Public Health and Wellbeing

Business Intelligence and Performance Improvement

JSNA 2015 – Drug Misuse Needs Assessment

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**Introduction**

In 2013-14, an estimated 8.8% of all adults in England and Wales used an illicit drug. While not all drug use is problematic, it poses health risks to the individual and roughly 15% of people who use drugs develop dependence.

Addiction and physical dependence occur over a prolonged period of regular use, during which the user slowly develops tolerance towards the substance and eventually begins to suffer withdrawal symptoms if they cease to take it. At this point, taking the substance is prioritised above other behaviours which the user previously considered important, despite this causing physical, psychological or social harm.

Criminality, mental health issues and a family history of substance misuse can increase the likelihood of an individual developing a drug or alcohol dependence. In turn, substance misuse can lead to a combination of:

- An increased risk of developing physical health problems;
- An increased risk of contracting blood-borne viruses (injecting drug users);
- Chaotic lifestyle and behaviour;
- Problems with personal relationships and family breakdowns;
- Criminality and a criminal record;
- Self-neglect;
- Unemployment; and
- Housing issues.

Treating substance misuse therefore requires a broad approach to cover:

- Helping people to recognise problematic patterns of behaviour before they develop into dependence;
- Reducing the personal and societal harms caused by addiction;
- Enabling users to overcome substance dependence;
- Addressing the underlying issues that led to the addictive behaviours;
- Assisting recovering users with reintegration into society; and
- Providing support to family members affected by the user’s substance misuse.

The move of drug and alcohol treatment services into Public Health and Wellbeing within the Local Authority has prompted a review of expected outcomes. This essentially re-focuses the services onto improving the quality and sustainability by meeting the needs of individual clients. Services need to address the causes of addiction both to make treatment more sustainable and to reduce the potential for the spread of addictive behaviours in families and communities.

This chapter will use a combination of local and national data to estimate the level of need for drug misuse services in Northamptonshire, assess the performance of services currently in place, and identify any gaps in service provision.

Throughout this paper, **opiate** users (i.e. individuals using opium or any of its derivatives, such as heroin, methadone, buprenorphine, codeine or tramadol) will be considered separately from **non-opiate** users (i.e. individuals using only non-opiate drugs, such as amphetamines, benzodiazepines, cannabis, cocaine, crack, ecstasy, hallucinogenics or inhalants). This is due to the two client groups having different treatment
needs; opiate use typically leads to more entrenched problems, including injecting, poly-drug use and criminal behaviours.

Local data have been used in this paper to supplement nationally produced statistics in order to provide added depth and context where relevant. It should be noted that locally produced figures will never exactly match official statistics due to differences in the base dataset and methodology used.

The commissioners of Northamptonshire’s substance misuse services are working closely with a range of organisations and agencies to obtain feedback that will inform future commissioning decisions. Appendix 1 provides a list of all parties involved in planning events and otherwise consulted during the preparation of this Needs Assessment.

**Key points**

**Statistics on treatment performance have been impacted by the recent recommissioning of services**

In February 2013, Northamptonshire’s treatment system was recommissioned and moved from a multi-agency model to CRI being the sole provider of recovery orientated treatment for drug and alcohol misuse. The initial transition caused some disruption, and it has taken many months to embed new values with both staff and the clients inherited from the old system.

It was anticipated that performance in relation to treatment outcomes would be affected while the old agencies wound down and CRI settled in – Public Health England confirm that retendering usually depresses successful completions indicators for up to a year – but there have been compounding factors that have delayed CRI in achieving their full potential:

- The number of clients in structured treatment was underreported by previous agencies and CRI inherited a larger client base than anticipated;
- It took more than a year to acquire appropriate premises for CRI’s Kettering branch;
- Responses to CRI’s recruitment drives have been poor – similar problems have been reported within Northamptonshire’s adult social care services;
- New presentations to treatment for alcohol and non-opiate use have increased significantly, which reflects well on the numbers accessing treatment but has had a negative impact on the performance indicators for these client groups that consider successful completions as a proportion of clients treated; and
- CRI have taken responsibility for managing Shared Care services through GPs, which have historically interfaced poorly with treatment services. Shared Care clients tend to be less likely to successfully complete treatment as these services are more suited for maintaining co-morbid opiate clients on methadone long-term than facilitating recovery.

**Northamptonshire has a growing treatment population**

Nationally, the numbers of opiate users accessing treatment services each year has been decreasing since 2008-09. Between 2012-13 and 2013-14, the England treatment population of opiate clients decreased by 1.9%, while according to the same measures the Northamptonshire opiate population has remained stable.

At the same time, figures from the National Drug Treatment Monitoring System (“NDTMS”) up to the end of 2013-14 show that the numbers of clients receiving treatment for non-opiate and/or alcohol misuse have increased dramatically since the recommissioning to CRI, and local figures suggest they have
continued to grow between then and the time of writing. While this is partly due to a review of client consents to NDTMS data sharing and improved data recording, there has also been a significant increase in new presentations to treatment for these client groups. Between February 2013 and March 2014, the yearly total clients treated for sole alcohol use more than doubled from 376 to 968, and the yearly total clients treated for non-opiate use more than quadrupled from 130 to 540. As CRI provide treatment for both alcohol and drug use disorders, the influx of alcohol clients impacts on the treatment system as a whole.

**CRI and Bridge have created a fresh environment for substance misuse clients in the county**

Since the recommissioning, CRI have implemented many positive changes to improve perceptions of treatment and client engagement:

- All of CRI’s premises have been refurbished to provide a bright, welcoming environment for service users;
- Clients are automatically referred to recovery support services;
- New clients are intensively engaged for the first 12 weeks of treatment to capitalise on their initial motivation;
- Clinicians are departing from old maintenance models used to treat opiate users and abstinence is offered as an alternative to opioid substitution therapy;
- Clients receiving opioid substitution therapy are encouraged to reduce their dosage and eventually cease use entirely; and
- Clients receiving opioid substitution therapy are engaged in psychosocial interventions, whereas under the previous system it was possible for clients to have no involvement with services other than collecting their prescriptions.

Also, as part of the recommissioning process Bridge became the main provider of recovery support services in Northamptonshire and started taking direct referrals from CRI. Bridge is a peer led organization specifically helping individuals build their own recovery from substance abuse with support from peers, some of whom are trained mentors. A client’s recovery starts when they decide to quit and Bridge’s role is to provide support during that process as part of the client’s overall treatment. Bridge have worked to expand their coverage and some of their peer mentors are crossing over into other services to make recovery visible and provide support as required.

**Bridge Service User Feedback**

“Today I know I have a future.”

“I’m feeling on top of the world.”

“It’s nice to feel appreciated and to be part of something good.”

"I am grateful for all support I received. You helped me out more than any other foundations."

"It gives me a reason to get up in the morning and there is always new challenges and activities changing to keep things fresh."

"I can't fault it. Keep doing what you're doing. Please."
**Key early priorities**

**Consult with users to obtain feedback to inform future service provision**

At the time of writing, commissioners are looking to develop ways in which service users can provide feedback regarding their experiences, both positive and negative, in ways that can inform the future direction of travel. A user group has been developed (Sunset) to collect and collate views from across all the drug and alcohol services in the county.

**Ensuring ongoing sustainability of treatment provision under the current contract**

The number of clients receiving treatment is much higher than was originally accounted for in CRI’s contract. While CRI are performing well within their budget at the time of writing, if the treatment population continues to grow it may be necessary to invest more funds to ensure that a high quality of treatment can be maintained.

**Improving outcomes for entrenched/treatment experienced opiate clients**

Local data shows that 72.3% of opiate clients in treatment on 1 November 2014 have been in treatment at least once before. Previous treatment experience has been evidenced both locally and nationally to have a negative impact on the likelihood of a client successfully completing treatment. Also, 37.3% of opiate clients had been in treatment for more than 2 years on 1 November 2014. These clients will have different expectations and perceptions of treatment to clients accessing services for the first time (“treatment naive”), and further work is required to determine how best to maximise their prospects of successfully completing treatment.

**Safeguarding and supporting families of service users and building a model for future family-based services**

Historically, the focus of substance misuse treatment has centred around the user. However, substance misuse is a complex issue that can impact on both adults and children in contact with the user and disrupt families. While some services are provided locally to support families affected by substance misuse, the capacity of these services and the number of families they work with are limited. Further work is required ahead of the next commissioning cycle in 2017 to determine the level of demand for family services and assessing how these can be embedded in the treatment system to provide a holistic approach.

**Developing drug-free communities in Northamptonshire**

Families and communities can have a significant impact on how a client responds to treatment and their likelihood of relapsing. Through Bridge and user groups like Sunset, commissioners are looking to encourage the development of local, culturally sensitive support networks and family groups that can help each other maintain drug-free lifestyles. These initiatives are currently small-scale and will need to be expanded.

**Reviewing pharmacy-based services**

Pharmacies have high volumes of client contacts and it is recognised that they could play a more significant part in the overall health agenda. From a substance misuse perspective, pharmacies could act as an access point for information regarding drugs and alcohol and the services available to those who may need them. Action to achieve this is currently under consideration.
Expanding Needle Exchange services and ensuring they are effective at reducing the spread of blood borne virus infections, and considering introducing a supply of foil in line with current guidance from the Advisory Council on the Misuse of Drugs (“ACMD”)  

The aim of Needle Exchange is to ensure that there are sufficient clean needles available for all injecting drug users in the county in order to eliminate the need to reuse or share injecting equipment, as contaminated injecting equipment can spread blood borne viruses such as Hepatitis B, Hepatitis C and HIV. Although the data available at the time of writing are not complete, they suggest that there is a shortfall in provision that will need to be addressed.  

Legislation was introduced in 2014 to allow drug services to provide users with aluminium foil for the purpose of smoking drugs, with the aim to provide an alternative to injecting in the context of a treatment intervention. This has not as yet been implemented in Northamptonshire. While encouraging the smoking of drugs could be considered to contradict other Public Health aims, the risks of injecting are such that transitioning users to smoking instead would provide an overall health benefit. Furthermore, such a scheme would create an additional, graduated pathway into treatment for injecting drug users.  

Develop a Needle Exchange policy for under 18s who inject drugs in line with NICE guidance  

At present, Needle Exchange services are aimed at adult injecting drug users. Commissioners are looking to investigate the potential need for needle provision amongst young people and develop a policy for this. It is envisaged that there may be some demand in relation to the injecting of image enhancing drugs and steroids.  

Ensuring equal access to services across the county  

There is currently a geographical inequality in the provision and accessibility of substance misuse services in Northamptonshire. In particular, there are no CRI offices or Needle Exchange pharmacies located in South Northamptonshire. Accessibility of services for people living in South Northamptonshire is poor, especially for those reliant on public transport, and this may act as a barrier to entering treatment. Further work is required to determine the potential demand for services and investigate the feasibility of expanding services to improve coverage across the county.  

Reviewing Shared Care services and working more collaboratively with GPs  

Analysis of local data has shown for several years that opiate clients in Shared Care, i.e. having their opioid substitution therapy managed by a GP, have a significantly reduced chance of successfully completing treatment. This is likely a result of GPs being remunerated in a way that effectively incentivises maintaining clients in treatment indefinitely, which is at odds with the focus on recovery found in the rest of the treatment system.  

CRI have taken over the management of Shared Care provision and are at the time of writing undertaking a review of which clients currently in Shared Care would benefit from being moved back into generic treatment. 379 Shared Care clients were migrated to CRI, of which 43 (11.3%) had been transferred from primary care to community treatment as at 31 October 2014. In total, there were 301 Shared Care clients in treatment on 31 October 2014.  

While Shared Care does not offer clients the best prospect for achieving abstinence, some clients may be best suited for long-term maintenance on opioid substitutes, and/or require concurrent treatment for comorbid conditions. Further work is required to determine the future form of Shared Care, and if these services are maintained there will need to be an agreement with GPs over the outcomes expected from them.
Reducing drug-related deaths, to include introduction of a strategy for Naloxone provision

Naloxone is a drug used in emergency situations to counter the effects of an opiate overdose. Take-home naloxone can be prescribed to individuals at risk of overdose, and in the event of an overdose would be administered by a carer or peer until emergency services arrive. Commissioners in Northamptonshire are seeking to implement prescription of naloxone as standard to opiate users accessing treatment services as part of a broader project to reduce numbers of drug-related deaths in the county.

A review of drug and alcohol related deaths is set to commence in 2015-16.

Improving Public Health’s understanding of the availability and usage patterns of Novel Psychoactive Substances (“NPSs”)

Novel Psychoactive Substances, also referred to as “legal highs”, have been making newspaper headlines and generating concern within Public Health with regards to the potential harms and proliferation of these drugs. The key issue with NPSs is the speed at which new drugs are manufactured, the effects of which are not fully understood. This makes it difficult to treat cases where they have resulted in poisoning, as it may not be possible to ascertain the type of substance the individual had taken.

While local partnerships are aware of “head shops” that sell NPSs and can take action through Trading Standards, distribution also takes place through internet shops. It is difficult to determine the extent to which these substances are being used. Treatment services are starting to see some presentations for NPSs, but this tends to be amongst young people or, in adults, concurrent with other illicit drug use. This is a rapidly evolving area and commissioners are still in the process of collating enough evidence to develop a strategy on how to deal with local issues relating to NPS use and distribution.

It is also important to obtain some perspective of the scale of the issue, as there is a risk that focusing on NPSs detracts attention from trends in other harmful drug use. For example, nationally, there has been an overall increase in the number of presentations for cannabis use since 2006-07, particularly amongst clients aged under 25.

Education of front line staff

“Healthy Futures”, a programme consisting of delivering drug and alcohol awareness sessions to front line staff working with people over the age of 45 years of age, was launched in December 2013 through Aquarius and at the time of writing over 1,000 people from the Voluntary and Statutory sectors have attended the training. The aim for 2015-16 is to increase the pace of change and the penetration of this approach across Northamptonshire.

Developing Acute Liaison Service for substance misuse in hospitals

At the time of writing, work is underway to expand the Alcohol Liaison Nurse services in Northampton and Kettering General Hospitals to work with patients admitted with drug misuse and/or mental health issues. This will provide an additional pathway to treatment services through the hospitals and A&E departments.

Recommendation: Integrated working within the Public Sector

Commissioners should be working to completely integrate substance misuse services into the full range of adults’, children’s and safeguarding services provided by Northamptonshire County Council, to include consultation on improving the quality and effectiveness of services for Northamptonshire’s population.
Why is drug misuse an important health issue in Northamptonshire?

Substance misuse puts the individual’s health at risk

There are a wide variety of health harms related to substance misuse, which vary depending on the type of drug being used and the method of administration. These harms may not be reversible; some drugs carry the risk of poisoning and death due to overdose.

Injecting drugs is a particularly high risk behaviour. Injectors are at risk of vein damage, infections at injection sites, and sharing of injecting equipment can lead to the spread of blood borne viruses such as Hepatitis B, Hepatitis C and HIV. Roughly two in every five people who inject psychoactive substances are living with Hepatitis C, and half of these infections are undiagnosed.

Substance misuse can also result in indirect health harms caused by behavioural changes. For example, the acquisition and use of drugs may be prioritised over nutrition, self-care and the care of others.

Substance misuse interventions lead to better Public Health outcomes across a wide variety of areas

Treating substance misuse mitigates the risks of drug-related health issues developing or worsening. Some health harms may be treated, and contact with drug and alcohol services may increase the chances of an individual accessing other services that can improve their overall health and wellbeing.

As a result, treatment services contribute to a wide range of outcomes on the Public Health Outcomes Framework.

Illicit drug use can lead to poisoning and death

In 2013-14, there were 199 hospital admissions in Northamptonshire with a primary diagnosis of poisoning by an illicit drug. This is similar to the 194 seen in 2012-13. Locally, this type of admission was more common amongst females than males, while nationally there were more admissions for males than females. The rate of admissions for Northamptonshire was similar to that for the East Midlands (28 and 25 per 100,000 population, respectively).

Due to death registration delays caused by coroner inquests, it is difficult to obtain a timely measure for the number of deaths caused by substance misuse in a given year. For example, just over half of all drug-related deaths registered in England and Wales in 2013 occurred in years before 2013.

Local analysis provided by the NDTMS East Regional Team shows that there were an average of around 14 drug-related deaths in Northamptonshire per year between 2009 and 2011. According to the National Programme on Substance Abuse Deaths, there were an average of 24 deaths per year for the same period, and 18 drug-related deaths in 2012. It is clear that the definitions and methodology used will affect how many deaths are captured by these measures.

56% of all deaths related to drug poisoning registered in England and Wales in 2013 involved an opiate drug. Deaths from opiate use may be prevented through treatment or by early administration of naloxone, a drug that counters the effects of opiate overdose. Commissioners are aiming to make naloxone available on prescription to individuals at risk of opiate overdose.
Health Harms Caused by Drug Misuse

- Depression, anxiety, psychosis and personality disorders
- Lung damage from drugs and tobacco
- Vein damage among injectors
- Blood borne viruses among injectors
- Arthritis and immobility among injectors
- Liver damage from untreated or undiagnosed hepatitis
- Harm to unborn babies
- Damage to kidneys and bladder
- Heart disease
Areas of the Public Health Outcomes Framework affected by substance misuse treatment

** Contribution Through Increased Access to Other Health Services

<table>
<thead>
<tr>
<th>Preventable sight loss</th>
<th>Under 18 conceptions</th>
<th>Recorded diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment completion for TB</td>
<td>Smoking status at time of delivery</td>
<td>Smoking prevalence - adult (over 18s)</td>
</tr>
<tr>
<td>Population vaccination coverage</td>
<td>Breastfeeding</td>
<td>Cancer screening programmes</td>
</tr>
<tr>
<td>Chlamydia diagnoses (15-24 year olds)</td>
<td>Access to non-cancer screening programmes</td>
<td>Cancer diagnosed at stage 1 and 2</td>
</tr>
</tbody>
</table>

** Health Protection

People presenting with HIV at a late stage of infection

** Healthcare, Public Health and Preventing Premature Mortality

- Mortality from causes considered preventable
- Mortality from communicable diseases
- Mortality from respiratory diseases
- Mortality from cardiovascular diseases
- Mortality from cancer
- Mortality from liver disease
- Excess under 75 mortality in adults with serious mental illness
- Infant mortality
- Suicide
- Hip fractures in over 65s
- Emergency readmissions within 30 days of discharge from hospital
- Health-related quality of life for older people

** Substance Misuse Treatment Specific

- Successful completion of drug treatment
- Alcohol-related admissions to hospital
- People entering prison with substance dependence issues who are previously not known to community treatment

** Health Improvement

- Falls and injuries in the over 65s
- Excess weight in adults
- Diet
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- Self-reported wellbeing
- Low birth weight of term babies
- Emotional wellbeing of looked after children
- Hospital admissions as a result of self-harm
- Take up of the NHS Health Check Programme by those eligible

** Improving the Wider Determinants of Health

- Pupil absence
- Killed or seriously injured casualties on England's roads
- Children in poverty
- First time entrants to the youth justice system
- Older peoples' perception of community safety
- Re-offending
- Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness
- 16-18 year olds not in education, employment or training
- Domestic abuse
- People in prison who have a mental illness or significant mental illness
- Statutory homelessness
- Sickness absence rate
- Violent crime (including sexual violence)
There are links between substance misuse and mental health issues

Around 30% of people accessing community mental health services can be expected to have problematic illicit drug use that meets the referral threshold for substance misuse services.

People with mental health issues may turn to drugs as a coping mechanism, which can lead to misuse and dependence. Also, substance misuse can exacerbate existing symptoms and even lead to the development of mental health disorders.

In 2013-14, there were 371 hospital admissions in Northamptonshire that had a primary or secondary diagnosis of drug-related mental health or behavioural disorders. This is up from 318 in 2012-13. Male patients accounted for two thirds of these admissions, which is similar to the national figures. Northamptonshire’s rate of drug-related mental health admissions was roughly half that for the East Midlands as a whole, with a rate of 53 admissions per 100,000 population compared to 101 per 100,000 for the East Midlands.

Historically, Northamptonshire’s mental health services have not always treated clients with concurrent substance misuse (“dual diagnosis”), requiring that the substance misuse problems be dealt with first. This approach does not benefit the patient and, while progress has been made to rectify the issue, users who have been exposed to this either first-hand or through word of mouth may not be accessing the mental health treatments they require as a result.

Substance misuse disrupts families and can have a profound impact on children

NDTMS statistics show that 668 (33.2%) of the 2,010 adult clients who received structured treatment for drug misuse in 2013-14 reported living with children some or all of the time. This is similar to the national total of 32%. However, there is likely to be an element of underreporting in this area as some clients may be reluctant to disclose the fact that they are living with children, for example due to the fear that social services will take the children into care.

Local figures suggest that the clients in substance misuse treatment who report living with children have on average 1.8 children each.

Substance misusing parents may be unable to provide their children with a safe, stable and caring home environment. This can lead to a variety of physical and psychological harms; also, children of substance misusers may be 7 times more likely to become substance users themselves than children from families without substance misuse issues.

Substance misuse may also cause or accelerate family breakdown – 499 (24.8%) of adult drug users treated during 2013-14 were parents not living with children.

The current model of treating substance misuse focuses on the substance users themselves, and while treatment can improve a user’s stability and ability to look after any children they are in contact with, it leaves emotional issues within the family unaddressed. In Northamptonshire, the charity Family Support Link is commissioned to provide additional support for families of substance misusers, and between 1 April and 31 December 2014 they received a total of 121 referrals. Long-term, commissioners aim to expand family support services and create a new model for providing substance misuse treatment that integrates these services. Further intelligence regarding recovery in families is required in order to support this.
Substance misuse impacts on communities

Addicted drug users commonly resort to acquisitive crime to fund their habits. In 2003-04, drug-related crime cost England and Wales an estimated £13.9 billion, which was around 90% of the total estimated cost of drugs to society. This figure includes both the costs incurred by the victims of crime and Criminal Justice services.

Problematic Class A drug use accounts for 99% of the estimated costs of drug-related crime. Criminal Justice Centres (CJCs) test for Class A drugs when a suspect has been arrested for a “trigger offence.” Trigger offences include robbery, burglary, possession of drugs and vehicle taking. According to local data from the two CJCs in Northamptonshire, there were 738 cases in 2013-14 where the drug test results were positive for Class A substances, and 51.6% of these were positive for opiate use. 490 individual clients tested positive, 128 of which (26.1%) of which did so on multiple occasions.

From May 2015 there will no longer be drug testing for clients arrested for trigger offences due to loss of funding. A new pathway based on voluntary referrals is set to be introduced. This is likely to impact on the number of offenders entering structured treatment.

Geographical mapping of clients based on local data (see page 24) shows that 39.6% of all opiate users in Northamptonshire who received treatment with CRI between 1 February 2013 and 31 October 2014 lived in one of the 20% most deprived Lower Super Output Areas (LSOAs) in England. Furthermore, drug treatment clients tended to live clustered in urban environments. In areas with a higher prevalence of problem drug use, volumes of crime may be increased as a result, further impacting on deprivation and community safety.

The paraphernalia of drug use can also pose problems. Improper disposal of injecting materials creates a hazard to other members of the community due to the risk of blood borne virus infections spreading through accidental contact with contaminated sharps. Also, litter containing used injecting equipment is unsightly and may give an area or neighbourhood a negative image.

Nationally, the cost benefit to society of providing treatment for drug misuse is estimated at £2.50 for every £1 spent. NDTMS value for money estimates for Northamptonshire show a £3.27 cost benefit for every £1 spent on treatment services in 2012-13, and the number of crimes prevented locally in 2012-13 was estimated at 45,731.

What is the local picture?

Prevalence of substance misuse

There were an estimated 3,124 opiate and/or crack cocaine users (OCUs) aged 15 to 64 living in Northamptonshire in 2011-12, and 910 injecting drug users. There has not been any statistically significant change to these prevalence estimates compared to the previous two years, and the prevalence rate by population calculated based on 2011 census figures is not significantly different from the England total.

OCUs are the most complex clients to treat as they tend to have more entrenched problems, including injecting, poly-drug use and criminal behaviours. Treatment for opiate addiction generally involves the prescribing of substitute medications to manage withdrawal and opiate clients may spend years in treatment.

According to local data, a total of 2,185 OCUs have received structured treatment in Northamptonshire between 1 April 2011 and 31 March 2014. This would suggest that there may be 939 OCUs in the county who have not been in contact with treatment over the past 3 years.
Comparison of OCU estimates and clients known to treatment, based on NDTMS data and local treatment figures

Estimated 3,124 opiate
and/or crack users in
Northamptonshire in 2011-12

939 (30.1%)
not treated since 1 April 2011

1,294 (41.1%)
in treatment on 31 March 2014

295 (9.4%)
completed and not returned

596 (19.1%)
Exited unsuccessfully and have not returned

Local treatment figures show that 2,185 OCU were treated between 1 April 2011 and 31 March 2014

There will also be some individuals who have begun using drugs problematically since the most recent prevalence studies were carried out.

In 2013-14, 8.8% of adults aged 16 to 59 who responded to the Crime Survey for England and Wales (CSEW) reported having used drugs in the past year. Drug use was more common amongst 16- to 24-year-olds, with 18.9% of young adults reporting having used drugs in the past year.

Frequent drug use (i.e. use of any drug at least once per month in the past year) was also more common amongst young adults, with 6.6% of respondents aged 16 to 24 reporting frequent drug use compared to 3.1% of all adult respondents. Frequent drug use was most commonly associated with cannabis use, with half of the people who had used cannabis in the last year using it at least monthly.

Overall, there has been a decreasing trend in reported adult drug use over recent years. However, the 2013-14 results marked a statistically significant increase compared to 2012-13, when 8.1% of adults aged 16 to 59 who reported using drugs in the past year.

The table overleaf shows estimates of the numbers of people in Northamptonshire who took drugs in the past year by drug use type, based on the national survey results and ONS mid-2013 population estimates. These prevalence rates may not be applicable to the local population, and it is likely that the prevalence of drug use is underestimated as the results are from a general household survey – some groups of people are not reached by the survey, such as the homeless or people in prisons.
### Estimated prevalence of adult drug use in Northamptonshire, based on national survey results

<table>
<thead>
<tr>
<th>Type of Drug Use</th>
<th>England &amp; Wales Prevalence - Ages 16 to 59</th>
<th>Estimated Local Users</th>
<th>England &amp; Wales Prevalence - Ages 16 to 24</th>
<th>Estimated Local Users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any cocaine</td>
<td>2.4%</td>
<td>9,755</td>
<td>4.2%</td>
<td>3,069</td>
</tr>
<tr>
<td>Powder cocaine</td>
<td>2.4%</td>
<td>9,755</td>
<td>4.2%</td>
<td>3,069</td>
</tr>
<tr>
<td>Crack cocaine</td>
<td>0.1%</td>
<td>406</td>
<td>0.1%</td>
<td>73</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1.6%</td>
<td>6,503</td>
<td>3.9%</td>
<td>2,850</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0.6%</td>
<td>2,439</td>
<td>1.4%</td>
<td>1,023</td>
</tr>
<tr>
<td>LSD</td>
<td>0.3%</td>
<td>1,219</td>
<td>0.9%</td>
<td>658</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>0.4%</td>
<td>1,626</td>
<td>0.8%</td>
<td>585</td>
</tr>
<tr>
<td>Opiates</td>
<td>0.2%</td>
<td>813</td>
<td>0.2%</td>
<td>146</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.1%</td>
<td>406</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Methadone</td>
<td>0.2%</td>
<td>813</td>
<td>0.2%</td>
<td>146</td>
</tr>
<tr>
<td><strong>Class A/B</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any amphetamine</td>
<td>0.8%</td>
<td>3,252</td>
<td>1.7%</td>
<td>1,242</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0.8%</td>
<td>3,252</td>
<td>1.6%</td>
<td>1,169</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>0.1%</td>
<td>406</td>
<td>0.1%</td>
<td>73</td>
</tr>
<tr>
<td><strong>Class B</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>6.6%</td>
<td>26,825</td>
<td>15.1%</td>
<td>11,035</td>
</tr>
<tr>
<td>Mephedrone</td>
<td>0.6%</td>
<td>2,439</td>
<td>1.9%</td>
<td>1,389</td>
</tr>
<tr>
<td><strong>Class B/C</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranquillisers</td>
<td>0.5%</td>
<td>2,032</td>
<td>0.5%</td>
<td>365</td>
</tr>
<tr>
<td><strong>Class C</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anabolic steroids</td>
<td>0.2%</td>
<td>813</td>
<td>0.5%</td>
<td>365</td>
</tr>
<tr>
<td>Ketamine</td>
<td>0.6%</td>
<td>2,439</td>
<td>1.8%</td>
<td>1,315</td>
</tr>
<tr>
<td><strong>Not classified</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amyl nitrite</td>
<td>0.8%</td>
<td>3,252</td>
<td>1.5%</td>
<td>1,096</td>
</tr>
<tr>
<td><strong>Frequent drug use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Class A drug</td>
<td>3.1%</td>
<td>12,600</td>
<td>6.6%</td>
<td>4,823</td>
</tr>
<tr>
<td>Any stimulant drug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any drug</td>
<td>8.8%</td>
<td>35,767</td>
<td>18.9%</td>
<td>13,812</td>
</tr>
</tbody>
</table>
These calculations suggest that a total of around 35,767 adults in Northamptonshire have used drugs in the past year, and 12,600 adults used drugs on at least a monthly basis in the past year.

The vast majority of reported drug use was non-opiate drug use; no respondents aged 16 to 24 reported having used heroin in the past year.

Older national survey results from 2007 suggest that 3.4% of adults aged 16 and over showed signs of drug dependence in the past year. Assuming that these figures are not outdated and are representative of the local population, this is equivalent to 19,206 adults in Northamptonshire having experienced some form of drug dependence last year. Men were twice as likely to have experienced drug dependence than women (4.5% of men compared to 2.3% of women). As with the CSEW results, cannabis was the most commonly used drug and also the most common problem substance where dependence was reported.

In addition, in 2013 11% of pupils aged 11 to 15 surveyed in England reported having used drugs in the past year, and 3% reported usually taking drugs at least once a month. This needs to be read in the context that rates of reported drug use amongst young people has fallen over the past 5 years; in 2008, 15.9% of pupils surveyed reported drug use. 15-year-olds were the most likely group to report drug use, with 24% reporting drug use in the past year and 6% reporting at least monthly use.

The table overleaf shows estimates of the numbers of young people in Northamptonshire who took drugs in the past year by drug use type, based on the national survey results and ONS mid-2013 population estimates. It is assumed that the national figures are representative of the local population, which may not be the case.

These survey results suggest that there are young people using hard drugs like crack and opiates, which are more commonly linked to dependent drug use than other drug types. Further work is required in order to ascertain the extent of this issue in Northamptonshire.

As with adult drug use, cannabis was the most common drug of use amongst young people, with 7% of all pupils surveyed reporting using it.

Of the pupils surveyed, those who reported having played truant or been excluded from school were considerably more likely to report frequent drug use – 10% of pupils who had truanted or been excluded reported using drugs at least once a month, compared to 1% who had not.
Estimated prevalence of drug use in Northamptonshire’s secondary school pupils, based on national survey results

<table>
<thead>
<tr>
<th>Type of Drug Use</th>
<th>England Prevalence - Ages 11 to 15</th>
<th>Estimated Local Users</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class A</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Powder cocaine</td>
<td>0.7%</td>
<td>292</td>
</tr>
<tr>
<td>Crack cocaine</td>
<td>0.4%</td>
<td>167</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.6%</td>
<td>251</td>
</tr>
<tr>
<td>LSD</td>
<td>0.4%</td>
<td>167</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>0.5%</td>
<td>209</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.3%</td>
<td>125</td>
</tr>
<tr>
<td>Methadone</td>
<td>0.2%</td>
<td>84</td>
</tr>
<tr>
<td><strong>Class A/B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0.4%</td>
<td>167</td>
</tr>
<tr>
<td><strong>Class B</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td>7.0%</td>
<td>2,923</td>
</tr>
<tr>
<td>Mephedrone</td>
<td>0.4%</td>
<td>167</td>
</tr>
<tr>
<td><strong>Class B/C</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tranquillisers</td>
<td>0.3%</td>
<td>125</td>
</tr>
<tr>
<td><strong>Class C</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketamine</td>
<td>0.4%</td>
<td>167</td>
</tr>
<tr>
<td><strong>Not classified</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poppers (amyl nitrite)</td>
<td>0.8%</td>
<td>334</td>
</tr>
<tr>
<td>Glue, gas, aerosols or solvents</td>
<td>3.6%</td>
<td>1,503</td>
</tr>
<tr>
<td><strong>Other drugs</strong></td>
<td>0.3%</td>
<td>125</td>
</tr>
<tr>
<td><strong>Frequent drug use</strong></td>
<td>3%</td>
<td>1,253</td>
</tr>
<tr>
<td><strong>Any stimulants</strong></td>
<td>2.1%</td>
<td>877</td>
</tr>
<tr>
<td><strong>Any psychedelics</strong></td>
<td>1.1%</td>
<td>459</td>
</tr>
<tr>
<td><strong>Any opiates</strong></td>
<td>0.4%</td>
<td>167</td>
</tr>
<tr>
<td><strong>Any Class A drug</strong></td>
<td>1.9%</td>
<td>793</td>
</tr>
<tr>
<td><strong>Any drug (excluding volatile substances)</strong></td>
<td>8.5%</td>
<td>3,550</td>
</tr>
<tr>
<td><strong>Any drug</strong></td>
<td>11.3%</td>
<td>4,719</td>
</tr>
</tbody>
</table>
Clients accessing structured treatment for substance misuse – adults

NDTMS figures show that in 2013-14, a total of 2,181 individuals resident in Northamptonshire received structured treatment for drug misuse. This is up from 1,758 in 2012-13, which is equivalent to a 24.1% increase. The treatment population can be broken down by client type as follows.

Breakdown of clients in treatment by substance type, based on NDTMS data – 2013-14 compared to 2012-13

<table>
<thead>
<tr>
<th>Type</th>
<th>2012-13</th>
<th>2013-14</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate</td>
<td>1580 (89.9%)</td>
<td>1641 (75.2%)</td>
<td>Increase 24.1%</td>
</tr>
<tr>
<td>Non-opiate</td>
<td>93 (5.3%)</td>
<td>254 (11.6%)</td>
<td>Increase 119.8%</td>
</tr>
<tr>
<td>Alcohol and non-opiate</td>
<td>85 (4.8%)</td>
<td>285 (13.1%)</td>
<td>Increase 238.1%</td>
</tr>
</tbody>
</table>

While there has been a small increase in the opiate client group, the increase in clients receiving treatment for non-opiate use is far more significant – 2013-14 totals are almost 3 times higher than the 2012-13 totals. This increase in numbers can be directly attributed to the recommissioning to CRI in February 2013, and may be partly due to positive word of mouth regarding the redesigning of treatment services and premises, and partly due to improved data recording practices.

National trends from 2013-14 were for drug treatment clients to be predominantly male (74%) with a median (mid-point) age of 36.

Local data taken from the treatment system allow opiate and non-opiate clients to be considered separately, and analysis of 2013-14 data shows that Northamptonshire’s opiate and non-opiate clients have different demographics.

Non-opiate clients tend to be much younger than opiate clients, as shown overleaf. This is in keeping with prevalence estimates that show that non-opiate use is significantly more common amongst young adults than opiate use.
Age profile of Northamptonshire’s opiate and non-opiate clients, based on local treatment data for 2013-14

Also, the gender split for non-opiate clients is more biased towards males than that for the opiate client group.

Gender split of Northamptonshire’s opiate and non-opiate clients, based on local treatment data for 2013-14

Although these figures are similar to the national totals, prevalence findings suggest that men are twice as likely as women to experience drug dependence, therefore the expected gender split would be around 66% male/33% female. The higher proportion of males seen in the treatment system may be due to behavioural characteristics; for example, men are more likely to be referred to treatment through Criminal Justice Services than women, particularly amongst the non-opiate client group. A breakdown of referral sources for drug clients in treatment during 2013-14 is shown overleaf (based on local data).
The chart below shows a breakdown of the primary problem substance for all clients receiving drug treatment during 2013-14, based on local data. Where alcohol was cited as the primary problem substance, the client also had secondary and/or tertiary problematic use of non-opiate drugs.

**Breakdown of primary problem substance cited by Northamptonshire’s clients in treatment, based on local data for 2013-14**

- **Heroin**: 58.4%
- **Cannabis**: 9.5%
- **Alcohol**: 8.7%
- **Other Opiates**: 7.1%
- **Methadone**: 6.7%
- **Cocaine**: 3.3%
- **Crack**: 2.5%
- **Amphetamines**: 1.7%
- **Prescription Drugs**: 1.1%
- **Benzodiazepines**: 1.0%
- **Other Drugs**: 0.3%
- **Solvents**: 0.3%
- **Hallucinogens**: 0.2%
Treatment for the misuse of opiates, particularly heroin, tends to be a longer process than treatment for non-opiate use. Generally speaking, opiate clients are more complex and have more entrenched problems, including injecting, poly-drug use and criminal behaviours. The following chart shows a breakdown of the time spent in treatment to date for opiate and non-opiate clients in treatment with CRI on 1 November 2014.

**Breakdown of length in treatment for clients in treatment on 1 November 2014, based on local data**

![Chart showing breakdown of length in treatment](chart.png)

The majority of opiate clients had been in treatment for more than a year, and roughly a quarter (24.5%) had been in treatment for 4 or more years. In comparison, 91.3% of non-opiate clients had been in treatment for less than a year.

NDTMS figures show that Northamptonshire’s distribution of opiate clients in treatment in 2013-14 by length of the latest treatment journey is similar to that of local comparator areas.

**Length of time in treatment and successful completions**

Nationally, it has been shown that the rate of successful completions amongst opiate clients decreases the longer the client has been in treatment, with clients in treatment for less than two years having the highest rates of successful completions. At a local level, there is the additional issue that the clients who have been in treatment for more than two years will have experience of the more medically driven models of treatment operated historically, and may therefore have different expectations of treatment to those entering the system for the first time under CRI. This is particularly the case for Shared Care GP clients, the majority of which have been maintained on methadone in excess of 4 years.

While some of these clients may respond well to an abstinence-based model, there will also be those who have been maintained on methadone for many years and in all other respects achieved the hallmarks of recovery. For the latter group, reduction off methadone may be detrimental to the client’s stability. Professor John Strang identified that there will be a group of opiate users who will require indefinite maintenance on opioid substitution therapy. It may be necessary to identify these clients on an individual basis and acknowledge them as being recovered in spite of their remaining in treatment.
Clients accessing structured treatment for substance misuse – young people

NDTMS figures show that in 2013-14, a total of 171 clients in Northamptonshire accessed young people’s ("YP") treatment services for substance misuse, including alcohol. This is up slightly from 163 in 2012-13.

The chart below shows the age breakdown for Northamptonshire’s YP clients as compared to the national total.

**Age profile of Northamptonshire’s YP clients, based on NDTMS data for 2013-14**

165 (96.5%) of the clients treated were aged under 18; YP services may treat clients up to age 24. Nationally, 14% of clients in YP services were aged 18 to 24. This difference does not present any cause for concern, as substance misuse clients aged over 18 at referral would be treated by CRI.

Nationally, the gender split for under 18s in substance misuse treatment is 66% male and 34% female. In Northamptonshire, the split is more similar to that seen in adult treatment services at 73% male and 27% female.

Clients in YP services generally have problematic non-opiate and/or alcohol use. Opiate and/or crack use is rare; in 2013-14, 5 YP clients were treated for heroin and/or crack use. This is equivalent to 3% of YP clients treated, which is similar to the national total of 2%.

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**CRI Service User Feedback**

“First experience – it made me feel safe and good.”

“I’ve really enjoyed being part of a group and feel it has helped me in my recovery.”

“I got the help I needed and wanted and have been officially discharged.

“I get help. I stopped. I came clean and I am very happy. I could not have come clean without CRI. I am very happy, thanks. It changed my life.”
The graph below shows the proportion of YP clients citing using different types of drug as a primary, secondary or tertiary problem substance. These are NDTMS figures for 2013-14 and the national total has been shown as a basis for comparison.

**Breakdown of YP clients by substance use type, based on NDTMS data for 2013-14 – Northamptonshire compared to the national total**

The proportions of YP clients citing tobacco or alcohol use were lower than the national total, but NPS use was noticeably more common in Northamptonshire. Further data would be required in order to understand local usage patterns.

**Young people vulnerable to drug misuse**

Services should provide a mixture of treatment and prevention that gives young people the opportunity to live a drug free childhood and to enter adulthood without the knowledge or desire to use drugs.

Young people’s misuse of drugs broadly falls into three categories:

1. Young people who through abusing drugs have harmed themselves or others and require treatment. This includes those young people who are highly vulnerable to drug abuse and/or exploitation using drugs.

2. Young people who are living with adults or older siblings who misuse drugs and need to be protected and supported to lead a drug free childhood and adult life.

3. Young people who through their peer groups are at the risk of the harms associated with experimental drug and alcohol use.

**CAN YP Service User Feedback**

“I found out the problem doesn’t affect the life of the person who is suffering from a drug or alcohol addiction, but has a knock-on effect with the whole family.” (Year 10 student)
Geographical distribution of adult drug treatment clients

The graph below shows the geographical breakdown of CRI’s opiate and non-opiate clients’ district of residence (where stated), as compared to the distribution of Northamptonshire’s population aged 18 and over. These figures are based on 2013-14 data from CRI and ONS mid-2013 population estimates.

Breakdown of Northamptonshire’s opiate and non-opiate clients by district of residence, based on local treatment data for 2013-14, compared to the overall population distribution for the county

<table>
<thead>
<tr>
<th>District</th>
<th>Non-opiate clients</th>
<th>Opiate clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corby</td>
<td>17.0%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Daventry</td>
<td>6.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>East Northamptonshire</td>
<td>6.3%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Kettering</td>
<td>12.7%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Northampton</td>
<td>42.1%</td>
<td>40.3%</td>
</tr>
<tr>
<td>South Northamptonshire</td>
<td>3.3%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Wellingborough</td>
<td>11.7%</td>
<td>15.5%</td>
</tr>
</tbody>
</table>

Compared to the overall distribution of the adult population in Northamptonshire, drug clients were more common in Northampton and Corby, particularly non-opiate clients.

Drug clients were least likely to live in South Northamptonshire. While this may be due to a lower prevalence of drug use in this predominantly rural district, there are no CRI offices in South Northamptonshire and poor accessibility of services may be a barrier to residents in this area entering treatment.

East Northamptonshire and Daventry residents were also underrepresented in the drug treatment population compared to the population of Northamptonshire as a whole. Again, these districts are predominantly rural.

A broader mapping exercise considering all clients accessing structured treatment at CRI between 1 February 2013 and 31 October 2014 at LSOA level and comparing against the Index of Multiple Deprivation 2010 (IMD) showed that clients accessing drug treatment in Northamptonshire are more likely to live in deprived areas than the rest of the adult population as a whole (ONS mid-2013 population estimates for individuals aged 18 and over). This is illustrated in the following graph; for clarity, IMD ranks have been grouped into deciles, with decile 1 representing the 10% most deprived LSOAs in England and 10 representing the 10% least deprived LSOAs in England.

Northamptonshire JSNA 2015 – Drug Misuse Needs Assessment 23
Breakdown of Northamptonshire’s opiate and non-opiate clients by the IMD decile ranking of their LSOA of residence, based on local treatment data for 2013-14, compared to the overall population distribution for the county

<table>
<thead>
<tr>
<th>Index of Multiple Deprivation - LSOA Decile Ranking</th>
<th>Opiate clients</th>
<th>Non-opiate clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15.6%</td>
<td>13.2%</td>
</tr>
<tr>
<td>2</td>
<td>24.0%</td>
<td>23.0%</td>
</tr>
<tr>
<td>3</td>
<td>22.0%</td>
<td>17.2%</td>
</tr>
<tr>
<td>4</td>
<td>11.7%</td>
<td>12.1%</td>
</tr>
<tr>
<td>5</td>
<td>7.5%</td>
<td>10.3%</td>
</tr>
<tr>
<td>6</td>
<td>4.6%</td>
<td>5.3%</td>
</tr>
<tr>
<td>7</td>
<td>4.3%</td>
<td>3.5%</td>
</tr>
<tr>
<td>8</td>
<td>3.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>9</td>
<td>4.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td>10</td>
<td>2.8%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

31.0% of all adults in Northamptonshire live in an LSOA that is within the 20% least deprived in England, compared to 12.6% who live in one of the 20% most deprived LSOAs in England.

In contrast, 38.5% of all drug treatment clients lived in one of the 20% most deprived LSOAs in England, and only 8.4% in one of the 20% least deprived LSOAs in England. Opiate clients were more likely to live in deprived areas than non-opiate clients.

**Blood-borne viruses and harm reduction**

Injecting drug users are at risk of contracting blood-borne viruses through the sharing of needles and other injecting paraphernalia. In order to reduce the spread of blood-borne virus infections, CRI offer injecting drug clients vaccinations against Hepatitis B. They also test current and former injectors for Hepatitis C, which is common amongst injecting drug users; without testing, Hepatitis C may go undetected and untreated until severe liver damage has already occurred.

**NDTMS** figures show that the 2013-14 uptake of Hepatitis B vaccinations amongst new drug treatment clients is much lower than the national average. Although 49% of eligible clients accepted the offer of a vaccination course, just 7% of these were on a course and 11% had completed a course as at 31 March 2014. The national average was for 26% to have started a course and 32% to have completed a course of Hepatitis B vaccinations.

Similarly, the rate of Hepatitis C tests amongst previous or current injectors entering treatment in Northamptonshire during 2013-14 was lower than the national average, with 61% of eligible clients receiving a test compared to 80% of all clients in England.
CRI are aware that there are issues in this area and are working with commissioners to improve client uptake of Hepatitis testing and vaccinations.

HIV testing and status are not currently reported through the NDTMS dataset. The most recent research from Public Health England estimated the HIV prevalence in England’s injecting drug users at 1% in 2014. In comparison, in 2013 the overall prevalence of HIV diagnoses in Northamptonshire’s population aged 15-59 was 1.85 per 1,000.

Injecting drug users also have an increased risk of contracting Hepatitis A. CRI do not currently test for this virus.

It is important to mitigate the health risks related to injecting behaviour for all injecting drug users in the county, regardless of whether they are in contact with treatment services. To this end, Northamptonshire operates a Needle Exchange programme through CRI and select pharmacies, which makes free, clean injecting paraphernalia available to the public and safely disposes of any used equipment returned to them. This initiative is aimed at reducing the potential for harm to both injectors and other members of the public through improper use and disposal of needles and syringes.

The equipment distributed by the Needle Exchange outlets is designed to encourage responsible behaviours through a combination of:

- “Nevershare” branding to promote the message that injectors should only ever use their own equipment;
- Colour-coded syringes to help injectors avoid accidental sharing when injecting in groups; and
- Ease of secure disposal by means of a discreet, portable sharps container – some models can detach the needle from the syringe barrel and lock it away within the device, leaving the barrel safe for disposal in normal household waste. The more compact the container, the more likely it is to be carried on the person and used.

At the time of writing, Needle Exchange activity is only recorded by the pharmacies offering the service. Client details are collected manually at each presentation and there is a high potential for inputting errors and non-disclosure. It is therefore, unfortunately, not possible to estimate the number of unique clients utilising the programme. The system used for data collection is under review and will be upgraded in 2015-2016 with the aim of expanding the dataset, improving data quality and allowing data recording at CRI.

2013-14 activity data from the Needle Exchange pharmacies show that a total of 30,334 needle packs (each containing 10 needles) were distributed during the year, which was an increase of 3,634 (13.6%) compared to 2012-13.

Clients reported their main drug of use in 77.1% of the collections that took place in 2013-14. The graph overleaf shows the trend in clients’ reported drug use since 2011-12. It should be noted that these figures may not be wholly accurate; the data suggests that there were cases where the same client reported different types of drug use on different occasions, and it is not possible to tell whether this is due to clients attempting to be misleading or actually using a combination of different drugs.

There has been a year-on-year increase in the proportion of collections for steroid use since 2011-12. Based on data where the drug use was recorded, 7.2% of collections and 6.4% of needle packs distributed during 2013-14 were for steroid use. Assuming the same pattern across all collections, this would be equivalent to roughly 1,940 needle packs being distributed to steroid users.
Breakdown of drug use amongst pharmacy Needle Exchange clients, where declared – 2011-12 through 2013-14

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crack cocaine</td>
<td>0.5%</td>
<td>0.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Heroin</td>
<td>91.6%</td>
<td>91.0%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Steroids</td>
<td>3.9%</td>
<td>5.6%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Stimulants</td>
<td>1.5%</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other</td>
<td>2.5%</td>
<td>2.4%</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

National findings show that although reported sharing of needles and syringes amongst injecting drug users has declined over the past decade, prevalence of HIV and Hepatitis C infections in this group has remained stable. This suggests there is a need to strengthen the harm reduction initiatives aimed to prevent the spread of blood-borne viruses through injecting drug use.

The impact of a Needle Exchange programme will depend on its coverage – ideally, the number of needles distributed should exceed the number required for each injecting drug user in the area to have a clean needle for each injection.

Based on the pharmacy activity data available, standard assumptions in relation to the needle requirements of injecting drug users, and estimates of the numbers of injecting drug users in Northamptonshire, coverage of the pharmacy-based Needle Exchange programme (i.e. the proportion of injections for which clean needles are supplied) can be estimated as being between 60% and 151%. This appears optimistic for the following reasons:

- In the absence of activity data from CRI, it is only possible to consider a portion of the overall distribution. 2012-13 invoices for Needle Exchange supplies to the previous treatment agencies showed that an average of around 43,500 needles were distributed to agency sites per month. This would equate to over 500,000 additional needles a year being provided for supply in the county, in which case pharmacy coverage of over 50% would be unlikely.
- There are currently no outlets in South Northamptonshire offering Needle Exchange. Accessibility of services elsewhere in the county from South Northamptonshire is poor and CRI and pharmacy Needle Exchange services are therefore unlikely to achieve true 100% coverage between them.

Further work will be undertaken to estimate the coverage of Northamptonshire’s Needle Exchange programme once more comprehensive data are available.
In the meantime, commissioners are keen to address the geographical gaps in Needle Exchange provision and increase the number of pharmacies that are part of the programme. The map below shows the locations of pharmacies that do and do not provide Needle Exchange services. A pharmacy has been considered an active provider if they have reported activity since 1 April 2013.

There are currently 15 active pharmacy providers of Needle Exchange out of 132 community pharmacies in Northamptonshire. Although not all of these pharmacies would be suitable providers, there is clearly opportunity for expanding the Needle Exchange programme and pharmacies located in areas where provision is lacking, e.g. South Northamptonshire and rural Daventry, should be considered as a priority.
Safeguarding

It is difficult to estimate the number of children living with substance misusing parents as the available prevalence studies are based on national survey results that are at least a decade old at the time of writing. However, given that the proportion of adults reporting recent drug use has decreased during that period, it would be reasonable to assume that the prevalence of children living with substance misusing parents is not higher than the published estimates of 8.4% of children under age 16 living with an adult who has used drugs in the past year, and 4.2% living with an adult who has used drugs in the past month. This is equivalent to 5,954 children in Northamptonshire living with an adult who has used drugs in the past month, based on ONS mid-2013 population estimates.

According to local data from CRI for 2013-14, a total of 1,129 children were declared as living with 631 adult drug clients. Women were twice as likely to declare living with children than men, but due to the higher number of male clients in treatment 58.8% of children lived with men and 41.2% with women.

It is not possible to tell from the data currently collected how many of the clients in treatment have partners that also use drugs and/or alcohol. Where both parents/guardians are substance misusers, the quality of the child’s care may be more likely to be compromised than where one parent is able to provide stability and routine.

Vulnerable adults affected by another person’s substance misuse may also require safeguarding and input from additional services. At the time of writing, these cases are not captured in the NDTMS dataset or recorded in CarePath, the local case management tool used by treatment providers.

In 2014-15, CRI documented a total of 60 referrals to social care. This is likely to be an underestimate as processes for accurately recording safeguarding referrals were being developed during this time.

What inequalities are there in health status and access to services?

Men are more likely than women to use drugs

National survey results consistently show that the prevalence of drug use in men is greater than that amongst women. Men are roughly twice as likely as women to have used drugs and to have experienced drug dependence in the past year.

The gender splits seen in treatment services are more biased towards males than would be expected based on these differences in drug use prevalence (see page 18). This may be due to more males than females entering the Criminal Justice system and being referred on to treatment from there, but it is also possible that there may be barriers to women entering treatment. For example, those living with children might be wary of accessing treatment in case it led to social services becoming involved and taking the children into care.

The proportion of males amongst the under 18s in substance misuse treatment at CAN YP is higher than the national average. The reasons for this are not understood.

Drug usage patterns vary by ethnicity and sexual orientation

National survey results from 2013-14 showed that adults from Asian backgrounds were the least likely to use drugs, whilst those from mixed backgrounds are the most likely. In particular, the prevalence of drug use in adults from mixed white and black Caribbean backgrounds was more than twice that amongst those from white backgrounds. This is predominantly due to a higher prevalence of reported cannabis use, which may be a result of social/cultural differences between communities.
Drug use was more common in people from white backgrounds than in any other ethnic group other than mixed backgrounds.

According to local data, in 2013-14 93.9% of non-opiate clients and 94.3% of opiate clients were white. The second most common ethnic group was mixed backgrounds, which accounted for 3.2% of non-opiate clients and 2.0% of opiate clients. By way of comparison, individuals from mixed ethnic backgrounds make up 2.0% of Northamptonshire’s total population. All other non-white ethnic groups were less common in the treatment population than Northamptonshire’s overall population, although this may be expected as a result of lower prevalence rates of drug use amongst these groups.

There was also a notable difference in the prevalence of drug use amongst heterosexual people and those who are gay or bisexual. In adults aged 16 to 59, 31.0% of men and 18.9% of women who reported being gay or bisexual had used drugs in the past year, compared to 11.1% of men and 5.2% of women who reported being heterosexual. Club drugs such as ecstasy, ketamine and amyl nitrite (poppers) were more popular amongst gay or bisexual respondents, particularly men.

Treatment agencies should continually work to ensure that the needs of different population groups are understood and that there are no barriers to them being met. Drug use in ethnic communities can be hidden due to cultural norms, e.g. khat use in Somali populations.

Accessibility of services may be an issue for individuals who do not have access to private transport

At the time of writing, CRI do not have any offices based in East Northamptonshire or South Northamptonshire. Accessibility of services may therefore be an issue for people who live in these areas, particularly if they need to rely on public transport links.

A mapping exercise using Google Maps to calculate the travelling time on public transport between the mid-points of each LSOA in the county and the nearest CRI branch produced the results plotted on page 31. These results were based on the client being able to arrive at CRI by midday on a weekday.

As would be expected, large areas of East Northamptonshire and South Northamptonshire had prohibitively long travelling times to the nearest service locations within the county if clients had to rely on public transport. Problems areas were also noted in Daventry and Kettering.

CRI do operate some services from GP premises in Brackley and Towcester in South Northamptonshire, which are areas with poor accessibility. They may also assist with access to services on a case-by-case basis; in some instances they have paid an individual’s travel costs to the nearest branch to facilitate engagement. However, even where it is possible to assist with access to appointments, the client is also likely to be far away from support networks that can assist with recovery.

The graph overleaf shows a breakdown of Northamptonshire’s population aged 18 and over by the approximate travelling time to treatment services by public transport, calculated based on ONS LSOA level population estimates for mid-2013.

18.4% of Northamptonshire’s population aged 18 or over would need to travel for 45 minutes or more on public transport in order to reach their nearest CRI branch. There will also be areas where the timetabling of services is such that it restricts the appointment times that would be practicable for the client to attend.
Assessing the accessibility of CRI’s services across Northamptonshire – population breakdown by estimated travel time on public transport

![Graph showing the percentage of the population in different travel time categories.]

Access to recovery services and support groups is also important as it allows individuals to form new social links within the community and benefit from mutual aid. With the growing focus on recovery support as part of substance misuse treatment, it seems likely that recovery-oriented services will be expanded in future. It would be possible to inform the positioning of such services using similar methodology to the above.

As internet accessibility through mobile devices becomes more commonplace, it may be that some degree of support can be offered online. CRI currently promote Breaking Free Online, which is a virtual service that offers guidance and resources at any time of day. This can also help service users who require immediate support between treatment appointments.

Accessibility of services is also an issue for CAN YP, which operates a single branch in Northampton. Under 18s in particular will be reliant either on others being able to drive them to appointments or on public transport. CAN YP staff do perform outreach work, but clients seen this way would be restricted in the types of services they are able to receive, e.g. group sessions would be unavailable.
Estimated Travelling Time by Public Transport, Including Walking, to Nearest CRI Branch (LSOA Level)

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Opiate clients referred to treatment by Criminal Justice Services have poorer outcomes than those from other referral sources

Commissioners are aware that there are issues in relation to opiate clients referred into treatment by Criminal Justice Services having poorer outcomes than the overall opiate treatment population. In 2013-14, the NDTMS successful completion rate for this client group was roughly half that for opiate clients as a whole.

Analysis of local data from CRI for all opiate clients treated between 1 February 2013 and 31 October 2014 shows significant differences in the treatment outcomes of those who have exited treatment depending on whether they were referred by Criminal Justice Services or not. This is illustrated in the graph overleaf.

Although Criminal Justice clients were less likely to drop out of treatment than other opiate clients, a total of 35.0% were either retained in or ultimately transferred to custody. Just 7.3% of Criminal Justice treatment exits were successful completions, compared to a third of all other treatment exits for opiate clients.

A clinical audit of CRI’s case files in late 2014 found that clients referred to treatment directly from prison were 9 times less likely to successfully complete treatment than those who were not. Links with community services on release from prison are currently poor, and progress in this area has been difficult as prisoners from Northamptonshire may be sent to one of four prisons outside the county. Commissioners are aware of this issue and it will be supporting CRI to improve client pathways from Criminal Justice Services into community treatment.

**Breakdown of exit reasons for Criminal Justice clients compared to those from other referral sources, based on local treatment data from 1 February 2013 to 31 October 2014**

<table>
<thead>
<tr>
<th>Exit Reason</th>
<th>Criminal Justice</th>
<th>All Other Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment completed</td>
<td>7.3%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Transferred - not in custody</td>
<td>5.1%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Transferred - in custody</td>
<td>28.1%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Incomplete - treatment declined by client</td>
<td>2.2%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Incomplete - retained in custody</td>
<td>6.9%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Incomplete - dropped out</td>
<td>14.4%</td>
<td>34.2%</td>
</tr>
<tr>
<td>Incomplete - client died</td>
<td>1.2%</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
Clients with previous treatment experience are less likely to successfully complete treatment than those who are new to treatment

“Treatment naive” clients, i.e. those who have no prior experience of substance misuse treatment, have a higher chance of successfully completing treatment than those who have been through the system before. This has been observed in national data for adult services, and local analysis based on discharges from CRI between 1 February 2013 and 31 October 2014 shows that the difference between the two cohorts is quite marked. This is illustrated in the graph below, which shows successful completions as a percentage of all treatment exits for each drug client group.

Successful completions as a proportion of all treatment exits for treatment naive and treatment experienced clients in each drug use cohort, based on local treatment data from 1 February 2013 to 31 October 2014

The proportion of treatment exits where the client successfully completed treatment was higher for treatment naive clients across all client groups, with non-opiate and opiate-clients seeing the biggest difference between treatment naive and treatment experienced clients.
Treatment naive clients may have the advantage of having no preconceptions of treatment services (e.g. treatment experienced opiate clients may expect to be maintained on methadone with minimal engagement as per older clinical models of treatment) and no prior experience of relapse. Furthermore, when clients enter treatment for the first time, CRI engage them in an intensive 12 week programme to capitalise on their early motivation and show recovery as being a real prospect.

However, further work still needs to be done in order to improve the prospects of treatment experienced clients. Of the clients in treatment with CRI on 1 November 2014, 28.4% of non-opiate clients and 72.1% of opiate clients had previous treatment experience. Furthermore, 55.6% of the treatment naive opiate clients had been in treatment for more than two years and will therefore no longer have the characteristics of a new client just entering treatment for the first time.

**Treatment experienced opiate clients are likely to become career service users**

Using local data, it is possible to consider representation rates over a much longer period of time than that considered in any indicators produced by Public Health England.

Models based on 3 years of data collected from 1 April 2011 showed that opiate clients who were treatment experienced when they completed treatment for the first time were more likely to represent to treatment than treatment naive clients. At 6 months following successful completion, around 30% of treatment experienced clients could be expected to have represented to treatment, compared to 13% of treatment naive clients. At 2 years, these figures increased to 57% of treatment experienced clients and 23% of treatment naive clients.

The following graph shows how the representation rates may be projected to estimate the proportions of clients who may relapse over longer periods of time. At 5 years, an estimated 76% of treatment experienced clients and 30% of treatment naive clients could be expected to have represented.

**Modelling representation rates for opiate clients over 5 years – treatment experienced clients compared to treatment naive**

![Graph showing representation rates over 5 years](image)
While these models will need to be revisited in future to improve accuracy – recent changes to the treatment system are likely to have affected client outcomes – they do suggest that treatment experienced clients are likely to require further treatment following a successful discharge.

**Impact of treatment experienced clients on the system**

Almost three quarters of opiate clients in treatment have had at least one previous treatment journey. These treatment experienced clients are less likely to successfully complete treatment than their treatment naive counterparts, and those who do complete are more likely to represent to treatment afterwards. Both clinical audits undertaken in Northamptonshire found previous treatment experience to be a negative indicator of successful completions.

Over time, it is likely that the opiate treatment population will become increasingly dominated by career service users who are cycling through the system without attaining long-term recovery, which would result in a decline in performance as measured by rates successful completions and representations. The England rate of successful completions for opiate clients is slowly declining, suggesting that this could already be happening elsewhere in the country.

**Defining and measuring recovery**

It is clear from both local and national data that opiate clients may have multiple contacts with treatment services over time. A successful treatment outcome does not in itself constitute recovery from substance misuse; long-term recovery requires building and maintaining positive outcomes across a variety of areas including relationships, wellbeing, housing, and occupation. The Advisory Council on the Misuse of Drugs has indicated that it may not be possible to tell if a substance misuser has achieved recovery until five years after they have overcome dependence.

Recovery support services like those provided at Bridge can help clients build recovery capital, and may be instrumental in preventing relapse. However, the milestones in achieving recovery will vary for each individual, and the tools used for monitoring clients’ progress quantifiably are not sophisticated enough to capture these nuances.

Thus, the current position is one where performance measures do not correlate with actual recovery outcomes, and the means by which the latter can be measured in a meaningful way have not as yet been developed.

**Additional support is required for families of substance misusers**

In 2013–14, a total of 2,181 adults in Northamptonshire received treatment for drug misuse; if alcohol only clients are included in the count, a total of 3,149 clients were seen by treatment services. While treatment services in their current format can aid the user in recovering from substance misuse, children and family members rarely receive any support in dealing with the issues caused by the user’s behaviour.

Family Support Link, who are commissioned to provide services to families, received 121 referrals between April and December 2014. Although it is not possible to estimate the number of service users at CRI with families who would benefit from additional support, the difference in activity levels suggests there is a significant shortfall in coverage for family based services. Northamptonshire’s commissioners are aiming to be in a position to offer family support services, where required, as a standard part of the substance misuse treatment package by 2017.
At the time of writing, Northamptonshire has run a pilot of the M-PACT programme, which is aimed at addressing issues relating to substance misuse in families with children where the user may not necessarily be in contact with structured treatment services. Although feedback has been positive, the scope of the pilot was limited and the project has not been progressed to date, however funding has been earmarked for continuing running the programme and rolling it out across the county.

**Family Support Link Service User Feedback**

“Family Support Link has been a real lifeline for my family and me. I did not feel able to talk to my relatives or friends about what was going on with my daughter because frankly I was worried about what they would think. Knowing FSL was there at the end of the telephone when things got too much and I needed to get it all off my chest helped me no end. I don’t feel alone anymore and am more confident in dealing with the problems that being the parent of a drug user can throw at you. I honestly do not know how we would have got through the last year without their support and friendship.”

**Early intervention to reduce demand on services**

Commissioners recognise the need for treatment services to take a family-oriented approach in order to deal with the impact of the user’s substance misuse in a way that builds the family’s resilience and reduces the risk of intergenerational transfer of substance misuse patterns. This requires re-thinking the structure and functioning of the whole treatment system.

While there is some Public Health guidance as to how substance misuse services could be interfaced with children and family services, this does not cover the needs of an integrated service. American research highlights the need to involve children and families in the recovery process, but does not provide a structure for service provision.

Translating the vision of an integrated family-based service into a workable model will require the assistance of treatment and recovery agencies, as well as the service users themselves.

**Recommendation: Providing high standards of holistic healthcare and advice for all clients**

Treatment services need to provide appropriate advice and education regarding health problems resulting from the abuse of drugs. They must ensure that that all practitioners are fully trained and competent to give advice. They should also consider training volunteers, champions and peer mentors to be able to reinforce the health message.

Treatment services must widen their harm reduction services to include testing for Hepatitis A, HIV, tuberculosis and other communicable diseases which result from lifestyle behaviours common amongst those that consume and abuse drugs. In conjunction with the local Authority they should also continually review the appropriateness of the range of healthcare services provided and seek to redress health inequalities within the population being treated.
Recommendation: Providing ready access to services

Commissioners and agencies should review the need for treatment services across the county on a regular basis and continually explore ways of making treatment accessible for anybody who may require it. This may mean bringing treatment to the client, rather than having the client come to the service itself.

Recommendation: Recovery to be available for all clients in treatment

The aim of providing treatment for substance misusers in Northamptonshire is not just to help them overcome addiction, but to provide the tools for them to rebuild their lives free of addiction. Recovery must be visible at all stages of the client’s journey in the treatment system, and following discharge it is important that the client still feels that they have access to support at any time they might need it in order to minimise the chances of relapse.

Services should be aware of clients dropping out of treatment and follow up wherever possible to obtain feedback and understand what led to the client disengaging. Similarly, they should seek to obtain insight into why clients relapse from clients representing to treatment. These processes may be facilitated by co-production with service user networks. Any lessons learned should be fed back to front line staff and used to improve future service provision.

Recommendation: Developing integrated pathways for family services

It is becoming increasingly apparent that family services need to be central to Northamptonshire’s treatment system in order to help overcome the wider harms caused by substance misuse. Commissioners are aiming to implement a family-based treatment model in 2017 and this will need to be considered in the design of systems and pathways.
**What is the evidence base for interventions? What is best practice?**

Guidance around best practice and evidence-based interventions can be found in the following publications.

- **National Institute for Health and Care Excellence (NICE)**
  - Guidance for needle and syringe programmes
  - Guidance on drug use disorders

- **National Treatment Agency (NTA) – now Public Health England**
  - Recovery-Orientated Drug Treatment: An interim report by Professor John Strang, chair of the expert group
  - Medications in recovery: re-orientating drug dependence treatment
  - Building recovery in communities: a summary of the responses to the consultation

- **Advisory Council on the Misuse of Drugs (ACMD)**
  - What recovery outcomes does the evidence tell us we can expect? Second report of the Recovery Committee
  - Prevention of drug and alcohol dependence

**What is the pattern of services in Northamptonshire at present?**

The following providers have been commissioned to provide treatment and support services for substance misusers and their families.

**Structured treatment (more than one intervention)**

- **Crime Reduction Initiatives (CRI) – local trading name Substance 2 Solution**, primary provider of substance misuse treatment services in the Northamptonshire
  - *Bases in Corby, Daventry, Kettering, Northampton and Wellingborough*

- **Shared Care** – providing opioid substitution therapy through select local GP practices
  - *Bases in all districts*

- **Residential rehabilitation**
  - *Run out of county but organised by CRI*

**Recovery support**

- **Bridge** – recovery support, life skills and social reintegration
  - *Bases in Northampton, Corby and Wellingborough*

- **Mutual aid**
  - Alcoholics Anonymous
  - Narcotics Anonymous
  - Cocaine Anonymous
  - *Bases in all districts.*
Harm reduction services
- Needle Exchange – provided by CRI and 15 pharmacies across the county
  Bases in Corby, Daventry, East Northamptonshire, Kettering, Northampton and Wellingborough
- Supervised consumption – provided by 57 pharmacies across the county
  Bases in Corby, Daventry, East Northamptonshire, Kettering, Northampton and Wellingborough

Education services
- Aquarius – focus on educating older adults regarding alcohol use
  Base in Northampton

Young people and family services
- CAN YP – providing structured treatment and recovery support for young people with substance misuse issues
  Base in Northampton
- Family Support Link – providing support to children and adults affected by a family member’s substance misuse
  Base in Wellingborough
- Moving Parents and Children Together (M-PACT) – family support groups for users and their families
  Base in Wellingborough

What is the cost of current services?
Drug and alcohol treatment services are funded through a single budget. The anticipated spend on substance misuse services in 2015-16 can be broken down as follows.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Adults</th>
<th>Young People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community treatment</td>
<td>£5,862,423</td>
<td>£485,000</td>
</tr>
<tr>
<td>Residential treatment</td>
<td>£370,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>£200,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Non-structured treatment</td>
<td>£1,093,000</td>
<td>N/A</td>
</tr>
</tbody>
</table>

What is the evidence of progress in developing those services?
Performance indicators from the National Drug Treatment Monitoring System are recovering from the impact of recommissioning services

The PHOF indicators for substance misuse treatment are produced and published by NDTMS. The indicators show the number of clients who successfully completed treatment and did not return to services within the next 6 months as a proportion of all clients treated during a rolling 12 month period. A successful completion is where the client exited in a planned manner as either drug free or an occasional, non-problematic user (not heroin or crack).
Using local data from CRI, it is possible to approximate the 12 month rolling successful completions element of the PHOF, i.e. the indicator without the 6 month representation window, which can provide a rough predictor of PHOF performance trends. This is illustrated in the graphs below and overleaf, which plot the local successful completions indicator values 6 months behind to coincide with PHOF reporting. The national averages for the PHOF indicators have been included for comparison.

It should be noted that the PHOF indicators do **not** measure the likelihood of a client recovering once in treatment. This is particularly true for opiate clients, who typically spend longer than a year in treatment.

The indicator trends show a significant fall in performance during 2013-14. This is directly related to the recommissioning of services in February 2013 and the changes seen in the treatment system since – most notably, the number of clients in treatment now significantly exceeds the treatment population on which CRI’s contract was based.

While the PHOF indicators have started to recover from the performance drop, due to the way in which the indicators are calculated it takes 18 months for a sustained improvement to be fully reflected in the figures.

Based on current local performance trends, the PHOF for opiate clients can be expected to reach the national average during 2015-16.

Performance for non-opiate clients is improving more slowly than that for opiates. This is due to the fact that the non-opiate treatment population has grown significantly (see page 42) since February 2013 – although successful completion volumes have also increased (see page 43), when the indicator considers total completions over a rolling 12 month period the lower volumes from earlier in the period when the client base was smaller will drag down the proportional performance as considered against the total clients treated. Non-opiate performance is likely to remain depressed until the population size has been stable for roughly 12 months.

**PHOF indicator 2 year trend to October 2014 with locally projected successful completions rates – opiate clients**
PHOF indicator 2 year trend to October 2014 with locally projected successful completions rates – non-opiate clients

The impact of recommissioning

Under current policies, all services contracted by Northamptonshire County Council must be recommissioned on a 4-yearly cycle. For most services, this helps promote market fairness and ensure that value for money is being obtained. However, the recent recommissioning of substance misuse treatment services has highlighted some of the negative consequences that these processes can have in health settings.

CRI’s contract will end in 2017. Although the aim is to redesign services at this time, a change of provider would cause significant disruption to both staff and clients, the effects of which may be felt for over a year as has been the case this cycle.

A further consideration is the upcoming change to the Health Premium Incentive Scheme funding allocations, which will be based on improving the PHOF outcomes for drug treatment clients year on year. Recommissioning services will lead to a drop in performance and likely result in this funding being lost.
The number of clients accessing treatment services is increasing

There has been a significant increase in the number of clients accessing treatment services in Northamptonshire since the recommissioning to CRI. This is particularly apparent when considering the total treatment population over a rolling 12 month period, as used by the NDTMS for calculating performance indicators. The graph below illustrates the changes to the treatment population sizes for all the NDTMS client groups between April 2012 and October 2014. Figures to March 2014 are from NDTMS official statistics and local estimates have been used to project trends into 2014-15 pending further official statistical releases. Alcohol clients have been included for completeness; CRI provide treatment for both alcohol and drug misuse, therefore the increase in alcohol client volumes impacts on their overall capacity.

Clients treated over a 12 month rolling period from April 2012 through October 2014, based on NDTMS data to March 2014 and local estimates thereafter

CRI have reported providing structured treatment for 3,489 clients in the year up to 31 October 2014, of which 47.4% were opiate clients. NDTMS figures show that in the year up to 31 January 2013 a total of 2,072 clients accessed structured treatment under the previous system, of which 75.8% were opiate clients. This increase in uptake is thought to be a result of the positive approach taken by CRI; the refurbishment of CRI’s premises in order to create a more welcoming atmosphere; and positive word of mouth regarding the new treatment system.

Although the increase in new clients primarily related to the non-opiate and alcohol client groups, it is also noteworthy that the opiate treatment population has increased slightly, contrary to the national total which has been gradually decreasing since 2008-09.
Growth in treatment population

As the rate of growth of Northamptonshire’s adult substance misuse treatment population slows, it is anticipated that the numbers in treatment will stabilise around their new, elevated levels. CRI’s contract was based around the provision of services for the number of clients in structured treatment at the time of recommissioning, and to date they have been coping well with the pressures caused by the increase in client volumes.

However, there are still unmet needs within the county and Northamptonshire’s commissioners are investigating new pathways for bringing clients into treatment, which would result in a further inflation of CRI’s client base. It is likely that additional funding will be required in order to maintain a consistent, high-quality service.

The number of clients successfully completing treatment is increasing

The graph overleaf shows the trends in successful completions volumes between February 2013 and October 2014, using official NDTMS statistics to March 2014 and projections based on local data thereafter. Again, this is based on the NDTMS 12 month rolling figures; as a result, the figures from February 2013 through January 2014 will include treatment exits from the previous system.

Successful completions for the non-opiate and alcohol client groups have increased with the growing treatment populations. After an initial dip in performance, successful completions for opiate clients have been steadily increasing and CRI are aiming to exceed national average performance.

Successful completions over a 12 month rolling period from February 2013 through October 2014, based on NDTMS data to March 2014 and local estimates thereafter
Independent clinical audits conducted before and after the recommissioning process evidence clear improvements to client engagement and case management

Prior to the start of CRI’s contract, an independent case mix audit was commissioned in order to inform both commissioners and CRI’s management of baseline demographics and complexities of the clients in treatment. The audit was conducted using data held on the local case management system, CarePath. A similar audit was carried out at the end of 2014 and the results of the two audits were compared.

The 2014 clinical audit findings echoed the NDTMS statistics in that treatment services have gone from seeing predominantly opiate clients at the baseline to a more mixed group containing roughly 40% primary alcohol clients.

The audit noted that, compared to the baseline, the quality and clarity of case notes in 2014 had improved and there was a clear focus on reducing prescription doses for clients receiving opioid substitution therapy. Furthermore, did-not-attend rates had halved between the baseline and 2014 audits from 16% of face-to-face appointments being missed to 8%.

**Recommendation: Treatment services must be of a high quality and maximise successful outcomes for their clients**

Commissioners and agencies should provide the means to develop staff skills and support them in striving for excellence. Agencies should play to their keyworkers’ individual strengths and provide access to training where appropriate. Objectives and measures of success must be clearly defined and achievable without encouraging practices that may compromise the quality of clients’ care for the sake of meeting targets. Consultation with service users should be used to ensure that their needs are being met throughout.

**Recommendation: Designing structures for early interventions to reduce the long-term demand for treatment**

The clients who access treatment services are those who already have a substance misuse problem. With early intervention, it may be possible to prevent the substance use from becoming problematic and thus keep the individual from requiring structured treatment.

Since the integration of substance misuse commissioning into Public Health within the Local Authority, there is now the opportunity to explore ways of engaging with clients across a wider array of services and providing these early interventions in healthcare settings as opposed to in treatment services, which may be viewed negatively due to the stigmas and stereotypes associated with addiction.
What do service users say about their needs and the services that they receive?

As part of ongoing contract monitoring for CRI, a member of the commissioning team collates clients’ views on their experiences in treatment through a combination of face-to-face interviews and written questionnaires. Generally, the consensus has been that the service has improved as a result of the changes brought about by CRI, and discussions with the service users have been positive.

Client feedback has also highlighted the impact that issues faced by CRI had on their treatment. For example, service users in Kettering were more negative about the level of service received while CRI did not have a permanent base in the town, and expressed dissatisfaction around the frequency of appointments during this time.

The following extracts illustrate service user views on a variety of topics surrounding their experiences with CRI.

Impressions of building and facilities

One gentleman said he had used the service previously and never liked coming through the door. Since coming back to the service he has been extremely pleased with the support, the friendliness of staff (warm welcome always extended to him at reception) and the positive changes made to the layout/decor of the building. He particularly likes the latest addition in reception – the book case!

“Happy with the new layout, feels safe.”

“Clean and welcoming.”

Did you get the support you were wanting/expecting?

“My worker goes above and beyond for me. Helping me know what help is available as well as helping me understand it.”

“I really do think, being as this is an opportunity to express my views as a client, that I should mention that my worker X and that she works exceptionally in my favour from working around my busy work schedule to ensuring that I am comfortable and progressing with my treatment and recovery. I couldn’t be happier with her. She deserves some credit.”

“Years ago I didn’t have a good experience but since it’s changed to CRI I’ve had great support.”

“Just talking. Same old thing, not moving forward.”

“I get help. I stopped. I came clean and I am very happy. I could not have come clean without CRI. I am very happy, thanks. It changed my life.”

“Above what I was expecting.”

“Good help when I was seen but appointments were irregular.”

What would make the service better for you?

“Option for home visits as I have young kids.”

“I would like to see a male parenting group.”

“Being seen on time.”

“Time short, could be longer for the first few sessions. So much to say.”
What additional information is needed?

Improved recording of Needle Exchange data

At the time of writing, the data collected by pharmacies in relation to Needle Exchange is of variable quality and it is not possible to obtain an accurate indication of the number of individuals accessing services. Furthermore, although CRI provide Needle Exchange services they do not record this activity.

A review of the systems being used to collect Needle Exchange data is underway, with the aim to provide means of improving the data quality and consistency of recording at pharmacies, and begin proper data recording at CRI. This will allow for more accurate analysis and assessment of the coverage of the scheme in future.

Review of drug and alcohol related deaths

At the time of writing, commissioners are in the process of establishing a process for reviewing drug and alcohol related deaths to determine whether there is any learning to be done from the circumstances. For this process to be effective, further information sharing with external organisations may be required.

Improved recording of users’ recovery capital

A user’s likelihood of recovering from substance misuse will be affected by their social circumstances, either positively or negatively. The presence or absence of a stable, supporting family and/or social circle will affect the type of support a client will require from treatment services. Although keyworkers are expected to assess this and refer clients to relevant recovery support services, current datasets do not capture the elements that make up a client’s social capital in a way that allows for quantitative analysis.

Information that would be useful include:

- Whether the client is living with another adult who is misusing drugs and/or alcohol;
- Whether the client has been experiencing or perpetrating domestic violence;
- Whether the client has accessed or is accessing mutual aid; and
- The client’s self-reported feelings of social integration/isolation.

Recording changes in these areas is also problematic; this has been noted at Bridge, which provides non-structured recreational and support activities that the member may access as and when they may wish to. Commissioners are investigating ways of gathering qualitative evidence of Bridge members’ progress through recovery.

Matching of prison and NDTMS data

NDTMS are producing a new PHOF indicator to show the proportion of adults starting structured substance misuse treatment in prison who had not received it in the community prior to custody. At the time of writing, it is unclear what intelligence this new indicator will provide. The supporting data available for this indicator shows that 78% of prisoners from Northamptonshire being treated for opiate use have received treatment in the community, which is higher than the national average of 70%. For alcohol clients, the percentage is 31%, compared to a national average of 37%.

The usefulness of this data would be improved if it were possible to determine the treatment outcomes of the individuals who offended after having been in community treatment; for example, a client who dropped out of treatment could be expected to be more likely to offend than one who had successfully completed treatment.
Conclusions

The dip in PHOF performance caused by the recommissioning of services has resulted in additional scrutiny being placed on Northamptonshire’s commissioners and services. For much of 2013-14 and 2014-15, the focus locally has been on driving and evidencing performance improvement, particularly for opiate clients.

Now that the indicators are improving and much of the groundwork for the core treatment system is in place, there is more scope for innovation and developing new pathways for treating clients. The integration of substance misuse commissioning into Public Health has widened the opportunity to meet the health needs of this vulnerable client group.

A lot of effort has gone into developing substance misuse treatment services in Northamptonshire, and ensuring that all service users have the best possible chances of recovery is an ongoing process. Local commissioners are ambitious in the outcomes they wish to see achieved, and are increasingly relying on local data and intelligence to inform their direction of travel as the NDTMS national reporting does not allow for analysis at the level of detail required. In particular, it is clear that qualitative research will be required to obtain a better understanding of the needs of local service users.

What are the recommendations to improve and support commissioning and forward planning to ensure quality of care and value for money?

Although the recent recommissioning of adult substance misuse treatment services has resulted in many positive changes to the design and functioning of the treatment system in Northamptonshire, the immediate negative impact of the process was greater and took longer to resolve than anticipated. Half-way into the 4-year contract, national performance indicators are only just starting to do justice to the hard work undertaken at all levels to ensure the success of the system, and there is still more work to be done in order for CRI to reach their full potential.

Treatment services are due for recommissioning again in 2017 under Local Authority procurement rules. In view of recent experiences, another major provider change should not be undertaken without a full impact assessment to cover the following areas:

- **Continuity of care** – Due to issues around data ownership, records for historic clients not actively in treatment at the time of the contract handover were not transferred to CRI. This may have impacted on CRI’s treatment of clients returning to services after the handover, as they would not be aware of any details around the client’s contact(s) with the previous services.

- **Demoralisation and loss of staff** – Uncertainty about the long-term future of services will impact on staff motivation and performance, and may result in the loss of skilled and experienced workers.

- **Losing the trust of a highly vulnerable client group** – Clients in substance misuse treatment will be affected by any disruption to services, and may not be accepting of changes brought about by a new provider. There is a risk of clients disengaging from treatment as a result, which could have a serious impact on their health and long-term prospects of recovery.

- **Loss of Public Health funding under the Health Premium Incentive Scheme** – It is clear that performance indicators suffer following a recommissioning of services. In view of recent announcements that the allocation of the Health Premium Incentive Scheme funding will be based around improvement to drug treatment performance indicators, a fall in performance is highly likely to lead to this funding being lost.

Retendering services on a 4-yearly cycle is likely to be detrimental to the long-term success of the treatment system. Commissioners will need to investigate avenues of extending successful contracts until such point that the benefits of reprocurement would outweigh the risks.
## Summary of recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsible Parties</th>
<th>Timescale</th>
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<tbody>
<tr>
<td><strong>Integrated working within the Public Sector</strong></td>
<td>Commissioners</td>
<td>2015-16</td>
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<td>Commissioners should be working to completely integrate substance misuse services into the full range of adults’, children’s and safeguarding services provided by Northamptonshire County Council, to include consultation on improving the quality and effectiveness of services for Northamptonshire’s population.</td>
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<td><strong>Providing high standards of holistic healthcare and advice for all clients</strong></td>
<td>Commissioners, treatment providers and service user networks</td>
<td>2015-16</td>
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<tr>
<td>Treatment services need to provide appropriate advice and education regarding health problems resulting from the abuse of drugs. They must ensure that all practitioners are fully trained and competent to give advice. They should also consider training volunteers, champions and peer mentors to be able to reinforce the health message. Treatment services must widen their harm reduction services to include testing for Hepatitis A, HIV, tuberculosis and other communicable diseases which result from lifestyle behaviours common amongst those that consume and abuse drugs. In conjunction with the local Authority they should also continually review the appropriateness of the range of healthcare services provided and seek to redress health inequalities within the population being treated.</td>
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<tr>
<td><strong>Recovery to be available for all clients in treatment</strong></td>
<td>Commissioners, treatment providers and service user networks</td>
<td>Ongoing</td>
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<td>The aim of providing treatment for substance misusers in Northamptonshire is not just to help them overcome addiction, but to provide the tools for them to rebuild their lives free of addiction. Recovery must be visible at all stages of the client’s journey in the treatment system, and following discharge it is important that the client still feels that they have access to support at any time they might need it in order to minimise the chances of relapse. Services should be aware of clients dropping out of treatment and follow up wherever possible to obtain feedback and understand what led to the client disengaging. Similarly, they should seek to obtain insight into why clients relapse from clients representing to treatment. These processes may be facilitated by co-production with service user networks. Any lessons learned should be fed back to front line staff and used to improve future service provision.</td>
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<td>2015-16</td>
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</table>
### Treatment services must be of a high quality and maximise successful outcomes for their clients

Commissioners and agencies should provide the means to develop staff skills and support them in striving for excellence. Agencies should play to their keyworkers’ individual strengths and provide access to training where appropriate. Objectives and measures of success must be clearly defined and achievable without encouraging practices that may compromise the quality of clients’ care for the sake of meeting targets. Consultation with service users should be used to ensure that their needs are being met throughout.

| Commissioners, treatment providers and service user networks | 2015-16 & 2016-17 |

### Providing ready access to services

Commissioners and agencies should review the need for treatment services across the county on a regular basis and continually explore ways of making treatment accessible for anybody who may require it. This may mean bringing treatment to the client, rather than having the client come to the service itself.

| Commissioners, treatment providers | 2015-16 |

### Designing structures for early interventions to reduce the long-term demand for treatment

The clients who access treatment services are those who already have a substance misuse problem. With early intervention, it may be possible to prevent the substance use from becoming problematic and thus keep the individual from requiring structured treatment.

Since the integration of substance misuse commissioning into Public Health within the Local Authority, there is now the opportunity to explore ways of engaging with clients across a wider array of services and providing these early interventions in healthcare settings as opposed to in treatment services, which may be viewed negatively due to the stigmas and stereotypes associated with addiction.

| Commissioners | 2015-16 & 2016-17 |

### Developing integrated pathways for family services

It is becoming increasingly apparent that family services need to be central to Northamptonshire’s treatment system in order to help overcome the wider harms caused by substance misuse. Commissioners are aiming to implement a family-based treatment model in 2017 and this will need to be considered in the design of systems and pathways.

| Commissioners | 2017 |
Appendix 1

List of organisations involved in consultation around the ongoing shaping of Northamptonshire’s substance misuse services

- ADFAM: Families, drugs and alcohol
- Aquarius
- BeNCH [Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire] Community Rehabilitation Company
- Bridge
- CAN [Council on Addiction Northampton] Young People’s Service
- CRI [Crime Reduction Initiatives] Northampton
- Department of Work & Pensions
- Family Support Link
- G4S
- Garden Organic
- HMP Onley
- HMP Woodhill
- Illy Systems
- Martindale Pharmacy
- National Health Service
- National Offender Management Service
- Nene Clinical Commissioning Group
- Northamptonshire County Council
- Northamptonshire Healthcare NHS Foundation Trust
- Northamptonshire Police
- The Prison Advice and Care Trust
- Public Health England
- Office of the Police and Crime Commissioner
- The Small Business Consultancy
- Sunset Independent user focus group