
<td>Batchley, Central, Church Hill, Greenlands, Lodge Park, Matchborough, Winyates</td>
</tr>
<tr>
<td>Worcester</td>
<td>Cathedral, Gorse Hill, Nunnery, Rainbow Hill, St Johns, Warndon</td>
</tr>
<tr>
<td>Wychavon</td>
<td>Bengeworth, Droitwich Central, Droitwich South West, Droitwich West, Great Hampton</td>
</tr>
<tr>
<td>Wyre Forest</td>
<td>Greenhill, Offmore and Comberton, Oldington and Foley Park</td>
</tr>
</tbody>
</table>

Source: Worcestershire County Council Instant Atlas Toolkit. Quintile classification is based on quintiles calculated for the whole of Worcestershire.

Source: Worcestershire County Council Instant Atlas Toolkit. Quintile classification is based on quintiles calculated for the whole of Worcestershire.
Figure 18 below shows the rate of alcohol-specific hospital admissions for under 18 year olds. Despite a downward trend, the rate in Redditch remains significantly higher than the national average and by far the highest rate of the six Worcestershire districts. It should be noted, however, that the actual number of admissions for Redditch for the period 2008/09 to 2010/11 is relatively small at 66.

**Figure 18 – Rate of Alcohol-specific Hospital Stays (Under 18s) in Worcestershire Districts 2008/09-2010/11**

The reason for Redditch’s higher than average rate of admissions is not yet known, however some investigation of a small number of cases by the local Alcohol Liaison Nurse revealed that young people were being admitted to hospital when a legal guardian was unable to come and pick them up from Accident and Emergency.

Figure 19 below shows the rate of emergency admissions for Alcoholic Liver Disease for all ages across each of the Worcestershire districts for the period 2007/08 to 2011/12.
It can be clearly seen from the chart that Redditch and Worcester have much higher rates of emergency admissions for Alcoholic Liver Disease than the other districts. In contrast the rate of admissions in Bromsgrove is almost half that of Redditch and Worcester.
Specialist alcohol treatment in Worcestershire

Numbers in Alcohol Treatment

Figure 20 below shows the number of adults engaged in structured alcohol treatment for each year from 2008-09 to Quarter 3 of the year 2013-14.

Figure 20 - Number of Adults Engaged in Structured Alcohol Treatment, 2008-09 to 2012-13

Source: NDTMS Needs Assessment Data and Quarterly Reports

From 2008-09 to 2011-12 there was a 55% reduction in the number of adults engaged in structured alcohol treatment. This compares to an increase of around 10% nationally for the same time period. It is not immediately clear why there was such a large fall in the number of clients in structured alcohol treatment, though there is some evidence to suggest that this can be explained by the re-commissioning of the local alcohol service, with the outgoing provider having discharged a significant proportion of their service users before the commencement of the new contract on 1st April 2011. Moreover, one of the key differences in terms of delivery under the new CRI contract, and the service commissioned previously, is that there is now robust and embedded provision of brief interventions, allowing treatment to be offered at an intensity more suited to individual needs. Between April and December 2011, 543 individuals successfully completed an alcohol brief intervention.

Since 2011-12, the number of alcohol clients engaged in structured treatment, and the number of new presentations, have increased to levels similar to those experienced in 2009-10. Indeed, the number of new presentations to structured alcohol treatment in just the first 9 months of 2013-14 is higher than for the whole of 2009-10.

Modelling work based on results from the Adult Psychiatric Morbidity Survey (2007) has estimated that there are 770,000 dependent drinkers in England who may benefit from some form of alcohol treatment, including Extended Brief Interventions or Brief Treatment. This will include those people who are severely dependent on alcohol and likely to require intensive specialist interventions. A full methodology for calculating the prevalence estimates, and the limitations of these estimates, can be found in the separate JSNA technical definitions document.
## Table 11 – Estimated Number of Dependent Drinkers

<table>
<thead>
<tr>
<th>Prevalence estimates (aged 18-75)</th>
<th>Worcestershire</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of dependent drinkers</td>
<td>14,623</td>
<td>774,029</td>
</tr>
<tr>
<td>Proportion of dependent drinkers in treatment</td>
<td>3%</td>
<td>13%</td>
</tr>
</tbody>
</table>

*Source: NTA JSNA Support Pack for Strategic Partners, Alcohol Data*
Figure 21 below shows the number of clients in alcohol treatment with CRI Pathways to Recovery per 1,000 of the adult population by Middle Super Output Area (MSOA) for the period April 2012 to November 2013.

**Figure 21 – Rate of Clients in Structured Alcohol Treatment per 1,000 of the Adult Population (Aged 18 and over) by MSOA April 2012 to November 2013**

Source: CRI Pathways to Recovery

It is important to note that the number of clients in structured alcohol treatment in a given area does not necessarily reflect the extent of the actual number of people with an alcohol problem in that area. Indeed, a higher rate of clients in treatment in one area compared to another may be due to a range of different factors such as easier access to treatment, service opening times, suitability of treatment options available, etc. Such issues would need to be explored further to put these figures into context.

The map shows that the following ward areas have rates of clients in alcohol treatment that were in the highest quintile for the period:

- Parts of Abbey (Redditch)
- Arboretum (Worcester City)
- Batchley (Redditch)
- Part of Bengeworth (Wychavon)
- Parts of Broadwaters (Wyre Forest)
- Cathedral (Worcester City)
- Parts of Church Hill (Redditch)
- Evesham North (Wychavon)
- Parts of Gorse Hill (Worcester City)
Substance Misuse Needs Assessment

- Great Hampton (Wychavon)
- Parts of Greenhill (Wyre Forest)
- Parts of Little Hampton (Wychavon)
- Parts of Lodge Park (Redditch)
- Offmore and Comberton (Wyre Forest)
- Pickersleigh (Malvern Hills)
- Oldington and Foley Park (Wyre Forest)
- Parts of Warndon (Worcester City)

Referral Source of Clients into Adult Alcohol Treatment

Figure 22 below shows the referral source of new clients presenting to adult alcohol treatment in Worcestershire, the West Midlands and England during 2012/13.

**Figure 22 - Percentage of New Client Presentations to Adult Alcohol Treatment by Referral Source 2012/13**

Source: NDTMS Needs Assessment data

Around 60% of clients entering adult alcohol treatment in Worcestershire in 2012/12 were self-referrals, compared to just over 40% nationally. There were very few referrals from Substance Misuse Services in Worcestershire in 2012/13 which accounted for just 1.5% of the new presentations compared to over 8% nationally.

Population in Alcohol Treatment

Around 40% of clients in Worcestershire's structured alcohol treatment services are female. This compares to a National average of 36%.

The mean age of male clients in Worcestershire alcohol treatment in 2011-12 was 41.4 years compared to a National average of 42.2. For females the mean age in Worcestershire in 2011-12 was 42.7 compared to 42.3 nationally.

Many adults in alcohol treatment experience complex and wide-ranging problems in addition to the number of alcohol units they consume. These are described as of ‘compounding factors’, and an examination of these ‘factors’ can give an impression of the additional characteristics of the people treated locally and identify issues which may warrant further investigation. These are defined below;
The data below shows the employment status of people starting alcohol treatment in Worcestershire in 2012-13. Being in work or undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training. However, the majority of people in drug and alcohol treatment will require significant support to address their education, training and employment needs and to get them job ready.

**Figure 23 - Percentage of Clients Starting Structured Alcohol Treatment in 2012-13 by Employment Status**

![Bar chart showing employment status percentages](chart)

**Source:** Alcohol and drugs: JSNA support pack Key data to support planning for effective alcohol prevention, treatment and recovery

It is important to note that the figures in the chart are only based on those clients that have completed the employment status data field. For Worcestershire, the number of clients in alcohol treatment that have provided this data is very low, so any small changes in these numbers will result in large changes in the above percentages. However, on the data available, it would appear that fewer clients starting alcohol treatment in Worcestershire in 2012-13 were unemployed or long-term sick or disabled than compared to the National average.
Figure 24 below shows the percentage of new alcohol treatment journeys in 2012/13 by the number of compounding factors scored by each client for both Worcestershire and England.

**Figure 24 – Percentage of New Alcohol Treatment Journeys by Number of Compounding Factors**

![Graph showing percentage of new alcohol treatment journeys by number of compounding factors for England and Worcestershire.]

**Source:** NDTMS Alcohol Client Profiling Tool

It can be seen that just over 50% of new clients entering Worcestershire’s alcohol treatment services in 2012/13 did not have any of the compounding factors listed above. This compares to just under 15% nationally, and implies that Worcestershire is dealing with a less complex client base.

**Alcohol and Crime**

Table 12 below shows the alcohol related crime for each Worcestershire district and how this compares to its ‘nearest neighbours’. The data reflects the level of crime linked to drinking in the population and is most likely to be found in binge drinkers, higher-risk drinkers and dependent drinkers.

**Table 12 – Worcestershire nearest Neighbour Comparison by District Area**

<table>
<thead>
<tr>
<th>District</th>
<th>Nearest Neighbour Comparison</th>
<th>Recorded crime attributable to alcohol: Persons, all ages, crude rate per 1,000 population (2011/12)</th>
<th>Violent crimes attributable to alcohol: Persons, all ages, crude rate per 1000 population (2011/12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bromsgrove</td>
<td></td>
<td>5.14 ↓</td>
<td>3.77 ↓</td>
</tr>
<tr>
<td>Malvern Hills</td>
<td></td>
<td>3.80 ↓</td>
<td>2.79 ↓</td>
</tr>
<tr>
<td>Redditch</td>
<td></td>
<td>8.86 ↓</td>
<td>7.19 ↓</td>
</tr>
<tr>
<td>Worcester</td>
<td></td>
<td>8.86 ↓</td>
<td>6.98 ↓</td>
</tr>
<tr>
<td>Wychavon</td>
<td></td>
<td>4.08 ↓</td>
<td>2.92 ↓</td>
</tr>
<tr>
<td>Wyre Forest</td>
<td></td>
<td>7.82 ↑</td>
<td>6.37 ↑</td>
</tr>
</tbody>
</table>

**Source:** Alcohol and drugs: JSNA support pack Key data to support planning for effective alcohol prevention, treatment and recovery
It can be seen from the data that Bromsgrove, Redditch, Worcester and Wyre Forest all rank amongst those Local Authorities with the most amount of harm when compared to their ‘nearest neighbours’. However, it should be noted that three of these areas have seen levels of harm generally decreasing since 2004/06, with Wyre Forest being the exception. It is also worth pointing out that the rates of both alcohol related recorded crime and alcohol related violent crime for Bromsgrove are actually below the National averages of 7.02 and 5.03 respectively.

**Drug Misuse**

**Estimated Opiate and/or Crack Using Population**

When viewing the information in this section, please note that:

i. ‘OCU’ refers to use of opiates and/or crack cocaine, including those who inject either of these drugs. It does not include the use of cocaine in a powder form, amphetamine, ecstasy or cannabis, or injecting by people who do not use opiates or crack cocaine. Although many opiate and/or crack users also use these drugs it is very difficult to identify exclusive users of these drugs from the available data sources.

ii. It must be stressed that these figures are estimates. They should always be interpreted in conjunction with their associated confidence intervals, which are specified in each table. The confidence intervals show the range within which there is a 95% certainty that the true value exists, though it is most likely to lie near the estimate itself.

Latest estimates show that there are 2,592 OCUs in Worcestershire. This equates to a prevalence rate 7.28 for every 1,000 of the adult population, and is an increase on the previous estimate of 2,218 in 2009/10, but below the 2008/09 estimate of 2,757.

Figure 25 below illustrates the change in both the estimated total number of OCUs and Opiate Users in Worcestershire over time and by age group.

**Figure 25 - Estimated Number of Opiate and/or Crack Users (OCUs) and Opiate Users in Worcestershire by Year and Age Group**

<table>
<thead>
<tr>
<th>Year</th>
<th>OCUs</th>
<th>Opiate Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>1,381</td>
<td>1,187</td>
</tr>
<tr>
<td>2009/10</td>
<td>1,085</td>
<td>1,055</td>
</tr>
<tr>
<td>2010/11</td>
<td>1,135</td>
<td>1,110</td>
</tr>
</tbody>
</table>

Source: Glasgow Prevalence Estimates 2010-11
It can be seen from the chart that although the total estimated number of OCUs has increased in 2010/11 compared to 2009/10, the number of those estimated to be aged between 15-24 has actually decreased. Although the number of OCUs estimated to be aged 25-34 has increased in 2010/11 compared to 2009/10, the majority of the overall increase in the number of OCUs is accounted for by those in the 35-64 age bracket, which account for 43.8% of all the estimated OCUs in Worcestershire in 2010/11, compared to 33.7% in 2008/09.

A similar pattern is shown for Opiate users; with the 2010/11 estimates showing an increase in those aged 25-34 and 35-64 compared to 2009/10, whilst those aged 15-24 have decreased.

Although the number of OCUs in Worcestershire has increased, the prevalence rates per 1,000 of the population are still below both the Regional and National averages. This also the case for the rates of Opiate only users, Crack only users, and Injectors, and is shown in figure 26 below.

**Figure 26 - Prevalence Rates per 1,000 population for Worcestershire, West Midlands and England 2010/11**

![Prevalence Rates Chart](chart.png)

Source: Glasgow Prevalence Estimates 2010-11

Table 13 below compares the OCU prevalence rates for Worcestershire with those local authorities that are considered to be its closest comparator.

<table>
<thead>
<tr>
<th>Area</th>
<th>Estimated OCU Population Aged 15-64</th>
<th>Rate per 1,000 pop</th>
<th>Confidence Intervals Lower</th>
<th>Confidence Intervals Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worcestershire</td>
<td>2,592</td>
<td>7.28</td>
<td>5.13</td>
<td>9.49</td>
</tr>
<tr>
<td>Warwickshire</td>
<td>2,186</td>
<td>6.31</td>
<td>5.80</td>
<td>7.26</td>
</tr>
<tr>
<td>Shropshire</td>
<td>1,123</td>
<td>6.13</td>
<td>5.57</td>
<td>6.96</td>
</tr>
<tr>
<td>Dorset</td>
<td>1,436</td>
<td>6.05</td>
<td>5.46</td>
<td>7.06</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>2,956</td>
<td>7.76</td>
<td>5.66</td>
<td>9.87</td>
</tr>
<tr>
<td>Essex</td>
<td>4,556</td>
<td>5.00</td>
<td>2.91</td>
<td>7.12</td>
</tr>
<tr>
<td>Hampshire</td>
<td>4,088</td>
<td>4.92</td>
<td>2.82</td>
<td>7.00</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>2,089</td>
<td>4.91</td>
<td>4.61</td>
<td>5.33</td>
</tr>
</tbody>
</table>
It can be seen from the table that only Gloucestershire has a higher prevalence rate of OCUs than Worcestershire. Worcestershire’s estimated prevalence rate of OCUs is higher than Warwickshire’s, which is considered to be the Local Authority that is closest in comparison.

Figure 27 below shows a breakdown of the OCU prevalence rates for Worcestershire by age group compared to the West Midlands and England average.

![Figure 27 - OCU Prevalence Rates per 1,000 population by Age Group for Worcestershire, West Midlands and England 2010/11](image)

The chart shows that Worcestershire has a lower prevalence rate of OCUs than the West Midlands across all the three age groups. However, when compared to the National prevalence rates, Worcestershire has a much higher prevalence of OCUs in the 25-34 age groups.

**Numbers in Adult Drug Treatment**

In contrast to an increase in the number of estimated OCUs in Worcestershire, the actual number of opiate and/or crack users entering drug treatment has fallen since 2010/11. Figure 28 below shows the number of clients in treatment in Worcestershire. Please note that the latest figures for 2013-14 are for the 12-month period of January 2013 to December 2013. All other figures are on a financial year basis.
It can be clearly seen from figure 28 that both the number of Opiate users and Non-Opiate users in Worcestershire’s adult drug treatment services has fallen since April 2010-March 2011. Indeed, the number of Non-Opiate users in structured drug treatment is now around 60% of the level in 2010-11. However, it should be noted that the number of both Opiate users Non-Opiate users in treatment have remained fairly stable in 2011/12 and 2012/13.

This is contrast to the National picture which has seen the number of Opiate users in treatment consistently fall during 2011/12 and 2012/13, whereas the number of Non-Opiate users in treatment has remained fairly stable.

Figure 29 below shows the number of all adult drug users in structured treatment for each Worcestershire district in 2012/13 by the clients’ postcode of residence. It can quite clearly be seen that there were more than twice as many clients that were residents of Worcester in adult drug treatment in 2012/13 than resided in any of the other County’s districts.

It is important to note that this does not necessarily mean that Worcester has more residents with drug problems than the other districts, but merely that more adults with drug problems that resided in this district accessed structured treatment in 2012/13.
Using the estimated number of OCUs in Worcestershire along with information regarding the number of OCUs in drug treatment, we can calculate the estimated number of OCUs that are not in treatment, as symbolised in figure 30 below.

**Figure 30 - 'Bullseye' of Opiate and /or Crack Users**

*Source:* NDTMS Needs Assessment data and Glasgow Prevalence Estimates

It can be seen from figure 30 above that;

- There were 1,097 opiate and/or crack cocaine users (OCUs) in Worcestershire adult drug treatment services at 31/3/3013.
There were a further 290 opiate and/or crack using clients that were in contact with Tier 3/4 agencies during 2012/13, but were not still in contact on the 31st March 2013.

Another 173 opiate and/or crack users were known to treatment services, but not in treatment during 2012/13 (i.e. Clients that were recorded in Tier 3/4 treatment in 2011/12, but had no contact in 2012/13.

There are around 1,032 opiate and/or crack users in Worcestershire that are not known to treatment services.

Looking at the latest figures from the quarter 2 Diagnostic Outcomes Monitoring Executive Summary (DOMES) report, it is estimated that 53.5% of OCUs are in treatment in Worcestershire compared to 53.4% nationally.

Table 16 in Appendix 1 shows a breakdown of the above figures, as well as those for Opiate only and Crack only users.

Table 17 in Appendix 1 shows a breakdown of the prevalence estimates for OCUs and numbers in drug treatment by age group.

**Referral Source of Clients into Adult Drug Treatment**

Figure 31 below shows the referral source of new clients presenting to adult drug treatment in Worcestershire, the West Midlands and England during 2012/13.

**Figure 31 - Percentage of New Client Presentations to Drug Treatment by Referral Source 2012/13**

<table>
<thead>
<tr>
<th>Source</th>
<th>GP</th>
<th>Self</th>
<th>Drug services</th>
<th>Arrest referral/DIP</th>
<th>Probation</th>
<th>CARAT</th>
<th>CJS other</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>6.3%</td>
<td>40.2%</td>
<td>12.7%</td>
<td>9.4%</td>
<td>5.4%</td>
<td>9.5%</td>
<td>7.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>3.9%</td>
<td>40.5%</td>
<td>8.9%</td>
<td>9.3%</td>
<td>9.3%</td>
<td>13.9%</td>
<td>7.2%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>7.3%</td>
<td>49.1%</td>
<td>5.0%</td>
<td>13.3%</td>
<td>9.1%</td>
<td>11.7%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** NDTMS Needs Assessment data.

Referrals from Arrest referral/DIP only 1.8% in Worcestershire compared to just over 9% both regionally and nationally. Similarly, referrals from Probation 2.6% in Worcestershire compared to around 9% in the West Midlands and over 5% for the whole of England. The percentage of referrals from ‘CJS Other’ and ‘other’ is slightly higher than both the Regional and National figures.

This raises questions around the current criminal justice service pathways into adult drug treatment that need to be explored further.
Age of Clients in Adult Drug Treatment

There is an ageing population of drug users in treatment. Those aged under-30 accounted for just over half of the treatment population in 2005/06, compared to around a third in 2010/11.

![Percentage of Clients in Adult Drug Treatment by Age Group and Year in Treatment](source: NDTMS View It)

Decreasing numbers of those in the 18-24 and 25-29 age groups are in treatment. These groups accounted for just over half of the treatment population in 2005/06, compared to less than a quarter in 2012/13.

In contrast the 30-49 age groups accounted for over 70% of the treatment population in 2012/13 compared to around 45% in 2005/06.

It is interesting to note that out of all the districts the proportion of 18-24 year olds in adult drug treatment is lowest in Redditch despite having the second highest proportion of its population aged 16-29 (after Worcester City). In contrast Malvern Hills has the largest proportion of adult drug treatment clients in the 18-24 year olds although the proportion of its overall population aged 15-29 is the lowest of all the districts. It should be noted, however, that although the overall numbers of clients in adult drug treatment that are resident in Malvern Hills are comparatively low, so small changes in the demographic make-up of these clients can have large effects on the percentages.
Substance Misuse Needs Assessment

Primary Substance Use in Adult Drug Treatment

Figure 33 shows the percentage of clients in adult drug treatment by primary substance of use from 2005/06 to 2011/12.

**Figure 33 - Percentage of Clients in Adult Drug Treatment by Primary Substance of Use and Year in Treatment**

The proportion of opiate only users in treatment has seen a steady decrease from 2005/06 to 2011/12, whilst conversely opiate and crack users steadily increased.

There was an increase in the proportion of cannabis users up to 2009/10 followed by a significant fall in 2011/12.

Opiate users still dominate adult treatment, and generally face a more complex set of challenges and are much harder to treat.

Source: NDTMS View It
Figure 34 shows the total number of clients in, and new presentations to, young persons’ drug and alcohol treatment by year.

**Figure 34 - Number in Young Persons Treatment and Number of New Presentations by Year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total in Treatment</th>
<th>New Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>72</td>
<td>58</td>
</tr>
<tr>
<td>2012-13</td>
<td>83</td>
<td>65</td>
</tr>
<tr>
<td>2013-14 Q2</td>
<td>41</td>
<td>16</td>
</tr>
</tbody>
</table>

*Source: NDTMS YP Quarterly Local Assurance Reports*

There were 83 young people in substance misuse treatment services during the 12-month period of April 2012 to March 2013. This is an increase on 72 clients in YP services for the 12-month period of April 2011 to March 2012. Latest figures for the second quarter of 2013-14 with 41 young people in treatment services in the first 6 months, although only 16 of these are new presentations to treatment.
Referral Source of Clients into Young Persons’ Treatment

Figure 35 below shows the percentage of clients in young persons’ substance misuse treatment by their referral source for both Worcestershire and England.

![Figure 35 - Percentage of Clients in Young people's Treatment by Referral Source - 2012/13](image)

**Source:** YP JSNA Support Pack

It is worth noting that in 2012/13 Worcestershire had a significantly lower proportion of referrals from Youth Justice Services than the National average. This trend has continued in 2013/14, where by the second quarter of the year there appear to be relatively few young people referred via the Youth Justice Services.

The majority of referrals into Worcestershire YP treatment services at quarter 2 of 2013/14 have come from either Education Services (31%) or Family, Friends or Self (31%), with 13% of new clients into YP treatment coming from the Youth Justice system. Nationally and for those areas similar to Worcestershire on the Child Wellbeing Index\(^2\), the majority of referrals have come from the Youth Justice system for the same period (33% and 26% respectively).

Substance Use in Young Persons’ Treatment

Of those clients in Worcestershire YP treatment services in Q1 of 2013-14, 88% cited Cannabis as an issue. This compares to 86% nationally and 88% on the Child Wellbeing Index. It is worth noting that 22% of clients in Worcestershire cited Amphetamines as an issue, compared to just 11% nationally and 19% on the Child Wellbeing Index.

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\(^2\) The “Child and Wellbeing Index Quintiles” are supplied in order to allow for sub-national comparisons to similar partnerships, all partnerships have been added to one of five groups based on their average score on the 2009 Child Wellbeing Index (as released by the Department for Communities and Local Government, [http://www.communities.gov.uk/publications/communities/childwellbeing2009]). These five groups (called the Child Wellbeing Index Quintiles) are grouped from Quintile 1 (with the lowest average scores and therefore deemed those with the least deprivation for young people) through to Quintile 5 (with the highest average scores and therefore deemed those with the most deprivation for young people).
In contrast just 22% in Worcestershire cited Alcohol as an issue compared to 55% nationally and 53% on the Child Wellbeing index. It is also worth noting that 16% of clients in Worcestershire cited 'Other' as an issue, compared to 6% nationally and 9% on the Child Wellbeing Index. This could be due to an increase in the use of NPSs and/or 'legal highs', but needs to be explored further.
### Outcomes Assessment

#### Public Health Outcomes Framework

The Public Health Outcomes Framework (PHOF) ‘Healthy lives, healthy people: Improving outcomes and supporting transparency’ sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected.

Table 14 below shows the appropriate outcomes in the PHOF for drug and alcohol treatment.

<table>
<thead>
<tr>
<th>Domain 2: Health Improvement</th>
<th>Brief Definition</th>
</tr>
</thead>
</table>
| 2.15: Successful Completion of drug treatment | 2.15 Number of drug users that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number in treatment  
Numerator: The number of adults that successfully complete treatment in a year and who do not re-present to treatment within 6 months  
Denominator: The total number of adults in treatment in a year  
This indicator will be published as two sub-indicators:  
2.15i Number of users of opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number of opiate users in treatment  
2.15ii Number of users on non-opiates that left drug treatment successfully (free of drug(s) of dependence) who do not then re-present to treatment again within 6 months as a proportion of the total number of non-opiate users in treatment |
| 2.16: People entering prison with substance dependence issues who are previously not known to community treatment* | 2.16 Proportion of people assessed for substance dependence issues when entering prison who then required structured treatment and have not already received it in the community  
Numerator: Number of individuals entering prison who are provided with a substance misuse triage assessment to determine dependence on drugs or alcohol, who then require structured treatment and who have not already received it in the community  
Denominator: Number of individuals entering prison who are provided with a substance misuse triage assessment to determine dependence on drugs or alcohol, who then require structured treatment  
The data source needs further development |
| 2.18: Alcohol-related admissions to hospital (Placeholder) | 2.18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 population (age standardised)  
The number is estimated by assigning an attributable fraction to each relevant admission, based on the diagnosis codes and age and... |
sex of the patient. The attributable fractions represent the proportion of cases of conditions that can be attributed to alcohol and are based on the latest review of research undertaken by Public Health England.

*Yet to be fully defined.

It could also be argued that drug and alcohol treatment services also have a less direct impact on other indicators set out in the PHOF. These are set out in figure 37 below.

**Figure 37 - PHOF Indicators linked to Substance Misuse**
Cost Savings

Investing in drug treatment cuts crime and saves money. The Drug Treatment Outcomes report found that for every £1 spent nationally on drug treatment £2.50 is saved in costs to society. Furthermore, drug treatment prevents an estimated 4.9m crimes every year and saves an estimated £960m costs to the public, businesses, criminal justice and the NHS. Investing in treatment equals lifetime gains of 28,262 Quality Adjusted Life Years (QALYs), worth £1.7bn\(^3\).

The NDTMS Value for Money (VFM) Tool provides local estimates of the costs and benefits of drug treatment and recovery. Table 15 below shows the key information for Worcestershire contained in the Tool for 2012-13. All costs and benefits presented are in real terms (2012-13 baseline years). Please note that this tool is based on a number of assumptions. This means that many of the figures produced by the tool are estimates and are indicative only. Local areas should handle this information with care and use it as a rough guide only. For more information on the assumptions and methodology used, please refer to the guidance document.

<table>
<thead>
<tr>
<th>Area</th>
<th>Cost or Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The estimated harm in this area in 2012-13 if no opiate and/or crack cocaine users were treated for their addiction is:</td>
<td>£23.3m</td>
</tr>
<tr>
<td>2. The total estimated spend in this area in 2012-13 in real terms, adjusted for area costs is:</td>
<td>£3.6m</td>
</tr>
<tr>
<td>3. The total benefits(^4) accrued(^5) in 2012-13 are:</td>
<td>£16.9m</td>
</tr>
<tr>
<td>(i) Below are the break downs in terms of crime and health benefits:</td>
<td></td>
</tr>
<tr>
<td>Estimated crime cost savings and QALY benefits</td>
<td>£11.6m</td>
</tr>
<tr>
<td>Estimated health cost savings and QALY benefits</td>
<td>£5.3m</td>
</tr>
<tr>
<td>(ii) Below are the break downs of cost savings and QALY benefits</td>
<td></td>
</tr>
<tr>
<td>Estimated cost savings</td>
<td>£11.6m</td>
</tr>
<tr>
<td>Estimated QALY benefits</td>
<td>£5.2m</td>
</tr>
<tr>
<td>(iii) Below are the break downs of effective treatment and sustaining recovery benefits:</td>
<td></td>
</tr>
<tr>
<td>Estimated benefits in 2012-13 from clients in effective treatment</td>
<td>£12.5m</td>
</tr>
<tr>
<td>Estimated accrued benefits from clients in sustained recovery</td>
<td>£4.4m</td>
</tr>
<tr>
<td>4. The accrued estimated number of crimes prevented in Worcestershire was:</td>
<td>50,999</td>
</tr>
<tr>
<td>5. In 2012-13, the accrued net benefit (Net benefit = Total benefit - Cost) was:</td>
<td>£13.3m</td>
</tr>
<tr>
<td>6. In 2012-13, the in-year net benefit (Net benefit = Total benefit - Cost) was:</td>
<td>£8.9m</td>
</tr>
<tr>
<td>7. In 2012-13, drug treatment in your area is estimated to have an accrued benefit-cost ratio (BCR) of:</td>
<td>4.71</td>
</tr>
<tr>
<td>8. In 2012-13, drug treatment in your area is estimated to have an in-year benefit-cost ratio (BCR) of:</td>
<td>3.49</td>
</tr>
</tbody>
</table>

Source: NDTMS Value for Money Tool

In other words, for every £1.00 spent on Worcestershire’s drug treatment system in 2012-13, it is estimated that £3.49 was gained in benefits.

\(^4\) The breakdown of benefits are rounded up to the nearest £100,000. As a result, totals may not add up to the overall benefit.
\(^5\) Accrued benefits include in effective treatment and recovery benefits. Recovery benefits accumulate from 2005-06, as the number of people in sustained recovery increases each year. This means that by 2012-13, the number of people receiving recovery benefits has accumulated over an 8 year period. Effective treatment benefits represent in-year estimates only.
There is also evidence from a number of studies that investing in alcohol interventions saves money. Using evidence on the effectiveness of GP screening and brief intervention in the TrEAT trial it has been calculated that;

Nationally every 5,000 patients screened in primary care may prevent 67 A&E visits and 61 hospital admissions. This is estimated to cost £25,000 but save £90,000\(^6\). Using evidence from a report by Royal College of Physicians ‘Alcohol: can the NHS afford it’ together with an unpublished report of a comparison between two hospitals, the Department of Health calculated that;

- One alcohol liaison nurse can prevent 97 A&E visits and 57 hospital admissions. This is estimated to cost £60,000 but save £90,000\(^7\).

The Department of Health also calculated that;

- Every 100 alcohol-dependent people treated can prevent 18 A&E visits and 22 hospital admissions. This is estimated to cost £40,000 but save £60,000\(^8\).

Nationally, young people’s drug and alcohol interventions result in £4.3m health savings and £100m crime savings per year. Drug and alcohol interventions can help young people get into education, employment and training, bringing a total lifetime benefit of up to £159m. Every £1 spent on young people’s drug and alcohol interventions brings a benefit of £5-£8.

Financial Challenge

The total spend for 2013/14 on drug and alcohol services and projects in the community is £6,475,482.

The projected spend for 2014/15 on drug and alcohol services and projects in the community is £5,031,524.

The budget beyond 2015 is as yet unknown. However, given the financial pressures within the Council and the need to make £25m savings annually, future cuts to the substance misuse budget cannot be ruled out.

Aspirations of the Population

Consultation for the substance misuse needs assessment was carried out across the county. Groups consulted include service providers, housing associations, mutual aid groups, service users and young people. The methodology for this section of the consultation consisted of online questionnaires and questionnaires distributed via various agencies to service users. A face to face consultation exercise was undertaken by Choice Checkers, a peer review group, to ascertain the views of the ‘hidden population’, i.e. substance users who may not be in treatment. Eight focus groups were conducted with young people at various colleges in Worcestershire.


Young People’s focus groups

There were six emergent themes resulting from the focus groups that were held in different colleges around the county.

1. Awareness; Young people were generally aware of alcohol and drugs.
2. Availability; It was perceived that drugs and alcohol were freely available, with marijuana being perceived as particularly acceptable and available.
3. Information and Misinformation; main sources of information were on the internet, media, magazines and their peers. There was strong belief that tobacco was bad for health, whilst marijuana was good for health. There was no awareness of the mental health impacts of using marijuana and there was a general minimisation of the risks of taking marijuana.
4. Risk and Effects; young people felt drug and alcohol usage was alright if it was within safe limits. The thought of getting "addicted" being more concerning than the effects. They find real life stories powerful and would like more communication on reducing harm and staying safe, not just don’t do.
5. Marijuana; Marijuana usage was perceived as being "normal" and acceptable. It was preferred as the "older brand". Negative effects were mentioned on occasion by some for example hallucinations and bad for mental health. However, this was always challenged and won by other members in the group on the conclusion that there was no "scientific evidence" for this.
6. Novel Pharmacological Substances; There was a preference for older drugs as they perceived these to be more reliable and "tested" in preference to more newly emerging pharmacological substances, which they perceived to be chemicals that weren’t really tried and tested. None of the young people knew this group of drugs as NPS’s they all referred to them as "legal highs" or by their names.

Stakeholder Themes

The stakeholder questionnaires included a number of categorical questions which will be provided in quantitative summaries as well as free text boxes for stakeholders to give more contextual information. This section deals with text that was extracted and analysed by two members of the needs assessment team.

There were six emergent themes

1. Access, availability and appropriateness; Access was discussed by many stakeholders as being a problem. There was frequent mention of restricted hours of access and inability to speak to service providers (particularly on a Tuesday when the service providers have meetings). There was also mention of waiting lists as barriers and not being able to access services at the point of need.
2. Mental health; Stakeholders frequently mentioned the poor quality of services that were both available to people with mental health problems and the quality of service being poor for those accessing services. They also felt that there was a general lack of joined up services for people with mental health problems and that they tended to get passed "from pillar to post"
3. Recovery; they felt that there was a lack of focus and preparation for recovery. This was mentioned in particular regard to employment and employability. Indeed they felt services were structured around not supporting those in employment or education in regards to opening and access times. They also felt that there was more need for education and supporting volunteers. Housing was also mentioned as being integral to recovery and a potential threat if it was unstable.
4. Information; there was a theme of a lack of information sharing and inadequate pathways for data sharing. There was also a general theme of a lack of awareness of what was actually
available, and therefor people just using what was available rather than what was appropriate. There was mention of ameliorating this with a well maintained website.

5. Partnership; agencies aren’t linked, information isn’t shared and no one has a true picture because agencies don’t work together, they only know "what is in front of them". Stakeholders mentioned solutions to this being partnership delivered on a consortium basis to deliver the range of options required for recovery. They also mentioned models of "co-location" and "Co-production" so that learning support and pathways would be clear and visible.

6. Payment by Results; many stakeholders highlighted that this had negatively impacted on the system and how that focussing on these narrow targets had deflected from client care and recovery. They quoted examples of how frequent organisational change and poor management was affecting the system with high levels of staff sickness particularly with stress related conditions, demotivation and the negative feedback they had received from clients.

Assessment of alternative provision

In an attempt to assess alternative provision and also consult some of the people who are potentially not accessing treatment commissioned by the local authority, the needs assessment team appointed "Choice checkers" to do a piece of work to establish what their issues were. Choice Checkers are a Quality Peer Review and Engagement Team, placed in the County Council Joint Commissioning Unit with the purpose of reviewing services in Worcestershire used by vulnerable people. The team consists of people who have lived experience of receiving support services and support workers who assist them to review services.

The Choice Checker team visited and interviewed people at many venues throughout the county including the Worcester Action Group, St Paul’s Hostel in Worcester, Core services in Worcester, Asha Women's' Centre in Worcester, Yellow Scarf; an Eastern European substance misuse peer support group and SPACE the young people's service.

Themes from the assessment of alternative provision

1. Access, availability and appropriateness
   There was a general theme of the need for a variety of services to be available, this included abstinence based and harm reduction services. People wanted to be able to choose individualised options that are appropriate to their needs at the time. They also expressed the need for a variety of services that were age, gender and culturally sensitive. For example, women’s concerns were mainly around the family and support with safeguarding and childcare. Young people brought up the issue of "skunk" usage and the need for services around recovery from marijuana addiction. Access times were mentioned as being a barrier, particularly for when people are working. People also wanted to be able to access services at the point of need and not have to go on lengthy waiting lists as they found these off putting.

2. Recovery
   There was a strong theme of people wanting to have a variety of activities and to be facilitated into main stream activities, for example social opportunities including at the weekend and during the evening. Peer Mentors were really valued however, they felt that they did not get enough support and training and they should have more input into them as particularly some of them might be very early in their recovery. People also mentioned that there was a need for on-going support at times that were appropriate to someone in recovery. They also mentioned that they would appreciate support back into education, training or work.
Service user themes

Questionnaires were widely distributed to service users via organisations such as housing associations, substance misuse services, YMCA and mutual aid services. Staff were asked to distribute the questionnaires and assist with completion if required.

There were six emergent themes

1. **Wide range of treatment**
   Service users wanted treatment that was tailored to individual need. The specific areas mentioned were, more 1-1 sessions, better access to other forms of treatment such as mutual aid, and correct individual attention for example more 'women only' groups. Core services, a mutual aid service, were praised as a service that has been life changing, and suggested that this type of service should be extended rather than wasting resources on inexperience staff running part time counselling sessions which are ineffective and of little value and often recommend controlled drinking when this is completely inappropriate.

2. **Less form filling**
   Service users felt that there was too much paperwork and that they were asked to repeat 'their story' several times when it could just have been shared between providers. Younger service users felt that some services were patronising to them, and that the forms were oversimplistic.

3. **Professional care**
   A large number of responses stated that services should employ more ex substance users as they would have a greater understanding of addiction, having experienced it themselves. Service users also felt that an ex user would be someone they could relate to. Service users wanted care to be professional, but they also wanted people to know what they were talking about. The issue of confidentiality was also frequently discussed. Whilst service users said they valued "lived experience" and having mentorship from ex-service users, conversely they said that there were conflicts at times as they may know the ex-users from their previous life, and this was seen as breaking their confidentiality. They also stated that there was a lack of education, training and support to enable ex-service users to do their roles well.

4. **Mental Health**
   Service users felt that there should be more understanding from providers of pre-existing mental health problems. They stated that there was no connection between mental health services and substance misuse services and they were not being treated for any underlying problems that may affect their substance misuse.

5. **Opening hours and access**
   There were a large number of service users who said that they needed workers to be available on the day they are needed instead of 'having to wait for weeks for an appointment'. SPACE was specifically mentioned as not being open on Mondays, and in Worcester City there was an issue about Tuesday morning where there is a team meeting and no-one is able to access services. People who need services and are for example in employment, cannot access help when it's needed as they are only open during the daytime. The service needs to be available in the evening and at weekends. Some replies also pointed to the lack of services in outlying areas as this posed problems in terms of access to the centres.

6. **Activities**
   Service users felt that there should be more information on what mainstream activities are available to them. Lack of information on what's available in relation to leisure was the main issue. Some people mentioned that they would like a dry bar, free access to leisure centres and day trips for those who are drug/alcohol free as an incentive to their recovery.
Qualitative responses

Out of 69 responses from service users, 60 (87%) said that they had ever considered their drug and/or alcohol use to be a problem. From 63 responses, 26 (41%) said that they had used drug and/or alcohol services other than CRI Pathways to Recovery in the past two years (details of which services not provided). Of these 63 responses 49 (78%) said that they had used CRI Pathways to Recovery in the past two years.

Service User Views on CRI Pathways to Recovery

Regarding particular views on CRI Pathways to Recovery, some of the qualitative survey results contradict the face to face consultation with service users,

Results found that:

- **Staff** - Out of 49 responses 25 (51%) rated the staff at CRI as excellent, 17 worked well, 6 needs improvement and only 1 thought they were poor.
- **Easy to get to** - Out of 49 responses 27 (55%) rated how easy it is to get to CRI as excellent, 20 worked well, and 2 needs improvement.
- **Opening hours** - Out of 49 responses 14 rated the opening hours of CRI as excellent, 22 (45%) worked well, 12 needs improvement and only 1 thought they were poor.
- **Treatment options** - Out of 47 responses 10 rated the treatment options of CRI as excellent, 25 (53%) worked well, 10 needs improvement, and 2 thought they were poor.
- **Waiting times** - Out of 49 responses 11 thought the waiting times at CRI as excellent, 28 (57%) worked well, 7 needs improvement and 2 thought they were poor.
- **Level and/or type of support** - Out of 48 responses 16 rated the level and/or type of support of CRI as excellent, 24 (50%) worked well, 4 needs improvement and another 4 thought it was poor.
- **Understanding of my needs** - Out of 48 responses 19 thought CRI's understanding of their needs as excellent, 21 (44%) worked well, 4 needs improvement and another 4 thought they were poor.
- **Respected and valued me** - Out of 48 responses 26 (54%) felt that the way CRI respected and valued them was excellent, 18 worked well, 3 needs improvement and just 1 felt they were poor.
- **Helped me recover** - Out of 47 responses 18 (38%) rated the way CRI helped them to recover was excellent, whilst another 18 thought they worked well, 5 needs improvement and 6 thought they were poor.
- **Confidential** - Out of 48 responses 28 (58%) thought that CRI's confidentiality was excellent, 15 worked well, 3 needs improvement and 2 thought they were poor.

Figure 38 below shows the number of responses regarding how service users found out about the CRI service. Please note that although there were only 52 respondents to these questions, there were in total 63 responses as some service users chose two of the options provided. It can be seen that most of the service users questioned found out about CRI through either a GP/Hospital or by 'Other' means. A fair proportion of service users also found out about the service through a friend.
Service users were also asked;

- 'Did you achieve what you wanted to with CRI Pathways to Recovery?'
  - 53 service users responded to the question with almost 53% stating that achieved either all or most of their goals in treatment with CRI.

- 'Would you go back to CRI Pathways to Recovery if you relapsed?'
  - 53 service users responded to the question with almost 70% of respondents stating that they would definitely go back to CRI if they needed to.

- 'Would you recommend our services to someone you thought might need help?'
  - 51 service users responded to the question with over 68% of respondents stating that they would definitely go back to CRI if they needed to.

Figure 39 below shows the number of responses regarding what made service users seek help for their drug/alcohol problem. Please note that although there were only 51 respondents to these questions, there were in total 63 responses as some service users chose two of the options provided. It can be seen that a significant majority of the service users questioned sought help because they were concerned about their drug/alcohol use.
Service User Views on the Future Direction of Services

Figure 40 below shows a breakdown of responses to the question 'Which 3 things could be made better'.

- Concerned about my drug/alcohol use: 33 responses
- Advised by someone to get help: 10 responses
- Advised by someone who is a friend/family member: 5 responses
- Advised by someone other than a health professional: 6 responses
- Had a health scare: 5 responses
- Was being made to (e.g. by the courts): 5 responses
Out of 49 respondents, 33 thought that more individual counselling was one of three things they would like to improve in any future service. It should be noted that not all the respondents chose 3 things to improve, 41 chose just 2, and 32 only 1.

Service users were also asked to indicate which areas of your life would you like help with, other than alcohol or drug treatment. Figure 41 below shows the number of responses for each given option, with each respondent free to tick as many as they deemed applicable.

**Figure 41 – Responses to 'Which areas of your life would like help with, other than alcohol or drug treatment'**
Substance Misuse Needs Assessment

It can be seen that those areas that most respondents would like help with are emotional health, stress management and money. Other important issues are family and relationships, employment/education/training, accommodation, counselling, and mentor/volunteer support.

Service User Views on Novel Psychoactive Substances (NPS)

Regarding particular views on Novel Psychoactive Substances (NPS), the survey found that;

- Out of 62 responses 46 (74%) stated that they had heard of NPS or ‘Legal Highs’.
- Out of 49 responses 30 (61%) stated that they had actually tried NPS or ‘Legal Highs’.
- Out of 31 responses 21 (68%) stated that they knew what they were taking when they tried a NPS or ‘Legal High’.
- Out of 27 responses 17 (63%) said that when they had taken these substances they were with friends or family, 3 (11%) stated they were on their own, and 7 (26%) stated they had done both.
- Out of 20 responses 13 (65%) stated that they took NPS or ‘Legal Highs’; occasionally, 4 (20%) weekly, and 3 (15%) daily.

Figure 42 below shows a breakdown of responses to the question ‘Why did you take NPS or ‘Legal Highs’?’. Respondents were asked to pick up to 3 reasons, with the most popular being ‘easy to get hold of’, ‘my friends were taking them’, and ‘cheap to buy’.

Figure 42 – Number of Responses to ‘Why did you take NPSs or ‘Legal Highs’?’
Current service provision

Model of service provision

The current drug and alcohol treatment provider in Worcestershire offers support for adults, young people and families affected by substance misuse problems, through a recovery-focused model of integrated drug and alcohol treatment. The aim is to minimise the harm caused by drugs and alcohol, and to support those with problematic use to achieve and sustain recovery.

The service comprises two elements:

- a Young Person’s service (SPACE) for those aged 21 and under
- an adults’ service (Pathways to Recovery) for anyone over 21

Young Persons Service

Young persons substance misuse services follow the recommendations of The Substance of Young Needs Health Advisory Service Review (2001).

This Service delivers Tier 2 and Tier 3 young people’s substance use services. This includes efforts “concerned with reduction of risks and vulnerabilities, reintegration and maintenance of young people in mainstream services”. Also “young people’s specialist substance misuse treatment...a care planned medical, psychosocial or harm reduction intervention aimed at alleviating current harm caused by a young person’s substance misuse”. The service supports a balanced local service system that offers a range of interventions, including: harm reduction, community / home detoxification, abstinence oriented treatment and substitute prescribing for primary opiate users and poly drug users.

Young people can access the service at any age up to 21 years. The service is delivered separately from adult services and is flexible, working with service users in the most appropriate venues at the most appropriate times, which may include evenings or weekends. The expectation is that services are delivered in a range of venues, including home visits.

Pharmacological Interventions for all drug and alcohol users

The service provides a range of pharmacological interventions to support clients in their treatment for problematic drug and/or alcohol use, includes prescribing for young people under the age of 21.

For those with opiate addiction, this includes titration, stabilisation and maintenance prescribing, as well as reduction and community detoxification.

For those with alcohol dependence, a range of prescribing options is offered, including community detox, relapse prevention medication and anti-craving medication.

Harm Reduction

The service is open access and offers the following:

- advice and information, including safer injecting and overdose prevention
- health promotion and health assessments
- contraception and advice on sexual health
- specialist needle exchange
- testing for blood borne viruses (BBVs)
- vaccinations for Hepatitis B

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9 Young People’s Substance misuse treatment services – essential elements. NTA (2005)
10 Young people’s specialist substance misuse treatment planning 2010/11 Guidance notes on planning processes for strategic partnerships. NTA (2009)
brief interventions re drug and alcohol use

Recovery focussed treatment
The service offers group work and individual psychosocial interventions, as well as access to inpatient detox and residential rehabilitation. Specific interventions offered include:
- action planning, and key work
- care coordination, referral and signposting to generic agencies
- recovery focussed group work, including relapse prevention
- referral and assessment for residential rehabilitation and detoxification
- Drug Interventions Programme (DIP), supporting alcohol and substance users involved in the criminal justice system
- life skills training

The service has a number of trained peer mentors; service users who have progressed through their recovery journeys and want to share their experiences with others who are at an earlier stage of recovery.

There are 5 locality bases across Worcestershire: Worcester City, Redditch, Kidderminster, Evesham and Malvern, all of which offer a full range of services. There are also 40 GP practices involved in shared care with recovery workers from the specialist service.

Services are generally available from 9.00 to 5.00 Monday to Friday, with one late night opening. Services at GP practices vary according to practice opening hours.

Inpatient Detoxification and Residential Rehabilitation
Worcestershire County Council does not have specific contracts with providers of inpatient detox and residential rehab. Access to these interventions is managed by the current treatment provider, which receives separate funding via a contract variation. Placements are ‘spot purchased’ for individuals who have been assessed as requiring inpatient or residential care.

Capacity
YP service – target for 2013/14 is for the service to work with 168 new clients
Adult drugs – target for 2013/14 is for the service to work with 390 new clients
Adult alcohol – target for 2013/14 is for the service to work with 550 new clients
Harm reduction - target for 2013/14 is for the service to work with a minimum of 400 new clients

In addition, the service continues to work with clients still in treatment at the previous year end.

Access
Access to the service is through a variety of routes, including:
- Self-referral
- GP
- Criminal justice organisations
- Social services
- Jobcentre Plus

Costs
The value of the contract is with the current provider is £3,938,000. In addition, for the year 2013/14 the provider received and additional £187,500 to fund additional drug costs incurred due to the
closure of the virtual shared care scheme, plus £50,000 for additional capacity within the Family Services Team.

The provider also administers £244,000 per annum for inpatient detox and residential rehabilitation.

The value of the contract is not broken down into unit costs, but there are specific payment by results payments across a number of targets and these are as follows:

- Alcohol extended brief intervention: £373
- Planned discharge alcohol free or at safe levels: £1,005
- Drug extended brief intervention: £311
- Planned discharge drug free or occasional use: £2,364
- Harm reduction – reduced risky behaviour: £281
- Young person planned discharge: £749
Assessment of current services
Effectiveness and Cost-Effectiveness

Adult Drug Treatment

Public Health Outcome Framework 2.15: Successful Completion of Drug Treatment

Figure 43 below shows the proportion of all Opiate and Non-Opiate clients successfully completing treatment and not re-presenting within 6 months for both Worcestershire and England, as measured in the Public Health Outcomes Framework.

Figure 43 - Percentage of Clients Successfully Completing Drug Treatment and Not Re-presenting to Treatment within 6 Months

Source: NDTMS Public Health Outcomes

It can be seen that the percentage of clients successfully completing treatment and not re-presenting within 6 months is lower in Worcestershire for both Opiate and Non-Opiate users compared to the England average. There has been a significant decline in the percentage of Non-Opiate using clients successfully completing treatment and not re-presenting in Worcestershire since the baseline period.

It should be noted that the baseline period for completions in 1st January 2010 to 31st December 2010 with re-presentations up to: 30th June 2011. The latest period for this indicator shows completions during 1st July 2012 to 30th June 2013 re-presentations up to: 31st December 2013.

Figure 44 below shows the latest available figures for the proportion of all Opiate clients successfully completing treatment and not re-presenting within 6 months for Worcestershire and its comparator authorities.

It can quite clearly be seen that Worcestershire is currently performing worse than all the other comparator authorities on this public health outcome.
Figure 44 – Percentage of Opiate Users Successfully Completing Drug Treatment and Not Re-presenting to Treatment within 6 Months by Comparator Authority

Source: NDTMS Public Health Outcomes

Figure 45 below shows a similar comparison for Non-Opiate clients.

Figure 45 - Percentage of Non-opiate Users Successfully Completing Drug Treatment and Not Re-presenting to Treatment within 6 Months by Comparator Authority

Source: NDTMS Public Health Outcomes
Again it can be seen that Worcestershire is achieving a lower level of clients that are successfully completing treatment and not re-presenting within 6 months than all the other comparator authorities.

**Successful Completions and Re-presentations**

The charts below show the successful completion and re-presentation rates for Worcestershire drug treatment services during 2010-11, 2011-12 and 2012-13, compared with the average rate of local authorities in the same ‘cluster’. These clusters were derived using a combination of information around drug treatment and wider socio-economic factors, and the associated guidance and methodology can be found in appendix 5.

It should be noted that the ‘clusters’ differ for each client type. Worcestershire is in ‘cluster’ E for Opiate users, and ‘cluster’ B for Non-Opiate users. A full list of the local authorities in each of Worcestershire's clusters can be found in table 28 in appendix 5.

Figure 46 below shows the percentage of all Opiate using clients in treatment that successfully completed drug treatment by year, compared with the cluster average.

**Figure 46 - Percentage of All Opiate Clients Successfully Completing Drug Treatment**

![Graph showing percentage of Opiate clients successfully completing drug treatment](image)

**Source:** NDTMS Recovery Diagnostic Toolkit and December 2013-14 Successful Completion and Re-Presentation Report.

It can be seen that Worcestershire drug treatment services have under-performed in each year when compared with the cluster average. It is also worth noting that the rate for Worcestershire fell in 2012-13 compared to the previous year whilst the cluster rate remained stable. The latest NDTMS data indicates that the rate of successful completions for Opiate clients in Worcestershire is just 4.9% for the 12-month period from 1st January 2012 to 31st December 2013. The top quartile range for those areas in Worcestershire’s cluster is 9% to 10%. For Worcestershire to achieve this it would need to approximately double its current number of successful completions of 68 for the latest 12-month period to somewhere between 118 and 139, assuming the same number of opiate clients in treatment.

Figure 47 below shows the proportion of Opiate clients who re-presented to treatment within six months following successful completion for Worcestershire and the Cluster average. Please note that re-presentations are based on calendar years, so for the 2012-13 re-presentation period this includes...
successful completions which occurred between January 2012 and December 2012 and re-presentations up to June 2013. However for Dec-13 the re-presentation period includes successful completions which occurred between 1st July 2012 and 30th June 2013 with re-presentations up to December 2013.

In contrast to the successful completion rates, the percentage of Opiate clients that then re-present to treatment after successful completion in Worcestershire has been significantly lower than the cluster average. Indeed, Worcestershire’s re-presentation rate in 2012-13 saw a decrease of over 9% compared to 2011-12, compared to just a 1.3% reduction in the cluster average.

However, latest figures show that 11.3% of Opiate clients that successfully completed treatment in and re-presented during the following 6 month period. Although this is an increase on the 2012 re-presentation rate, it is still lower than the cluster average and within the top quartile for the cluster partnerships, at 15% to 6%.

**Figure 47 - Percentage of Opiate Clients Successfully Completing Drug Treatment that Re-present to Treatment within 6 months**

![Figure 47: Percentage of Opiate Clients Successfully Completing Drug Treatment that Re-present to Treatment within 6 months](source)

It is important to note that whilst the re-presentation rate for Worcestershire’s Opiate clients has increased in recent months, the actual number of re-presentations remains fairly low. The above figure of 11.3% is based on just 9 re-presentations occurring out of 80 successful completions.

Figure 48 below shows the actual number of Opiate clients that have successfully completed treatment and re-presented to treatment within 6 months in Worcestershire.
Figure 48 – Number of Opiate Clients Successfully Completing Drug Treatment and Re-presenting to Treatment within 6 months

Source: NDTMS Recovery Diagnostic Toolkit and December 2013-14 Successful Completion and Re-Presentation Report.

Figure 49 below is the same as figure 48 above, but for Non-Opiate users.

Figure 49 - Percentage of All Non-Opiate Clients Successfully Completing Drug Treatment

Source: NDTMS Recovery Diagnostic Toolkit and December 2013-14 Successful Completion and Re-Presentation Report.

It can be seen that Worcestershire drug treatment services have under-performed in each year when compared with the cluster average. Once again the rate for Worcestershire is below the cluster
average, but for this client group the difference is far more significant in 2011-12 and 2012-13. Indeed, the fall in the rate of successful completions for this client group from 38.4% in 2010-11 to 23.4% in 2012-13 is quite dramatic. Furthermore, the latest NDTMS data indicates that the rate of successful completions for Non-Opiate clients in Worcestershire is just 22.4% for the 12-month period from 1st January 2013 to 31st December 2013. The top quartile range for those areas in Worcestershire’s cluster is 49% to 68%. For Worcestershire to achieve this it would need to increase its current number of successful completions of 37 for the latest 12-month period to somewhere between 80 and 112, assuming the same number of non-opiate clients in treatment.

Figure 50 below shows the proportion of Non-Opiate clients who re-presented to treatment within six months following successful completion for both Worcestershire and the Cluster average.

**Figure 50 - Percentage of Non-Opiate Clients Successfully Completing Drug Treatment that Re-present to Treatment within 6 months**

Source: NDTMS Recovery Diagnostic Toolkit and December 2013-14 Successful Completion and Re-Presentation Report.

Latest figures show that the re-presentation rate for Non-Opiate clients in Worcestershire is now 6.1%, although again the actual numbers are very low (out of 33 successful completions during the period of 1st July 2012 and 30th June 2013, just two clients re-presented in the following 6 months up to 31st December 2013).

In the case of Non-Opiate clients, not a single one of those successfully completing treatment re-presented in Worcestershire in 2011 or 2012. It should be noted, however, that the total number of Non-Opiate clients successfully completing treatment in these two years was significantly smaller than in 2010, as shown in figure 51 below.
Successful Completions by District

Using data from the NDTMS quarterly reports we can calculate the rate of clients successfully completing adult drug treatment as a percentage of all clients in treatment for each of the 6 Worcestershire districts. These reports are based on clients’ postcode of residence and are shown in figure 52 below for the period 1\textsuperscript{st} April 2012 to 31\textsuperscript{st} March 2013. It should be noted that these are not official figures, and should therefore be used with caution.
Using these calculated figures, it appears that the rate of successful completions for residents of the Worcester district was significantly lower than the other areas in 2012/13. It should be noted that there were more than twice as many clients in adult drug treatment in 2012/13 that were residents of Worcester than of any other district. Therefore small changes in the number of successful completions in the other districts will have greater impacts on the percentage of successful completions. Reasons for this apparent disparity in success rates would need to be explored further before any conclusions can be drawn.
Length of Time in Adult Drug Treatment

Evidence suggests that clients who remain in treatment for longer periods of time are less likely to leave treatment. Figure 53 below shows the percentage of clients in Worcestershire’s adult drug treatment services by year and the length of time they have been in treatment.

**Figure 53 - Percentage of All Clients in Adult Drug Treatment by Length of Time in Treatment**

![Graph showing percentage of clients in treatment by length of time]

*Source: NDTMS View It*

The proportion of clients that have been in treatment for over 4 years has more than doubled since 2005/06, accounting for more than a third of the treatment population in 2012/13.

Of those clients that have been in treatment for more than 4 years, almost two thirds have now been in treatment for more than 6 years. The number of clients that have been in treatment for over 6 years have more than tripled since 2005/06.

The 2012/13 figures for Worcestershire of 14.8% of clients in treatment for 4 to 6 years and 23.4% for more than 6 years compare to National averages of 11.5% and 19.0% respectively. Further data for 2012/13 shows that the average length of time for a client in Worcestershire drug treatment is 4.3 years.

Figure 54 below shows the percentage of Opiate clients in adult drug treatment by length of time in treatment for both Worcestershire and the Cluster average. Again it can be seen that the length of time Opiate using clients have been staying in treatment has been increasing over time, with the percentage of Opiate clients that have been in treatment for more than 6 years in Worcestershire consistently higher than the Cluster average.
**Figure 54 - Percentage of Opiate Clients in Adult Drug Treatment by Length of Time in Treatment**

Source: NDTMS 2012-13 Recovery Diagnostic Toolkit and NDTMS Jan-13 to Dec-13 Recovery Diagnostic Toolkit

Figure 55 below shows the percentage of Non-opiate clients in adult drug treatment by length of time in treatment for both Worcestershire and the Cluster average.

**Figure 55 - Percentage of Non-opiate Clients in Adult Drug Treatment by Length of Time in Treatment**

Source: NDTMS 2012-13 Recovery Diagnostic Toolkit and NDTMS Jan-13 to Dec-13 Recovery Diagnostic Toolkit

Here the picture is more varied with the vast majority of Non-opiate clients in treatment for less than two years, as you would expect with this less complex group. However, the percentage of this client group that has been in treatment for more than 6 years has been consistently high in Worcestershire when compared to the Worcestershire average. The latest figures also show that almost 10% of Non-
opiate clients in Worcestershire have been in treatment for more than 2 years. In comparison the Cluster average proportion of Non-opiate clients that have been in treatment for more than 2 years has been steadily falling and is now around 5.6%.

**Completions by length of time in treatment**

Figure 56 below shows the percentage of all clients successfully completing treatment by the length of time they have been in treatment for both Worcestershire and the Cluster average in 2012/13.

*Figure 56 - Percentage of Successful Completions by Length of Time in Treatment in 2012/13*

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>Worcs Opiate only</th>
<th>Cluster Opiate only</th>
<th>Worcs Non-Opiate</th>
<th>Cluster Non-Opiate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 years</td>
<td>8.5%</td>
<td>10.6%</td>
<td>28.4%</td>
<td>43.4%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>4.4%</td>
<td>9.1%</td>
<td>11.8%</td>
<td>36.5%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>7.8%</td>
<td>8.0%</td>
<td>0.0%</td>
<td>32.1%</td>
</tr>
<tr>
<td>3-4 years</td>
<td>8.2%</td>
<td>8.5%</td>
<td>0.0%</td>
<td>23.8%</td>
</tr>
<tr>
<td>4-5 years</td>
<td>4.4%</td>
<td>6.1%</td>
<td>0.0%</td>
<td>18.9%</td>
</tr>
<tr>
<td>5-6 years</td>
<td>4.4%</td>
<td>6.5%</td>
<td>0.0%</td>
<td>6.5%</td>
</tr>
<tr>
<td>6 + years</td>
<td>4.7%</td>
<td>5.0%</td>
<td>0.0%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

*Source: NDTMS Recovery Diagnostic Toolkit*

It can be seen that in terms of Opiate clients, Worcestershire has slightly lower completion rates than the Cluster average for all treatment lengths apart from those Opiate clients that have been in treatment for 5 to 6 years. Indeed the success rate for Worcestershire Opiate clients that have been in treatment for 5 to 6 years is only marginally inferior for those clients that have been in treatment for less than 1 year.

In terms of Non-opiate clients, the differences in the success rates are more marked, with the chances of a Non-opiate client successfully completing treatment after more than one year greatly reduced. However, it should be noted that the actual number of Non-opiate clients in treatment in Worcestershire is quite low, so small changes in the numbers can have relatively large impacts on the percentages.
Adult Alcohol Treatment

Successful Completions and Re-presentations

Figure 57 below shows the 2012/13 baseline and the latest rolling 12-month periods for both Worcestershire and the National average.

Figure 57 – Percentage of All Alcohol Clients Successfully Completing Treatment

Source: NDTMS Successful Completion and DOMES Reports

It can be seen that whilst the rate of successful completion for Alcohol clients in Worcestershire has been in steady decline since the baseline period of 1st April 2012 to 31st March 2013 to the 12-month period to 30th September 2013, the National average has remained stable at around 36%. However, the latest NDTMS data indicates that the rate of successful completions for Alcohol clients in Worcestershire is improving and is now 32.5% for the 12-month period from 1st January 2013 to 31st December 2013. This remains below the latest National average of 36.6% and the Worcestershire baseline figure of 34.4%. 
NDTMS data tells us that re-presenting clients (i.e. those who have had many goes round the system) are less likely to complete treatment successfully. Clients who do so may require more recovery capital to complete treatment and not return, such as access to housing and employment and a strong support network of peers, friends and family.

Figure 58 below shows the percentage of clients that successfully completed alcohol treatment in Worcestershire and then re-presented within 6 months of exiting treatment since the year 2012/13. The baseline data is calculated on the number of successful completions during the period of 1st April 2012 to 30th September 2012 with re-presentations up to 31st March 2013.

**Figure 58 - Percentage of Alcohol Clients Successfully Completing Treatment that Re-present within 6 months**

Source: NDTMS Successful Completion and DOMES Reports

It can be seen from the chart that Worcestershire’s representation rate has been steadily increasing from August 2013 to October 2013, and has now exceeded its previous peak of 10.1% in July 2013.

Nationally, 10.3% of alcohol clients that completed treatment successfully during the period 1st January 2013 to 30th June 2013 re-presented within the following 6 month period to 31st December 2013.
Length of Time in Adult Alcohol Treatment

Figure 59 below shows the percentage of clients in adult alcohol treatment by the length of time in treatment and year.

**Figure 59 - Percentage of Clients in Adult Alcohol Treatment by Length of Time in Treatment**

<table>
<thead>
<tr>
<th>Year</th>
<th>Under 3 months</th>
<th>Between 3 and 6 months</th>
<th>Between 6 and 12 months</th>
<th>Over 1 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14 Q3</td>
<td>39.6%</td>
<td>28.7%</td>
<td>21.5%</td>
<td>10.3%</td>
</tr>
<tr>
<td>2012/13</td>
<td>40.8%</td>
<td>27.2%</td>
<td>22.9%</td>
<td>9.1%</td>
</tr>
<tr>
<td>2011/12</td>
<td>54.2%</td>
<td>25.8%</td>
<td>16.0%</td>
<td>16.0%</td>
</tr>
</tbody>
</table>

*Source: NDTMS Alcohol Needs Assessment Data and Domes 2013-14 Q2 Report.*

As at Q3 of 2013/14, clients had spent an average of 6 months in alcohol treatment in Worcestershire.
Substance Misuse Needs Assessment

Young Persons Drug and Alcohol Treatment

Successful Completions and Re-presentations

Figure 60 below shows percentage of those clients exiting young persons’ substance misuse treatment that did so in a planned way in Worcestershire compared with the National average.

Figure 60 – Percentage of All Clients Exiting Young Persons’ Treatment Services in a Planned Way

![Percentage of All Clients Exiting Young Persons’ Treatment Services in a Planned Way](image)

Source: YP Executive Summary and Local Assurance Reports

Of those clients exiting Worcestershire young persons' treatment services in Q2 of 2013-14, 64% did so in a planned way. For the same time period, this compares to 80% both nationally and with those areas similar to Worcestershire on the Child Wellbeing Index. In 2012-13 almost 73% of clients exiting Worcestershire's young persons' services did so in a planned way compared to around 79% nationally.

Of those clients that exited Worcestershire young persons' treatment services in a planned way in Q1 of 2013-14, only 2% then re-presented to treatment within 6 months. This compares to 7% nationally and 6% with the Child Wellbeing Index areas for the same period. In 2012-13 5% of clients exiting Worcestershire's young persons' services in a planned way re-presented to treatment within 6 months. Again this compares favourably with the National average where 7% re-presented to treatment during the same time period.

The “Child and Wellbeing Index Quintiles” are supplied in order to allow for sub-national comparisons to similar partnerships, all partnerships have been added to one of five groups based on their Average Score on the 2009 Child Wellbeing Index (as released by the Department for Communities and Local Government, http://www.communities.gov.uk/publications/communities/childwellbeing2009). These five groups (called the Child Wellbeing Index Quintiles) are grouped from Quintile 1 (with the lowest average scores and therefore deemed those with the least deprivation for young people) through to Quintile 5 (with the highest average scores and therefore deemed those with the most deprivation for young people).
### Length of Time in Young Persons' Substance Misuse Treatment

Figure 61 below shows the percentage of clients in young persons’ substance misuse treatment by the length of time in treatment and year.

**Figure 61 – Percentage of Clients in Young Persons' Substance Misuse Treatment by Length of Time in Treatment**

<table>
<thead>
<tr>
<th>Year</th>
<th>0 - 12 weeks</th>
<th>13 - 26 weeks</th>
<th>27 - 52 weeks</th>
<th>More than 52 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14 Q2</td>
<td>24.4%</td>
<td>39.0%</td>
<td>26.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td>2013/14 Q1</td>
<td>40.6%</td>
<td>28.1%</td>
<td>18.8%</td>
<td>12.5%</td>
</tr>
<tr>
<td>2012/13</td>
<td>37.3%</td>
<td>41.0%</td>
<td>16.9%</td>
<td>4.8%</td>
</tr>
<tr>
<td>2011/12</td>
<td>49.0%</td>
<td>28.0%</td>
<td>19.0%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

**Source:** YP Executive Summary and Local Assurance Reports

As at Q2 of 2013/14, clients had spent an average of 26.6 weeks in treatment. This compares to an average of 23.35 weeks nationally.
Alternative models of service provision

Alcohol and drug misuse is a complex issue, and someone's misuse and dependency affects everybody around them, including their families, friends, communities and society.

People are more likely to complete their recovery if they have wider support to help them to rebuild their lives. These services include stable homes and employment prospects.

A recovery focused treatment system, which aims to maximise the number of people who achieve and maintain recovery, needs to have effective links with a range of support organisations, such as housing and employment services, and organisations offering support to families affected by substance use. As there are clear links between substance misuse and crime, there need to be well defined pathways between the criminal justice and treatment services, so that those picked up in the criminal justice system are rapidly engaged in treatment. Evidence shows that outcomes from ‘coercive’ treatment differ little to outcomes from voluntary treatment.

Best Practice

As the Recovery Orientated Drug Treatment Expert Group report points out “it is neither possible nor ethical to predict which individual’s will eventually overcome their dependence. This is why we are obliged to create a treatment system that makes every effort to provide the right package of support to maximise every individual’s chances of recovery”.

The report recommends the most effective way of moving people towards recovery is an integrated, recovery-orientated system of care, that involves other health and social care services with drug treatment to provide recovery support, including mental health, employment, housing, mutual aid, recovery communities etc. It will be particularly important that specialist treatment services have clear and robust referral pathways and joint working arrangements with generic services, now that much of the substance misuse related housing and employment support has been discontinued.

The Recovery Orientated Drug Treatment Expert Group report recommends that a “A full range of treatment options ... including residential rehabilitation, so that there is the necessary flexibility to build a range of treatment and recovery pathways for different needs; from brief interventions for those not needing structured treatment to full packages of care-managed pharmacological, psychosocial and recovery interventions for those with complex needs.”

Services should be available for everyone with drug and alcohol problems, whether they are ready to start to overcome their problems or just wish to reduce the impact of problematic use on their life. Harm reduction interventions, such as needle exchange and Hepatitis B vaccination, can reduce the short term impact on someone’s health, and act in as preventative measure for longer term health. (NICE). Opportunistic brief interventions should also be employed, to offer advice on how to reduce risk taking behaviour.

NICE guidelines indicate that a comprehensive treatment system should provide a wide range of treatment options, to suit individual choice. Options should include psychosocial interventions, pharmacological interventions, detoxification (both inpatient and community) and residential rehabilitation.

NICE also recommends that services should provide support to families and carers affected by someone else’s substance use.

Options

Community Assets

Every community has a tremendous supply of assets and resources that can be used to build the community and solve problems, and the asset mapping helps to identify them.
Building recovery in the local community should be a focus for local strategies. The focus of recovery is about providing support to some of the most marginalized people in the local community to enable them to build full and satisfying lives to integrate and to contribute. The recovery journey also involves enabling people to live better and stay better, by mobilizing the ‘natural resources’ of the local community, by empowering people to do things to support themselves and others – for example, involvement in peer mentoring, mutual aid groups or family support groups.

There are a number of themes that have emerged regarding how to achieve recovery from drug and alcohol dependency in the last two years. Key documents being the 2010 Drug Strategy, its 2011 review, and the 2012 Medication in Recovery report. Primary care is well positioned to support recovery, and there are a number of ways in which primary care might evidence its contribution to a full range of recovery focused outcomes. The active promotion of mutual aid networks in considered to be essential as there is a growing evidence base for the benefits of mutual aid while in treatment. Primary care is used to signposting and can also develop links with community groups. The 2012 Medications in recovery report suggests that recovery be made visible to people at all stages of their treatment journey.

Evidence also shows that treatment is more likely to be effective and recovery sustained, where families, partners and carers are closely involved. Developing relationships with local schools/children's services provides invaluable support from health visitors.

Recovery involves three overarching principles, wellbeing, citizenship and freedom from dependence. It is an independent person centred approach as opposed to an end state. Therefore the individual and their personal needs have to be wholly considered.

Within Worcestershire there are a number of independent organisations who provide support within the substance misuse arena. Mapping of the services available in Worcestershire has shown that there is a wealth of resources which are available and have capacity to support individuals with their recovery journey (Appendix 6).

It is clear that there are a range of natural resources available in Worcester and Redditch but these need to be strengthened and broadened to incorporate other areas such as Wychavon, Wyre Forest and Malvern Hills.

There should be effective links with mutual aid organisations, such as AA, NA and SMART, as the evidence clearly demonstrates that these can be extremely valuable in assisting people to achieve and maintain recovery. “Mutual aid improves drug and alcohol treatment and its recovery orientation, say NICE (2007 & 2011) and the report of the Recovery Orientated Drug Treatment Expert Group.

“According to NICE there is good evidence that 12-step has a positive impact on substance misuse outcomes, so treatment staff should routinely provide people with information about mutual aid groups and facilitate access for those who are interested in attending (NICE, 2007; NICE, 2011; NICE, 2012)”. Employment and Recovery; A Good Practice Guide (NTA, 2012) highlights the need for treatment services and local employment organisations to work together to “promote more effective approaches to the education, training and employment (ETE) needs of people in drug treatment”.

Peer mentors and volunteers can play a vital role in assisting people to achieve recovery, particularly those who have themselves achieved recovery and are ‘visible’ recovery champions.

Prevention and early intervention is key to minimising the harm that substance misusers cause to themselves, their families and communities. Services such as needle exchange and BBV testing and vaccination play a pivotal role in reducing health harms, while brief interventions can help not only to
reduce health harms, but also to prevent substance use becoming more entrenched and thus harder to overcome.

Prevention and early intervention services that take place in the community, e.g. pharmacies, can provide particularly useful opportunities to engage people who would not necessarily engage with specialist services. Maximising opportunities for delivering brief interventions in community settings could not only increase the number of drug and alcohol users reached, but could also reduce the demand on the specialist treatment service, thus enabling them to focus on more complex clients.

According to the latest prevalence estimates, opiate use in Worcestershire is increasing, and the average age of opiate users is also increasing. This is leading to a higher proportion of clients with complex needs, and poorer physical and mental health. The PHE Recovery Diagnostic Tool evidences that these clients are harder to treat and have poorer outcomes from treatment. Enabling the specialist treatment service to focus on more complex clients should lead to an increase in positive outcomes for this client group.

The various interventions that should comprise a comprehensive drug treatment system were described in Models of Care for Treatment of Adult Drug Misusers (2002) and updated in Models of Care for Treatment of Adult Drug Misusers: Update 2006. Similarly, Models of Care for Alcohol Misusers (2006) outlined best practice guidance for a comprehensive alcohol treatment system.

Although the focus is now much more on recovery than was the case at the time of publication of MoC and MoCAM, the guidance given on interventions for drug and alcohol users remains relevant today.

However, there a number of alternative models for configuring service provision:

- drug and alcohol treatment can be provided by different services, as is the case in Cambridgeshire
- prescribing services can be delivered by a different service to recovery focussed services, as per the current model in Dudley
- specialist drug and alcohol services for young people can be delivered by a separate organisation, as is the case in Oxfordshire
- all services can be delivered by one organisation, or through a consortium (as in Wolverhampton) or sub-contract arrangement, as in Worcestershire

Having separate organisations focussing on one aspect of treatment means that workers can develop more specialist skills, which can be lost if workers are required to work in a more generalist way as part of an integrated service. However, this needs to be balanced with the need to deliver a comprehensive service across a large geographic area such as Worcestershire in the most cost effective way. Given the financial constraints at the time of the previous retendering exercise, it was agreed that the most cost effective model was to have one integrated service, as this enabled the elimination of multiple bases and duplication of management.

At the present time all interventions, from brief interventions through to structured treatment for complex cases, are delivered by on service provider. It is feasible for prevention and early help services to be delivered by a variety of generic agencies, such as police, probation, social services, housing organisations and voluntary sector agencies. An investment in training front line staff to deliver interventions would be required.

**Awareness**

There is evidence that awareness raising does increase knowledge and understanding and delay the onset of risky behaviour around drugs, whilst it may not prevent it altogether. Schools are well placed to reach children before they initiate drug use, or in the early stages of experimentation. Although UK-based studies are generally lacking, there is international evidence (mainly from the US)
that school-based prevention programmes can delay the onset of substance use by non-users for a short time, and temporarily reduce use by some current users. A systematic review of school-based programmes found that those based on developing life skills were the most consistent at reducing aspects of drug use in school settings\textsuperscript{12}.

**Impact on Quality**

However, past experience shows that it can be very difficult to persuade organisations to release staff for training, (primary care proved particularly challenging). Given the current financial climate it is likely to prove even more difficult to persuade organisations to take on additional tasks, since virtually all organisations are subject to funding cuts, and widespread restructuring is leading to greater workloads for remaining staff. In addition, even where a financial incentive is offered for brief interventions to be carried out, take up can still be extremely low (as the current pharmacy alcohol brief interventions scheme demonstrates).

Having brief interventions delivered by an integrated treatment service means that should someone need to progress to treatment this can be delivered by the same worker, or at least someone in the same team. This has the advantage of fewer drop outs than a client is referred from one organisation to another.

Any reduction in early help for drug and alcohol problems is likely to lead to an increase in entrenched problems requiring more costly interventions at a later stage.

**Impact on Health Inequalities**

A full Equality Impact Assessment will be conducted as part of the retendering process.

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\textsuperscript{12} Bambra C, Joyce K and Maryon-Davis A (2009) Task Group on priority public health conditions, final report. Submission to the Marmot Review
## Appendices

### Appendix 1 – Opiate and/or Crack User Prevalence Estimates

#### Table 16 - Prevalence Estimates by Drug Type

<table>
<thead>
<tr>
<th>Worcestershire</th>
<th>Opiate and/or crack 15-64</th>
<th>Opiate only 15-64</th>
<th>Crack only 15-64</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>Estimated total</td>
<td>2,592</td>
<td>2,288</td>
<td>1,306</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>In treatment at 31/3/13</td>
<td>1,097</td>
<td>1,091</td>
<td>347</td>
</tr>
<tr>
<td></td>
<td>42.3%</td>
<td>47.7%</td>
<td>26.6%</td>
</tr>
<tr>
<td>In treatment during 12/13</td>
<td>290</td>
<td>277</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>11.2%</td>
<td>12.1%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Known to treatment but not in during 12/13</td>
<td>173</td>
<td>164</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>6.7%</td>
<td>7.2%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Not known</td>
<td>1,032</td>
<td>756</td>
<td>798</td>
</tr>
<tr>
<td></td>
<td>39.8%</td>
<td>33.1%</td>
<td>61.1%</td>
</tr>
<tr>
<td>Not known to treatment but known to DIP</td>
<td>156</td>
<td>139</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>15.1%</td>
<td>18.4%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

*Source*: NDTMS Needs Assessment data and Glasgow Prevalence Estimates

#### Table 17 - Prevalence Estimates by Age Group

<table>
<thead>
<tr>
<th>Worcestershire</th>
<th>Opiate and/or crack 15-24</th>
<th>Opiate and/or crack 25-34</th>
<th>Opiate and/or crack 35-64</th>
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<tr>
<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
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<tr>
<td>Estimated total</td>
<td>306</td>
<td>1,152</td>
<td>1,135</td>
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<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>In treatment at 31/3/13</td>
<td>41</td>
<td>480</td>
<td>576</td>
</tr>
<tr>
<td></td>
<td>13.4%</td>
<td>41.7%</td>
<td>50.8%</td>
</tr>
<tr>
<td>In treatment during 12/13</td>
<td>29</td>
<td>124</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>9.5%</td>
<td>10.8%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Known to treatment but not in during 12/13</td>
<td>13</td>
<td>64</td>
<td>96</td>
</tr>
<tr>
<td></td>
<td>4.3%</td>
<td>5.6%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Not known</td>
<td>223</td>
<td>484</td>
<td>326</td>
</tr>
<tr>
<td></td>
<td>72.9%</td>
<td>42.0%</td>
<td>28.7%</td>
</tr>
<tr>
<td>Not known to treatment but known to DIP</td>
<td>23</td>
<td>80</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>10.3%</td>
<td>16.5%</td>
<td>16.9%</td>
</tr>
</tbody>
</table>

*Source*: NDTMS Needs Assessment data and Glasgow Prevalence Estimates
Appendix 2 - Service Specification - Interventions

Young People’s Substance Use Services (excluding pharmacological interventions)

Service Description
This Service Specification is for Tier 2 and Tier 3 young people’s substance use services. This includes efforts “concerned with reduction of risks and vulnerabilities, reintegration and maintenance of young people in mainstream services”\(^\text{13}\). Also “young people’s specialist substance misuse treatment...a care planned medical, psychosocial or harm reduction intervention aimed at alleviating current harm caused by a young person’s substance misuse”.\(^\text{14}\) The service provider will support a balanced local service system that offers a range of interventions, including: harm reduction, community / home detoxification, abstinence oriented treatment and substitute prescribing for primary opiate users and poly drug users.

Eligibility criteria
Service users will be young people. Young people can access the service at any age up to 18 years. The service will work with young people with:

- Drug or / and alcohol use problems who require specialist intervention as defined by the thresholds guidance

Services will make pro-active endeavours to reach under-represented groups. This will include acting on findings from an equality impact assessment.

Those engaged in treatment must be transitioned to adult services by their 19\(^\text{th}\) birthday. The only exception to the age limits is where there is an assessment that the young person does not have the emotional maturity to effectively engage with adult services, this is expected to be in exceptional circumstances.

Service users can self-refer or be referred by other agencies/services or by their GP.

Service Delivery
The service provider will work within an integrated local service system that delivers substance use and associated services to adults and young people across Worcestershire.

The range of services available should include the five treatment interventions set out in the NTA assessment and commissioning guidance.

The service provider will be expected to:

- Work in an integrated way with all providers delivering children’s services to support their delivery of universal advice and information, screening using CAF and referral using the local ‘young people’s substance misuse screening tool’.
- Work in an integrated way with all providers operating within Worcestershire’s drug and alcohol treatment systems and associated services, to deliver a coordinated package of care that includes appropriate transition arrangements, aftercare, wrap around and mainstream services to address substance use alongside impacting health, criminal and social issues.
- Work closely with Young Offender Institutions across the UK, to ensure continuity of treatment to individuals leaving custody whether release is planned or unanticipated.
- Work in an integrated way with the professionals delivering the pharmacological interventions.

\(^{13}\text{Young People’s Substance misuse treatment services – essential elements. NTA (2005)\hspace{1cm}}
\(^{14}\text{Young people’s specialist substance misuse treatment planning 2010/11 Guidance notes on planning processes for strategic partnerships. NTA (2009)\hspace{1cm}}
Substance Misuse Needs Assessment

• Ensure an appropriate level of access and support is available to service users with co-existing mental health needs, providing support to service users with mild to moderate needs and working collaboratively with CAMHS and AMHS to support those with severe and enduring mental illness.

Location of service delivery
The service will be delivered separately from adult services and will be flexible, working with service users in the most appropriate venues at the most appropriate times. The expectation is that services will be delivered in a range of venues, including home visits.

Days/Hours of opening
The service will be accessible at times that can best demonstrate they meet young people’s needs. It will include evenings and may include weekends.

Pharmacological Interventions for all Drug and Alcohol users

Service Description
The service provider will support a balanced local service system that offers a range of interventions:

For drug users to include: harm reduction, community / home detoxification, abstinence oriented treatment and substitute prescribing for primary opiate users and poly drug users.

For alcohol users to include: harm reduction, community / home detoxification.

Key references include:
• Clinical governance in drug treatment: A good practice guide for providers and commissioners, NTA (2009)
• Guidance for the pharmacological management of substance misuse among young people. NTA/YJB (2009)
• Alcohol Use Disorders – clinical Management. NICE (Due June 2010)

Eligibility criteria
Service users will be adults and young people who are eligible to receive services based in Worcestershire. They will be:

• People with complex drug or / and alcohol use problems
• For whom, a pharmacological intervention need has been identified within their specialist service comprehensive assessment.

Services for young people must be delivered separately to adult services; the provider will need to detail specific arrangements in their delivery plan.

In line with current guidance, the service will work with mental health services to ensure a continuity of care for those experiencing co-morbidity (substance use and mental health problems).

Services will make pro-active endeavours to reach under-represented groups. This will include acting on findings from an equality impact assessment.

The Needs Assessment details underrepresented groups which currently include:
• Homeless populations
• Women
• BME populations (including temporary residents)

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Substance Misuse Needs Assessment

- Young adults

Service Delivery

The service will:
- Employ a team of specialist prescribers with an appropriate range of skills and knowledge, led by a suitably experienced and qualified clinician, to provide a consistent service to meet the diverse and changing needs of the people of Worcestershire. This needs to include skills and knowledge regarding prescribing for young people.
- Provide specialist prescribing services including rapid opiate substitute prescribing from a range of locations across the county.
- Provide associated support and specialist healthcare interventions including:
  - Medical assessment
  - BBV testing and where appropriate, immunisation or referral for specialist treatment,
  - Harm minimisation and intervention
  - Community stabilisation and detoxification
  - Relapse prevention
  - Brief psychotherapeutic intervention as part of an overall prescribing system for drug and alcohol users.
  - Relapse prevention medication for alcohol users
  - Anti-craving medication for alcohol users
- Ensure the service is underpinned by clear and accountable governance arrangements that include regular supervision, continuing professional development and appraisal.
- Appoint an accountable officer for ensuring compliance with use of drugs legislation and the safe effective management of controlled drugs.
- Ensure appropriate dispensing pharmacists are engaged in care planning and management, when prescribing controlled drugs and that arrangements are in place to supervise consumption for an appropriate period of time.
- Work in an integrated way with all other parts of the young person’s and adult community drug and alcohol services, to offer high quality, easily accessible pharmacological interventions at times convenient to service users, including in the evenings and at weekends.
- Work in an integrated way with all providers operating within Worcestershire’s drug and alcohol treatment systems and associated services, to deliver a coordinated package of care that includes appropriate aftercare, wrap around and mainstream services to address substance use alongside impacting health, housing, criminal and social issues.
- Ensure an appropriate level of access and support is available to service users with co-existing mental health needs, providing support to service users with mild to moderate needs and working collaboratively with mental health services to support those with severe and enduring mental illness.
- Liaise with Worcestershire’s Children and Family Services especially where there are safeguarding concerns.
- Support the continuing development of shared care arrangements in Worcestershire.

Tier 4

All Tier 4 placements, for detoxification and also residential rehabilitation are delivered out of county. The provider will manage a devolved Tier 4 budget.

The 2011/12 budgets are: still to be confirmed, as an indicative illustration the 2010/11 budgets for adult drug and alcohol users are detailed below:

- Community Care Assessments (within S75 monies) £47,000
- Out of county placements can be inpatient
• detoxification (PTB monies) £32,000
• In patient detoxification (PTB monies) £50,000
• Residential rehabilitation (Community care monies) £109,000

There is no dedicated budget for young people; individual cases will need to be presented to the commissioners as and when they arise.

Location(s) of Service Delivery
The service provider will be flexible and will identify the most appropriate venues in the interest of the service user whilst continuing to ensure effectiveness and efficiency.

Therefore the expectation is that adult clinic sessions will be delivered within the community, providing coverage in:
• Malvern
• Redditch
• Evesham
• Kidderminster
• Worcester

Young people’s services will be delivered at appropriate and separate venues:

There will be an additional expectation that service providers, noting the rural nature of the county, will consider the needs of all communities in Worcestershire and will target resources for example through outreach working or clinics in non-clinical community settings.

Days/Hours of Operation
The service will be accessible at times that can best demonstrate they meet service user need. It is expected that that will include evenings and may include weekends.

Service Budgets
Substitute pharmaceutical drugs and pharmacy costs associated with the delivery of this specification will be met by The Provider. However these will be subject to the service provider undertaking to ensure balancing medical, pharmacological and service user considerations with cost effective and efficient prescribing practices.

The costs of drugs prescribed via shared care arrangements will be met directly by NHS Worcestershire. The dispensing costs for these are met by DH as part of a national contract.

Adult Drug and Alcohol Psychosocial interventions
Service Description
The service provider will support a balanced countywide service system that offers a range of interventions described in both MOC and MOCAM as Tiers 2 and 3:
• Open Access Low Threshold Engagement, Advice, Brief Interventions Psychosocial Interventions and Key working,
• Care Planned Psychosocial Interventions and Key working,
• Care Planned Psychosocial Interventions and Key working to Support Delivery of Pharmacological Interventions.

Eligibility criteria
Service users will be adults who are eligible to receive services based in Worcestershire. They will be:
• People experiencing chaotic or harmful drug and / or alcohol use
• People with complex drug or / and alcohol use problems
• People with physical or psychiatric complications or co-morbidity
Pregnant women with chaotic drug and/or alcohol use

Priority will be given to those defined by the NTA as Problematic Drug Users (PDUs) and those who are physically dependent on alcohol.

The Criminal Justice System creates specific demands and imposes targets on the drug and alcohol treatment system which need to be accommodated in the service.

Services for young people must be delivered separately to adult services; the provider will need to detail specific arrangements in their delivery plan.

In line with current guidance, the service will work with mental health services to ensure a continuity of care for those experiencing co-morbidity (substance use and mental health problems).16

Services will make pro-active endeavours to reach under-represented groups. Many service users are part of families where there are children under the age of 16 years; service providers must incorporate proactive safeguarding arrangements in their delivery plan.

Service delivery

The service provider will be expected to:

- Work in an integrated way with specialist prescribers, GPwSIs and GPs, in support of pharmacological interventions
- Work closely with drug and alcohol inpatient services. There will be clear operational policies and clinical pathways in place to ensure service users receive treatment in the most appropriate setting in accordance with the level of presenting complexity/need.
- Work in an integrated way with all providers operating within Worcestershire’s drug and alcohol treatment systems and associated services, to deliver a coordinated package of care that includes appropriate aftercare, wrap around and mainstream services to address substance use alongside impacting health, criminal and social issues.
- Ensure an appropriate level of access and support is available to service users with co-existing mental health needs, providing support to service users with mild to moderate needs and working collaboratively with mental health services to support those with severe and enduring mental illness.
- Liaise with Worcestershire Children and Family Services especially where there are any safeguarding concerns.

Criminal Justice Programmes

The integrated Criminal Justice Interventions Team will deliver services to both drug and alcohol users, this will usually be responding to a court order but will also include other interventions with offenders. The service will incorporate criminal justice programmes, namely delivery of treatment to offenders on Drug Referral Requirements (DRRs) and Alcohol Treatment Requirements (ATRs):

The service will provide treatment and testing services in order to meet the DRR of the Community Order following the implementation of the Criminal Justice Act 2003. Sections 209 to 211 of the Act particularly apply and will need to be delivered in accordance with Probation National Standards 2007.

The service must acknowledge the National Offender Management Service’s target set for the West Midlands Probation Area on an annual basis for DRR commencements and successful completions. Worcestershire will also have targets set for DRR commencements and successful completions which the service will have to meet.

The service will need to meet the following specific requirements of a DRR/ATR:

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• Mandatory drug testing and regular review of the offender’s progress in court – contributing to the DRR/ATR joint court review
• Joint reviews of offender cases taking place between the Probation Offender Manager and treatment provider within ‘local surgeries’
• 3-way review meetings taking place between the Probation Offender Manager, treatment provider and offender as a minimum at the 16 week stage to align with National Standards.
• Contributing to the risk management of offenders and sharing appropriate risk information in a timely fashion
• Data checking of DRR/ATR commencements and completions against Probation data on a monthly basis
• Assessing offenders to determine suitability for treatment under a DRR/ATR.

The service will provide an arrest referral service across the County for both drug and alcohol users.

The treatment system will work in partnership with the Criminal Justice System to support the offender management process, with the aim of stabilising substance misuse and reducing reoffending. The provider will proactively respond to the management of PPO’s and other high crime causing offenders.

**Integrated Drug Treatment System (IDTS)**

The service provider will seek a service users consent to inform HM Prison Service of their care, should the service user be remanded or detained in custody. The provider will make proactive endeavours to respond effectively to the prescribing and care plan needs of all prisoners on release. NB This should include access to prescribing clinics and appropriate dispensing on Fridays which is the busiest day for releases.

The provider will as requested, engage with the Multi Agency Public Protection Panel (MAPPA) and The Multi-Agency Risk Assessment Conference (MARAC). In addition the provider will liaise and seek support where they have concerns in respect of either serious sexual or violence offenders (MAPPA) or perpetrators of Domestic Violence (MARAC)

**Location(s) of Service Delivery**

The service provider will be flexible and will identify the most appropriate venues in the interest of the service user whilst continuing to ensure effectiveness and efficiency.

Therefore the expectation is that adult clinic sessions will be delivered within the community, providing coverage in:

- Malvern
- Redditch
- Evesham
- Kidderminster
- Worcester

There will be an additional expectation that service providers will consider the needs of all communities in Worcestershire and will target resources for example through outreach working or clinics in non-clinical community settings.

**Days/Hours of Operation**

The service will be accessible at times that can best demonstrate they meet service user need. It is expected that that will include evenings and may include weekends.
Substance Misuse Needs Assessment

Adult Harm Reduction Services

Service Description
Harm Reduction Services are described separately to highlight their importance; a harm reduction approach should be incorporated into all aspects of service delivery. The method of delivery will need to reflect best practice in responding to the diverse needs of adult drug users and young substance users.

Needle and Syringe Programmes and harm reduction initiatives are developed within a wider approach that advocates the following hierarchy of goals:

- Stopping sharing injecting equipment
- Moving from injectable to oral drug use
- Decreasing drug/alcohol use
- Abstinence from drugs and alcohol.

Key references include:
- Best practice in Harm reduction, NTA (2008)
- Needle and syringe programmes: providing people who inject drugs with injecting equipment, NICE (2009)

Harm reduction services is one of many areas of work where service users can be extremely effective delivery partners and will have a valuable contribution to service design.

Drug and alcohol related death
The provider will do all in their power to reduce the incidence of drug and alcohol related deaths.

Drug and alcohol related death should be viewed as far more than acute poisoning and the response to drug/alcohol related death needs to include efforts to reduce long-term physiological damage which reduces life expectancy. (Examples may include education and awareness campaigns in needle exchanges to reduce the incidence of femoral injecting).

Proactive steps will be taken to prioritise people immediately on release from prison. This is a time of exceptionally high risk of accidental drug overdose.

Proactive steps will be taken to re-engage those who exit treatment in an unplanned manner, especially where this occurs during or after detoxification.

The provider will, contribute to any relevant Confidential Enquiry Process.

Wellbeing
Where there are concerns about either vulnerable adults or vulnerable children, the provider will take appropriate safeguarding measures.

100% of service users will be subject to a health check as part of their initial assessment for any structured or semi structured intervention (Tiers 3-4 and also the more structured end of Tier 2).

Allied to this are interventions which impact directly on the quality of life by reducing ill health. (Examples may include vitamin B treatment to reduce the incidence of Korsakoff’s Syndrome amongst chronic drinkers.)

Infection control is not limited to interventions in respect of blood borne virus associated with shared injecting equipment. The lifestyle of some service users exposes them to increased risk of exposure to infections such as Hepatitis B and Tuberculosis. These will be addressed by the provider.
For those under the age of 18 years, exchange is a Tier 3 function and in line with guidance including Essential Elements should only follow a comprehensive assessment. “Every effort should be made to encourage all young injectors to change their route of administration”

The section below focuses on Adult Needle and Syringe Programme (NSP). Wider adult harm reduction, alcohol and young person’s related harm reduction should form an integral part of the overall service and providers will be expected to detail their responses in these sections. NSP is distinct and sits alongside both pharmacological and psychosocial interventions so is detailed separately.

**Adult Needle and Syringe Programme (NSP)**

This specification includes the provision of harm reduction interventions within specialist services and also the management and oversight of the pharmacy based NSPs across Worcestershire.

A wide range of services providing NSP will include:

- dedicated needle exchanges and harm reduction services
- community and hospital pharmacies (currently distributing packs, commissioners would prefer to see a ‘pick and mix’ scheme)
- advice, information and support drug services
- accident and emergency departments
- the distribution of emergency injecting equipment by arrest referral workers and others.

May also include:

- detached and peripatetic outreach services
- mobile services
- hostel needle exchanges

The provision of these services includes the distribution of sterile injecting equipment collection of used equipment and their safe disposal, and the ongoing provision of a range of other harm reduction support for the users of services.

There are currently 22 pharmacies engaged in the scheme and 5 Tier 2 outlets.

**Eligibility Criteria**

These are open access services with the route in being by self-referral.

**Service delivery**

Pharmacy outlets are intended to have reduced barriers to access, so any screening needs to be limited, however well trained staff should be able to ask a few questions and include brief harm reduction advice in transactions.

Tier 2 exchanges will conduct a fuller assessment and health check on initial visit and regularly offer detailed injecting and harm reduction advice. This will require access to suitably qualified staff.

The provider will be responsible for procuring and distributing a range of equipment that reflects contemporary best practice advice and legislation. Distribution will include supply of pharmacy packs and then direct supply to injectors in a range of settings.

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17 Needle Exchange for Young people under 18 years old: a framework for providing needle exchange to young people. DrugScope (2005)
Location(s) of Service Delivery

The service provider will be flexible and will identify the most appropriate venues in the interest of the service user whilst continuing to ensure effectiveness and efficiency.

Therefore the expectation is that services will be delivered within the community; services are currently located at:

Tier 2 service delivered in:
- Malvern,
- Kidderminster
- Evesham
- Worcester
- Redditch

There will be an additional expectation that service providers will consider the needs of all communities in Worcestershire and will target resources for example through outreach working or clinics in non-clinical community settings. These provisions will need to be incorporated within the overall budget, agreed with commissioners and incorporated in the final contract.

Days/Hours of Operation

The Tier 2 service will be open access with drop in facilities, available at times that can best demonstrate they meet service user need. It is expected that that will include evenings and may include weekends. Providers will need to submit details of intended operation times in their delivery plan, which will be agreed with commissioners and incorporated into the final contract.

Pharmacy providers should provide a range of extended opening hours.

Response Time and Prioritisation

The response should be immediate.

Priority groups include:

“Injectors who are under-using the service; this includes but is not limited to:
- women
- amphetamine and cocaine/crack injectors
- minority ethnic injectors
- younger injectors (see below for more information)
- injectors in rural areas
- injectors who have characteristics associated with high risk injecting practices:
  - poly-drug users (including use of opiates, stimulants, benzodiazepine and alcohol)
  - people with severe drug dependence
  - frequent injectors
  - people who have spent time in prison, especially those released from prison
  - people who have left residential rehabilitation and those who have left in-patient facilities.
  - people who spend more time with other injectors
  - homeless or people in poor accommodation
  - those with a sexual partner who is an injector
  - those out of treatment
  - injectors who have to travel to other areas to receive clean injecting equipment”

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Appendix 3 – References Informing Service Specification and Delivery Principles

Below is a list of some of the key references, guidance informing this service is not limited to these documents:

Alcohol

- Models of care for adult alcohol misusers (MoCAM), DH. (2006)
- Review of the Effectiveness of Treatment for Alcohol Problems, NTA (2006)

Commissioning

- Commissioning Standards. Drug and Alcohol Treatment and Care, SMAS (2000)
- Improving services for substance misuse Commissioning drug treatment and harm reduction services, Healthcare Commission and NTA (2008)

Families

- Hidden Harm, Responding to the needs of children of problem drug users, ACMD (2003)
- Carers at the heart of 21st century families and communities, DH (2008)
- Think Family: Improving the Life Chances of Families at Risk, Cabinet Office (2008)
- Safeguarding the children of drug misusing parents guidance, NTA, DoH, DCSF (2009)
- Joint Guidance on Development of Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services, NTA, DCSF, DH (2009)

Drugs

- Models of Care, NTA (2002)
- The International Treatment Effectiveness Project. Implementing psychosocial interventions for adult drug misusers, NTA (2007)
- NTA Business Plan 2009-10

General

- QuADS, Quality in Alcohol and Drug Services, Alcohol Concern & SCODA (1999)
- Standards for Better Health, DH. 2004 (updated 2006)
- Local government and Public Involvement in Health Act 2007
- DANOS. Skills for Health, (Various)
- NICE guidance, (Various)
Harm Reduction

- Needle Exchange for Young people under 18 years old: a framework for providing needle exchange to young people, DrugScope (2005)
- Needle and syringe programmes: providing people who inject drugs with injecting equipment, NICE (2009)

Criminal Justice

- Priority and Prolific Offenders – Maximising the impact, HO/MoJ (2009)
- Cutting crime two years on, HO (2009)
- Prisons Integrated Drug Treatment System Continuity of Care Guidance, DH/MOJ (2009)

Mental Health


Pharmacological Interventions

- Clinical governance in drug treatment: A good practice guide for providers and commissioners, NTA (2009)
- Guidance for the pharmacological management of substance misuse among young people, NTA/YJB (2009)
- Alcohol Use Disorders – clinical Management, NICE (Due June 2010)

Young People

- Health Advisory Service (HAS) Four Tiers for YP Substance Misuse Treatment, DH (2001)
- Young People’s substance misuse treatment services – Essential Elements, NTA (2005)
- You’re Welcome Quality Criteria, DH (2005)
- Every Child Matters: Change for Children Young People and Drugs, DCSF (2006)
- Assessing Young People for Substance Misuse, NTA (2007)
- Community-Based Interventions to Reduce Substance Misuse Among Vulnerable and Disadvantaged Children and Young People, NICE. (2007)
- Community Based Interventions to Reduce Substance Misuse among Vulnerable and Disadvantaged Children and Young People, NICE (2007)
- Key Elements of Effective Practice: Substance Misuse, YJB, (2008)
- Young People’s Specialist Substance Misuse Treatment: Exploring the Evidence, NTA (2008)
- Healthy Children, Safer Communities, DoH/MoJ/HO/DCSF (2009)
- Guidance for the pharmacological management of substance misuse among young people, NTA/YJB (2009)
Appendix 4 – Service Outcomes

Table 18 - Young People’s Outcomes

<table>
<thead>
<tr>
<th>Service User Milestone</th>
<th>Total</th>
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<td>Halo</td>
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<tr>
<td>Initial Assessment</td>
<td>225</td>
<td>0.9</td>
<td></td>
<td></td>
<td>Halo/case file</td>
</tr>
<tr>
<td>Complete Brief</td>
<td>75</td>
<td>0.33</td>
<td></td>
<td></td>
<td>Halo/case file</td>
</tr>
<tr>
<td>Intervention</td>
<td>68</td>
<td>0.9</td>
<td></td>
<td></td>
<td>Increased score &amp; user feedback</td>
</tr>
<tr>
<td>Service user completes</td>
<td>150</td>
<td>0.66</td>
<td></td>
<td></td>
<td>Halo/NDTMS</td>
</tr>
<tr>
<td>BI and able to describe relevant harm reduction technique</td>
<td>120</td>
<td>0.8</td>
<td></td>
<td>Halo/case file/NDTMS/TOP's/STAR</td>
<td></td>
</tr>
<tr>
<td>Start Tier 3 intervention</td>
<td>180</td>
<td>0.83</td>
<td></td>
<td></td>
<td>Halo/case file/NDTMS/TOP's/STAR</td>
</tr>
<tr>
<td>TOP's for over 16's and recovery star for under 16's</td>
<td>120</td>
<td>0.8</td>
<td></td>
<td>Halo/case file/NDTMS/TOP's/STAR</td>
<td></td>
</tr>
<tr>
<td>Achieve drug free or occasional use</td>
<td>100</td>
<td>0.83</td>
<td></td>
<td>Halo/case file/NDTMS/TOP's/STAR</td>
<td></td>
</tr>
<tr>
<td>Sustain drug free or occasional use for 4 weeks and planned discharge</td>
<td>80</td>
<td>0.8</td>
<td></td>
<td>Halo/case file/TOP's/STAR</td>
<td></td>
</tr>
</tbody>
</table>

TOP/Recovery Star/Outcomes improvements will demonstrate; reduction in days of primary substance, reduction in criminal activity, improvement in quality of life. These will be captured on an individual basis and quality assured against quarterly performance reports.

Adult Drug Outcomes

Table 19 - Adult Drugs Tier 3 Main Funnel

<table>
<thead>
<tr>
<th>Service User Milestone</th>
<th>Total</th>
<th>Conversion</th>
<th>Payment rate</th>
<th>Outcome value</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery plan agreed &amp; identified</td>
<td>1819</td>
<td></td>
<td></td>
<td></td>
<td>Halo/ Case file/NDTMS</td>
</tr>
<tr>
<td>Demonstrate improvement against TOPs</td>
<td>1364</td>
<td>0.75</td>
<td></td>
<td></td>
<td>Halo/case file/NDTMS/TOP's</td>
</tr>
<tr>
<td>Achieve identified goals</td>
<td>1023</td>
<td>0.75</td>
<td></td>
<td></td>
<td>Halo/case file/NDTMS/TOP's</td>
</tr>
<tr>
<td>Achieve drug free/occasional use</td>
<td>329</td>
<td>0.32</td>
<td></td>
<td></td>
<td>Halo/case file/NDTMS/TOP's</td>
</tr>
<tr>
<td>Sustain substance free for 4 weeks and planned discharge</td>
<td>265</td>
<td>0.8</td>
<td></td>
<td></td>
<td>Halo/case file/NDTMS/TOP's</td>
</tr>
</tbody>
</table>
### Table 20 - Adult Drugs Tier 3 Sub-Funnel (Prescribing)

<table>
<thead>
<tr>
<th>Service user Milestone</th>
<th>Total</th>
<th>Conversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Px need identified in Recovery Plan</td>
<td>1376</td>
<td></td>
</tr>
<tr>
<td>Demonstrate improvement against TOPs</td>
<td>1032</td>
<td>0.75</td>
</tr>
<tr>
<td>Achieve identified goals</td>
<td>774</td>
<td>0.75</td>
</tr>
<tr>
<td>Sustain goals for 4 weeks</td>
<td>619</td>
<td>0.8</td>
</tr>
<tr>
<td>Commence detox/reduction regime</td>
<td>402</td>
<td>0.65</td>
</tr>
<tr>
<td>Achieve drug free/occasional use</td>
<td>241</td>
<td>0.6</td>
</tr>
</tbody>
</table>

TOP/Recovery Star/Outcomes improvements will demonstrate; reduction in days of primary substance, reduction in criminal activity, improvement in quality of life. These will be captured on an individual basis and quality assured against quarterly performance reports.

### Table 21 - Adult Drugs Tier 2 (Brief Interventions)

<table>
<thead>
<tr>
<th>Service user Milestone</th>
<th>Total</th>
<th>Conversion</th>
<th>Payment rate</th>
<th>Outcome value</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice &amp; Information</td>
<td>500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention Commences</td>
<td>450</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service user completes BI and able to describe relevant harm reduction technique</td>
<td>400</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 22 - Harm Reduction

<table>
<thead>
<tr>
<th>Service User Milestone</th>
<th>Total</th>
<th>Conversion</th>
<th>Payment rate</th>
<th>Outcome value</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged with centre based Needle Exchange &amp; Harm Reduction Intervention</td>
<td>720</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate reduced risky behavior</td>
<td>576</td>
<td>0.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate Healthcare and/or BBV Intervention</td>
<td>432</td>
<td>0.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer into Tier 3 Recovery Intervention</td>
<td>151</td>
<td>0.35</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOP/Recovery Star/Outcomes improvements will demonstrate; reduction in days of primary substance, reduction in criminal activity, improvement in quality of life. These will be captured on an individual basis and quality assured against quarterly performance reports.

### Alcohol Outcomes - Table 23 - Alcohol Tier 3 Main Funnel

<table>
<thead>
<tr>
<th>Service User Milestone</th>
<th>Total</th>
<th>Conversion</th>
<th>Payment rate</th>
<th>Outcome value</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery Plan identified &amp; agreed</td>
<td>780</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improvement against ?</td>
<td>663</td>
<td>0.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieve identified goals</td>
<td>564</td>
<td>0.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Discharge, drinking at or below safe drinking levels</td>
<td>468</td>
<td>0.83</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 24 - Alcohol Tier 3 Sub-Funnel (Prescribing)

<table>
<thead>
<tr>
<th>Service User Milestone</th>
<th>Total</th>
<th>Conversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detox need identified</td>
<td>234</td>
<td></td>
</tr>
<tr>
<td>Commence community/inpatient detox</td>
<td>211</td>
<td>0.9</td>
</tr>
<tr>
<td>Complete detox</td>
<td>179</td>
<td>0.85</td>
</tr>
<tr>
<td>Sustain drinking at or below safe drinking levels for 4 weeks and planned discharge</td>
<td>153</td>
<td>0.85</td>
</tr>
</tbody>
</table>

### Table 25 - Alcohol Tier 2 (Brief Intervention)

<table>
<thead>
<tr>
<th>Service User Milestone</th>
<th>Total</th>
<th>Conversion</th>
<th>Payment rate</th>
<th>Outcome rate</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice &amp; Information</td>
<td>576</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention Commences</td>
<td>518</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service user completes BI and able to describe relevant harm reduction technique</td>
<td>467</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOP/Recovery Star/Outcomes improvements will demonstrate; reduction in days of primary substance, reduction in criminal activity, improvement in quality of life. These will be captured on an individual basis and quality assured against quarterly performance reports.

### Table 26 – Family Service

<table>
<thead>
<tr>
<th>Service User Milestone</th>
<th>Total</th>
<th>Conversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact with children indicated. Implement stages 1 to 3 of Alex Copello model as part of care plan.</td>
<td>1,069</td>
<td>0.3</td>
</tr>
<tr>
<td>Family intervention assessment completed by family services worker Implement stages 1 to 5 of Alex Copello model.</td>
<td>320</td>
<td>0.3</td>
</tr>
<tr>
<td>Family focused intervention completed</td>
<td>192</td>
<td>0.6</td>
</tr>
<tr>
<td>Connect with appropriate community resource</td>
<td>153</td>
<td>0.8</td>
</tr>
</tbody>
</table>

### Monitoring Requirements

The Client expects that in addition to the specific performance outcome targets, the Contractor will contribute towards the overall aim of the DAAT Partnership – "To reduce the harm that drugs and alcohol cause to individuals, families and communities within Worcestershire" through offering every support for people to choose recovery as an achievable way out of dependency.

In order to monitor activity against this aim, further monitoring by the Contractor will be required against the following key outcomes:

- Reducing drug and alcohol related deaths and ill health
- Reducing drug and alcohol related crime and disorder
- Preventing the problematic use of drugs and alcohol
- Improving access to drug and alcohol treatment and support
- Increasing positive outcomes from drug and alcohol treatment

In addition to key performance reports generated by both the Contractor, and nationally through the NTA and NDTMS, progress will be measured by:

- **The use of recovery tools**: this will provide an evidence base of assessed needs, distance travelled during treatment and outcomes
- **Auditing and spot checks**: this will allow DAAT verification of client experience, progression and care, alongside the specific outcome measures agreed with services
• **External validation**: where possible, progress reported by services will be compared to information held by other services, for instance if someone is reported to no longer be claiming benefits, this may be checked against information held by Job Centre Plus.

The following table sets out the key outcomes that services are expected to deliver against in conjunction with their specific targets for payment by results. It will be expected that progress against these outcome measures will be provided at both a service-wide level, and broken down into key client groups (alcohol, young people, adult drugs and criminal justice).

Failure to meet outcomes and targets may result in a Performance Notice or Non Compliance Notice being issued (see section F5 of contract).

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
<th>Target</th>
<th>Evidence Base</th>
<th>External verification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improving access to drug and alcohol treatment and support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total caseload</td>
<td>Total number in contact with service on an ongoing basis, irrespective of level of intervention Should be able to split this into: • New referrals • Advice only • Tier 2 • Tier 3/4 • PDUs</td>
<td>Monitor Only</td>
<td>HALO, NDTMS monthly reports, NTA summary reports</td>
<td></td>
</tr>
<tr>
<td>Access to treatment within 3 weeks</td>
<td>Length of time between referral and the first appt offered for a structured intervention/treatment</td>
<td>100%</td>
<td>HALO, NTA summary performance reports, spot-check</td>
<td>Service Users</td>
</tr>
<tr>
<td>Proportion of prescribing delivered through shared care</td>
<td>Proportion of people for whom a prescribing need is identified, who receive support in a shared care rather than specialist setting</td>
<td>Continual improvement</td>
<td>Number of GPs involved in shared care, HALO</td>
<td>GPs</td>
</tr>
<tr>
<td><strong>Reducing drug and alcohol related deaths and ill health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of clients receiving appropriate advice and support for general health problems</td>
<td>Proportion of clients with a general health care assessment &amp; the proportion who receive, or are referred to appropriate support</td>
<td>100%</td>
<td>HALO, NTA summary performance reports, spot-checks</td>
<td>Referral to sexual health, GP, Every contact counts, and involvement of health lifestyles, hospital admissions</td>
</tr>
<tr>
<td>Proportion of clients with a completed risk</td>
<td></td>
<td>100%</td>
<td>HALO, Care plans, spot checks</td>
<td>Serious Case Reviews CAF MAPPA/PPO/MARAC</td>
</tr>
<tr>
<td>Measure</td>
<td>Definition</td>
<td>Target</td>
<td>Evidence Base</td>
<td>External verification</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Proportion of clients receiving appropriate advice and support for BBV</td>
<td>Proportion offered Hep B/C interventions &amp; the proportion who then receive an intervention</td>
<td>100%</td>
<td>HALO, NTA summary performance reports, spot-checks</td>
<td>Acute Hospital specialist service</td>
</tr>
<tr>
<td>Increasing positive outcomes from drug and alcohol treatment</td>
<td>Evidence of individualised, tailored treatment options for clients Clients with a personalised care plan &amp; evidence of ongoing review Completion of an appropriate outcome tool (TOPs, Recovery Star)</td>
<td>100%</td>
<td>HALO, evidence use of recovery tools, NTA Monthly TOP reports, spot-checks</td>
<td></td>
</tr>
</tbody>
</table>
| Evidence of positive progression through treatment & distance travelled | Proportion of service users reporting:  
  - a reduction in their substance use & injecting behaviours  
  - improvement in physical and psychological health, and quality of life  
  - improvement in their housing, education and employment Ongoing review of care plans | 80% of YP 75% of Adult Drugs 85% of Alcohol (based on funnels) | HALO, TOPs, NTA quarterly outcomes reports, evidence use of recovery tools                                      | Care Farms, Stonham, St Paul's, Job Centre Plus            |
<p>| Proportion of the treatment population leaving treatment in a planned way | Clients recorded as leaving treatment either drug/alcohol free, or as an occasional user/drinking within sensible limits | 53.3% of YP 14.6% of Adult Drugs 60% of Alcohol 90% Brief Interventions (based on funnels) | HALO, NTA quarterly outcomes &amp; performance reports, evidence use of recovery tools                              |                                                            |
| Onward referral to appropriate support following completion of treatment | Clients who at the end of treatment require further support and are signposted to an appropriate intervention | | HALO, evidence use of recovery tools, spot-checks                                                              | Stonham, FIP, Children's Services (TYS),                    |
| Reducing drug and alcohol related crime and disorder                    |                                                                                                                                                                                                            |              |                                                                                                               |                                                            |</p>
<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
<th>Target</th>
<th>Evidence Base</th>
<th>External verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective engagement of criminal justice clients into treatment</td>
<td>Proportion of referrals from CJS routes who receive appropriate interventions Number of DRR/ATR commencements &amp; successful completions</td>
<td>HALO, West Mercia Probation, TOPs, Partnership Green Report</td>
<td>West Mercia Police, West Mercia Probation, IOM, PPO</td>
<td></td>
</tr>
<tr>
<td>Evidence of positive progression through treatment &amp; distance travelled</td>
<td>Proportion of service users reporting a reduction in their criminal behaviour Proportion of service users reporting improvement in physical and psychological health, and quality of life</td>
<td>TOPs, HALO, NTA quarterly outcome reports</td>
<td>West Mercia Police, West Mercia Probation, IOM, PPO</td>
<td></td>
</tr>
<tr>
<td>Proportion of referrals from CARAT teams for whom follow up action is taken by services</td>
<td>Referrals of alcohol/drug clients from prisons who subsequently receive support in the community</td>
<td>DIRweb, NTA summary performance report, HALO, spot-checks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of offenders leaving treatment in a planned way</td>
<td>Clients recorded as leaving treatment either drug/alcohol free, or as an occasional user/drinking within sensible limits</td>
<td>HALO, NTA quarterly outcomes reports, evidence use of recovery tools</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Monitoring and Review**

To enable the Service to be monitored and reviewed, the Contractor shall;

- Submit monitoring data as specified by the Client.
- Allow the Client access to relevant records and staff.
- Participate in monitoring and review meetings arranged by the Client.
- Allow the Client to access relevant case files for auditing and quality assurance purposes.
Appendix 5 - Creating opiate drug partnership clusters – guidance and methodology

Introduction
This document explains the methodology of how the opiate partnership clusters have been determined and also guidance about their usage.
The clusters provide a sub national grouping that can be used for comparative purposes when considering the outcomes within the DOMES report.

Using the opiate partnership clusters
The partnership clusters have been created to enable partnerships to be able to compare their performance for opiate users with other areas that have similar characteristics in respect to those that seem to influence recovery outcomes.
They should be used as a starting point to identify where they might be significant variation in performance from the cluster group benchmarks. Where there variation identified it is suggested that this is investigated to see why this might be the case and if the causes can be determined and addressed where appropriate.
It may be helpful to share information and knowledge with other partnerships in the cluster about the practice and delivery mechanisms that are in place to support clients with similar profiles to achieve outcomes and to sustain recovery.

Overview of methodology of producing the opiate partnership clusters
As a starting point the variables collected within NDTMS and other external factors such as multiple deprivation indices (IMD), were analysed to see which predicted better or worse performance against the main outcomes include with the DOMES report.
The outcomes used were:
- Successful completions
- Re-presentations
- Abstinence from opiates / crack
- Working
And the factors that were common across these outcomes in terms of predicting performance were identified as:
- Two or more previous unplanned episodes of treatment
- Criminal justice referrals
- Injecting
- Deprivation
- Crack use
- The length of drug using career prior to first treatment presentation
- Rural / Urban
- Housing issues
What could also be determined was how much influence or weighting each factor had in terms of achieving an outcome or not and the list above is ordered in descending order with having more than three previous unplanned episodes being the most significant factor in predicting if an outcome would be achieved or not.
Substance Misuse Needs Assessment

Using the NDTMS data, the IMD scores and the ONS rural / urban descriptors it was then possible to determine the proportion of each of these factors within a partnership. These proportions are included in the accompanying spreadsheet.

The size of the opiate treatment population was also included to ensure that partnerships would be grouped mainly with areas that are similar in terms of commissioning structures and number of providers.

The proportion of each factor was then multiplied by the weighting that each one had in terms of predicting outcomes to get a score for each. So for example if a partnership had 20% of clients that had had three or more unplanned episodes this was multiplied by the weight to give a score for that factor.

All the scores of each factor were then totalled to give an overall score for the partnership. Grouping areas with similar scores together then derived five clusters; these groups can be seen in the accompanying spreadsheet.

**Why the partnership clustering can never be perfect**

While every attempt has been made to ensure that the partnership clustering is as robust as possible, there will be some limitations to making it perfect. These are outlined below as well as the mitigations that have been put in place where it has been possible to do so.

NDTMS does not collect information on some of the factors that potentially could affect the likelihood of achieving outcomes, such as co morbidity, client motivation and peer support networks. It is not possible at this stage to estimate what affect the additional inclusion of these factors might have had on the cluster groups that have been derived.

The methodology to determine the likelihood of an outcome being achieved utilises the triage data collected at the start of a client’s latest treatment journey. For outcomes such as abstinence at six months this closeness in time between the two events (start of treatment and first review) means that the triage information is a very good predictor of the achievement of this outcome.

However for successful completions, this can happen on average about 18 months after commencing treatment, with many clients now having been in for much longer than that, which means that the status of a client at their initial triage may not be as relevant to their likelihood now of leaving treatment successfully or not. This is mitigated to a large extent by the factors used being common across all the outcomes suggesting that they are good in predicting abstinence, working etc which when achieved would then in turn greatly increase the prospects of achieving completion and sustained recovery.

Whenever partnerships or areas are grouped it is impossible to ensure that all the partnerships in the cluster have more in common with all the other partnerships in the cluster rather than a partnership in another cluster by the very fact that at the extremities there will always be partnerships at the top of one group whose overall score is closer to the bottom of another group than to the partnership at the bottom of the group they are in.

This is inescapable without having tens of clusters with only a handful of areas in each, however it has been mitigated as much as possible in the approach used that reshuffles the cut off of each cluster group until each members mean score is closer to the mean of the cluster group they are in rather than the mean of any other group. This is why there are not five groups with 30 partnerships equally in each.

Table 28 below shows all the partnerships in the same cluster as Worcestershire for both opiates and non-opiates.
### Table 28 - Partnerships in Worcestershire’s ‘Cluster’ for both Opiates and Non-Opiates

<table>
<thead>
<tr>
<th>Opiates - Cluster E</th>
<th>Non-Opiates - Cluster B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birmingham</td>
<td>Bedfordshire</td>
</tr>
<tr>
<td>Bolton</td>
<td>Blackburn with Darwen</td>
</tr>
<tr>
<td>Bradford</td>
<td>Blackpool</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>Bromley</td>
</tr>
<tr>
<td>Bristol</td>
<td>Bury</td>
</tr>
<tr>
<td>Camden</td>
<td>Calderdale</td>
</tr>
<tr>
<td>Doncaster</td>
<td>Cambridgeshire</td>
</tr>
<tr>
<td>Gloucestershire</td>
<td>Cheshire</td>
</tr>
<tr>
<td>Hackney</td>
<td>Derby</td>
</tr>
<tr>
<td>Islington</td>
<td>Dudley</td>
</tr>
<tr>
<td>Kingston Upon Hull</td>
<td>East Sussex</td>
</tr>
<tr>
<td>Lambeth</td>
<td>Halton</td>
</tr>
<tr>
<td>Lancashire</td>
<td>Hounslow</td>
</tr>
<tr>
<td>Leeds</td>
<td>Kingston Upon Hull</td>
</tr>
<tr>
<td>Leicester</td>
<td>Kirklees</td>
</tr>
<tr>
<td>Liverpool</td>
<td>Leicestershire</td>
</tr>
<tr>
<td>Manchester</td>
<td>Medway towns</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>Merton</td>
</tr>
<tr>
<td>Newham</td>
<td>North East Lincolnshire</td>
</tr>
<tr>
<td>Nottingham</td>
<td>North Yorkshire</td>
</tr>
<tr>
<td>Nottinghamshire</td>
<td>Oldham</td>
</tr>
<tr>
<td>Sefton</td>
<td>Portsmouth</td>
</tr>
<tr>
<td>Sheffield</td>
<td>Rotherham</td>
</tr>
<tr>
<td>Southwark</td>
<td>Shropshire</td>
</tr>
<tr>
<td>Staffordshire</td>
<td>Slough</td>
</tr>
<tr>
<td>Stoke-on-Trent</td>
<td>Somerset</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>South Gloucestershire</td>
</tr>
<tr>
<td>Wakefield</td>
<td>Southampton</td>
</tr>
<tr>
<td>Westminster</td>
<td>St Helens</td>
</tr>
<tr>
<td>Worcestershire</td>
<td>Stoke-on-Trent</td>
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<td></td>
<td>Swindon</td>
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<td></td>
<td>Warrington</td>
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<td></td>
<td>Wiltshire</td>
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<tr>
<td></td>
<td>Worcestershire</td>
</tr>
</tbody>
</table>

*Source: NDTMS*
<table>
<thead>
<tr>
<th>Location</th>
<th>Organization</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worcester</td>
<td>SPACE - Young person's substance misuse service</td>
<td>SPACE can provide a range of substance misuse services including one to one advice via telephone, face to face or tailored drug or alcohol education sessions, with the emphasis on harm reduction.</td>
</tr>
<tr>
<td>Worcester</td>
<td>Worcester City Council - Detached youth team</td>
<td>Substance misuse workshops provided in a range of educational settings.</td>
</tr>
<tr>
<td>Worcester</td>
<td>YMCA - Young Health champions</td>
<td>Young people aged 16-24 are trained to deliver training in settings such as youth clubs around various health issues.</td>
</tr>
<tr>
<td>Worcester</td>
<td>CRI - Pathways to Recovery</td>
<td>Pathways to Recovery in Worcestershire offers support for adults, young people and families with alcohol and substance misuse problems.</td>
</tr>
<tr>
<td>Worcester</td>
<td>Health Trainer</td>
<td>The health trainer service offers free confidential and convenient support and motivation to people aged 16+.</td>
</tr>
<tr>
<td>Worcester</td>
<td>Street Pastor</td>
<td>Main role is to be available to support, care and listen to help vulnerable people, in particular young people to move in to positive endeavours.</td>
</tr>
<tr>
<td>Worcester</td>
<td>St Pauls Hostel Bromyard Road Project</td>
<td>The need for substance free, safe accommodation has been identified for a number of years. As a result of this and in consultation with contributing agencies, it was decided to establish a substance free house at Bromyard Road. Everyone living at the house has the common goal to live an independent substance free lifestyle.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Pathways to recovery - Inside out</td>
<td>Support for children and young people who have been affected by alcohol abuse.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Acute Hospital NHS Trust</td>
<td>Alcohol Liaison Nurses- provide screening, brief intervention, referral to treatment services for 15-18 year olds attending A&amp;E or admitted to hospital.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Youth Offending Service</td>
<td>Screen all young people for substance misuse and provide tier 2 drug and alcohol brief interventions.</td>
</tr>
<tr>
<td>Redditch</td>
<td>West Mercia Police</td>
<td>Workshops for pre and young drivers includes drink driving messages.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Multi Agency contact local CSP or DAAT</td>
<td>Operation Stay Safe: Run in selected areas on specific dates which link to young people's events e.g. end of exams to approach drinking.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Multi Agency</td>
<td>Targeted education work in Youth Centres and education in school about drugs and alcohol.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Straight Line Project - Youth Support, Police and ASB teams</td>
<td>One to one support, screening, info, advice, guidance to young people caught drinking on the street.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Pathways to recovery</td>
<td>Recovery Café.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Pathways to recovery</td>
<td>A wide range of support, advice and treatment options (inc pressure point and inside out- support for families and young people.</td>
</tr>
<tr>
<td>Redditch</td>
<td>Alcoholics anonymous</td>
<td>Support group.</td>
</tr>
</tbody>
</table>
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