FIGURE 8
CONSULTANCY SERVICES LTD

2014

WEST SUSSEX ALCOHOL AND DRUG NEEDS ASSESSMENT

Report prepared for West Sussex County Council

EVIDENCE INTO PRACTICE

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CHAPTER 1: INTRODUCTION

1.1 Introduction and background

Figure 8 Consultancy Services Ltd. was commissioned by West Sussex County Council (Public Health) in August 2013 to carry out a comprehensive alcohol and substance misuse health needs assessment project; and field work took place between September 2013 and December 2013.

Drug Action Teams were established by the Government in 1995 to ensure the strategic co-ordination of local action on drug misuse. In 2012, the West Sussex Drug & Alcohol Action Team (WSDAAT) was incorporated into Public Health England (PHE) with a view to transfer to the management of West Sussex County Council in April 2013. This Needs Assessment is a report that presents an evaluation to alcohol and substance misuse stakeholders across West Sussex and forms an important and independent component in the service commissioning process.

The document takes cognisance of the Drug Strategy 2010[1] which "sets out the Government's approach to tackling drugs and addressing alcohol dependence, both of which are key causes of societal harm, including crime, family breakdown and poverty". There are three main themes to this strategy: reducing demand, restricting supply and building recovery in communities. The Government's Alcohol Strategy[2] is also reflected with the requirements for alcohol-related issues to be tackled locally and individuals are challenged to "change their behaviour" by receiving information and support. The West Sussex Joint Health and Wellbeing Strategy[3] is also considered. This sets out key priorities that will deliver better health and wellbeing for residents of West Sussex, especially children and vulnerable adults, to live long lives. It also sets out a series of principles against which it will judge and challenge commissioning plans. This report has been compiled with these principles in mind:

- Based on the Joint Strategic Needs Assessment.
- Demonstrating engagement with patients and customers in the design of services.
- Identifying not only financial and resource constraints but also assets.
- Clear on improved outcomes.
- Demonstrating improved collaboration and integration (between health and social care commissioning).
- Identifying contributions to reduced health inequalities, increased patient access, choice and control and more seamless patient pathways.

[1] HM Government Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery.

[2] The Government's Alcohol Strategy – March 2012.

[3] West Sussex Joint Health and Wellbeing Strategy 2013-2015. Accessed at: http://www2.westsussex.gov.uk/ds/cttee/hwb/hwbstrategyaddendum.pdf [10th January 2014].

- Being transformational and innovative where necessary.
- Removing barriers to change that would have an early impact.
- Shifting the focus towards all aspects of early intervention and prevention.
- Identifying the potential interaction with other services such as housing, transport and education.

The Needs Assessment is informed by various data sources including:

- the National Drug Treatment Monitoring System (NDTMS);
- Public Health England;
- the National Treatment Agency for Substance Misuse;
- the Crime Survey for England and Wales;
- West Sussex Partnership Reports / submissions;
- West Sussex Public Health & Wellbeing Directorate;
- Sussex Police;
- other locally gathered information and lifestyle surveys etc.

The Needs Assessment has been designed to reflect proposals to restructure the current adult treatment model – to streamline pathways into a more person-centric treatment and support provision across specific geographical areas throughout West Sussex. It focuses on the diverse needs of West Sussex communities and considers the changing trends and market forces related to alcohol and substance misuse.

1.2 Scope of the Project

This document presents findings of the Needs Assessment and reports on the future requirements for services for people with alcohol and/or substance misuse problems across West Sussex. Evidence from the Needs Assessment will assist:

- In providing evidence on the extent to which current services are meeting demand;
- In the commissioning of new services;
- In identifying gaps in existing service provision;
- In identifying areas of over provision;
- In providing evidence on the extent to which services are accessible and in the right location;
- In suggesting ways as to how West Sussex County Council and its partners could extend / adapt services to meet need; and
- In providing objective comment on the re-structuring of relationships between specialist alcohol and substance misuse services, wider health and social care services, communities, families and individuals to promote and maintain a recovery-oriented system of care across the county.

1.3 Objectives

The specific objectives of this project, as indicated by the project brief, are as follows:

- To describe the epidemiology of drug and alcohol use in West Sussex including prevalence, risk factors, drivers and impact.
- To assess current and estimate future health and social care needs of adults and children and young people with Opiate & Crack Use (OCU), non – OCU and Alcohol use.
- To assess the health and social care needs of adults and young people with dual diagnosis.
- To assess the needs of children and young people whose parent or guardian is at risk of drug and or alcohol misuse.
- To summarise existing treatment provision and resources for adults, children and young people presenting with drug and alcohol misuse and other preventative services and activities.
- To understand where local services are working well and where improvements are needed.
- understand how substance misuse treatment services are working with other health and social care services (including VCS services), in particular links with mental illness treatment for adults and children and links with prevention and treatment for infectious diseases such as HIV and Hepatitis.
- To understand the issues which are important to service users, their families and the wider population.

1.4 Summary of study methods

The study was conducted in eight stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods and sample populations. These are set out in Table 1.1 below. All questionnaires and interview schedules were approved by commissioners prior to use. Copies of these are available on request.

Table 1.1: Summary of Study Methods

Stage 1	**Method**	
Review of existing datasets	Desk-based review of national and local datasets	
Stage 2	**Method**	**Sample**
Scoping Exercise on the concept of Recovery	Online survey	• Specialist staff across West Sussex – alcohol and/or substance misuse services[4]
	Online survey	• Non-specialist staff across West Sussex[5]
Stage 3	**Method**	**Sample**
Quantitative Survey	Online survey	• Managers of all services that work with people with drug and/or alcohol problems (whether specialist or non-specialist) across West Sussex.
Stage 4	**Method**	**Sample**
Qualitative Surveys	Online & Paper-based survey	• Users of specialist alcohol and substance misuse services in West Sussex
	Online & Paper-based survey	• Non-service users (those who do not currently use, but may benefit from using, specialist alcohol and/or substance misuse services in West Sussex)
	Online & Paper-based survey	• Family members / Carers of those with alcohol and/or substance misuse issues in West Sussex
	Online survey	• Specialist staff across West Sussex – alcohol and/or substance misuse services
	Online survey	• GPs across West Sussex
	Online survey	• Pharmacists across West Sussex
	Online survey	• General population of West Sussex[6]
Stage 5		
Qualitative Interviews	Semi-structured interviews (face to face and telephone)	• Providers • Stakeholders

[4] See Supplementary Report 1

[5] See Supplementary Report 2

[6] See Supplementary Report 3

		• Users of specialist alcohol & substance misuse services in West Sussex
Stage 6	**Method**	**Sample**
Focus Groups	Focus Groups	• Users of specialist alcohol & substance misuse services in West Sussex • Family members / Carers of those with alcohol and/or substance misuse issues in West Sussex • Key stakeholders
Stage 7	**Method**	
Gap Analysis	Desk-based comparison of range and capacity vs. need	
Stage 8	**Method**	
Analysis & Reporting	Final report and executive summary	

1.5 Definitions and Concepts

The methodology of calculating need is derived from the *Scottish Alcohol Needs Assessment* (SANA).[7] This in turn uses the definitions and concepts set out in the *Alcohol Needs Assessment Research Project* (ANARP) conducted by Drummond and colleagues in England.[8]

In order to ensure consistency and comparability these definitions and concepts have been adopted for use in this report. This chapter details the following terms as they apply to this report:

- Specialist alcohol and drug treatment;
- Needs Assessment;
- Need; and
- Assumptions in Needs Assessment for Alcohol and Drug Use Disorders.

1.5.1 Specialist Alcohol and Drug Treatment

This refers to a wide range and intensity of interventions from, for example, one or more sessions of Motivational Enhancement Therapy through to intensive residential rehabilitation lasting up to 12 months. The commonality between these interventions is that they are provided for patients actively seeking help for substance misuse disorders, and the interventions are provided by specialist staff trained to provide them.

[7] Drummond C, Deluca P, Oyefeso A, Rome A, Scrafton S, Rice P. (2009) *Scottish Alcohol Needs Assessment*. Institute of Psychiatry, King's College London: London.

[8] Drummond, C., Oyefeso, N., Phillips, T., Cheeta, S., Deluca, P. *et al* (2005) *Alcohol Needs Assessment Research Project (ANARP). The 2004 national alcohol needs assessment for England*. Department of Health: London.

Specialist treatment is primarily targeted at people with alcohol or drug dependence, and the more intensive forms (e.g. inpatient or residential treatment) are generally reserved for people with more severe dependence and/or significant psychiatric co-morbidities or social problems. Both alcohol and drug related harm and dependence exist on a continuum of severity and, although they are categorised within ICD-10, the precise point at which dependence or harm reach a threshold requiring a specialist intervention is, in practice, difficult to determine.

1.5.2 Needs Assessment

In broad terms, health care needs assessment (HCNA) is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way. It involves methods to describe the health problems of a population, identify inequalities in health and access to services, and determine the priorities for the most effective use of resources.

Health care needs assessment has become important as the costs of health care are rising and resources for health care are, at the same time, limited. In addition, there is a large variation in availability and use of health care by geographical area and point of provision (Andersen and Mooney, 1990).[9]

Another force of change is consumerism. The expectations of members of the public have led to greater concerns about the quality of the services they receive, from access and equity to appropriateness and effectiveness.

Rush (1990)[10] presented a model of alcohol needs assessment which influenced the HCNA review and has been influential in alcohol needs assessment internationally. Rush's model suggests a range of access to specialist treatment: an access level of 1 in 10 (10%) alcohol dependent individuals entering treatment per annum is regarded as a 'low' level of 'required capacity'; 1 in 7.5 (15%) 'medium'; and 1 in 5 (20%) 'high'. It is however important to note that Rush's model is based on a large number of assumptions about the size of the 'in-need' population, the process of referral to various agencies and treatment drop-out. Rush's study also used a large number of proxy measures rather than direct measurement of need and access. Therefore estimation of need for alcohol treatment and access would be improved by actual data from surveys as in the work presented in this report. In this study, we have followed the methodology recommended in the *Health Care Needs Assessment Review of Alcohol Misuse* (Cook, 2004).[11]

[9] Andersen, T.F. & Mooney, G. (eds) (1990) *The challenges of medical practice variations.* MacMillan Press: London.

[10] Rush, B. (1990) A systems approach to estimating the required capacity of alcohol treatment services. British Journal of Addiction, 85: 49-59.

[11] Cook, C. (2004) Alcohol Misuse, in A. Stevens, J. Raftery, J. Mant, S. Simpson (Eds), *Health Care Needs Assessment: the epidemiologically based needs assessment reviews. First Series Update.* Radcliffe Medical Press: Oxford.

1.5.3 Need

In health care, need is commonly defined as 'the capacity to benefit'. If health needs are to be identified then an effective intervention should be available to meet these needs and improve health. There will be no benefit from an intervention that is not effective or if there are no resources available (Wright, Williams & Wilkinson, 1998).[12] The definition of need used in this study is 'the number of individuals in the general population with alcohol or drug dependence who could benefit from intervention'.

There are several challenges in estimating the prevalence of alcohol and drug dependence in the general population involving the definition of dependence and the methods used to obtain the estimate.

The estimates used for the drug component of this study are taken from the national prevalence study conducted by the National Treatment Agency for Substance Misuse (2010-11).[13]

The estimates used for the alcohol component of this study are taken from the 'Alcohol Needs Assessment Research Project' (ANARP) 2004.[14]

1.5.4 Assumptions in Needs Assessment for Alcohol and Drug Use Disorders

Clearly the above definition of need is based on a number of assumptions. As in standard needs assessment methodology described above, it does not take account of natural remission: that is the proportion of people with alcohol or drug dependence who will recover without formal specialist or other interventions. This has been estimated in general population follow-up studies and using other methods, primarily in the US, and different studies have provided different estimates. We have not incorporated natural remission into the estimates since no specific estimates are available for England. Furthermore, while there is evidence of natural remission of alcohol dependence over time, we have no way of knowing at present what proportion of people who eventually recover without specialist intervention would have had the course of the disorder shortened by a timely specialist intervention had it been available and accessible.

Another assumption is that the treatment provided is universally effective. This is clearly unlikely to be the case, but it is not possible to assess this within the scope or methodology of the research brief. Thirdly, not everyone who is offered treatment, assuming it is widely available, would want or accept treatment as they may not be in an 'action' stage of motivational readiness to change (Prochaska & DiClemente, 1987).[15]

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[12] Wright, J., Williams, R., & Wilkinson, J.R. (1998). Development and Importance of Health Needs Assessment. *British Medical Journal,* 316; 1310-1313.

[13] Hay, G., Santos, A., and Millar, T., *Estimates Of The Prevalence Of Opiate And/Or Crack Cocaine Use 2010-11: A Summary of Key Findings*, National Treatment Agency for Substance Misuse, 2013. Available at http://www.nta.nhs.uk/uploads/prevalencesummary2013v1.pdf

[14] Drummond (2005), op. cit.

[15] Prochaska, J.O & DiClemente, C.C. (1983) Stages of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology,* 51, 390-395.

The subgroup of those in need who wish to receive treatment is sometimes referred to as the 'potential demand' for treatment.

Fourthly, not everyone who indicates in a survey that they would wish to receive treatment, will actually access treatment. This may both reflect a gap between what people say in surveys and what they actually do, and the barriers (real or perceived) to people actually accessing the services they need and want. Therefore, in line with previous alcohol needs assessments, in this study we have studied the 'access' to treatment which is defined as 'the estimated number of treatment places available (capacity)'. This is also referred to here as 'Service Utilisation'. Some US surveys have attempted to estimate potential demand as distinct from need, based on survey questions as to whether people with alcohol dependence would want to access treatment if it was available. However, no comparable estimate is available in Scotland.

Clearly engaging with treatment is not synonymous with receiving the full programme or course of treatment on offer, as some people will disengage prematurely. Also, within the limitations of the methodology we are unable to differentiate between people accessing treatment who are harmful drinkers as opposed to dependent drinkers.

1.6 Comparison of costs

In an international systematic review of the evidence of effectiveness of treatment for opiate dependent drug users (Simoens et al, 2003)[16] commissioned by the former Effective Interventions Unit (Scottish Executive), the authors made a number of conclusions including:

- Very few high-quality economic evaluations have been undertaken.
- Most studies omit major costs or consequences.
- Many economic evaluations were carried out in the U.S.A. The transferability of these results to the U.K. may be limited.
- There are no economic evaluations of residential rehabilitation.

Overall, they concluded that the economic evaluation literature was of low quality and the evidence to support the cost-effectiveness of any particular intervention was sparse.

There are a number of economic evaluations used in healthcare systems including cost-offset (or cost analysis) studies, cost-effectiveness analysis, cost-utility analysis and cost-benefit analysis.

Simoens et al (2003) set out the costs and consequences relevant to assessing cost-effectiveness. This is replicated in Table 1.2 below.

Table 1.2: Costs and consequences relevant to assessing cost effectiveness

[16] Simoens, S., Matheson, C., Inkster, K., Ludbrook, A., Bond, C. (2003) The effectiveness of treatment for drug users: An international systematic review of the evidence (Scottish Executive, 2003).

Costs
Direct intervention costs e.g. resource costs for treatment **Costs to other agencies** e.g. social care demands from more people in treatment **Costs to the individual and their families** e.g. time and travel costs of treatment
Consequences
Benefits to individuals and families of reduced drug dependence: Improved quality (less premature deaths) and quality of life; Improved social and family functioning, including reductions in criminal justice involvement and less financial problems; Improved earnings and employment. **Resource savings:** Potential fall in future health care costs; Reduction in criminal justice expenditure and victim costs from less criminal activity. **Other value** created from drug dependence interventions: Increased productivity; Impact on communities from reducing criminal activity.

Sindelar and colleagues (2004) recognised the difficulty is applying a cost-effectiveness model to substance misuse stating that, "Given the multiple important outcomes of substance abuse treatment potential problems arise because the clinical-effectiveness analysis is intended primarily for single outcome programmes, yet addiction treatment results in a variety of outcomes such as reduced drug use and crime and increased employment."[17]

Given the lack of good quality research in this area and the methodological difficulties of conducting economic evaluation in the substance misuse field, this report focuses on identifying the activity of services in relation to need.

1.7 Limitations and Assumptions

There are a number of factors which should be taken into account when reading this report. These are:

- The views of stakeholders interviewed are given in good faith and are representative of their organisation.
- Making comparisons with other areas of similar population and/or geography, as well as prevalence of drug and alcohol problems, allows for a degree of 'benchmarking' to observe the relative position of West Sussex. It should be

[17] Sindelar, J., Jofre-Bonet, M., French, M. McLellan A.T. (2004) Cost-effectiveness analysis of addiction treatment: Paradoxes and multiple outcomes. *Drug and Alcohol Dependence* Vol 73 Issue 1, pp 41-50.

noted that there may be variations between areas in the way in which this data is collected.

- The prevalence rates and service activity data used for calculating the gap analysis relate to people with alcohol dependency or problem drug use. While it is recognised and acknowledged that a significant amount of work is conducted in primary care, mental health teams and criminal justice teams with people with drug and alcohol problems, the focus of the gap analysis section of this report (Chapter 7) and the international work cited is on the extent to which current specialist substance misuse services can meet need in their area.

1.8 Additional Evidence

This report is augmented by Supplementary Reports 1 – 3, which provide further attitudinal data gathered from specialist alcohol and substance misuse staff, non-specialist service staff, and the general population of West Sussex. These reports are available upon request.

CHAPTER 2: EPIDEMIOLOGY OF DRUG AND ALCOHOL USE IN WEST SUSSEX

2.1 Introduction and Aims

The aim of this element of the project was to review existing datasets to identify the prevalence and trends of alcohol and drug use in West Sussex.

2.2 Method of Data Collection

Information was identified and drawn together from a range of local and national sources on prevalence and trends in the consumption of alcohol and drugs in England over the past ten years. In order to provide comparative analysis on a range of health and social indicators two local authority areas were identified from the same socioeconomic deprivation background as West Sussex.[18] Essex and Dorset were chosen as comparators since both are located in the south of England; the former has both a coastal and a commuting population akin to that in West Sussex, and the latter has similar rural populations.

2.3 Key Findings

2.3.1 Demography

- West Sussex has an aging population and current population projections estimate an overall population increase of 10% over the next ten years, but with higher percentage increases in the 65-84 and 85+ year old age groups.
- West Sussex is becoming more ethnically diverse (11% ethnic minority in 2011 Census; 6.5% in 2001 Census), although there is significant local variation across the county.
- West Sussex is a large county with a variety of large towns and many smaller, scattered villages. In 2011, the population of rural wards in West Sussex accounted for 24% of the county total. Residents of rural West Sussex generally have to travel further to access services than in other rural areas across the country.

2.3.2 Prevalence of alcohol misuse in West Sussex

- Rates of 'Increased and higher risk drinking' in West Sussex is slightly, although not significantly, lower than the average in England.

[18] West Sussex is in socioeconomic decile 9 along with Bromley, Cambridgeshire, Cheshire East, Dorset, East Riding of Yorkshire, Essex, Gloucestershire, Merton, North Somerset, North Yorkshire, Oxfordshire, Warwickshire, Wiltshire, and York.

- In 2011/12 West Sussex had fewer than average hospital admissions attributable in whole or in part to alcohol.
- West Sussex does better than the national average in terms of alcohol-related crimes, and local statistics from Sussex Police suggest the number of these offences is decreasing over time. But it is important to note any change in recorded figures over time may be as a result of a change in Police activity in a geographic area or as a result of a Police Operation instead of demonstrating an actual increase/decrease in offences.

2.3.3 Prevalence of drug misuse in West Sussex

- For all classes of drug misuse, prevalence estimates in West Sussex are below the national average.
- In 2011/12 West Sussex had fewer than average hospital admissions with a primary diagnosis of poisoning by drugs.
- Using the nationally accepted prevalence rate of 1%, it is fair to surmise that around 90 of the maternities in West Sussex in 2012 were problem drug users.
- Local police statistics show a reduction in drug-related offences in West Sussex between 2008 and 2013. But it is important to note any change in recorded figures over time may be as a result of a change in Police activity in a geographic area or as a result of a Police Operation instead of demonstrating an actual increase/decrease in offences.

2.3.4 Risk factors / Vulnerable Populations

- Deprivation has been linked to problem drug use, but the association between alcohol misuse and deprivation is not as clear. Deprivation in West Sussex is lower than average, however, county level data masks considerable differences within areas and there are some very deprived neighbourhoods.
- Using prevalence figures suggested by the research of Manning et al (2009), currently, in West Sussex, around 32,500 children under the age of 16 live with a hazardous drinker; 8,800 with a dependent drinker; and over 5,000 are at potentially elevated risk of harm living with a problem drinker who uses drugs.
- Extrapolating the estimates made by the Advisory Council on the Misuse of Drugs, currently in West Sussex, between 1,400 and 3,000 children under the age of 16 are affected by serious parental drug misuse.

2.4 Demography of West Sussex

Present and future need for services and assets to address alcohol and drug misuse in West Sussex depends in part on the demography of the county. In this section basic population data is therefore briefly assessed.

2.4.1 Population: Age

There are approximately 808,900 people resident in West Sussex, 495,700 aged 16-64 and 168,100 aged 65 years or over.

Table 2.1: Population (Resident and Registered Patients) by CCG Area[19]

Resident Population	**Total**	**Total 18+ Population**	**Specific Age Groupings**			
			0 - 15	**16 - 64**	**65 & over**	**18 - 24**
West Sussex	808,900	645,420	145,200	495,700	168,100	58,700
Coastal CCG	480,030	389,560	79,910	284,950	115,180	34,720
Crawley CCG	107,050	82,360	22,190	71,300	13,560	9,250
Horsham & Mid Sussex CCG	221,830	173,500	42,840	139,680	39,310	15,630
Registered PATIENT Population	**Total**	**Total 18+ Population**	**Specific Age Groupings**			
			0 – 15	**16 – 64**	**65 & over**	**18 - 24**
Coastal CCG	490,935	400,350	79,913	291,129	119,893	58,606
Crawley CCG	127,072	98,530	25,506	84,730	16,836	18,012
Horsham & Mid Sussex CCG	227,203	179,580	42,214	142,199	42,790	27,681

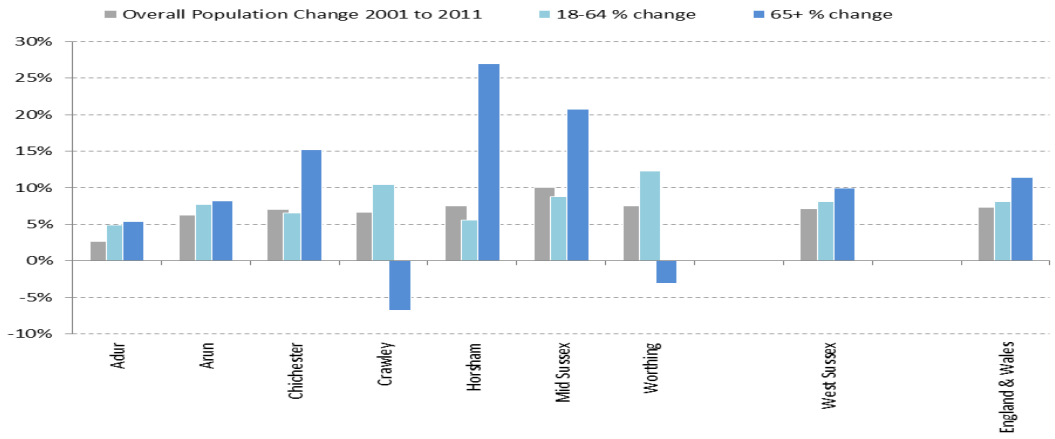
Overall there has been a 7% increase in population in West Sussex since 2001, with a 9% increase in 65+ year olds. There are however considerable differences across the county. In Horsham and Mid Sussex there have been 27% and 21% increases in the number of people aged 65+ respectively, whereas in Crawley and Worthing there have been large increases in the number of 18-64 year olds (10.5% and 12.7% respectively) as shown in the Figure below. [20]

Figure 2.2: Age Group Changes Change 2001 to 2011[21]

[19] Source: Resident population – ONS MYE 2011, Registered Patient Population Exeter 2013

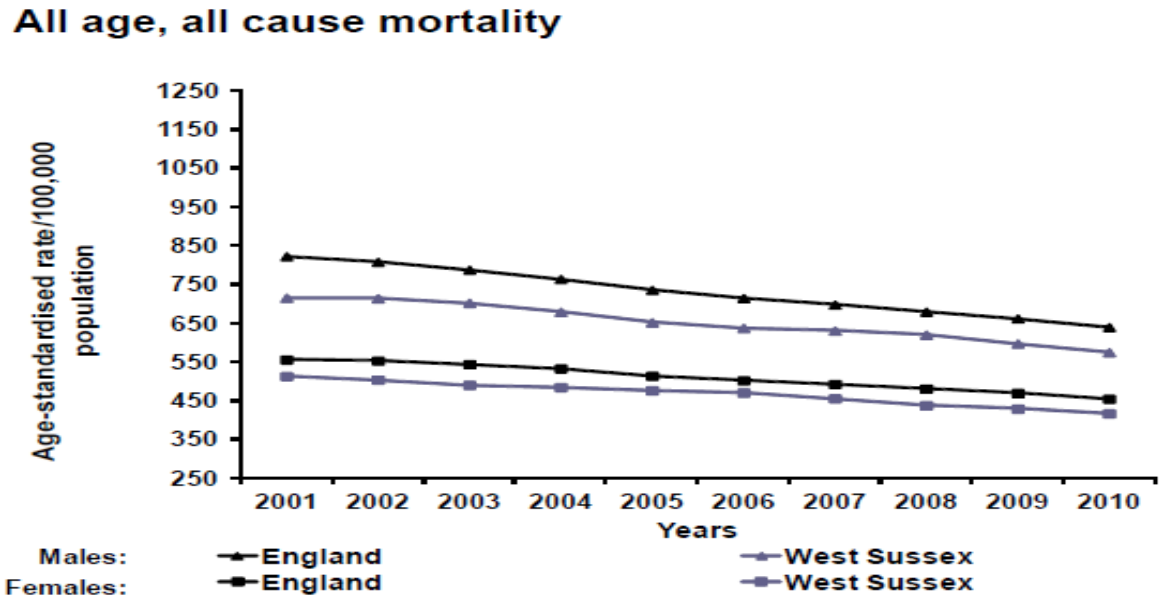
[20] All statistics taken from ONS Mid-Year Estimates 2011

[21] ONS Mid-Year Estimates 2011



Life expectancy for both males and females in West Sussex is significantly better than the average in England. According to Public Health England data for 2013, in West Sussex life expectancy at birth for males is 80.2 years (78.9 years England average; 81.1 Dorset; 79.9 Essex)[22] whilst it is 83.8 years for females (82.9 years England average; 85.1 Dorset; 83.4 Essex).[23] Further, over the last 10 years, all cause mortality rates have fallen in West Sussex, and are consistently lower than the national average (see figure below). In particular, early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.[24]

Figure 2.3: Rates of death, at all ages and from all cause, West Sussex/National Comparison[25]



[22] Statistics from Public Health England Data Table: Life Expectancy - Male (2009-2011)

[23] Statistics from Public Health England Data Table: Life Expectancy - Female (2009-2011)

[24] West Sussex Health Profile 2013, Public Health England, 24th September 2013

[25] Ibid.

That withstanding, there are significant variations across the region. Life expectatancy is 7.2 years lower for men and 5.3 years lower for women in the most deprived areas of West Sussex than in the least deprived areas.[26]

Using this information amongst other data, current population projections for West Sussex estimate an overall population increase of 10% over the next ten years, but with higher percentage increases in the 65-84 and 85+ year old age groups.[27]

[26] Ibid.

[27] Sub National Population Projections (SNPP) produced by ONS in 2013.

Table 2.4: Population 2011 (MYE) and 2021 Projected[28]

Age Group	2011 (MYE)	2021 Projection	% Change
0-15	144,900	163,800	13.0%
16-64	495,900	518,700	4.6%
65-84	141,100	174,100	23.4%
85+	**26,900**	**35,200**	**30.6%**
Overall	808,900	89,1800	10.3%

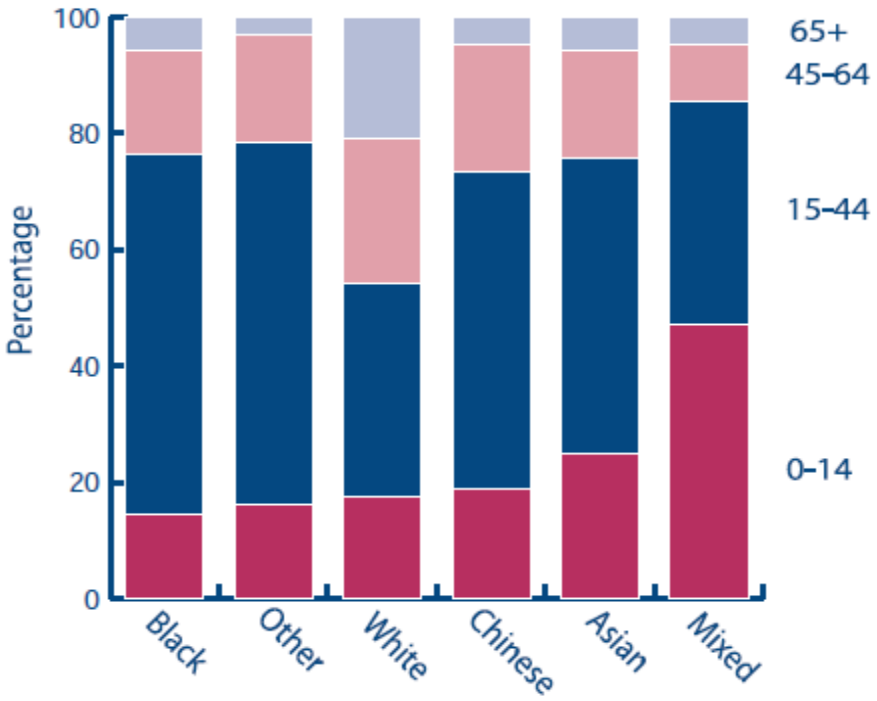
2.4.2 Population: Ethnicity

West Sussex is becoming more ethnically diverse. It can be seen from the figure below that the White population has an older age structure than the non-White populations, with approximately double the proportion of people aged 45 and over, and around four times the proportion of people aged 65 and over. The Mixed ethnic population has the youngest age structure, with just under half of its population below 15 years of age. Interestingly, the Black and Chinese populations have similar proportions of people below the age of 15 to the White population, whilst having higher proportions of 15-44 year olds to the White population:

Figure 2.5: Age distribution of ethnic groups in West Sussex based on 2001 Census[29]

[28] Ibid. Figures rounded to the nearest 100.

[29] Source: Fitzpatrick, K., *Census Bulletin Issue No. 5: Ethnicity and Religion in West Sussex*, West Sussex Public Health Observatory. Available at http://www2.westsussex.gov.uk/communityandliving/census2001/cb5_ethnicityandreligion.pdf



Data from the 2011 census show that 11% of the population is from an ethnic minority, compared with 6.5% in 2001. Of the black and ethnic minority (BME) groups, 'white other' accounts for 4% of the West Sussex population. There is a higher proportion of ethnic minorities in West Sussex than in both Essex and Dorset as illustrated below:

Table 2.6: Ethnic Background of Population[30]

2011 Census Data	Numbers *(Figures rounded so may not sum)*				Percentage			
	West Sussex[31]	Essex	Dorset	ENG	West Sussex	Essex	Dorset	ENG
ALL	806,890	1,393,587	412,905	53,012,500				
White: English/Welsh/Scottish/Northern Irish/British	717,550			42,279,200	88.9			79.8
White: Irish	5,980			517,000	0.7			1.0
White: Other White	31,900			2,430,000	4.0%			4.6
White: (Which includes White: English/Welsh/Scottish/Northern	755,430	1,311,695	403,762	45,226,200	93.6	94.1	97.8	85.4

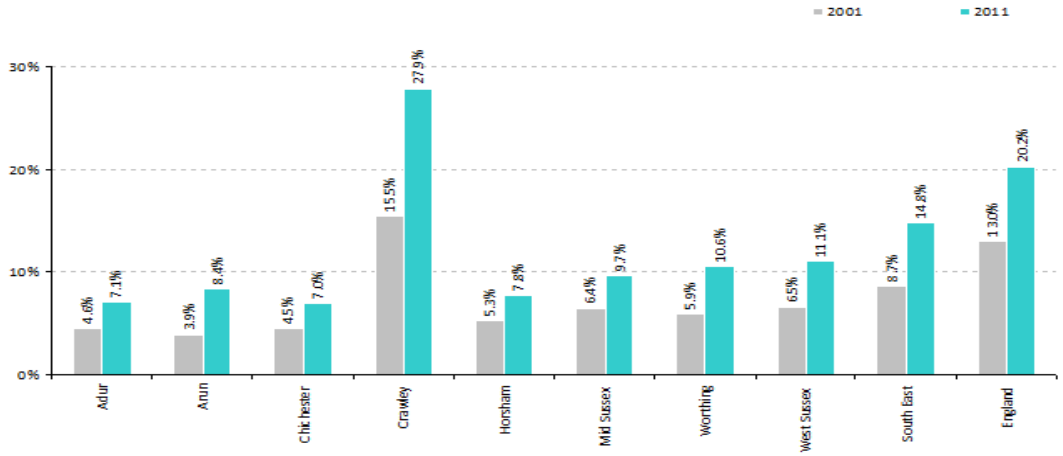
[30] Source: ONS Census 2011

[31] West Sussex specific information taken from document prepared by Jacqueline Clay. Comparison data taken from 2011 Census Table KS201UK: Ethnic group local authorities in the UK. Available at http://www.ons.gov.uk. Accessed 28/11/2013.

Irish/British White: Irish; White: Other White)								
White: Gypsy or Irish Traveller	1,070	2,161	555	54,900	0.1	0.2	0.1	0.1
Mixed/multiple ethnic group	12,160	20,885	3,400	1,192,900	1.6	1.5	0.8	2.2
Asian/Asian British	28,340	34,860	3,833	4,143,400	3.5	2.5	0.9	7.7
Black/African/Caribbean/Black British	7,150	18,709	924	1,846,600	1.0	1.3	0.2	3.4
Other ethnic group: Any other ethnic group	2,760	5,277	431	548,400	0.3	0.4	0.1	1.0

The above withstanding, the ethnic breakdown of West Sussex differs considerably between local authority areas. For example, in Crawley almost 28% of the population has an ethnic minority background, compared with just 7% in Chichester.

Figure 2.7: Percentage of the Population from BME Groups – 2001 and 2011 Compared[32]



A review of the UK literature on ethnicity and alcohol conducted in 2010[33] surmised that there is diversity both within and between ethnic groups. Most minority ethnic groups have higher rates of abstinence and lower levels of drinking compared to people from white backgrounds (see table below), but over time generational differences may emerge, for example, frequent and heavy drinking has increased for Indian women and Chinese men.

Table 2.8: Percentage of people exceeding the recommended daily limit within the week preceding the survey, by ethnic group, 2004[34]

	Male	Female
General population	45%	30%
Irish	56%	36%
Black Caribbean	28%	18%
Indian	22%	8%
Chinese	19%	12%
Black African	17%	7%
Pakistani	4%	<1%
Bangladeshi	1%	<1%

Moreover, people from some ethnic groups are more at risk of alcohol-related harm:

[32] Ibid.

[33] Hurcombe, R., Bayley, M. & Goodman, A., *Ethnicity and alcohol: a review of the literature*, Joseph Rowntree Foundation, 2010

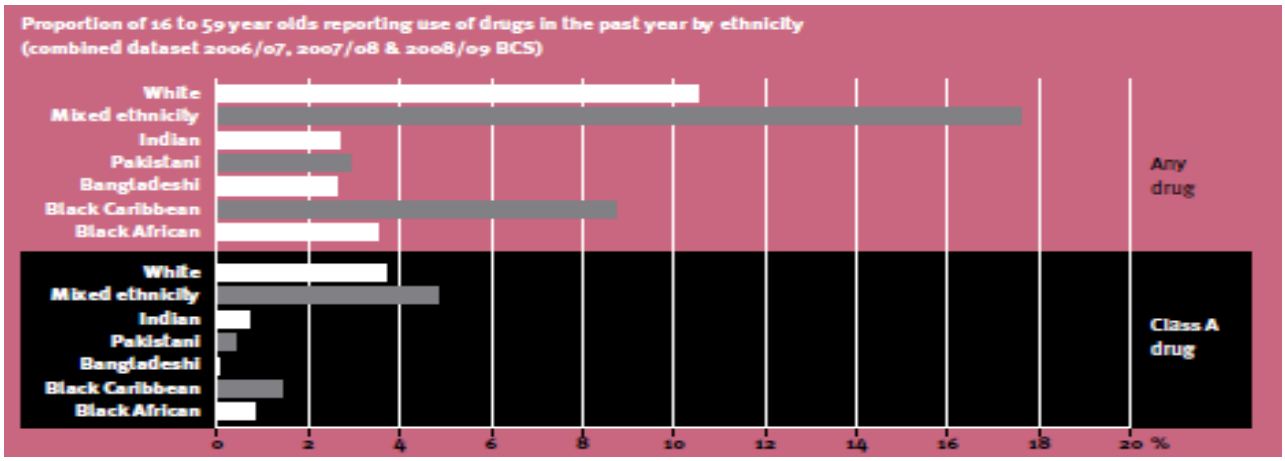
[34] Source: Health Survey for England 2004: The health of minority ethnic groups: summary of key findings, The Information Centre, 2006

- Irish, Scottish and Indian men, and Irish and Scottish women have higher than national average alcohol-related deaths in England;
- Sikh men overpresent for liver cirrhosis;
- People from minority ethnic groups have similar levels of alcohol dependence compared to the general population, despite drinking less.

Yet, the review concluded, minority ethnic groups are under-represented in seeking treatment and advice for drinking problems.

Similarly, in general, overall drug use is lower among ethnic minority ethnic groups than among the White population, although according to a review of the evidence undertaken by the UK Drug Policy Commission, this may change as young people become more absorbed into predominant national culture with the potential for increasing drug problems in these communities. Moreover, there are high rates of use among mixed race which 'may be of concern, as they are likely to be an increasing group in the future.'[35]

Figure 2.9: Proportion of 16 to 59 year olds reporting use of drugs in the past year by ethnicity[36]



As with specialist alcohol services, BME groups are underrepresented in UK specialist drug misuse services. The UKDPC review concluded that this was in part due to a lack of knowledge about such services and a reluctance amongst this demographic to seek help due to stigma.

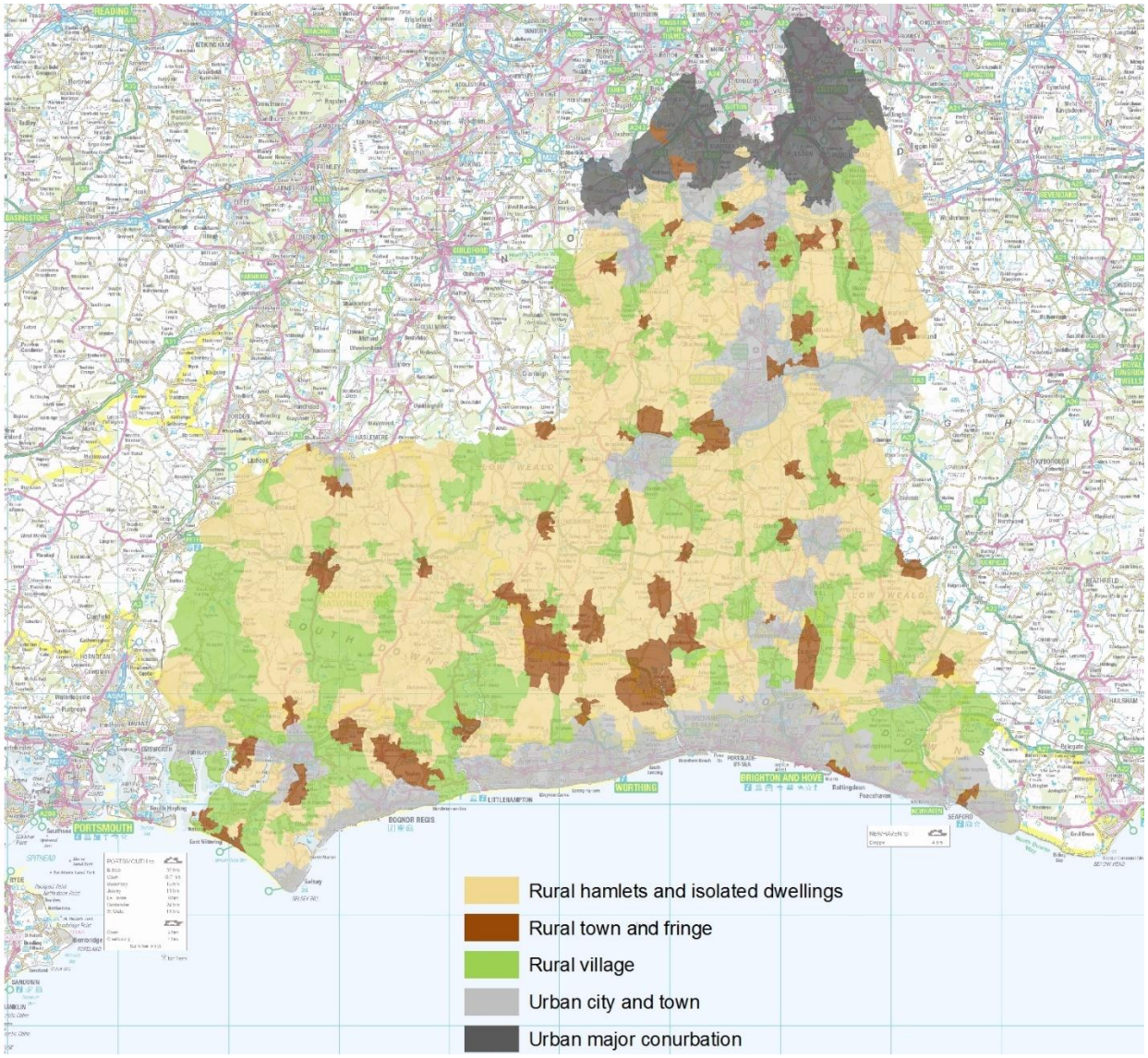
[35] UK Drug Policy Commission, *Drugs and Diversity: Ethnic minority groups, Learning from the evidence,* July 2010. Available at www.ukdpc.org.uk. Accessed 29/11/2013.

[36] UK Drug Policy Commission, *Drugs and Diversity: Ethnic minority groups, Learning from the evidence,* July 2010. Available at www.ukdpc.org.uk. Accessed 29/11/2013.

2.4.3 Population: Rurality

West Sussex is a large county with a variety of large towns and many smaller, scattered villages. In 2011, the population of rural wards in West Sussex accounted for 24% of the county total.[37]

Figure 2.10: West Sussex Rural/Urban classification 2011[38]



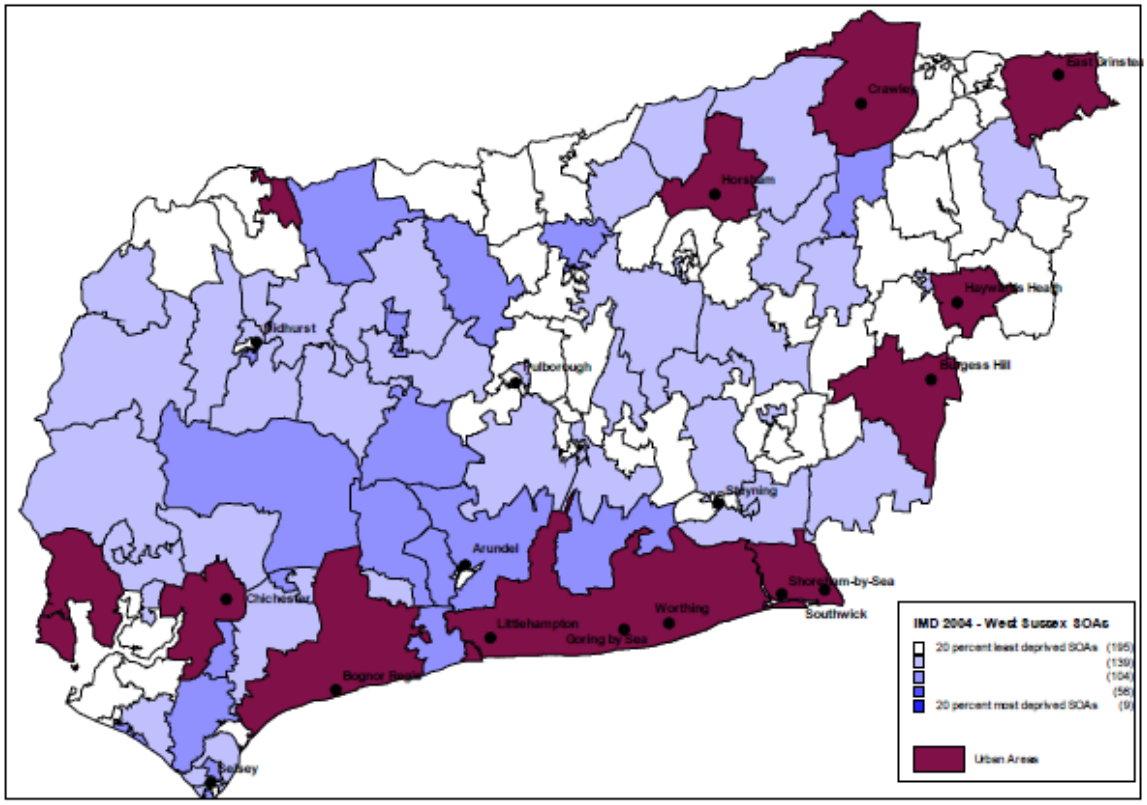
The Rural Profile for West Sussex (2006) notes that rural areas in the county do not generally suffer problems caused by severe concentrations of deprivation, see Figure

[37] Source: 2011 Census data. West Sussex Ward Profile 2013 available at http://jsna.westsussex.gov.uk/JSNA-Profiles and Ward, MSOA, and LSOA Urban/Rural Classifications available at http://jsna.westsussex.gov.uk/jsna-Core-dataset?item=278

[38] Source: Department for Environment & Rural Affairs, Coast to Capital LEP OAs by rural/urban classification 2011, 2014. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270521/Coast_to_Capital_LEP_full_class.jpg

below. The darkest blue areas denote the 20% most deprived Super Output Areas (SOAs) in the country. There are only nine in West Sussex. Moderate concentrations of deprivation (SOAs in the 40 – 60 % most deprived nationally, coloured light and medium blue in the figure below) can be found in areas with more dispersed populations, mainly in the hinterlands of the coastal urban areas towards the south of the county:

Figure 2.11: Index of Multiple Deprivation 2004, Rural[39] West Sussex[40]



That withstanding, of potential relevance to this research is the finding that residents of rural West Sussex generally have to travel further to access services than in rural areas across the country (see table below). On average, residents have to travel 3.3km (15% higher than the national rural average) to GP surgeries, 1.5km (7% higher) to primary schools, and 1.7km (14% higher) to Post Offices. This imposes higher transport and travel costs on rural residents, and may make access difficult for some residents.[41]

Table 2.12: Average Distance to Services (Kilometres), Rural West Sussex, 2004[42]

	GP Surgery	Primary School	Post Office	Supermarket

[39] DEFRA Rural Definition – Lower Level Super Output Areas

[40] Source: ODPM, Defra. Taken from West Sussex Rural Strategy: Rural Profile 2006, ECOTEC Research and Consulting Ltd. p. 6

[41] West Sussex Rural Strategy: Rural Profile 2006, ECOTEC Research and Consulting Ltd. p. 15

[42] Source: Index of Multiple Deprivation 2004, ODPM. Cited West Sussex Rural Strategy: Rural Profile 2006, ECOTEC Research and Consulting Ltd. p. 15

Rural West Sussex	3.38	1.53	1.67	3.06
West Sussex	2.11	1.12	1.19	1.71
Rural England	2.93	1.43	1.46	3.94
England	1.49	0.90	0.94	1.59

The 2009 study by Erskine et al found that people living in urban areas experienced higher alcohol-related mortality relative to those living in rural areas, with differences remaining after adjustment for socioeconomic deprivation. Adjusted relative risks for urban relative to rural areas were 1.35 (95% CI 1.20 to 1.52) and 1.13 (95% CI 1.01 to 1.25) for men and women respectively.[43]

Whilst alcohol-related mortality may be relatively lower in rural areas, studies undertaken in remote/rural and island locations in Scotland highlight specific considerations pertaining to those with alcohol and drug issues. Although arguably more rural than conditions in West Sussex, the major intractable issues highlighted in the Highlands and Islands may have some applicability here. The issues identified in these studies revolve around the following: community denial of alcohol/drug problems; limited financial resources; higher unit costs; lack of availability of premises; limited level and range of services, e.g. needle exchange; inconsistent availability of GPs and pharmacists willing to support drug users; difficulties maintaining anonymity and confidentiality; problems related to travel and transport; and difficulties in staff recruitment and retention.[44]

2.5 Prevalence of alcohol misuse in West Sussex

In order to provide a prevalence estimate that is as accurate as possible, evidence from a variety of sources has been utilised. Evidence from sources such as Public Health England, West Sussex County Council and Sussex Police is examined in this section.

2.5.1 Alcohol Consumption: Level

The General Household Survey (GHS) and the General Lifestyle Survey (GLF) have, in concert, been measuring drinking behaviour in England and Wales for over 30 years. The Department of Health estimates that the harmful use of alcohol costs the National Health Service around £2.7bn a year and 7% of all hospital admissions are alcohol related. Excessive consumption of alcohol is a major preventable cause of premature

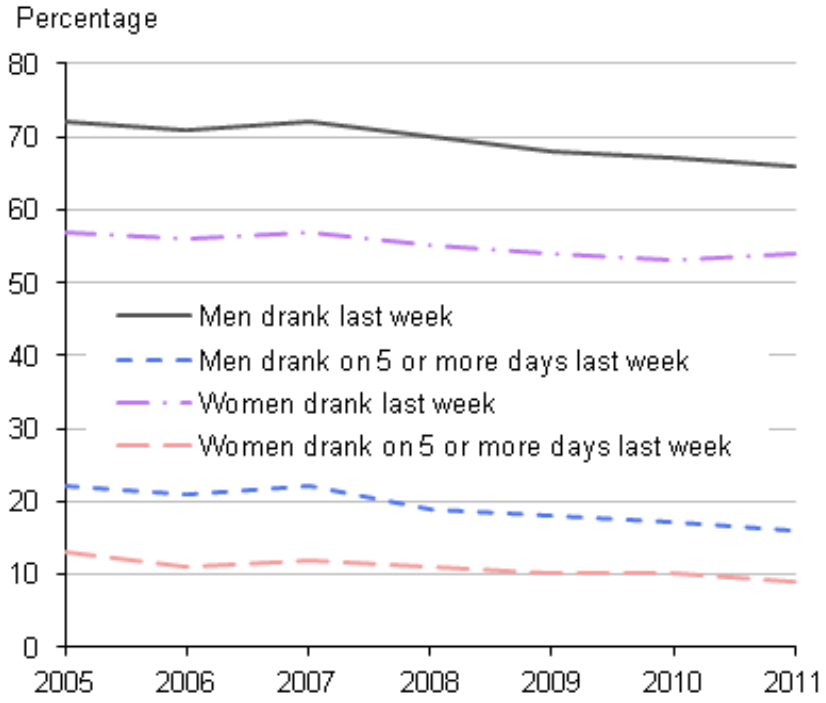
[43] Erskine, S., Maheswaran, R., Pearson, T., & Gleeson. D., 'Socioeconomic deprivation, urban-rural location and alcohol-related mortality in England and Wales', *BMC Public Health* 2010, 10:99. Available at http://www.biomedcentral.com/1471-2458/10/99, last accessed 24/11/2013.

[44] Effective Interventions Unit Service Provision for Drug Users in Rural and Remote Areas of Scotland: a Qualitative Study: Summary Report, Scottish Executive: Effective Interventions Unit, February 2005. Available at http://www.drugmisuse.isdscotland.org/eiu/pubs/eiu_090.htm. Last accessed 26/11/2013.

mortality with alcohol-related deaths accounting for almost 1.5% of all deaths in England and Wales in 2011.[45]

The Royal College of Physicians (RCP) advises an alcohol intake of no more than 21 units per week for men and 14 units per week for women. They also recommend having 2-3 alcohol-free days a week to allow the liver time to recover. This equates, as per advice from the Department of Health, to a daily limit for men of no more than 3-4 units of alcohol a day and a daily limit for women of 2-3 units.[46] Data from the 2011 GLS showed a continuing downward trend over time in both the level and frequency of alcohol consumption for both men and women.

Figure 2.13: Drinking in the last week (Great Britain) by sex, 2005 to 2011[47]



The proportion of men exceeding four units on their heaviest drinking day was 41% in 2005 and 34% in 2011. The proportion of women exceeding three units was 34% in 2005 and 28% in 2011. The estimates for heavy drinking follow a similar pattern. Heavy drinking is defined as exceeding twice the Government daily benchmarks on a single day: more than 8 units of alcohol on that day for men and consuming more than 6 units on that day for women. The proportion of men drinking more than 8 units on their

[45] Source: Chapter 2 - Drinking (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey). Available at http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-2.html. Last accessed 24/11/2013.

[46] Source: 1987 RCP, *The medical consequences of alcohol abuse, a great and growing evil*, Tavistock Publications Ltd.; 1995 RCP, RCGP, RCPsych, *Alcohol and the heart in perspective, sensible limits reaffirmed*, Oxprint, Oxford.

[47] Source: Chapter 2 - Drinking (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey). Available at http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-2.html. Last accessed 24/11/2013.

heaviest drinking day fell from 23% in 2005 to 18% in 2011. The corresponding estimates for women drinking heavily were 15% in 2005 and 12% in 2011.[48]There are however differences across age-groups with men aged 25-44 and women aged 16-24 consuming greater quantities of alcohol in any one day than other age groups of their gender:

Table 2.14: Maximum drunk on any one day in the last week, by sex and age 2011[49]

Age	16-24 (%)	25-44 (%)	45-64 (%)	65 and over (%)	Average Total (%)
Men					
More than 8, up to 12 units	9	11	10	4	9
More than 12 units	13	13	9	2	9
Total proportion heavy drinkers	22	24	19	6	18
Women					
More than 6, up to 9 units	7	7	6	2	5
More than 9 units	12	9	6	1	6
Total proportion heavy drinkers	18*	16	12	2*	12*

*Rounding differences

The 2011 Health Survey for England (HSE) indicates that on average, men in the South East Coast Strategic Health Authority (SHA) consume fewer units of alcohol on both a daily[50] and weekly basis[51] than the national average. Women in this area consume levels on a par with that seen nationally (see table below).

Table 2.15: Maximum alcohol consumption on any day in the last week (age-standardised) & Estimated weekly alcohol consumption (age-standardised), by strategic health authority & sex[52]

Strategic Health Authority	North East	North West	Yorkshire & tHumber	East Midlands	West Midlands	East of England	London	South East Coast	South Central	South West	England Average
Men											
Mean no. Units/day[53]	9.3	8.9	7.8	8.0	8.2	7.7	6.4	**7.1**	7.2	7.9	7.7

[48] Source: Chapter 2 - Drinking (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey). Available at http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-2.html. Last accessed 24/11/2013.

[49] Source: Table 2.4, Chapter 2 - Drinking (General Lifestyle Survey Overview - a report on the 2011 General Lifestyle Survey). Available at http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-2.html. Last accessed 24/11/2013.

[50] Source: Fuller, E. & Fat, L. N., Table 6.8,'Drinking Patterns', HSE (2011), pp.24-5

[51] Source: Fuller, E. & Fat, L. N., Table 6.13,'Drinking Patterns', HSE (2011), pp.30-31

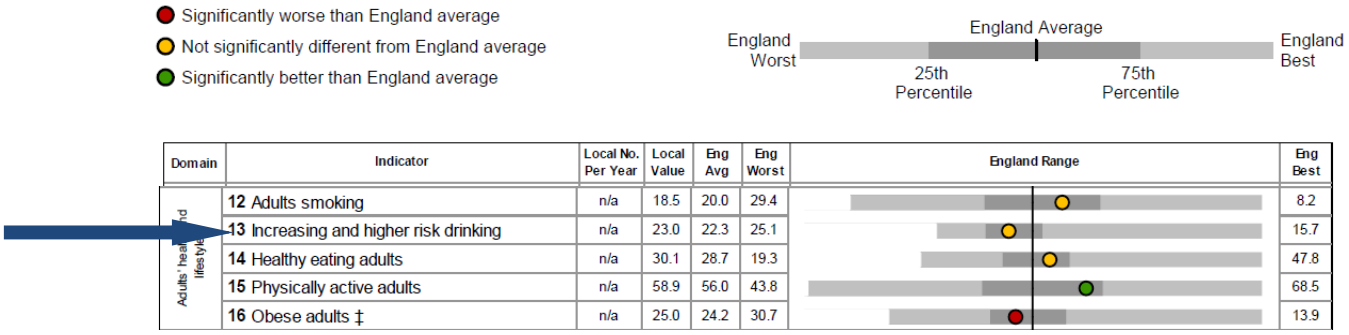
[52] Source: Fuller, E. & Fat, L. N., combination of Tables 6.8 & 6.13, 'Drinking Patterns', HSE (2011),) pp.24-5

[53] Based on those aged 16 and over, who drank in the preceding week.

Mean no. Units/week	20.0	17.5	18.4	18.5	18.8	14.4	15.1	**16.5**	16.4	18.5	17.2
Women											
Mean no. Units/day[54]	6.5	5.5	5.6	4.8	4.4	4.8	4.2	**5.0**	4.7	5.1	5.0
Mean no. Units/week	11.2	11.0	9.3	9.7	9.1	7.6	7.2	**9.4**	9.5	9.6	9.4

Public Health data published in September 2013 suggests that rates of 'Increased and higher risk drinking' in West Sussex is slightly, although not significantly, lower than the average in England (see Figure below).

Figure 2.16: Excerpt from Health Summary for West Sussex 2013[55]



The 'local values' in Essex and Dorset are similar to that in West Sussex at 22.7 and 23.1 respectively.[56]

2.5.2 Alcohol Consumption: Health Harm

Evidence from clinical and epidemiological studies shows a relationship between heavy drinking and certain clinical presentations (for example injuries, physical and psychiatric illnesses,[57] frequent sickness absence) and social problems.[58]

Alcohol Concern estimated alcohol-related health care costs in West Sussex (2010/11) to be £46.7m, which equates to £71 per adult.[59] The figures below illustrate the extent of health-related harm due to alcohol misuse in West Sussex. It can be seen that although the number of alcohol-attributable hospital admissions has shown a small but steady increase year on year since 2006, compared with other Primary Care Trusts (PCTs) West Sussex does better according to many alcohol-related indicators. It is

[54] Based on those aged 16 and over, who drank in the preceding week.

[55] West Sussex Health Profile 2013, Public Health England, 24th September 2013

[56] Essex and Dorset Health Profiles 2013, Public Health England, 24th September 2013

[57] The issue of dual diagnosis is addressed separately in a subsequent chapter.

[58] Scottish Intercollegiate Guidelines Network 74 (2003). The management of harmful drinking and alcohol dependence in primary care.

[59] Source: Alcohol Concern harm map for West Sussex, available at http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map. Accessed 26/11/2013.

however noteworthy that whilst West Sussex's national ranking for most alcohol-related indicators is between 23 and 55 (out of 151, where 1 is the best), for 'Alcohol-specific hospital admission – Under 18', West Sussex ranks significantly lower at 71 out of 151.

Figure 2.17 Alcohol-attributable hospital admission West Sussex 2006-2011[60]

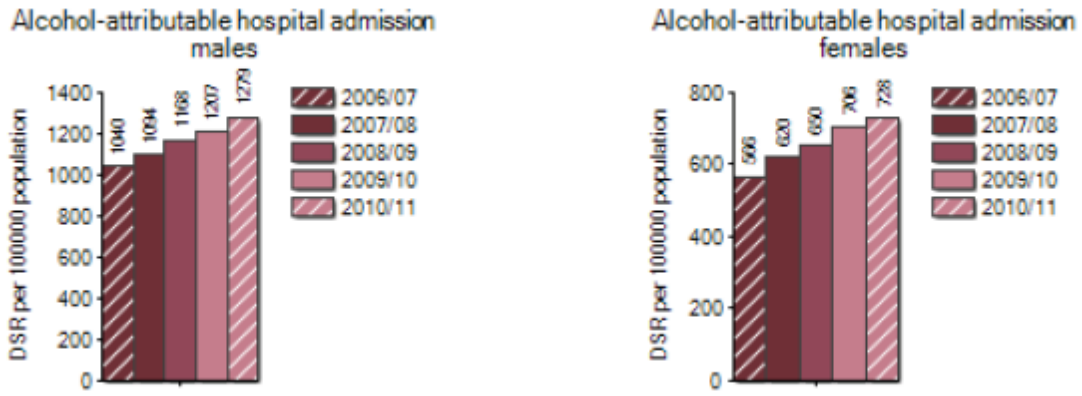


Table 2.18 Alcohol-related health harm West Sussex[61]

Indicator	West Sussex PCT[62]	Dorset PCT	Mid Essex PCT	North East Essex PCT	South East Essex PCT	South West Essex PCT	West Sussex National Rank[63] (1=highest rank)
Months of life lost – Males	7.5	8.0	6.8	7.8	8.0	6.9	31
Months of life lost – Females	3.4	3.3	3.4	4.5	4.4	3.6	31
Alcohol-specific[64] mortality – Males (directly standardised rate per 100,000 population)	10.2	11.7	9.4	12.6	11.6	8.2	38
Alcohol-specific mortality – Females (directly standardised rate per 100,000 population)	4.4	4.4	3.7	7.2	6.3	3.9	38
Mortality from chronic liver disease – males (directly standardised rate per 100,000 population)	11.1	12.3	7.9	12.1	11.3	9.2	41
Mortality from chronic liver disease – females (directly standardised rate per 100,000 population)	5.5	5.2	4.2	8.3	5.9	6.1	35

[60] Local Alcohol Profiles for England: West Sussex. Available at http://www.lape.org.uk. Last accessed 24/11/2013.

[61] Source: Local Alcohol Profiles for England: West Sussex PCT; Dorset PCT; Mid, North East, South East & South West Essex PCTs. Available at http://www.lape.org.uk/pctProfile.aspx?reg=q37. Last accessed 24/11/2013. Statistics compiled from a variety of sources and over a variety of time periods. For full details see LAPE footnotes at http://www.lape.org.uk/pctProfile.aspx?reg=q37.

[62] The actual indicator value for the primary care organisation as calculated in the definitions below.

[63] The rank of the local indicator value among all 151 primary care organisations in England. A rank of 1 is the best local authority in England and a rank of 151 is the worst.

[64] Definition Alcohol-specific: Conditions that are wholly related to alcohol (e.g. alcoholic liver disease or alcohol overdose). A list of alcohol-specific conditions with their ICD-10 codes and associated attributable fractions can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf

Alcohol-attributable[65] mortality – Males (directly standardised rate per 100,000 population)	29.8	32.6	29.7	36.7	31.0	27.2	25
Alcohol-attributable mortality – Females (directly standardised rate per 100,000 population)	12.9	12.2	13.4	17.9	16.2	11.5	37
Alcohol-specific hospital admission – Under 18 (crude rate per 100,000 population)	50.8	59.4	28.2	38.9	27.2	29.6	71
Alcohol-specific hospital admission – Males (directly standardised rate per 100,000 population)	363.1	340.3	183.5	317.0	315.0	234.5	50
Alcohol-specific hospital admission – Females (directly standardised rate per 100,000 population)	195.4	194.8	128.5	166.0	163.4	105.8	55
Alcohol-attributable hospital admission – Males (directly standardised rate per 100,000 population)	1,279.3	1,213.1	1,100.4	1,209.6	1,427.5	1,265.8	31
Alcohol-attributable hospital admission – Females (directly standardised rate per 100,000 population)	728.2	695.4	680.4	653.3	785.6	677.4	30
Admission episodes for alcohol-attributable conditions (previously N139) (directly standardised rate per 100,000 population)	1,559.2	1,466.3	1,409.3	1,357.6	1,836.1	1,562.4	23

Moreover, recently published NHS statistics indicate that at 296 per 100,000 head of population, West Sussex has fewer than average hospital admissions attributable in whole or in part to alcohol. This is comparable to figures across Dorset and most Essex PCTs; although Mid, South and South West Essex report a significantly lower rate of admissions wholly attributable to alcohol:

[65] Alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases (e.g. stomach cancer and unintentional injury). For these latter conditions, different attributable fractions are used to determine the proportion related to alcohol for males and females. A list of alcohol-attributable conditions with their ICD-10 codes can be found at: http://www.nwph.net/nwpho/publications/AlcoholAttributableFractions.pdf

Table 2.19: NHS hospital admissions with a primary diagnosis wholly or partly attributable to alcohol, by Strategic Health Authority (SHA) and Primary Care Trust (PCT), 2011/12[66]

	Total		Wholly-attributable		Partly-attributable	
	Admissions (to nearest hundred)	Number of admissions per 100,000 population	Admissions (to nearest hundred)	Number of admissions per 100,000 population	Admissions (to nearest hundred)	Number of admissions per 100,000 population
England	**200,900**	**378**	**70,300**	**132**	**130,600**	**246**
Mid Essex PCT	1,100	276	200	54	900	222
North East Essex PCT	1,000	291	300	93	700	198
South East Essex PCT	1,000	281	200	59	800	222
South West Essex PCT	1,100	283	200	47	900	236
Dorset PCT	1,400	288	400	97	1,000	191
West Sussex PCT	**2,500**	**296**	**700**	**90**	**1,800**	**205**

To get a more comprehensive picture locally, data was requested on NHS emergency admissions within West Sussex localities that had a record of alcohol in the diagnosis codes.[67,68] The numbers involved are relatively small so caution should be used when attempting to identify trends. However, the tables below show consistent presentations year on year, with Coastal West Sussex CCG having the highest overall per 1,000 head of population rate for alcohol-related emergency admissions. The figures also suggest a higher prevalence for alcohol-related emergency admission amongst those aged between 40 and 64:

[66] Excerpt from Table 4.10 Statistics on Alcohol - England (2013), National Statistics (Health & Social Care Information Centre), published 30/05/2013. Available at http://www.hscic.gov.uk/catalogue/PUB10932. Accessed 24/11/2013. Figures based on Hospital Episode Statistics, Health and Social Care Information Centre - Data for total number of admissions for each ICD-10 code. North West Public Health Observatory - Attributable fractions for alcohol-related ICD-10 codes.

[67] Whilst the accuracy of this data relies on hospital staff noting alcohol misuse as a primary or secondary cause/factor in admission and thus will not capture all relevant incidents, the figures are presented to be appraised in conjunction with all other data to build up a comprehensive picture of prevalence in West Sussex. Please also note, some of the admissions tabulated below will have both alcohol and drugs in the diagnosis codes, there will therefore be some double counting between Tables 2.16/2.17 and 2.24/25.

[68] We also repeatedly requested alcohol/drug-related call-out data from South East Coast Ambulance Service NHS Foundation Trust. This data was not forthcoming.

Table 2.20: Emergency Admissions 2011/12 that have a record of alcohol in the diagnosis codes[69]

Year 2011-12	Age Bands									
	0 - 4	10 - 14	15 - 19	20-29	30-39	40-49	50-64	65+	Unknown	Total
CWS CCG (per 1,000 pop)		9 (0.36)	89 (3.34)	219 (4.21)	266 (5.03)	489 (7.0)	498 (5.2)	346 (2.97)		1,916 (3.93)
Crawley CCG (per 1,000 pop)		5 (0.68)	13 (0.98)	44 (2.45)	53 (2.62)	90 (4.75)	94 (4.4)	57 (3.46)		356 (2.82)
HMS CCG[70] (per 1,000 pop)		8 (0.59)	24 (1.80)	61 (2.68)	73 (2.60)	113 (3.12)	191 (4.31)	93 (2.26)	<5	564 (2.51)
Unknown			<5	19	24	14	20	<5		83
TOTAL (per 1,000 pop)		22 (0.48)	129 (2.70)	343 (3.70)	416 (4.11)	706 (5.64)	803 (4.99)	499 (2.87)	<5	2,919 (3.48)

Table 2.21: Emergency Admissions 2012/13 that have a record of alcohol in the diagnosis codes[71]

Year 2012-13	Age Bands									
	0 - 4	10 - 14	15 - 19	20-29	30-39	40-49	50-64	65+	Unknown	Total
CWS CCG (per 1,000 pop)	<5	5 (0.20)	62 (2.32)	251 (4.82)	260 (4.93)	479 (6.89)	494 (5.17)	417 (3.49)		1,972 (4.02)
Crawley CCG (per 1,000 pop)		<5	18 (2.37)	49 (2.76)	77 (3.77)	91 (4.80)	120 (5.57)	47 (2.79)		405 (3.19)
HMS CCG[72] (per 1,000 pop)		<5	24 (1.78)	64 (2.81)	93 (3.33)	115 (3.18)	147 (3.30)	102 (2.38)	<5	550 (2.42)
Unknown			<5	6	11	14	13	<5		46
TOTAL (per	<5	11	105	370	441	699	774	567	<5	2,973

[69] Data source: SUS; ICD 10 codes used: F1* and T51*; Admission Method = 2* (Emergency).

[70] Please note, this is the only CCG without an Alcohol Liaison Nurse employed which may mean fewer recorded alcohol/drug presentations than would otherwise be the case.

[71] Data source: ICD 10 codes F10 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF ALCOHOL and T51 TOXIC EFFECT OF ALCOHOL; Admission Method = 2* (Emergency).

[72] Please note, this is the only CCG without an Alcohol Liaison Nurse employed which may mean fewer recorded alcohol/drug presentations than would otherwise be the case.

1,000 pop)		(0.24)	(2.20)	(4.00)	(4.36)	(5.61)	(4.79)	(3.16)		(3.52)

2.5.3 Alcohol Consumption: Maternity Harm

The debate about alcohol use in pregnancy is still ongoing, even though ethanol is well known to be teratogenic and fetotoxic when consumed in excess during pregnancy.[73] The Department of Health recommends pregnant women and women trying to conceive should avoid drinking alcohol. If they do choose to drink, they should not drink more than 1-2 units of alcohol once or twice a week and should avoid getting drunk.[74] This is because miscarriage, stillbirth, premature birth, small birth weight, and Foetal Alcohol Spectrum Disorder (FASD) are all associated with a mother's binge drinking – consuming more than six units on one occasion whilst pregnant.

As noted by Day & George (2005), it is difficult to estimate accurately the prevalence of high-risk drug use during pregnancy for a variety of reasons: feelings of shame, denial and stigma experienced by the drug user, lack of awareness among professionals in antenatal services, the presence of comorbid psychiatric disorders, and sociocultural barriers that may prevent a thorough assessment. A number of large surveys of drug use in different populations conducted in the USA do however provide an insight. [75] For example, in 2005, 12% to 15% of pregnant women reported use of some alcohol, with 3% to 4% reporting binge drinking during pregnancy.[76]

2.5.4 Alcohol Consumption: Social Harm

Alcohol consumption is associated with a substantial burden of social harm and estimates from some countries suggest that it is roughly equal to the burden of health harm.[77]

In 2008, West Sussex DAAT undertook some research to calculate the annual costs to society and the NHS of alcohol misuse in West Sussex. The total cost was calculated to be around £300m per annum.[78] Included in these costs are the following:

- £70.5m of this related to domestic and social costs (impact on family members and communities). This includes costs such as claimants of incapacity benefits whose main medical reason is alcoholism. In West Sussex this calculation stood at 69.6 per 100,000 (working age, persons) population. This is lower than the

[73] Guerrini, I., 'Pregnancy and alcohol misuse', *BMJ*, 2009;338:b845.

[74] Cited http://www.nhs.uk/conditions/alcohol-misuse/Pages/Introduction.aspx

[75] Cited Day, E. & George, S., 'Management of Drug Misuse in Pregnancy', *Advances in Psychiatric Treatment*, (2005)11: 253-261.

[76] Office of Applied Studies. Substance Abuse and Mental Health Services Administration. Substance abuse and mental health statistics. Cited Bhuvaneswar, C., Chang, G., Lucy, M., Epstein, E., and Stern, T., 'Alcohol Use During Pregnancy: Prevalence and Impact', *Prim Care Companion J Clin Psychiatry,* 2007; 9(6): 455–460.

[77] Room, R, 'International control of alcohol: alternative paths forward', Drug and Alcohol Review (2006), 25, 581-595.

[78] Tearle, S., *Substance Misuse Treatment Investment Cost Benefit Analysis Appendix B*, West Sussex DAAT, March 2011.

regional average of 75.2 per 100,000 and means West Sussex ranks 50th place nationally.[79]

- £96m related to workplace productivity costs;
- But the largest proportion pertained to crime related costs at £109.5m.

Public concern about 'alcohol-related crime' often relates to offences involving a combination of criminal damage offences; drunk and disorderly and other public order offences involving young males, typically between 18 and 30 years of age, but increasingly, also young females; and to those often occurring in the entertainment areas of town and city centres.

The high proportion of penalty notices given for drunk and disorderly behaviour aids the perception of a fifth of the public in England and Wales who believe drunk or rowdy behaviour poses a significant problem to their local community. The 2009/10 report, *Crime in England & Wales,* notes alcohol is cited as the third major cause of criminal activity in Britain today:

Table 2.22: Factors considered as causes of crime in Britain today, 2009/10[80]

Percentages	England & Wales, 2009/10 BCS	
	Major causes of crime[1,2]	Main cause of crime[1]
	Percentage perceiving this as a factor:	
Drugs	69	26
Lack of discipline from parents	65	27
Alcohol	53	9
Too lenient sentencing	39	11
Breakdown of family	36	6
Lack of discipline from school	34	3
Unemployment	36	5
Too few police	23	2
Poverty	25	5
None of these	0	n/a
Do not think there is one main cause	n/a	5
Unweighted base	*11,003*	*11,003*

This supports earlier findings reported by the Offender Assessment System Data Evaluation and Analysis Team[81] (covering 41 probation areas in 2004-5) which found that whilst approximately 9% of men in England were afflicted by alcohol-dependence:

[79] Source: Local Alcohol Profiles for England: West Sussex. Available at http://www.lape.org.uk. Data from (NWPHO from Department for Work and Pensions data Aug 2011 and Office for National Statistics 2010 mid-year population estimates).

[80] Source: Flatley, J., Kershaw, C., Smith, K., Chaplin, R., and Moon, D., 'Crime in England & Wales, 2009/10', Table 5a. Cited *Institute of Alcohol Studies website*, available at http://www.ias.org.uk/Alcohol-knowledge-centre/Crime-and-social-impacts/Factsheets/Public-perceptions-of-crime.aspx#_edn2. Accessed 26/11/2013.

[81] Working with alcohol-misusing offenders – a strategy for delivery: National Offender Management Service, May 2006. Cited 'Alcohol and Crime', Civitas Crime. Available at http://www.civitas.org.uk/crime/factsheet-alcoholcrime.pdf. Accessed 26/11/2013.

- Over one-third (37%) of offenders had a current problem with alcohol use
- A similar proportion (37%) had a problem with binge drinking
- Nearly half (47%) had misused alcohol in the past
- 38% were found to have a criminogenic need relating to alcohol misuse, potentially linked to their risk of reconviction

According to the LAPE profile for West Sussex, the area does better than average in terms of alcohol-related crimes:

Table 2.23 Alcohol-related crime West Sussex[82]

Indicator[83]	West Sussex PCT[84]	Dorset PCT[85]	West Sussex National Rank[86] (1=highest, 151 = lowest)
Alcohol-related recorded crimes (crude rate per 1,000 population)	5.1	3.9	27
Alcohol-related violent crimes (crude rate per 1,000 population)	4.0	3.0	41
Alcohol-related sexual offences (crude rate per 1,000 population)	0.1	0.1	50

More specifically, Sussex Police crime database has an incident marker to reflect whether perpetrators were believed to be under the influence of either drugs or alcohol. The marker does not differentiate between drugs or alcohol and is only completed for violent offences. However it is not a system mandatory field so is not completed in all cases.

For the three year period 1st August 2010 to 31st July 2013 in West Sussex there were 1,784 Violent Crimes and Other offences where perpetrators were specified as being under the influence. This implies that at least 22% of such offences were committed by individuals who were affected by drugs or alcohol.

[82] Source: Local Alcohol Profiles for England: West Sussex. Available at http://www.lape.org.uk. Last accessed 24/11/2013. Statistics compiled from a variety of sources and over a variety of time periods. For full details see LAPE footnotes at http://www.lape.org.uk/pctProfile.aspx?reg=q37.

[83] Alcohol-attributable recorded crimes - Alcohol-related recorded crimes, crude rate per 1,000 population. (NWPHO from Home Office recorded crime statistics 2011/12). Office for National Statistics 2010 midyear population were used. Attributable fractions for alcohol for each crime category were applied, based on survey data on arrestees who tested positive for alcohol by the former UK Prime Minister's Strategy Unit.

[84] The actual indicator value for the primary care organisation as calculated in the definitions below.

[85] Please note, four PCTs cover Essex thus West Sussex is just compared to Dorset in this table.

[86] The rank of the local indicator value among all 151 primary care organisations in England. A rank of 1 is the best local authority in England and a rank of 151 is the worst.

Table 2.24: Under the Influence information by Crime Group 1st Aug 2010-31st July 2013[87]

Crime Group	Under the Influence	Number	As % of 'Other Offences'
Other Offences	Yes (the perpetrator was or was perceived to be under the influence)	175	41%
	No (the perpetrator was not under the influence)	54	13%
	Not Specified (field is blank)	147	35%
	Unknown (the inputter has recorded that it is Unknown)	50	12%
Other Offences Total		426	100%
Crime Group	**Under the Influence**	**Number**	**As % of 'Violent Crime'**
Violent Crime	Yes (the perpetrator was or was perceived to be under the influence)	1,609	21%
	No (the perpetrator was not under the influence)	1,749	22%
	Not Specified (field is blank)	2,826	36%
	Unknown (the inputter has recorded that it is Unknown)	1,630	21%
Violent Crime Total		7814	100%
Grand Total		**Number**	**As % of all crimes**
Total all crimes where perpetrator was perceived to be under the influence		**1,784**	**22%**

All West Sussex local authorities saw a decrease in the number of these crimes over the three year period, although there were differences between areas as shown in the table below:

[87] Source: Report prepared by West Sussex Police at behest of Lyn Williams August 2013.

Table 2.25: Under the Influence Crimes by local authority area1st Aug 2010-31st July 2013[88]

Local Authority	District	2010/11	2011/12	2012/13	3 year total	3 year % difference	Pop.	Crimes/ 1,000 pop	Crimes/ 1,000 pop %
Adur	Adur and Worthing	56	26	30	**112**	-46%	61334	1.83	12%
Arun	Arun	205	111	104	**420**	-49%	149811	2.80	19%
Chichester	Chichester	105	62	55	**222**	-48%	113995	1.95	13%
Crawley	Crawley	179	113	127	**419**	-29%	107053	3.91	26%
	Gatwick	30	21	9	**60**	-70%			
Horsham	Horsham	50	33	48	**131**	-4%	131540	1.00	7%
Mid-Sussex	Mid-Sussex	66	30	47	**143**	-29%	140188	1.02	7%
Worthing	Adur and Worthing	133	69	75	**277**	-44%	104998	2.64	17%
All	**All**	**824**	**465**	**495**	**1784**	**-40%**	**808919**	**2.21**	

2.6 Prevalence of drug misuse in West Sussex

Prevalence estimates provided by Public Health England in 2013, based on 2010/11 data, suggest the number of opiate and/or crack users (OCU) and injectors in West Sussex to be as follows:

Table 2.26: Prevalence estimates (Aged from 15-64) 2010/11[89]

	West Sussex		National	
	Number	Rate per 1,000 head of population	Number	Rate per 1,000 head of population
OCU	2,336	4.69	298,752	8.67
Opiate	2,124	4.27	261,792	7.59
Crack	1,638	3.29	170,627	4.95
Injecting	651	1.31	93,401	2.71

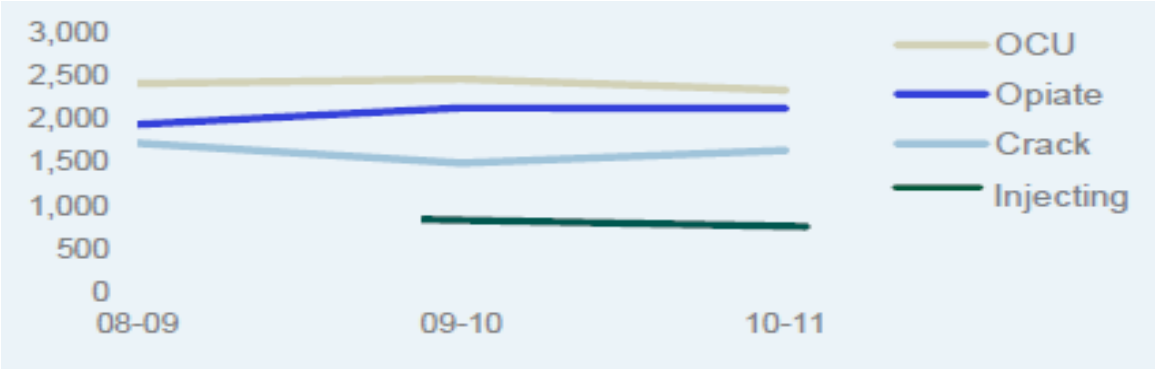
For all classes of drug misuse, prevalence estimates in West Sussex are below the national average – significantly so for 'injecting' and OCU – although it should be noted the numbers involved are small so caution should be used when interpreting these result. That withstanding, prevalence rates in West Sussex have remained fairly

[88] Source: Report prepared by West Sussex Police at behest of Lyn Williams August 2013.

[89] Source: Alcohol and drugs: JSNA support pack for West Sussex (2012-13) - Drugs, Public Health England, p.2

consistent over this period, with 'crack' use increasing slightly from 2009/10 to 2010/11 and 'OCU' decreasing slightly over the same interval:

Figure 2.27: Prevalence estimates over time, West Sussex, 2008-2011[90]



Please note, as highlighted by the Advisory Council on the Misuse of Drugs, reliable data on the prevalence of use and societal impact of Novel Psychoactive Substances (NPS) are difficult to obtain. In their report to the Home Secretary in October 2011 they note, "Surveys of young people suggest that 20 to 40% have ever tried NPS and in the case of mephedrone (pre-ban) one survey indicated 34% had used in the past month [self-reported data from the Mixmag survey 2011], although these may be heavily biased samples."[91] This paucity of data has made it impossible to effectively estimate the prevalence of NPS misuse in West Sussex.

Illicit drug use (of all kinds) causes significant problems in terms of social harm in areas like antisocial behaviour, violence and crime, prostitution, homelessness and family breakdown. In addition, there is a substantial financial cost attached to drug misuse (in England and Wales) estimated at £15.4 billion each year,[92] roughly £13.3 billion of which pertains to crimes relating to drugs. [93]

2.6.1 Drug use: Health-Related Harm

In 2011/12, there were 12,344 hospital admissions with a primary diagnosis of poisoning by drugs which equates to 23 admissions per 100,000 head of population.[94] Only 114 such admissions were recorded in West Sussex, equating to 14 admissions

[90] Source: Alcohol and drugs: JSNA support pack for West Sussex (2012-13) - Drugs, Public Health England, p.2

[91] ACMD, *Consideration of the Novel Psychoactive Substances ('Legal Highs')*, October 2011, p6. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/119139/acmdnps2011.pdf. Last accessed 29/11/0213.

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

[93] Home Office statistic, 'Reducing drug misuse and dependency, cited https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence#background. Accessed 26/11/2013.

[94] The number of admissions per 100,000 population all ages use estimated resident population mid-2010 figures based on the 2001 census published by the Office for National Statistics (ONS).

per 100,000 head of population based on the same population figures (Dorset c.12; Mid Essex c.11; North East Essex c.8; South East Essex c.9; South West Essex c.7).[95]

To get a more comprehensive local picture, data was requested from West Sussex Public Health & Wellbeing Directorate. After discussion with the epidemiologist, it was ascertained that the most accurate reflection would be gleaned from analysing NHS emergency admissions within West Sussex localities that have a record of drugs in the diagnosis codes.[96] The numbers involved are small so caution should be used when attempting to identify trends. However, broadly speaking the data shows a slight increase in the level of drug-related emergency admissions over the years 2011-2013, with the highest overall presentation per 1,000 head of population in Coastal West Sussex CCG.

Table 2.28: Emergency Admissions 2011/12 that have a record of drugs in the diagnosis codes[97]

2011-12	Age Bands									
	0 - 4	10 - 14	15 - 19	20-29	30-39	40-49	50-64	65+	Unknown	Total
CWS CCG (per 1,000 pop)		<5	24 (0.90)	62 (1.19)	82 (1.55)	60 (0.86)	29 (0.30)	<5		264 (0.54)
Crawley CCG (per 1,000 pop)			<5	6 (0.33)	<5	7 (0.37)	<5	<5		20 (0.16)
HMS CCG[98] (per 1,000 pop)		<5	7 (0.53)	17 (0.75)	17 (0.61)	12 (0.33)	7 (0.16)	<5		65 (0.29)
Unknown				5	5	8				18
TOTAL (per 1,000 pop)		5 (0.11)	32 (0.67)	90 (0.97)	108 (1.07)	87 (0.70)	37 (0.23)	8 (0.05)		367 (0.44)

[95] These calculations are based on ONS mid 2008 PCT population estimates so are not strictly comparable with the national and West Sussex per 100,000 calculations. These figures are however noted here as the population estimates are not likely to have altered between 2008 and 2010 to such an extent to make the figures cited significantly inaccurate.

[96] Whilst the accuracy of this data relies on hospital staff noting drug misuse as a primary or secondary cause/factor in admission and thus will not capture all relevant incidents, the figures are presented to be appraised in conjunction with all other data to build up a comprehensive picture of prevalence in West Sussex. Please also note, some of the admissions tabulated below will have both alcohol and drugs in the diagnosis codes, there will therefore be some double counting between Tables 2.16/17 and 2.24/25.

[97] Data source: SUS; ICD 10 codes used: F11 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF OPIOIDS; F12 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF CANNABINOIDS; F13 MENTAL & BEHAVIOURAL DISORDERS DUE USE SEDATIVES/HYPNOTICS; F14 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF COCAINE; F15MEN & BEHAV DIS DUE USE OTH STIMS INC CAFFEINE; F16 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF HALLUCINOGENS; F18 MENTAL & BEHAVIOURAL DISORDERS DUE USE VOLATILE SOLVENTS; F19 MENTAL & BEHAV'L DISORDERS DUE MULTIPLE/PSYCHOACT DRUG USE; Admission Method = 2* (Emergency).

[98] Please note, this is the only CCG without an Alcohol Liaison Nurse employed which may mean fewer recorded alcohol/drug presentations than would otherwise be the case.

Table 2.29: Emergency Admissions 2012/13 that have a record of drugs in the diagnosis codes[99]

2012-13	Age Bands									
	0 - 4	10 - 14	15 - 19	20-29	30-39	40-49	50-64	65+	Unknown	Total
CWS CCG (per 1,000 pop)		<5	29 (1.09)	87 (1.67)	79 (1.50)	76 (1.09)	19 (0.20)	7 (0.06)		299 (0.61)
Crawley CCG (per 1,000 pop)			<5	17 (0.96)	22 (1.08)	11 (0.58)	<5	<5		57 (0.45)
HMS CCG[100] (per 1,000 pop)		<5	11 (0.81)	25 (1.10)	17 (0.61)	20 (0.55)	<5	<5		80 (0.35)
Unknown				<5	<5	<5				10
TOTAL (per 1,000 pop)		<5	42 (0.88)	132 (1.43)	122 (1.21)	110 (0.88)	27 (0.17)	10 (0.06)		446 (0.53)

2.6.2 Drug use: Drug Related Deaths

According to the latest report from the national programme on Substance Abuse Deaths (np-SAD), there were 1,263 notifications of drug-related deaths occurring in 2011 in England (70.5% male cases; 29.5% female cases). This represents a decrease of 95 (7.0%) over the same reporting period in 2010.[101]

At the county district level, numbers are so small that caution should be used in attempting to identify trends, and the actual figures are shown below alongside rate per 100,000 head of population:

[99] Data source: SUS; ICD 10 codes used: F1* and T51*; Admission Method = 2* (Emergency).

[100] Please note, this is the only CCG without an Alcohol Liaison Nurse employed which may mean fewer recorded alcohol/drug presentations than would otherwise be the case.

[101] Ghodse, H., Cockery, J., Claridge, H., Goodair, C., Schifani, F., *Drug-related deaths in the UK: Annual Report 2012*, International Centre for Drug Policy, 2013

Table 2.30: Changes in annual death rate for np-SAD cases (16 years old and over)[102]

	2009		2010		2011	
Coroner's Jurisdiction & county district	**Number of *np*-SAD deaths**	**Annual death rate per 100,000 population**	**Number of *np*-SAD deaths**	**Annual death rate per 100,000 population**	**Number of *np*-SAD deaths**	**Annual death rate per 100,000 population**
West Sussex	6	0.93	16	2.45	12	1.81
Essex: Essex & Thurrock	8	0.71	8	0.71	No Data Available	
Essex: Southend & South East Essex	16	5.85	8	7.77	No Data Available	
Dorset: Bournemouth, Poole & Eastern Dorset	25	6.15	24	5.88	24	5.61
Dorset: Western Dorset	5	2.71	1	0.54	6	3.08

Statistics compiled by the West Sussex Reducing Drug Related Deaths Steering Group indicate np-SAD deaths in 2012 may number 18[103] (10 male; 8 female), which equates to 2.15 per 100,000 head of population.

2.6.3 Drug use: Maternity Harm

Data from the Diagnostic Outcomes Monitoring Executive Summary (DOMES) for West Sussex show that in 2012/13 eight pregnant women presented to drug treatment services. This equated to 6.3% of all new female presentations. The national average was 4.9%. However, this does not provide a complete picture of the situation in West Sussex.

As noted by Day & George (2005),[104] it is difficult to estimate accurately the prevalence of high-risk drug use during pregnancy. However, about one-third of drug users in treatment in the UK are female and over 90% of these women are of childbearing age (15–39 years). Research conducted by the Advisory Council on the Misuse of Drugs[105] concluded that approximately 1% of babies delivered are to problem drug users (and a similar amount to problem drinkers), whilst in 2009/10, Scotland had 925 maternities

[102] Ghodse et al (2013), Table A; & Ghodse, H., Cockery, J., Claridge, H., Goodair, C., Schifani, F., *Drug-related deaths in the UK: Annual Report 2011*, International Centre for Drug Policy, Table B.

[103] This number is an estimation given time lags in some Coroner and Inquest verdicts.

[104] Day, E., & George, S., 'Management of drug misuse in pregnancy', *Advances in Psychiatric Treatment (2005)*, vol. 11, 253–261.

[105] AMCD inquiry: 'Hidden harm' report on children of drug users, Advisory Council on the Misuse of Drugs, June 2011.

for which drug misuse was recorded, a rate of 16.1 per 1,000 maternities.[106] Whilst it must be acknowledged that these prevalence figures are not adjusted for local conditions, as a crude measure they can be used to provide an indication of local need. There were 9,089 maternities in West Sussex during 2012,[107] assuming a prevalence rate of 1%; it is possible that around 90 of these were problem drug users.

2.6.4 Drug misuse: Social Harm

The Office of National Statistics (ONS) collects data on the number of police recorded crimes committed each year. These figures will not represent all of the offences actually committed, since not all offences are detected.

The number of drug offences recorded in the 12 months to June 2013 was 7% lower than the number recorded in the preceding 12 months. However, as noted by the ONS to a certain extent, the more the police look for drug crimes, the more they find: 'The number of drug offences recorded by the police is heavily dependent on police activities and priorities. As a result, changes over time may reflect changes in the policing of drug crime rather than real changes in its incidence.'[108]

Table 2.31: Police recorded crime by offence (England & Wales) and percentage change between year ending June 2012 and year ending June 2013[109]

Offence	12 months to June 2012	12 months to June 2013	% change between years
Trafficking in controlled drugs	30,948	29,353	-5
Other drug offences	1,089	1,132	4
Possession of controlled drugs (excluding cannabis)	36,062	34,419	-5
Possession of controlled drugs (cannabis)	154,799	141,722	-8
TOTAL DRUG OFFENCES	222,898	206,626	-7

In the three year period from 1st August 2010 – 31st July 2013, there were 6,676 crimes recorded in West Sussex that concerned either drug possession, supply or other drug

[106] Drug Misuse Statistics Scotland (2011), ISD Scotland, Table B4.2., available at http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2012-02-28/2012-02-28-dmss2011-report.pdf Last accessed 28/11/2013.

[107] Source: Births by Area of Usual Residence of Mother, England and Wales, 2012, ONS, release date 18/09/2013. Available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-320857. Accessed 28/11/2013.

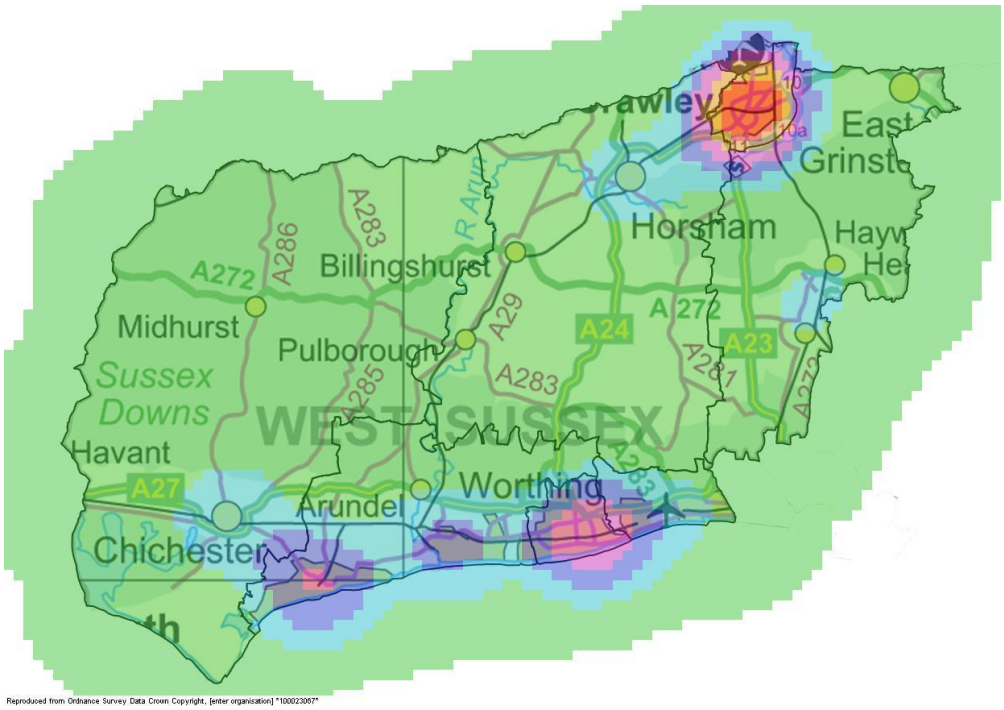
[108] ONS narrative. Available at http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/period-ending-june-2013/stb-crime-in-england-and-wales--year-ending-june-2013.html#tab-Other-crimes-against-society. Accessed 28/11/2013.

[109] Source: Crime in England & Wales, year ending June 2013 - appendix tables Table A4. Available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-324159. Last accessed 28/11/2013.

offences. This corresponds to 6,805 offenders,[110] of which, 83% were male (n=5,630) and 10% were female (n=678). The gender was either not recorded or was designated 'unknown' for the remaining 497 (7%). Overall there has been a decline in recorded offences of 7% with 2,289 recorded in the first twelve months August 2012 to July 2011 compared with 2,132 offences recorded in the most recent twelve month period.

Hot Spot analysis (based on number of incidents) shows, not surprisingly, that Drug Offences are more prominent in the town centres.

Figure 2.32: Hot Spot Analysis for Drug Offences in West Sussex 1st August 2010 – 31st July 2013[111]



Limitations of data:

Drug offences will often only get recorded when offenders are caught by Police in possession of any offending substances. Therefore any change in recorded figures over time may be as a result of a change in Police activity in a geographic area or as a result of a Police Operation instead of demonstrating an actual increase/decrease in offences.

2.7 Risk factors / Vulnerable Populations

Problematic alcohol and drug use is more prevalent amongst some groups within society. In this section several such 'at risk' or vulnerable populations are examined. The specific health and social needs of those with a dual diagnosis (substance misuse and mental health) are examined in Chapter 3 of this report.

[110] This figure is higher than the total number of crimes noted above as Home Office counting rules stipulate the recording of one crime per group for some offences e.g. trafficking.

[111] Source: Report prepared by West Sussex Police at behest of Lyn Williams August 2013.

2.7.1 Deprivation

Drug Misuse

Deprivation has been linked to problem drug use. Individuals who are socially and economically marginalised are seen as most at risk of developing drug problems.[112]

Alcohol Misuse

The association between alcohol misuse and deprivation is not however as clear and, in fact, there is evidence to suggest that the more deprived the neighbourhood, the lower the alcohol consumption level.[113] *Data from both the 2011 HSE and GLS* showed the proportions of adults exceeding 4/3 units of alcohol and drinking heavily (exceeding 8/6 units) tended to rise with increasing gross weekly household income. In households in the lowest income quintile 22% of adults exceeded 4/3 units of alcohol and 10% drank heavily (exceeded 8/6 units) on at least one day in the previous week. Adults living in households in the highest income quintile were twice as likely to have exceeded 4/3 units of alcohol and were twice as likely to have drunk heavily as adults in households in the lowest income quintile (44% and 23% compared with 22% and 10%).[114]

Table 2.33: Maximum drunk on any one day in the last week by sex and equivalised gross weekly household income[115]

Maximum daily amount	Equivalised gross weekly household income quintiles					
	Lowest	Second	Third	Fourth	Highest	Total
Lower boundary of group (£ per week)	0	232	355	537	832	
Drank more than 4/3 units on at least one day last week (%)						
Men	24	24	30	37	47	34
Women	21	16	26	33	42	28
All persons	22	19	28	35	44	31
Drank more than 8/6 units on at least one day last week (%)						
Men	12	10	15	20	28	18
Women	9	8	11	14	18	12
All persons	10	9	13	17	23	15

[112] Drugs and poverty: A literature review. Published by Scottish Drugs Forum on behalf of the Scottish Association of Alcohol and Drug Action Teams. 2007.

[113] Neighbourhood deprivation and alcohol consumption: does the availability of alcohol play a role? Pollack, Craig Evan; Cubbin, Catherine; Ahn, David; Winkleby, Marilyn. International Journal of Epidemiology, Volume 34, Number 4, August 2005, pp. 772-780(9).

[114] Source: Chapter 2 - Drinking (General Lifestyle Survey Overview). Available at http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-2.html. Last accessed 24/11/2013.

[115] Source: Table 2.11, General Lifestyle Survey (2011), Office for National Statistics.

However, the relationship between area deprivation and harmful drinking is different from that of hazardous drinking. Harmful drinking is defined as the consumption of over 50 units per week for men and over 35 units per week for women. The Local Alcohol Profiles for England (LAPE 2010) confirm that poorer communities have substantially higher levels of alcohol-related ill health, anti-social behaviour and premature deaths than their wealthier neighbours.[116]

Further, a study by Erskine et al (2009) concluded there was a clear association between alcohol-related mortality and socioeconomic deprivation, with progressively higher rates in more deprived areas. The strength of the association varied with age. Greatest relative inequalities were seen amongst people aged 25-44 years, with relative risks of 4.73 (95% CI 4.00 to 5.59) and 4.24 (95% CI 3.50 to 5.13) for men and women respectively in the most relative to the least deprived quintiles.[117]

Deprivation in West Sussex

Deprivation in West Sussex is lower than average, however some 19,300 children live in poverty.[118]

Table 2.34: Percentage of population living in the most deprived quintile in an area 2010[119]

Area Name	Level of deprivation of population living in area	Significance
England	20.3	n/a
Essex	6.0	Significantly better than England average
Dorset	4.6	Significantly better than England average
West Sussex CC	**3.6**	**Significantly better than England average**
Adur CD	9.4	Significantly better than England average
Arun CD	8.6	Significantly better than England average
Chichester CD	0.0	Significantly better than England average
Crawley CD	1.5	Significantly better than England average
Horsham CD	0.0	Significantly better than England average
Mid Sussex CD	0.0	Significantly better than England average
Worthing CD	8.6	Significantly better than England average

[116] Cited: 'New Alcohol Profiles for England provide national map of alcohol-related harms', *Alcohol Alert*, Issue 2 2012. Available at http://www.ias.org.uk/What-we-do/Publication-archive/Alcohol-Alert/Issue-2-2012/New-Alcohol-Profiles-for-England-provide-national-map-of-alcohol-related-harms.aspx. Last accessed 24/11/2013.

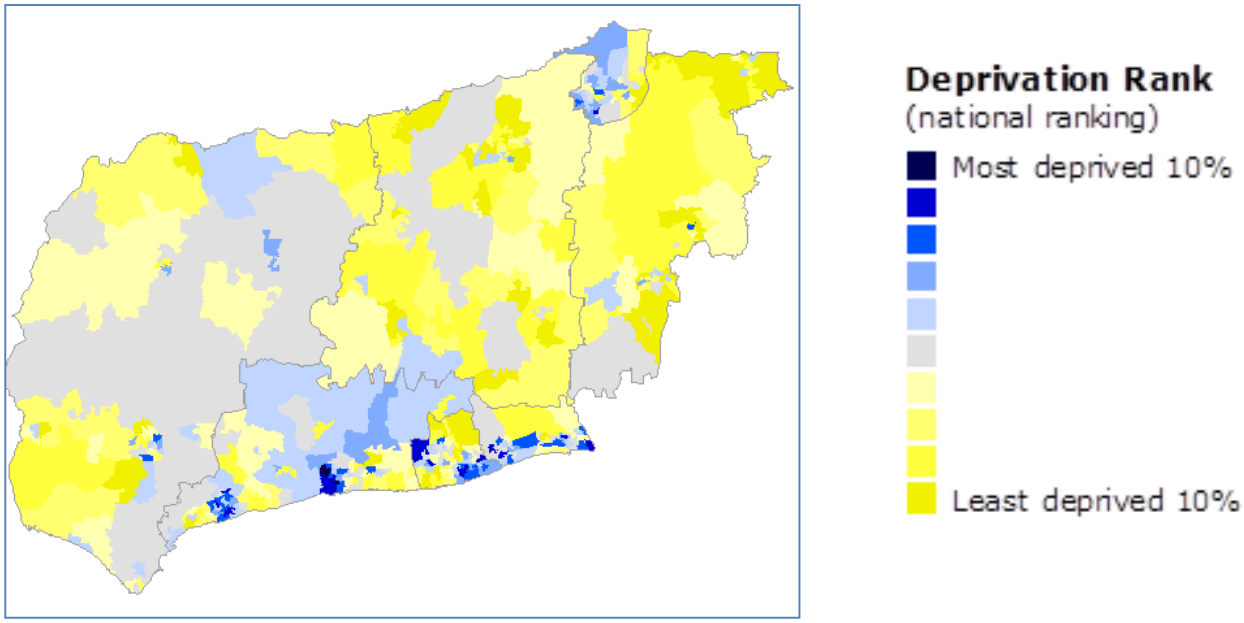
[117] Erskine, S., Maheswaran, R., Pearson, T., & Gleeson. D., 'Socioeconomic deprivation, urban-rural location and alcohol-related mortality in England and Wales', *BMC Public Health* 2010, 10:99. Available at http://www.biomedcentral.com/1471-2458/10/99, last accessed 24/11/2013.

[118] West Sussex Health Profile 2013, Public Health England, 24th September 2013.

[119] Statistics from Public Health England Data Table: Deprivation (2010).

However, as evidenced above, county level data masks considerable differences within areas and there are some very deprived neighbourhoods. West Sussex has three small areas (within River and Ham wards in Littlehampton) falling in the 10% most deprived areas in England. At *ward* level River and Ham wards are within the most deprived 10% in England, a further seven wards are within the most deprived 20% in England. Decline in coastal areas, such as Littlehampton, is in line with the wider national picture of coastal decline.

Figure 2.35: Overall Deprivation in West Sussex



Level of unemployment/economic activity is a specific indicator of deprivation, and it is recognised within the Joint Strategic Needs Assessment (JSNA) framework that being in work or undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training.

The rate of economic inactivity and unemployment across West Sussex is lower than the both the national average and that seen in Essex, but higher than in Dorset (see tables below). Moreover, in November 2012, there were only 2.3 JSA claimants per unfilled Jobcentre vacancy compared to the South East average of 2.6, and the national average of 3.8 (2.3 Essex; 2.0 Dorset). Further, there are significantly fewer long term unemployed in West Sussex than in England generally (4.7/1000 resident population compared to 9.5/1000 head of population nationally).[120]

[120] Statistics from Public Health England Data Table: Long term unemployment (2012).

Table 2.36: Level of Economic Inactivity July 2012 - June 2013[121]

West Sussex (%)	Essex (%)	Dorset (%)	Great Britain (%)
17.5	20.0	16.9	22.7

% is a proportion of those aged 16-64

Table 2.37: Total JSA Claimants October 2013[122]

	West Sussex (%)	Essex (%)	Dorset (%)	Great Britain (%)
All people	1.6	2.4	1.2	3.0
Males	2.0	3.0	1.6	3.9
Females	1.2	1.8	0.9	2.2

% is a proportion of resident population of area aged 16-64 by gender

The level of employment deprivation in West Sussex is therefore below that in England as a whole, although, as with the more general measures of deprivation noted above, it is likely this masks significant differences between areas.

Unstable housing provision can also be an indicator of deprivation and in financial year 2012/13, 688 users of the Housing Support Services in West Sussex listed substance misuse (drugs and/or alcohol) as either a primary or secondary issue. This equates to 98% of those for whom records are kept.[123] Moreover, a snapshot of those presenting to the Bognor Hub (homeless shelter run by Stonepillow) on one day in November 2013 revealed that two thirds reported to have an alcohol or drug issue (12 of the 18 presenting).[124]

2.7.2 Children and Families

According to a recent report researched and written jointly by Alcohol Concern and The Children's Society (2010), more than 100 children a week contact ChildLine with worries about their parent's drinking or drug use, and alcohol plays a part in 25-33% of known cases of child abuse. Moreover, nationally, 75% of child deaths involve parental drug or alcohol use.[125] Furthermore, in a study of young offending cases where the young

[121] NOMIS Labour Market Statistics available at www.nomisweb.co.uk. Last accessed on 22/11/2013.

[122] NOMIS Labour Market Statistics available at www.nomisweb.co.uk. Last accessed on 22/11/2013.

[123] Data received from Guy Rodgers, Service Development Worker, Local Assistance Network, Health & Social Care Commissioning Directorate, West Sussex County Council on 29th November 2013. The remit for this team until April 2013 included Mental Health and Learning Difficulty services and Substance Misuse services. After April 2013 the team no longer covered these services, which may explain why in the first two quarters of 2013, only 236 users of the Housing Support Services in West Sussex listed substance misuse as either a primary or secondary issue. This equates to 39.4% of those for whom records are kept. The majority of those self-reporting with substance issues were in the Homelessness or Young Person's services.

[124] Data received from Helen Keats, Rough Sleeping Advisor, on 26th November 2013.

[125] Cited: West Sussex Protocol for Children's Services and Drug and Alcohol Services: Protocol for Maternity Services and Adult Drug and Alcohol Treatment Services: To Safeguard Children and Families living with Drug and/or Alcohol Misuse, November 2012. Available at

person was also misusing alcohol, 78% had a history of parental alcohol abuse or domestic abuse within the family.[126] It is therefore widely acknowledged that the impact of parents' harmful drinking and alcohol-related domestic abuse on children is a "serious hidden consequence."[127]

Research by Manning et al (2009) identified profiles where the risk of harm to children could be increased by patterns of parental substance use and generated new estimates following secondary analysis of five UK national household surveys. They showed that the Health Survey for England (HSfE) and General Household Survey (GHS) (both 2004) generated consistent estimates – that around 30% of children under-16 years (3.3 - 3.5 million) in the UK lived with at least one binge drinking parent, 8% with at least two binge drinkers and 4% with a lone (binge drinking) parent. Further, using data from the National Psychiatric Morbidity Survey (2000), they estimated that 22% (2.6 million) children lived with a hazardous drinker and 6% (705,000) with a dependent drinker.[128] Whilst it must be acknowledged that these prevalence figures are not adjusted for local conditions, as a crude measure they can be used to provide an indication of local need. Thus, based on current population statistics, in West Sussex around 32,500 children under the age of 16 live with a hazardous drinker; 8,800 with a dependent drinker.

The Advisory Council on the Misuse of Drugs estimate there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems.[129] This represents about 2–3% of children under the age of 16. With the same caveat as above, extrapolated, based on current population statistics, between 1,400 and 3,000 children under the age of 16 in West Sussex are affected by serious parental drug misuse.

The co-occurrence of alcohol and drug misuse was identified by Manning et al as potentially leading to 'elevated risk of harm' for the 3.6% (around 430,000) of children in the UK who live with a problem drinker who also uses drugs.[130] At the West Sussex level, this prevalence rate (limitations recognised), would equate to over 5,000 children under the age of 16.

As mentioned above, little local data is available on the prevelance and impact of parental substance misue, however, West Sussex, during 2009-10 there were 636 Child

https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CC0QFjAA&url=https%3A%2F%2Fwww.westsussex.gov.uk%2Fidoc.ashx%3Fdocid%3D4e3a7633-7833-48b6-8f7d-81d1d523f259%26version%3D-1&ei=43a5UuvNJI6ShgfwzYGABQ&usg=AFQjCNGK219QWKXy691DaE-kqm0ZUvFEWg&bvm=bv.58187178,d.d2k

[126] Delargy, A., Shenker, D., Manning, J. & Rickard, A., *Swept Under the Carpet: Children Affected by Parental Alcohol Misuse*, Alcohol Concern and The Children's Society, October 2010.

[127] Ibid p. 4.

[128] Manning, V., Best, D., Faulkner, N., Titherington, E., 'New Estimates of the number of children living with substance misusing parents: results from UK national household surveys', *BMC Public Health*, 2009, Vol 9:377.

[129] AMCD inquiry: 'Hidden harm' report on children of drug users, Advisory Council on the Misuse of Drugs, June 2011, p.10.

[130] Op. cit. Manning (2009).

Protection conferences. Of these, 204 (32.1%) cited alcohol as a risk factor, and 121(19.0%) cited drug use as risk factor.[131]

[131] Source: West Sussex 'Quarterly monitoring 3 monthly reports – produced with information gathered from Chairs of Child Protection Conferences'. Cited op. cit. West Sussex Protocol for Children's Services and Drug and Alcohol Services.

CHAPTER 3: HEALTH & SOCIAL CARE NEEDS OF THOSE WITH DUAL DIAGNOSIS

3.1 Introduction and Aims

The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance abuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder.[132] This client group are very vulnerable and have complex needs relating to health, social, economic, and emotional stressors or circumstances which can often be exacerbated by their substance misuse.[133] People with a dual diagnosis are more likely to have experienced difficulties with education, employment, housing, personal relationships and their physical health. They are also more likely to have suffered trauma or abuse.[134]

Research has shown that service users with a dual diagnosis typically use NHS services more and cost more. A study of services in South London found a greater proportion of the patients with dual diagnosis used the support of community psychiatric nurses, inpatient care and emergency clinics. Their analysis found that dual diagnosis patients had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than patients without a dual diagnosis.[135] Moreover, service users with a dual diagnosis are more likely to be non-compliant and fail to respond to treatment than either people with substance misuse issues or a mental illness, and in their National audit of violence, the Healthcare Commission and the Royal College of Psychiatrists identified drug and alcohol use as a major trigger for violence in mental health services.[136]

In his 2004 report to the Secretary of State for Health on the implementation of the National Service Framework for Mental Health, Professor Louis Appleby stated that "services for people with dual diagnosis - mental illness and substance misuse - are the most challenging clinical problem that we face."[137]

The aim of this element of the project was to review existing datasets to identify the prevalence and trends of dual diagnosis in West Sussex and to identify the health and social care needs of this demographic within the county.

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[132] Lehman (1996), cited Evans, K., & Sullivan, J. M., *Dual Diagnosis: Counselling the Mentally Ill Substance Abuser,* Guilford Press, 2001 p. 1.

[133] Afuwape S. A., 'Where are we with dual diagnosis (substance misuse and mental illness)?: A review of the literature', November, 2003.

[134] Banerjee, S., Clancy, C., Crome, I., *Co-existing problems of mental health and substance misuse (dual diagnosis): An Information Manual*, Royal College of Psychiatrists, 2002. Available at http://www.rcpsych.ac.uk/pdf/ddipPracManual.pdf. Accessed 04/12/2013.

[135] National Mental Health Development Unit, Briefing 189, *Meeting the challenge of dual diagnosis*, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf. Accessed 09/12/2013.

[136] Ibid.

[137] The National Service Framework for Mental Health - Five Years On, Appleby L., Dept of Health, Dec 2004.

3.2 Method of Data Collection

There are no routinely available national or local data on the prevalence of dual diagnosis, and because the definition of the term varies widely, so too do prevalence estimates. That being so, information was identified and drawn together from a range of local and national sources which indicate prevalence of mental health issues and substance abuse problems, and from other sources which speak to the vulnerabilities those with dual diagnosis are subject to e.g. suicide and self harm data. This is supplemented with information drawn from the management surveys and qualitative stakeholder interviews undertaken in the course of this research. This should help provide initial indications as to the level of need in West Sussex, and to identify any gaps in existing provision for this client group. In order to provide comparative analysis where appropriate, we used the same two local authority areas introduced in Chapter 2 – Essex and Devon.

3.3 Key Findings

3.3.1 Background/Context

- The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance abuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder.
- This client group are very vulnerable and have complex needs relating to health, social, economic, and emotional stressors or circumstances which can often be exacerbated by their substance misuse
- Research has shown that service users with a dual diagnosis typically use NHS services more, cost more and are less likely to comply with treatment than those with single mental health or substance misuse issues.
- There are no routinely available national or local data on the prevalence of dual diagnosis, and because the definition of the term varies widely, so too do prevalence estimates.
- The Department of Health 'Good Practice Guide' (2002) remains the most specific national policy document pertaining to dual diagnosis, the central tenet of which is a policy referred to as 'mainstreaming'.
- In 2011, the Sussex Partnership NHS Foundation Trust (SPFT) developed a dual diagnosis strategy and formulated seven key themes into objectives to be reached within the five year implementation period.

3.3.2 Epidemiology of dual diagnosis

- The nature of the relationship between mental health and substance misuse problems is complex and co-morbidity can occur at any level of severity.

- Frisher et al (2005) concluded that, only a comparatively small proportion of psychiatric illness could be attributed to substance use (0.2%), whereas a more substantial proportion of substance use seems possibly attributable to psychiatric illness (14.2%).
- The estimated risk of suicide in the presence of current alcohol misuse or dependence is eight times greater than in the absence of such misuse/dependence and as many as 65% of suicides have been linked to excessive drinking. According to np-SAD data, of the 131 cases noted as diagnosed with mental health issues, 51.9% (68/131) were listed as suffering from depression, with 25.0% of these (17/68) deaths being attributed to suicide.
- At least two thirds of alcohol-dependent individuals entering treatment show evidence of anxiety, sadness, depression and/or manic-like symptoms and a higher incidence of alcohol use disorders (AUDs) is reported for patients in treatment for depression.
- A higher incidence of alcohol use disorders (AUDs) is reported for patients in treatment for depression, and a recent study found that a diagnosis of affective disorder was associated with a five-fold increased risk of developing alcohol dependence within five years of onset.
- Amongst the general population, alcohol dependence and major depression co-occur at higher levels than would be expected by chance.
- Using alcohol or drugs to reduce emotional distress (self-medication) has been proposed as an explanation for the high co-morbidity rates between non-clinical anxiety, depression and substance use disorders.
- Up to 50% of problem drinkers have a personality disorder, up to 80% have neurotic disorders and people with anti-social disorders have 21 times the average population risk of experience alcohol abuse or dependence. Personality disorder is also strongly associated with an increased risk of substance misuse issues. Estimates suggest that over half the patient population of drug and alcohol services will meet criteria for one or more personality disorders. Personality disorder can influence: the clinical course of alcohol/substance-dependence; their response to treatment; and their risk of relapse.
- Individuals with severe and enduring mental illnesses, such as schizophrenia and bipolar disorder, are at least three times as likely to be alcohol dependent as the general population, and an estimated 40% of people diagnosed with psychosis have also misused a substance at some point in their lifetime.

3.3.3 Prevalence of dual diagnosis across the UK

- In the UK, 'Rethink Mental Illness' estimated that a third of patients in mental health services have a substance misuse problem, and around half of patients in drug and alcohol services have a mental health problem. There is however widespread social and regional variation.

- The COSMIC Study (2002) estimated that 74.5% of drug service users and 85.5% of alcohol service users experienced co-occurring mental health problems and 44% of the community mental health team (CMHT) patients reported problem drug use of harmful alcohol use in the preceding year.
- In 2011 the MEAM coalition estimated that around 60,000 people living in the UK were experiencing multiple needs relating to mental health, substance misuse, homelessness and offending.
- An estimated 18% of rough sleepers have a mental health issue combined with a substance misuse issue.
- The prevalence of dual diagnosis among the prison population has been estimated at 75%. This has ramifications for local areas when prisoners are released.
- Estimates of prevalence of mental health problems amongst those with learning difficulties vary from 25-40% and there is a small but growing trend for people with learning disabilities to misuse substances (prevalence rates for alcohol misuse somewhere between 0.5% - 2%; similar low prevalence rates for drug misuse). Service providers have reported a number of difficulties in recognizing and meeting the complex needs of this population.
- There is very limited data available to assess the trend in prevalence rates of dual diagnosis either nationally or locally, but there are suggestions that co-morbidity is being increasingly recognised over time.

3.3.4 Prevalence of Dual Diagnosis in West Sussex

- Residents of West Sussex experience better than average personal wellbeing, although there is variation across the county with the Worthing sample consistently reporting poorer wellbeing than the West Sussex average.
- Compared to the national average West Sussex had:
    - Significantly more adults on the GP resister for depression in 2011/12 than the national average.
    - A higher prevalence of panic disorders and hospital admissions for unipolar depressive disorders 2009/10 to 2011/12.
    - Significantly better rates of neurotic disorders, mixed anxiety & depression and generalised anxiety disorders (in those aged 16-74) than the national average.
    - Low rates of health service use for mental health problems.
    - A slightly higher than average rate of hospital admissions for self-harm 2009/10 to 2011/12.
- In any one night in West Sussex 85 individuals sleep rough. Based on a dual diagnosis prevalence rate of 18% this implies around 15 of these people both misuse substances and have a mental health issue. A snapshot of clients undertaken by Stonepillow at their homeless shelter one night in November 2013 revealed 55.6% had both mental health and substance abuse issues.

- Around 3,500 people in West Sussex have both a learning difficulty and a mental health issue. Of these, a small proportion will also misuse substances.
- Figures from specialist substance misuse services across West Sussex suggest 14% of those presenting with drug and/or alcohol problems also had a diagnosed mental health condition. This is significantly below national estimates, but information provided in the Management Survey sent to all specialist substance misuse services in West Sussex points to a much higher prevalence of dual-diagnosis amongst this client group.
- Treatments and interventions are generally in line with national policy, guidance and standards. However, currently there is no West Sussex based dual diagnosis service for adults with co-occurring mental health problems and substance misuse problems. Some stakeholders wish to see such a service reinstated.
- Joined up working between specialist mental health services and specialist alcohol and drug services for adults is sporadic.
- Co-occurring mental health problems and substance misuse problems are generally managed in a way which addresses the primary problem, followed by the secondary problem; regardless of equity of condition – co-occurring problems are not effectively managed simultaneously.

3.4 Legislation and Policy Context

Dual diagnosis has been a priority area since 1999 when the Department of Health commissioned a review of psychiatric disorder and substance misuse.[138] Since then, several projects and literature reviews have been conducted and training/information manuals have been issued. A very brief review of the most recent relevant policies and strategies is undertaken below to provide context for this chapter.[139]

3.4.1 National Policy Context

In 2002, the Department of Health produced a framework for practice around dual diagnosis and this 'Good Practice Guide' remains the most specific national policy document pertaining to dual diagnosis.[140] The central tenet of this guide is that individuals with both substance misuse and mental health problems deserve integrated care delivered either by mental health services (in the case of those with severe mental health problems) or specialist substance misuse services (for those with mild to moderate mental health conditions), but with appropriate support from the other agency – a policy referred to as 'mainstreaming'.

[138] Crome, I. B. (1999) Overview: Psychiatric Comorbidity and Substance Misuse: What Are the Issues? Drugs: Education, Prevention and Policy, 6 (2), pp.149–150.

[139] A more in depth literature review will be conducted for the subsequent report which will focus specifically on Dual Diagnosis in West Sussex (due March 2014).

[140] Department of Health, *Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide*, 2002.

Specific guidance has subsequently been issued on the assessment and management of those in mental health inpatient and day-hospital settings who have co-morbid conditions (2006),[141] and for the management of dual diagnosis in prisons (2009).[142]

Whilst not examined in depth, dual diagnosis is referenced in the most recent mental health strategy 'No Health Without Mental Health' (2011),[143] which focuses on mainstreaming mental health and emphasises the symbiotic relationship between inequality and mental health. The approach taken within the strategy is to "promote mental wellbeing, preventing mental illness and early intervention as soon as the problem arises [to]...help to reduce the risk of substance misuse across the population."[144] This approach is referenced in the Government's latest alcohol strategy (2012), which also notes the "clear association between having a mental illness and increasing risk of alcohol dependence."[145] The 2010 drugs strategy[146] does not specifically refer to dual diagnosis, but it too recognises preventing mental illness will reduce the risk of substance misuse, and reiterates the need for services to work together to enable recovery.

3.4.2 Local Policy Context

In 2011, the Sussex Partnership NHS Foundation Trust (SPFT) developed a dual diagnosis strategy[147] with reference to national policy, research and evidence – including the aforementioned 'Good Practice Guide'. The strategy adopted a broad definition of dual diagnosis adapted from the 2002 guide[148] and formulated seven key themes into objectives to be reached within the five year implementation period. Objectives included:

- An emphasis on harm reduction strategies, Motivational Interviewing, relapse prevention and recovery principles;
- Developing links with and support to, housing and supported accommodation agencies;

[141] Department of Health, *Dual Diagnosis in mental health inpatient and day hospital settings*, October 2006.

[142] Department of Health & Ministry of Justice, *A Guide for the Management of Dual Diagnosis for Prisons*, 2009.

[143] Department of Health, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, February 2011. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf. Accessed 02/12/2013.

[144] Ibid. p. 41.

[145] HM Government, *The Government's Alcohol Strategy*, London: The Stationary Office, 2012. Available at https://www.gov.uk/government/publications/alcohol-strategy. Accessed 02/12/2013. p. 26.

[146] HM Government, *Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Support People to Live a Drug Free Life*. Available at https://www.gov.uk/government/publications/drug-strategy-2010--2. Accessed 02/12/2013.

[147] Sussex Partnership NHS Foundation Trust, *The Dual Diagnosis Strategy 2011-2016*. Available at http://www.sussexpartnership.nhs.uk/gps/dual. Accessed 02/12/2013.

[148] "A primary psychiatric illness precipitating or leading to substance misuse, substance misuse worsening or altering the course of a psychiatric illness, intoxication and/or substance dependence leading to psychological symptoms or, substance misuse and/or withdrawal leading to psychiatric symptoms or illness" (p. 5 of the SPFT strategy).

- Ensuring service users and (with the service user's permission) their family/carers, are included in care planning/decision making;
- Providing dedicated dual diagnosis champions in each team across the care groups;
- Ensuring mental health and substance misuse workers have the knowledge, skills and confidence to provide assessment, care and treatment for people with a dual diagnosis;
- Reporting and analysing dual diagnosis activity data to inform current and future dual diagnosis health and social care provision, training and education.

Future council policy should be cognisant of all the aforementioned legislation and strategy.

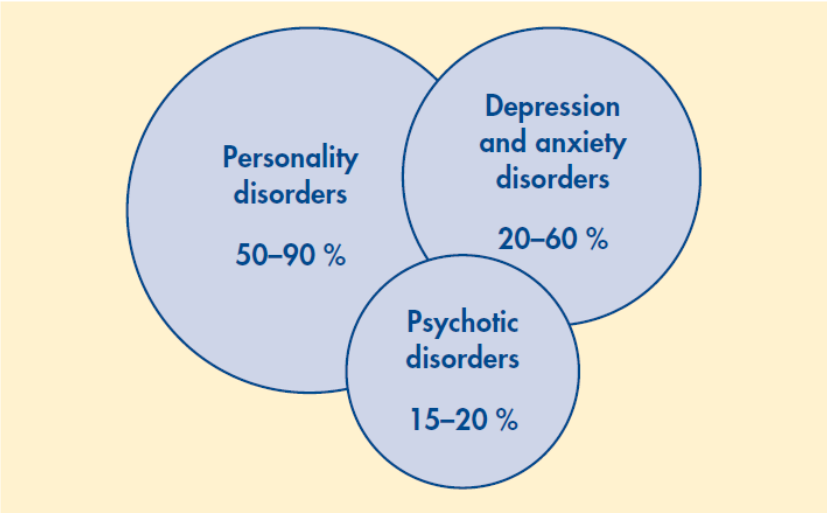
3.5 Epidemiology of Dual Diagnosis

Dual diagnosis or co-morbidity is often underestimated and under-diagnosed. Between 30 and 50% of psychiatric patients in Europe today have a mental illness as well as a substance use disorder, mainly with alcohol, sedatives or cannabis. In clinical prevalence samples of drug dependent patients, personality disorders (50–90%) are the most prevalent form of co-morbidity, followed by affective disorders (20–60%) and psychotic disorders (15–20%), although these syndromes interact and overlap which means a person might have more than one of these disorders in addition to drug-related disorders.[149]

Figure 3.1: Overlap of the three dominating diagnostic syndromes in patients with co-morbid drug-use disorders[150]

[149] Fridell, M. And Nilson, M., *Drugs in Focus: Briefing of the European Monitoring Centre for Drugs and Drug Addiction*, 2004. Office for Official Publications of the European Communities. Available at http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Good%20Practice/dual.pdf Accessed 04/12/2013.

[150] Op. cit. Fridell & Nilson (2004).



Furthermore, estimates of substance use of more than 50% are not uncommon in mental health services embedded in urban psychiatric facilities, although estimates in ruralities have been shown to be three to four times lower.[151]

The prevalence of co-occurring disorders has also been studied in community/general population samples[152] and particular links have been found between high alcohol consumption and depression (see section 3.5.2).

The nature of the relationship between mental health and substance misuse problems is complex, but possible mechanisms recognised by Crome et al (2009)[153] include:

- A primary psychiatric illness may precipitate or lead to substance use, misuse, harmful use, and dependent use, which may also be associated with physical illness and affect social ability.
- Substance use, misuse, harmful use and dependent use may exacerbate a mental health problem and physical health problem, e.g. painful conditions, and any associated social functioning.
- Substance use e.g. intoxication, misuse, harmful use and dependent use may lead to psychological symptomatology not amounting to a diagnosis, and to social problems.

[151] Rush, B, and Koegl, C., 'Prevalence and Profile of People with Co-occurring Mental and Substance Use Disorders Within a Comprehensive Mental Health System', *La Revue Canadienne de Psychiatrie*, 2008; 53(12):810-22.

[152] For example: Reiger DA, Farmer ME, Rae DS. 'Co-morbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiological Catchment Area (ECA) study,' *JAMA*, 1990;264;2511–2518; Kessler, R., Nelson, C., McGonagle, K., Swartz, M., Blazer, D., 'Co-morbidity of DSM-III-R major depressive disorder in the general population: results from the US National Co-morbidity Survey', *British Journal of Psychiatry Supplement*, 1996; (30):17-30; Kessler R., Chiu W., Demler O, et al., 'Prevalence, severity, and co-morbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey Replication.,' *Archive of General Psychiatry,* 2005;62(6):617–627; Grant B., Stinson F., Dawson D., et al. 'Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States,' *Archive of General Psychiatry,* 2004;61:361–368.

[153] Crome, I., Chambers, P., Frisher, M., Bloor, R. & Roberts, D., *The relationship between dual diagnosis: substance misuse and dealing with mental health issues*, Research Briefing 30, January 2009. Available at http://www.scie.org.uk/publications/briefings/files/briefing30.pdf. Accessed 02/12/2013. p. 4.

- Substance use, misuse, harmful use and dependent use may lead to psychiatric illnesses, physical illness, and social dysfunction.

Establishing which problem came first is often complicated and some authors warn that focussing on this issue can result in vulnerable individuals with co-morbidity being excluded from services whilst a decision about ultimate attribution is made.[154]

Co-morbidity can occur at any level of severity, and it is important to note that whilst in the UK there has been both an increased prevalence of substance misuse (particularly alcohol)[155] and an increased prevalence of dual diagnosis,[156] there is not necessarily a causal relationship between substance misuse and mental illness. Frisher et al (2005) concluded that, based on their sample of 3,969 patients with both substance misuse and psychiatric diagnosis, only a comparatively small proportion of psychiatric illness could be attributed to substance use (0.2%), whereas a more substantial proportion of substance use seems possibly attributable to psychiatric illness (14.2%).[157]

3.5.1 Specific Associations: Substance misuse, self harm and suicidal behaviour

Alcohol can make people lose their inhibitions and behave impulsively; it can therefore lead to actions they might not otherwise have taken – including self-harm and suicide.[158] Furthermore, according to the National Mental Health Development Unit (2009)[159] people who have – or are recovering from – both alcohol and drug alcohol problems are at a significantly greater risk of self-harm and suicide than the general population.

Data gathered by the NHS in Scotland, reveal that more than half of those who presented to hospital with self-inflicted injuries reported to have consumed alcohol before or during the act of self-harm, and 27% of men and 19% of women gave alcohol as the reason for self-harming.[160] More recently, in a study involving 1108 people presenting at general hospitals in Manchester with self-inflicted injuries (a third of whom

[154] Op cit. Crome et al (2009), p.3.

[155] British Medical Association Science and Education Department and BMA Board of Science (2008) Alcohol Misuse: Tackling the UK Epidemic. London, British Medical Association; NHS Information Centre (2008) Statistics on Alcohol: England 2008, London, NHS Information Centre; Murphy, R. and Roe, S. (2007) Drug Misuse Declared: Findings from the 2006/07 British Crime Survey – England and Wales, London, Home Office.

[156] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *J Epidemiology and Community Health* 2005;59:847–850; Frisher, M., Collins, J., Millson, D., Crome, I., and Croft, P. (2004) 'Prevalence of co-morbid psychiatric illness and substance misuse in primary care in England and Wales', *Journal of Epidemiology and Community Health* 2004;58:1034–1041.

[157] Frisher, M., Crome, I., Macleod, J., Milson, D., & Croft, P., 'Substance misuse and psychiatric illness: prospective observational study using the general practice research database', *Journal of Epidemiological Community Health* 2005;59:847–850.

[158] Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H (2001) Psychiatric morbidity among adults living in private households, 2000. Her Majesty's Stationery Office (HMSO): London.

[159] Royal College of Psychiatrists: College Report CR158, Self-harm, suicide and risk: helping people who self-harm: Final report of a working group, June 2010, Royal College of Psychiatrists, London.

[160] NHS Quality improvement Scotland, *Understanding alcohol misuse in Scotland: Harmful drinking three –alcohol and self-harm'*, 2007. Accessed 02/12/2013. Available at http://healthcareimprovementscotland.org/programmes/mental_health/programme_resources/harmful_drinking_3.aspx.

were assessed by mental health specialists), probable depression was identified in 29%; alcohol or drug misuse in 32% (a further 9% were alcohol dependent); anxiety/stress-related disorders in 13%; a severe mental illness in 7%; and a further 4% were diagnosed with personality disorders (Dickson *et al*, 2009).[161]

The estimated risk of suicide in the presence of current alcohol misuse or dependence is eight times greater than in the absence of such misuse/dependence[162,163] and as many as 65% of suicides have been linked to excessive drinking.[164] The risk is especially great for men.[165] Up to 40% of men who try to kill themselves have an enduring problem with alcohol, and as many as 70% of those who succeed are intoxicated at the time,[166] this may be explained in part by the fact that people who are intoxicated by alcohol tend to use more lethal methods of suicide or attempt suicide using means that have a very low probability of survival.[167]

The link between substance misuse and early death has been touched upon in the previous chapter, and according to np-SAD data, overall 18.1% of drug-related deaths in 2011 were ruled suicide. There was however more deaths attributed to suicide in females than in males (23.1% vs. 16.1%).[168] Moreover, of the 131 cases noted as diagnosed with mental health issues, 51.9% (68/131) were listed as suffering from depression, with 25.0% of these (17/68) having deaths attributed to suicide.[169]

According to the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013,*[170] in 2011 there were 5,880 suicides in England in patients[171] with a history of alcohol misuse (45% of the total sample) and 4,079 patient suicides had a history of drug misuse (31% of the total sample). Between 2001-2010, the number of patient suicides with a history of alcohol or drug misuse did not change, although the report projects a rise in 2011 (see figure below).

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[161] Dickson, S., Steeg, S., Donaldson, I., *et al*. (2009) *Self-Harm in Manchester*. 1st September 2005 to 31st August 2007. The University of Manchester.

[162] World Health Organisation, *Global Status Report on Alcohol 2004*, 2004, Geneva, WHO.

[163] Flensborg-Madsen, T., Knop, J., Mortensen, E., Becker, U., Sher, L., Grønbæk, M., 'Alcohol use disorders increase the risk of completed suicide — Irrespective of other psychiatric disorders. A longitudinal cohort study', *Psychiatry Research*, 2009; 167(1-2):123-30.

[164] Department of Health, *Health of the Nation key area handbook: mental health*, 1993, London: HMSO.

[165] Lucas Ginera, L., Blasco-Fontecillab, H., Perez-Rodriguezc, M., Garcia-Nietod, R., Ginera, J., Guijaa, J., Barreroe, A., Lunaf, M., de Leong, J., Oquendoh, M., Baca-Garciad, E., 'Personality disorders and health problems distinguish suicide attempters from completers in a direct comparison', *Journal of Affective Disorders*, 2013; 151(2):474-83.

[166] The Royal College of Psychiatrists, *Alcohol and Depression: Help is at Hand*, 2004, London: The Royal College of Psychiatrists.

[167] Sher L. 'Alcohol consumption and suicide', *Quarterly Journal of Medicine*, 2006; 99:57–61.

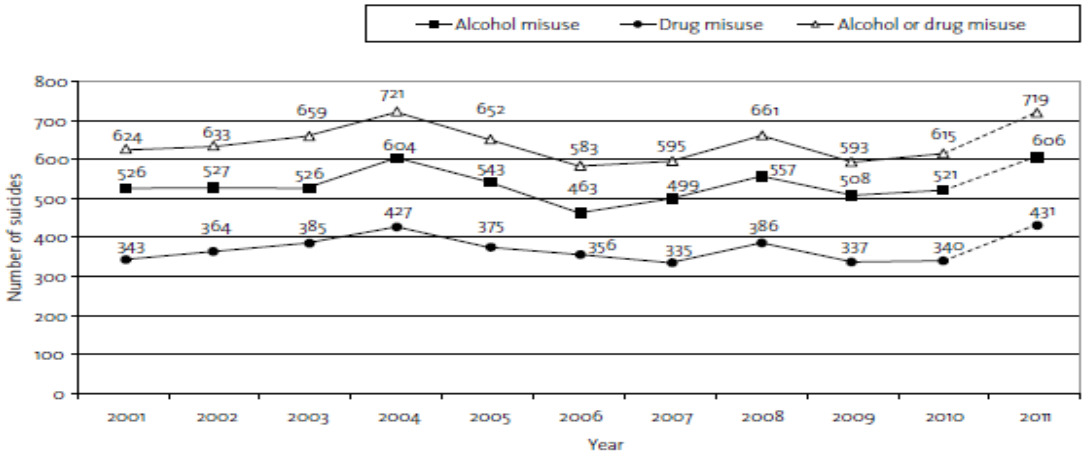
[168] Op. cit. Ghodse et al (2012) p.7.

[169] Op. cit. Ghodse et al (2012) p.43.

[170] The University of Manchester, *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report England, Northern Ireland, Scotland and Wales*, July 2013. Available at http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/NCIAnnualReport2013V2.pdf. Accessed 11/12/2013.

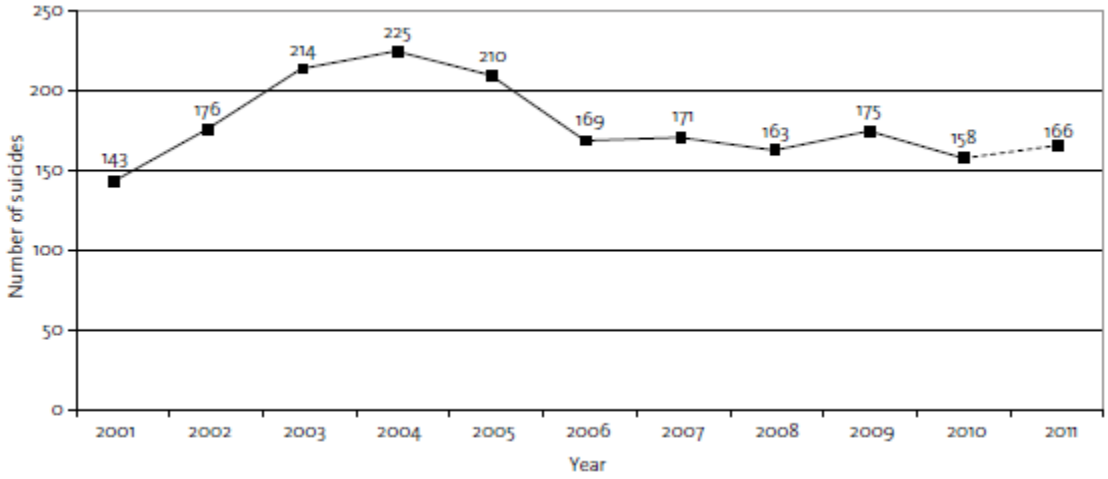
[171] i.e. the person had been in contact with mental health services in the 12 months prior to death.

Figure 3.2: Patient suicide: number with a history of alcohol or drug misuse (England)[172]



Further, 1,970 (15%) patient suicides had severe mental illness and co-morbid alcohol drug dependence/misuse (dual diagnosis) – an average of 179 deaths per year. There was no trend during the report period overall (see figure below) but numbers have fallen since a peak in 2004.

Figure 3.3: Patient suicide: number with dual diagnosis (England)[173]



3.5.2 Specific Associations: Substance misuse, depression & anxiety

Evidence suggests that at least two thirds of alcohol-dependent individuals entering treatment show evidence of anxiety, sadness, depression and/or manic-like symptoms.[174] Likewise, a higher incidence of alcohol use disorders (AUDs) is reported

[172] Figure 19, *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report*

[173] Figure 20, *The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: Annual Report.*

[174] Crawford, V., *Co-existing problems of mental health and substance misuse ('Dual Diagnosis'): A Review of Relevant Literature*, London: RCP College Research Unit, 2001.

for patients in treatment for depression,[175] and a recent Australian study found that a diagnosis of affective disorder was associated with a five-fold increased risk of developing alcohol dependence within five years of onset and for generalised anxiety the risk was three-fold.[176]

A 2011 literature review and analysis by Boden and Fergusson confirmed that the presence of either an AUD or major depression (MD) doubled the risks of the second disorder. They surmise that the epidemiological data suggests the linkages between disorders cannot be fully accounted for by common factors that influence both AUD and MD, and that the disorders appear to be linked in a causal manner. They go on to note that evidence suggests the most plausible causal association between AUD and MD is one in which AUD increases the risk of MD, rather than vice versa, although they acknowledge that further research is needed to clarify the nature of this causal link.[177]

Amongst the general population, alcohol dependence and major depression co-occur at higher levels than would be expected by chance,[178] and there is evidence to suggest that whilst light to moderate alcohol consumption may be associated with a lower prevalence of depression and generalised anxiety disorder compared to abstinence, higher volume consumption is associated with more severe symptoms of depression.[179,180,181] The primary source of information on the prevalence of both treated and untreated psychiatric disorders and their associations in England is the Adult Psychiatric Morbidity Survey (APMC). Data from the most recent survey (2007) suggests that among the 'cluster' with cothymia (co-occurring anxiety and depression) 39.7% were also dependent on alcohol, and 19.9% were dependent on drugs.[182]

Collectively the evidence seems to suggest that AUDs often co-occur with depressive symptoms, although there is less evidence to indicate whether, in the individual case, the depression causes the alcohol problems, the alcohol problems cause the depression, or whether a third factor causes both. That withstanding, according to the World Health Organisation "the evidence indicates that a clear and consistent association exists

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[175] Alpert J., Fava, M., Uebelacker, L., Nierenberg, A., Pava, J., Worthington, J., et al, 'Patterns of Axis I co-morbidity in early-onset versus late-onset major depressive disorder', *Biological Psychiatry*, 1999; 46(2):202-11; Blixen, C., McDougall, G., Suen, L., 'Dual Diagnosis in elders discharged from a psychiatric hospital', *International Journal of Geriatric Psychiatry*, 1997; 12(3):307-313.

[176] Liang, W., Chlkritzhs, T., 'Affective disorders, anxiety disorders and the risk of alcohol dependence and misuse', *British Journal of Psychiatry*, 2011;199:219-24.

[177] Boden, J., & Fergusson, D., 'Alcohol and depression', *Addiction Review*, 2011; 106(5):906-14.

[178] Op. cit. Kessler et al (1996); Lynskey, M., 'The co-morbidity of alcohol dependence and affective disorders: treatment implications', *Drug and Alcohol Dependence*, 1998; 52(3):201-9; Mehrabian, A., 'General relations among drug use, alcohol use, and major indexes of psychopathology,' *Journal of Psychology*, 2001; 135(1): 71-86.

[179] Op. cit. Mehrabian (2001); Alcohol Concern, *Factsheet 17: Alcohol & Mental Health*, 2004, London.

[180] Bellos, S., Skapinakis, P., Rai, D., Zitko, P., Araya, R., Lewis, G., Lionis, C., Mavreas, V., 'Cross-cultural patterns of the association between varying levels of alcohol consumption and the common mental disorders of depression and anxiety: Secondary analysis of the WHO Collaborative Study on Psychological Problem in General Health Care', *Drug and Alcohol Dependence*, 2013; 133(3): 825-31.

[181] Flensborg-Madsen, T., Becker, U., Grønbæk, M., Knop, J., Mortensen, E., 'Alcohol consumption and later risk of hospitalisation with psychiatric disorders: prospective cohort study', *Psychiatric Research*, 2011; 187(1-2):214-9.

[182] National Centre for Social Research & Department of Health Sciences, University of Leicester, *Adult psychiatric morbidity in England, 2007: Results of a household survey*. Available at http://www.hscic.gov.uk/catalogue/PUB02931 Accessed 03/12/13. p227-8.

between alcohol dependence and depressive disorders and that chance, confounding variables and other bias can be ruled out with reasonable confidence as factors in this association."[183]

Using alcohol or drugs to reduce emotional distress (self-medication) has been proposed as an explanation for the high co-morbidity rates between non-clinical anxiety, depression and substance use disorders. Bolton et al (2009) analysed data from the National Epidemiologic Survey on Alcohol and Related Conditions (a large (n=43,093) nationally representative survey of mental illness in community-dwelling adults in Canada) and found that almost one-quarter of individuals with mood disorders (24.1%) used alcohol or drugs to relieve symptoms, with men more than twice as likely as women to engage in self-medication.[184] The risk of such self-medication has been examined in a recent study which concluded that drinking to alleviate mood symptoms is associated with the development of alcohol dependence and its persistence once dependence develops.[185] Similarly, Lazareck et al (2012) concluded that self-medication with drugs among individuals with mood disorders confers substantial risk of developing incident drug dependence and is associated with the persistence of co-morbid mood and drug use disorders.[186] Conversely, other studies have suggested that substance use can lead to the development of anxiety disorders, that substance misuse worsens psychiatric symptoms and the biological effects of withdrawal from substances can mimic anxiety disorders.[187]

Whilst the direction of causality has yet to be proved conclusively, there is a wealth of evidence demonstrating the co-occurrence of anxiety disorders and substance issues.

3.5.3 Specific Associations: Substance misuse and personality disorders

As noted by the Mental Health Foundation, individuals receiving treatment for alcohol dependence are often diagnosed with a personality disorder.[188] Up to 50% of problem

[183] WHO (2004).

[184] Bolton, J., Robinson, J., Sareen, J., 'Self-medication of mood disorders with alcohol and drugs in the National Epidemiologic Survey on Alcohol and Related Conditions', *Journal of Affective Disorders*, 2009; 115(3):367-375.

[185] Crum, R., Mojtabai, R., Lazareck, S., et al. A Prospective Assessment of Reports of Drinking to Self-medicate Mood Symptoms With the Incidence and Persistence of Alcohol Dependence. *JAMA Psychiatry.*2013;70(7):718-726. This supports the estimations made by Robinson et al (2011) that, based on the evidence, 10% of new cases of alcohol dependence and 28% of new drug dependence cases were attributable to self-medication of anxiety (see Robinson, J., Sareen, J., Cox, B., Bolton, J., 'Role of self-medication in the development of co-morbid anxiety and substance use disorders: a longitudinal investigation', *Archives of General Psychiatry*, 2011; 68(8):800-7).

[186] Lazareck, S., Robinson, J., Crum, R., Mojtabai, R., Sareen, J., Bolton, J., 'A longitudinal investigation of the role of self-medication in the development of co-morbid mood and drug use disorders: findings from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)', *Journal of Clinical Psychiatry*, 2012; 73(5):588-93.

[187] Tomlinson, K., Tate, S., Anderson, K., McCarthy, D., Brown, S., 'An examination of self-medication and rebound effects: psychiatric symptomatology before and after drug relapse', *Addictive Behaviour*, 2006;31(3):461-74; Schuckit, M., 'Co-morbidity between substance use disorders and psychiatric conditions', *Addiction*, 2006;101(Supplement 1):76-88. Both cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p30.

[188] Mental Health Foundation, *Cheers? Understanding the relationship between alcohol and mental health*, 2006. Available at http://www.mentalhealth.org.uk/publications/.

drinkers have a personality disorder, up to 80% have neurotic disorders[189] and people with anti-social disorders have 21 times the average population risk of experiencing alcohol abuse or dependence.[190] There are however differences between genders, with a recent study confirming that borderline personality disorder is more prevalent among females than males accessing alcohol detoxification treatment.[191]

In their review of the evidence,[192] the Mental Health Foundation noted that as well as possibly being a pre-disposing factor to alcohol-dependence, a personality disorder can affect the individual's use of alcohol in other ways. It may, for example, influence: the clinical course of alcohol-dependence; their response to treatment;[193] and their risk of relapse.

Personality disorder is also strongly associated with an increased risk of substance misuse issues, indeed estimates suggest that over half the patient population of drug and alcohol services will meet criteria for one or more personality disorders. [194,195]

As with alcohol, a personality disorder can affect the individual's substance misuse. A recent study concluded that the presence of co-occurring Borderline Personality Disorder (BPD) among male substance misuse patients may increase the risk for dropout from residential substance abuse treatment, necessitating targeted interventions focused on decreasing dropout within this patient subgroup.[196] Furthermore, poorer outcomes have been associated with (i) those who both misuse substances and have a mental health disorder compared to those with just a single disorder, with a recent US study among those with cannabis or alcohol dependence finding that those with personality disorders had an increased risk of the disorder

[189] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p29. See also Preuss, U., Johann, M., Fehr, C., Koller, G., Wodarz, N., Hesselbrock, V., Wong, W., Soyka, M., ` Personality Disorders in Alcohol-Dependent Individuals: Relationship with Alcohol Dependence Severity', *European Addiction Research*, 2009; 15(4): 188-95.

[190] Institute of Alcohol Studies, *Alcohol and Mental Health*, 2004, Cambridge cited op. cite. Mental Health Foundation (2006).

[191] Picci, R., Vigna-Taglianti, F., Oliva, F., Mathis, F., Salmaso, S., Ostaoli, L., Sodano, A., Furlan, P., 'Personality disorders among patients accessing alcohol detoxification treatment: prevalence and gender differences', *Comprehensive Psychiatry*, 2012; 53(4):355-63.

[192] Op. cit. Mental Health Foundation (2006).

[193] Further supported by: Poldrugo, F. And Forti, B., 'Personality disorders and alcoholism treatment outcome', *Drug and Alcohol Dependence*, 1988; 21(3):171-6; Bottlender, M., and Soyka, M., 'Impact of different personality dimensions (NEO Five-Factor Inventory) on the outcome of alcohol-dependent patients 6 and 12 months after treatment', *Psychiatry Research*, 2005; 136(1):61-7.

[194] Welch, S., 'Substance use and personality disorders', *Psychiatry*, 2007; 6(1):27-9.

[195] Pennay, A., Cameron, J., Reichart, T., Strickland, H., Lee, N., Hall, K., Lubman, D., 'A systematic review of interventions for co-occurring substance use disorder and borderline personality disorder', *Journal of Substance Abuse Treatment*, 2011; 41(4):363-73.

[196] Tull, M., Gratz, K., 'The impact of borderline personality disorder on residential substance abuse treatment dropout among men', *Drug and Alcohol Dependence*, 2012; 121(1-2):97-102.

persisting for at least three years[197] and (ii) dual diagnosis patients with prior mental disorder compared to dual diagnosis patients with prior substance use disorders.[198]

3.5.4 Specific Associations: Substance misuse and severe and enduring mental illness

Individuals with severe and enduring mental illnesses, such as schizophrenia and bipolar disorder, are at least three times as likely to be alcohol dependent as the general population,[199,200] and an estimated 40% of people diagnosed with psychosis have also misused a substance at some point in their lifetime.[201]

The incidence of dual diagnosis amongst those with a severe and enduring mental illness may be higher in the UK than elsewhere. A recent pan-European study into the lifetime prevalence of substance dependence among those with schizophrenia found that rates of co-morbidity were highest in this country; 35% reported dependence on a substance – 26% alcohol dependence and 18% drug dependence.[202] Despite this relatively high rate of co-presentation there is still no consensus on the aetiology of increased rates of substance use in people with psychosis. As noted by Gregg et al (2007), there is therefore a clear need to understand the reasons for such high rates of substance use if treatments designed to help patients abstain from substance use are to be successful.[203]

3.6 Prevalence of Dual Diagnosis across the UK

As noted above, there are no routinely collected datasets on dual diagnosis; it is therefore difficult to estimate the prevalence of such co-morbidity. This difficulty is further compounded by an inconsistency in definition. Moreover, most studies are based on data collected from those already known to specialist services (mental health or substance misuse) and do not therefore tell us about the prevalence of dual diagnosis amongst the general population.

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[197] Hasin, D., Fenton, M., Skodol, A., Krueger, R., Keyes, K. Geier, T., et al, 'Personality disorders and the three year course of alcohol, drug and nicotine use disorders', *Archive of General Psychiatry*, 2011; 68(11):1158-67. Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p30.

[198] Najt, P., Fusar-Poli, P., & Brambilla, P., 'Co-occurring mental and substance abuse disorders: A review on the potential predictors and clinical outcomes', *Psychiatry Research*, 2011; 186(2-3):159-64.

[199] Institute of Alcohol Studies, *Alcohol and Mental Health*, 2004, Cambridge cited op. cite. Mental Health Foundation (2006).

[200] Phillips, P., Johnson, S., 'How does drug and alcohol misuse develop among people with psychotic illness? A literature review,' *Soc Psychiatry Psychiatry Epidemiology* 2001; 36(6):269-76.

[201] National Institute for Clinical Excellence, *Clinical Guideline (CG120) Psychosis with co-existing substance misuse*, March 2011, p 4. Available at http://guidance.nice.org.uk/CG120/NICEGuidance/pdf/English. Accessed 04/12/2013.

[202] Carra, G., Johnson, S., Bebbington, P., Angermeyer, M., Heider, D., Brugha, T., et al, 'The lifetime and past-year prevalence of dual diagnosis in people with schizophrenia across Europe: findings from the European Schizophrenia Cohort (Euro SC), *European Archive of Psychiatry and Clinical Neuroscience*, 2012. Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p30.

[203] Gregg, L., Barrowclough, C., Haddock, G., 'Reasons for increased substance use in psychosis', *Clinical Psychology Review*, 2007; 27(4):494-510.

In line with European estimates, the charity 'Rethink Mental Illness' estimate that in the UK, a third of patients in mental health services have a substance misuse problem, and around half of patients in drug and alcohol services have a mental health problem.[204] Studies have however shown widespread social and regional variation in the prevalence of dual diagnosis, with higher rates recorded in deprived areas than in affluent areas. That withstanding, it has been suggested that the rate is increasing more rapidly in affluent areas.[205]

3.6.1 The 'COSMIC' Study

In 2002, the Co-Morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC) estimated the prevalence of dual diagnosis in four inner-city areas in England (two in London, Sheffield and Nottingham). They reported that 74.5% of drug service users and 85.5% of alcohol service users experienced co-occurring mental health problems.[206] The prevalence of particular mental health problems amongst the subject group are shown in the table below:

Table 3.4: COSMIC study: Estimated prevalence of mental health problems among substance misuse patients[207]

Condition	% of drug treatment population	% alcohol treatment population
Psychiatric disorder	75	85
Non-substance induced psychosis disorders	8	19
Personality disorder	37	53
Depression &/or anxiety disorder	68	81
Severe depression	27	34
Mild depression	40	47
Severe anxiety	19	32

Similar rates of dual diagnosis were also reported in a study undertaken at the same in time the London borough of Bromley. Strathdee et al (2002) estimated that 83% of substance misuse clients had a dual diagnosis.[208]

[204] Cited in *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.32.

[205] Op. cit., Frischer et al (2005).

[206] Weaver, T., Charles, V., Madden, P., & Renton, A., 'A study of the Prevalence and Management of Co-Morbidity amongst Adult Substance Misuse & Mental Health Treatment Populations', Drug Misuse Research Initiative/Dept of Health, 2002. Available at http://dmri.lshtm.ac.uk/docs/weaver_es.pdf. Accessed 06/12/2013.

[207] Source: Table 2 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.33.

[208] Strathdee et al (2002), 'Dual diagnosis in a primary care group (PCG) – a step by step epidemiological needs assessment and design of a training and service response model', Department of Health/National Treatment Agency.

The COSMIC study also found that 44% of the community mental health team (CMHT) patients reported problem drug use of harmful alcohol use in the preceding twelve months – the most commonly used substances being alcohol and cannabis:

Table 3.5: COSMIC study: Use of substances by CMHT patients[209]

Substance	Use in the past 12m by CMHT patients (%)
Harmful alcohol or drug use	44
Any drug use	31
Harmful alcohol use (AUDIT ≥8)	26
Cannabis	25
Dependent cannabis use	12.8
Sedatives/tranquilisers	7
Crack cocaine	6
Heroin	4
Ecstasy	4
Amphetamines	3
Cocaine	3
Opiate substitutes	1.4

The study in Bromley suggested lower levels of dual diagnosis within community mental health clients (20%), but recorded a prevalence rate of 43% for psychiatric in-patients and 56% in forensic patients.[210]

Other key findings of the COSMIC report were that around 30% of drug service users and 50% of alcohol service users had 'multiple morbidity' (i.e. complex needs); and some 38.5% of drug users with a psychiatric disorder were receiving no treatment for their mental health problem. Also important is the conclusion drawn that the treatment population is heterogeneous, and that responding to the range and level of need is challenging.

It should be noted that both of the aforementioned studies were conducted in city locations, care should therefore be used when applying the findings to more rurual locations.

3.6.2 Making Every Adult Matter coalition

In their 2011 vision paper *Turning the Tide*, the Making Every Adult Matter (MEAM) coalition of voluntary sector organisations Clinks, DrugScope, Homeless Link and Mind, estimated that around 60,000 people living in the UK were experiencing multiple needs relating to mental health, substance misuse, homelessness and offending.[211] The report paid particular attention to those who are excluded from services either because they do not meet their criteria or because they have complex needs and are seen as 'hard

[209] Source: Table 3 *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.34.

[210] Op. cit. Strathdee et al (2002).

[211] MEAM and Revolving Doors, *Turning the Tide: A vision paper for multiple needs and exclusions,* MEAM/RDA,2011. Available at http://meam.org.uk/wp-content/uploads/2011/09/turning-the-tide.pdf. Accessed 06/12/2013.

to reach' or 'not my problem'. It recommended a cross-agency approach and suggested that local leaders should make tackling multiple needs and exclusions a priority.

Homelessness

It is estimated that 18% of rough sleepers have a mental health issue combined with a substance misuse issue[212] and according to rough sleeping statistics published for Autumn 2012, an estimated 2,309 people are sleeping rough in England on any one night.[213]

Criminal Justice/Prison Population

Those with a dual diagnosis are at higher risk of contact with the criminal justice system, both compared to the general population and to others with just mental health issues.[214] Consequently, the prevalence of dual diagnosis among the prison population has been estimated at 75%.[215] This finding has wider implications within a community setting, for example, the Bradley review into offender mental health concluded that dual diagnosis was a vital component, and that no approach to diverting offenders with mental health issues from custody would be effective unless it addressed alcohol and drug misuse.[216]

Learning Difficulties

According to the Mental Health Foundation, there are around 1 million people with learning disabilities in England and estimates of prevalence of mental health problems vary from 25-40%, depending on the population sampled and the definitions used.[217]

Due to the growth of 'substance abuse' (i.e. alcohol, illicit drugs and over use of prescribed medications) in both the general and psychiatric populations, there is also a growing trend for people with learning disabilities to misuse such substances (Degenhardt et al., 2000, Sturmey et al., 2003).[218] There is however a paucity of

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[212] *Preventing suicide in England: A cross-government outcomes strategy to save lives,* Department of Health, Sept 2012, p.29. Available at https://www.gov.uk/government/publications/suicide-prevention-strategy-launched. Accessed 06/12/2013.

[213] *Rough Sleeping Statistics England:2012*, Dept for Communities and Local Government, available at http://data.gov.uk/dataset/rough_sleeping_statistics_england. Accessed 06/12/2013.

[214] Cited *Dual Diagnosis Needs Assessment: Brighton & Hove*, December 2012, p.36.

[215] Prison Reform Trust. Prison Fact File December 2011. Available at http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefing%20December%202011.pdf. Accessed 06/12/2013.

[216] The Bradley Report Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system, April 2009. Available at http://www.rcpsych.ac.uk/pdf/Bradley%20Report11.pdf. Accessed 06/12/2013.

[217] Giraud-Saunders , A., *Mental health in people with learning disabilities*, Mental Health Foundation. Accessed 06/12/2013. Available at http://www.mentalhealth.org.uk/content/assets/PDF/policy-archive/Mental_health_in_people_with_learning_disabilities.pdf.

[218] Cited Taggart et al, An Exploration Of Substance Misuse In People With Learning Disabilities Living Within Northern Ireland, University of Ulster, 2004. Available at

evidence examining the misuse of substances amongst those with learning difficulties. Sturmey et al. (2003) stated that "it is difficult to define any consensus among the studies as to the prevalence of alcohol misuse among people with learning disabilities, however, prevalence rates may vary somewhere between 0.5% - 2% of this population" (p. 44). Figures for illicit drug misuse in people with learning disabilities also indicate far lower prevalence rates (Westermeyer et al., 1988, Gress & Boss, 1996, Christian & Poling, 1997, Pack et al., 1998). Nonetheless, ARAC (2002) have reported that few learning disability, and also mainstream addiction, service providers have clear written policies and procedures for co-working with this population. Consequently, both service providers have reported a number of difficulties in recognising and meeting the complex needs of this population.[219]

3.6.3 Future

There is very limited data available to assess the trend in prevalence rates of dual diagnosis either nationally or locally. A study in primary care in England and Wales in 2004 did however estimated that the prevalence of co-morbid psychiatric illness and substance misuse was increasing by 10% each year, but it is not clear this has occurred.[220]

National trends show that over the last 20 years there have been large increases in rates of substance dependency. This, together with the increasing prevalence of common mental health disorders such as anxiety and depression suggest that dual diagnosis could increasingly be recognised. It is however difficult to quantify any such increase with the data currently available.[221]

3.7 Prevalence of Dual Diagnosis in West Sussex

There are separate prevalence estimates available for mental health conditions, and for substance misuse in the local population of West Sussex, however these estimates do not indicate how many people have both conditions. Data from treatment services approximates how many people in the area are being treated for a dual diagnosis, but this does not give an insight into unmet need, therefore in this section such data is supplemented by information from a range of other sources (detailed below).

http://www.dhsspsni.gov.uk/an_exploration_of_substance_misuse_in_people_with_learning_disabilities_living_in_northern_ireland.pdf. Accessed 06/12/2013.

[219] Ibid.

[220] Frisher, M., et. al, 'Prevalence of co-morbid illness and substance misuse in primary care in England and Wales', *Journal of Epidemiology & Community Health*, 2004;58:1036-41.

[221] National Mental Health Development Unit, Briefing 189, *Meeting the challenge of dual diagnosis*, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf. Accessed 09/12/2013.

3.7.1 Mental health in West Sussex

Personal Wellbeing

Since April 2011, the Office for National Statistics has measured personal wellbeing across the UK against four domains: life satisfaction, worthwhile, happiness and anxiety. According to all four measures, residents of West Sussex experience better than average personal wellbeing (similar to that reported in Essex and Dorset). There is however variation across the county, with the Worthing sample consistently reporting poorer wellbeing than the West Sussex average in all measures bar one, where the Arun sample reported the highest level of anxiety.

Table 3.6: Life satisfaction, Worthwhile, Happiness and Anxiety ratings by UK, country, region, UA/ County, April 2012 to March 2013[222]

Area names	Life satisfaction rating[223]	Worthwhile rating[224]	Happiness rating[225]	Anxiety rating[226]
UNITED KINGDOM	7.45	7.69	7.29	3.03
ENGLAND	7.44	7.68	7.28	3.05
Essex	7.41	7.67	7.25	2.96
Dorset	7.65	7.93	7.39	2.91
West Sussex	7.59	7.86	7.40	2.81
Adur	7.43	7.66	7.27	2.54
Arun	7.64	7.82	7.43	3.04
Chichester	7.61	8.01	7.52	2.68
Crawley	7.53	7.82	7.26	2.83
Horsham	7.80	8.06	7.56	2.79
Mid Sussex	7.73	7.86	7.49	2.84
Worthing	7.20	7.70	7.16	2.41

[222] Source: Estimates of personal well-being from the Annual Population Survey (APS) Personal Well-being dataset: by UK, country, region, UA/ County in England, LADs in England, UAs in Wales, LAs in Scotland, DCAs in Northern Ireland, April 2012 to March 2013, available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-327124. Last accessed 22/11/2013.

[223] Sample populations were asked 'Overall, how satisfied are you with your life nowadays?' A scaling of 0-10 was given, where 0 was 'not satisfied at all' and 10 was 'completely satisfied'.

[224] Sample populations were asked, 'Overall, to what extent do you feel the things you do in your life are worthwhile?' A scaling of 0-10 was given, where 0 was 'not at all worthwhile' and 10 was 'completely worthwhile'.

[225] Sample populations were asked, 'Overall, how happy did you feel yesterday?' A scaling of 0-10 was given, where 0 was 'not at all happy' and 10 was 'completely happy'.

[226] Sample populations were asked, 'Overall, how anxious did you feel yesterday?' A scaling of 0-10 was given, where 0 was 'not at all anxious and 10 was 'completely anxious'.

Regular physical activity is also associated with improved personal wellbeing. In the period 2009/10-2011/12, the percentage of adults (16+) participating in the recommended level of physical activity in West Sussex was higher than both the England average (11.2%) and that reported in Essex (10.9%) at 13.4%, and similar to that seen in Dorset (13.8%).[227]

Mental Health Conditions

The above withstanding, West Sussex had significantly more adults on the GP resister for depression in 2011/12 than the national average. There was also a higher prevalence of panic disorders and hospital admissions for unipolar depressive disorders 2009/10 to 2011/12. The Table below does however show that the rate of neurotic disorders, mixed anxiety & depression and generalised anxiety disorders (in those aged 16-74), was significantly better in West Sussex than the national average. West Sussex also has low rates of health service use for mental health problems, with significantly fewer adults receiving care under a Care Programme Approach, significantly fewer patient contacts by Outpatient & Community Psychiatric Nurses per year and significantly fewer total patient contacts by mental health staff.

Table 3.7: Mental health in West Sussex

Prevalence	West Sussex		Dorset		Essex	England
	No.	Rate per 1,000 pop	No.	Rate per 1,000 pop	Rate per 1,000 pop	Rate per 1,000 pop
Adults on GP register for depression 2011/12[228]	83,363	124	43,313	131	96.8	116.8
Adults on Mental Health Register 2011/12[229]	6,125	7	2,906	7	As Essex comprises of four separate PCTs, data under these prevalence indicators could not be provided.	7.9
Any neurotic disorder (16-74)*	74,398.3	137.3	41,846.0	148.4		166
Mixed anxiety & depression (16-74)*	41,283.8	76.2	23,679.4	84.0		89.0
Generalised anxiety disorder (16-74)*	19,861.3	36.7	10,881.8	38.6		45.0
Panic disorder (16-74)*	3,958.8	7.3	1,546.2	5.5		6.5
Depressive episode (16-74)*	10,337.6	19.1	3,341.4	11.8		
Rate for hospital admissions for mental health 2009/10 to 2011/12†		2.34		3.28	1.97	2.43
Rate for hospital admissions for unipolar depressive disorders 2009/10 to 2011/12†		0.40		0.54	0.25	0.32

[227] Community Mental Health Profiles 2013: West Sussex/Essex/Dorset, North East Public Health Observatory. Accessed December 2013. Available at http://www.nepho.org.uk.

[228] Source: Quality and Outcomes Framework - 2011-12, PCT level: Prevalence Table. Available at http://www.hscic.gov.uk/article/2021/Website-Search?productid=9592&q=. Accessed 06/12/2013.

[229] Total number of people with schizophrenia, bipolar disorder and other psychoses. Source: Quality and Outcomes Framework - 2011-12, PCT level: Prevalence Table. Available at http://www.hscic.gov.uk/article/2021/Website-Search?productid=9592&q=. Accessed 06/12/2013.

Rate for hospital admissions for schizophrenia, schizotypal & delusional disorders 2009/10 to 2011/12†	0.54		0.60	0.28	0.57
Rate for hospital admissions for self-harm 2009/10 to 2011/12†	2.12		1.98	1.41	2.07
Adults receiving care under a Care Programme Approach 2010/11 (CPA)†[230]	5.9		4.3	3.9	6.4
Number of patient contacts by Outpatient & Community Psychiatric Nurses per year 2010/11†	153		167	105	169
Total patient contacts by mental health staff 2010/11†	247		229	256	313

* Source: National Psychiatric Morbidity Survey 2006. Accessed 06/12/2013. Available at http://www.nepho.org.uk/publications.php5?rid=628.

†Source: Community Mental Health Profiles 2013: West Sussex/Essex/Dorset, North East Public Health Observatory. Accessed December 2013. Available at http://www.nepho.org.uk.

Significantly lower than England average

Significantly worse than England average

Significantly better than England average

Not significantly different to England average

High prescribing of psychotropic drugs, particularly benzodiazepines and anxiolytics, is associated with higher than average levels of deprivation and with a high prevalence of substance misuse. In West Sussex, in 2004/5, benzodiazepine prescribing was highest in the Adur, Arun and Worthing areas. However, more recently this is likely to have reduced in all areas as reduced prescribing of benzodiazepines became a Department of Health performance indicator.[231]

3.7.2 Self harm and suicide

West Sussex had a slightly higher than average rate of hospital admissions for self-harm 2009/10 to 2011/12, which is an indicator of emotional and mental distress. Those who self-harm have a one in six chance of repeat attendance at A&E within a year, and there is a significant and persistent risk of future suicide following an episode of self-harm.[232]

[230] The Care Programme Approach is a way of co-ordinating community mental health services for people with severe and enduring mental health problems. It involves carrying out a comprehensive assessment and producing a care plan for each patient.

[231] Mental Health Needs Assessment For Adults Aged 16-64 In East And West Sussex: Executive Summary, accessed 09/12/2013, available at http://www.eastsussexjsna.org.uk/JsnaSiteAspx/media/jsna-media/documents/comprehensiveneedsassessment/16b-Adult_mental_health_Excec_Summary.pdf.

[232] Department of Health (2012), *Improving outcomes and supporting transparency: Part 2 – Summary technical specifications of public health indicators*, Available at http://www.vision2020uk.org.uk/core_files/dh_Summary_technical_specifications_of_public_health_indicators_Jan_2012.pdf, p.35. Accessed 09/12/2013.

In 2011 there were 62 deaths registered in West Sussex with an underlying cause of suicide[233] (68 in 2012)[234]. According to data held by the Reducing Drug Related Deaths Steering Group, of the 12 np-SAD deaths recorded in West Sussex in 2011, three recorded a verdict of suicide/taking of one's own life.[235]

3.7.3 Homelessness

According to the street counts and estimates published for Autumn 2012, in any one night in West Sussex 85 individuals sleep rough. Based on a dual diagnosis prevalence rate of 18% this implies around 15 of these people both misuse substances and have a mental health issue.

Table 3.8: Rough sleeping estimates West Sussex Autumn 2012

Area	Estimate of rough sleeping[236]	Estimated prevalence of dual diagnosis (n)
Adur	0	-
Arun	26	5
Chichester	26	5
Crawley	17	3
Horsham	2	-
Mid Sussex	6	1
Worthing	8	1
TOTAL WEST SUSSEX	**85**	**15**

More specifically, a snapshot of clients undertaken by Stonepillow at their homeless shelter one night in November 2013 revealed that of the 18 people who presented 10 (55.6%) had both mental health and substance abuse issues.[237] Of the substances misused:

- All 10 were either binge drinkers or alcohol dependent;
- Three used cannabis;

[233] Office for National Statistics, Number of deaths where the underlying cause of death was suicide, by sex and local authority in England and Wales, deaths registered in 2012, available at http://www.ons.gov.uk. Accessed 09/12/2013.

[234] Office for National Statistics, Suicides in the United Kingdom, 2011, available at http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-288089. Accessed 09/12/2013.

[235] Data received from Vicky Fenwick, Harm Reduction Programme Manager, 12/11/2013.

[236] Source: *Rough Sleeping Statistics England:2012*, Dept for Communities and Local Government, available at http://data.gov.uk/dataset/rough_sleeping_statistics_england. Accessed 06/12/2013.

[237] Source: information received from Helen Keats, Rough Sleeping Advisor, 26/11/2013.

- Three used crack/cocaine;
- Three were on a methadone programme (one of whom also used heroin).

Of the mental health issues reported:

- Seven had depression (two were suicidal/ had suicidal thoughts);
- Two had anxiety related conditions/panic attacks;
- One had paranoia;
- One had schizophrenia.

Further, when the managers of specialist substance misuse services were asked what particular needs the homeless/street drinkers present with, one comment provided specifically mentioned multiple/complex needs and mental health issues: *"Often dependent on alcohol and also poly drug use and addiction to opiates which is difficult to manage in terms of risk with prescribing. Often severe mental health difficulties that don't get picked up because of alcohol use."*

3.7.4 Learning difficulties

Overall, applying national prevalence assumptions to local population figures, it is estimated that there are over 14,000 adults with some form of learning disability living in West Sussex, 3,000 of whom are estimated to have a 'moderate or severe' learning disability.[238] Using the lowest prevalence estimate of 25%, (and with all the attendant caveats noted in Chapter 2), it is possible that around 3,500 people in West Sussex have both a learning difficulty and a mental health issue. Of these, at least 18 are likely to also have a substance misuse issue.

3.7.5 Specialist alcohol and drug service – quantitative data

Prevalence statistics indicate that at least 50% of clients attending specialist drug and alcohol services will also have mental health issues.

Adult Partnership Performance Reports provide information on the number of those attending specialist services and 2012 data is thus:

- Number of clients with a new presentation to alcohol treatment financial year 2012/13 = 593
- Number of clients with a new presentation to drug treatment calendar year 2012 = 537

However, only 81 of the alcohol treatment clients were recorded as presenting with dual diagnosis; and only 78 of the drug treatment clients had dual diagnosis noted. These figures suggest a dual diagnosis prevalence rate of 14%, which is significantly below national estimates. There are a number of potential reasons for this. There may be

[238] West Sussex Joint Strategic Needs Assessment: Update of local data – March 2013, West Sussex Public Health Research Unit. Available at http://jsna.westsussex.gov.uk. Accessed 09/12/2013.

differences in recording practices and the figures reported may be an underestimate, depending on how different professionals define dual diagnosis. It could also indicate a degree of unmet need amongst this group.

It is interesting to note that information provided in the Management Survey sent to all specialist substance misuse services in West Sussex points to a much higher prevalence of dual-diagnosis amongst this client group. When asked 'In 2012/13, what percentage of your service users had already been diagnosed with the following mental health problems at first contact?' the results from the six services who responded were thus:

Table 3.9: Mental health status of specialist substance misuse clients – Management Survey results

	No Mental Health Diagnosis (%)	Depression (%)	Anxiety (%)	OCD (%)	PTSD (%)	Bipolar Disorder (%)	Schizophrenia (%)	Personality Disorder (%)	ARBD (%)
Addaction Mid-Sussex*	20	70	80	10	20	<5	<5	30	20
Stonepillow	60	70	70	0	5	10	0	5	0
Recovery Project*	5	50	50	10	5	20	10	10	5
Alcohol Specialist Nurse*	50	20	20	Nil response	Nil response	Nil response	Nil response	Nil response	10
CRI Crawley*	60	70	50	Nil response	10	Nil response	Nil response	20	20
CRI Clock Walk*	65	15	5	<5	<5	<5	Nil response	5	Nil response

* Estimated figures

3.7.6 Specialist alcohol and drug service – qualitative data

The information in this section derives from a combination of methods including interviews with young people and professional stakeholders; and focus groups with current and former adult service users, former service users, non service users including people in recovery as well as the lay; and family and friends affected by someone else's drinking and/or drug taking. Some findings are supported by quotes from study informants.

For the sake of brevity, the information is presented in bullet point form.

- Mental health problems often occur in tandem with not only alcohol or drug misuse but other problems such as homelessness, unemployment, destitution, crime, relationship breakdown, trauma; and negative childhood or other experiences.

- Whilst West Sussex used to have a dual diagnosis service, currently there is no West Sussex based dual diagnosis service for adults with co-occurring mental health problems and substance misuse problems. It not clear why the dual diagnosis service ceased.
- There is perception from identified informants that a West Sussex based dual diagnosis service would improve the scope and quality of current mental health as well as alcohol and drug misuse services. And there is aspiration from some key stakeholders (including substance misuse service providers, GP, nurse, pharmacist, Programme Manager, homeless providers) to re-create a West Sussex based dual diagnosis service.
- Outlying regions such as East Sussex have a dual diagnosis service.
- There are specialist community mental health services in West Sussex; however, it is not currently possible to accurately and comprehensively comment upon the capacity of such services due to the limitations of this study – this question will be explored and answered in a subsequent scheduled West Sussex dual diagnosis needs assessment which will follow this study.
- There is very limited general hospital based mental health services for adults in West Sussex – the focus is on community based provision, supported by purchased out of area services.
- There is a single specialist alcohol and drug service provider in West Sussex, which contracts specialist locum doctors (n=2) and employs mental health nurses (n=8) and a general nurse (n=1) to support substitute related treatment including prescribing (partial resource provision); as opposed to a mental health or dual diagnosis basis.
- Co-occurring mental health problems and substance misuse problems are generally managed in a way which addresses the primary problem, followed by the secondary problem; regardless of equity of condition – co-occurring problems are not effectively managed simultaneously.
- Treatments and interventions are generally in line with national policy, guidance and standards, despite the lack of a dual diagnosis service which is commonplace throughout the UK and often viewed as best practice.
- Joined up working between specialist mental health services and specialist alcohol and drug services for adults is sporadic.
- The scheduled dual diagnosis needs assessment will explore needs, benefits, issues and solutions in much more detail; and conveys afresh opportunity for model and service analysis and improvement.

Select supporting quotes:

> *"Social workers need basic training in substance misuse. There is a huge barrier between adult social work services, substance misuse services and mental health services. By design, the West Sussex system is not integrated - the substitute*

treatment provider is dealing with severe mental health issues, often beyond their scope, competence and wish. Need a dual diagnosis worker."

"The 'Options' dual diagnosis service was lost about 5 years ago. A specialist substance misuse provider employs mental health nurses but they do not do mental health work. Needs to include collaborative working, valuing each profession."

"We work jointly and well with the specialist substance misuse provider when alcohol patients are in hospital. There are no dual diagnosis services so patients are normally led down a mental health route."

"There are good relationships and communications between the substitute treatment service and mental health services. There is no dual diagnosis service."

CHAPTER 4: CHILDREN AND YOUNG PEOPLE

4.1 Introduction and Aims

Most young people do not use illicit drugs or misuse alcohol, and among those who do only a minority will develop serious problems. For some, however, substance misuse may be damaging to the developing brain, interfere in the normal challenges of development, exacerbate other life and developmental problems, and further impoverish the life chances of already vulnerable groups of young people. Indeed, the National Treatment Agency's (NTA's) 'Substance Misuse among Young People 2010-11' explains that drug and alcohol misuse among teenagers 'is usually a symptom rather than a cause of their vulnerability', and compounds other problems in their lives such as 'family breakdown, inadequate housing, offending, truancy, anti-social behaviour, poor educational attainment and mental health concerns such as self-harm.'[239] This is a major problem for the UK, which 'has amongst the highest rates of young people's cannabis use and binge drinking in Europe' with 'some 13,000 hospital admissions linked to young people's drinking each year' (Home Office, Drug Strategy, 2010).[240]

The aim of this element of the project was to review existing datasets to identify the prevalence and trends of alcohol and drug use amongst young people in West Sussex. The issue of parental substance misuse will also be addressed.

For the purpose of this chapter, a 'young person' is taken to be someone under the age of 24/25; however, data sets for alcohol misuse are often presented for those under 18. All statistics used and prevalence estimates made will clearly indicate to what age group they pertain.

4.2 Method of Data Collection

Information was identified and drawn together from a range of local and national sources on prevalence and trends in youth consumption of alcohol and drugs in England over the past ten years, and on the issue of parental substance misuse. In order to provide comparative analysis on a range of health and social indicators as pertains to young people, two local authority areas were identified from the same socioeconomic deprivation background as West Sussex.[241] Essex and Dorset were chosen as comparators as both are located in the south of England; the former has both a coastal

[239] NTA, *Substance Misuse Among Young People 2010-11*. Available at http://www.nta.nhs.uk/uploads/yp2011commentaryfinal.pdf. Accessed 11/12/2013.

[240] Cited: Royal College of General Practitioners, Alcohol Concern, DrugScope, Royal College of Psychiatrists, *Practice Standards for young people with substance misuse problems*, June 2012. Available at http://www.rcpsych.ac.uk/pdf/Practice%20standards%20for%20young%20people%20with%20substance%20misuse%20problems.pdf. Accessed 10/12/2013.

[241] West Sussex is in socioeconomic decile 9 along with Bromley, Cambridgeshire, Cheshire East, Dorset, East Riding of Yorkshire, Essex, Gloucestershire, Merton, North Somerset, North Yorkshire, Oxfordshire, Warwickshire, Wiltshire, and York.

and a commuting population akin to that in West Sussex, and the latter has similar rural populations.

4.3 Key Findings

- Most young people do not use illicit drugs or misuse alcohol, but drug and alcohol misuse among teenagers 'is usually a symptom rather than a cause of their vulnerability'.
- 13,000 hospital admissions are linked to young people's drinking each year (Home Office, Drug Strategy, 2010).
- Of the 808,900 people resident in West Sussex, 145,200 are aged under 15 (18.0%) and current population projections estimate a population increase of 13% over the next ten years for children and young people aged 0-15.
- Based on data from the Annual School Survey (2012) (and subject to usual limitations of population estimates), the report authors estimated that 10% of 11 to 15 year olds in England will have drunk alcohol in the last week. Applied to the relevant population of West Sussex, this implies that around 4,500 11 to 15 year olds in the area will have drunk alcohol in the last seven days.
- Data from the local lifestyle survey suggests that at least 10% of Year 10 pupils drink alcohol regularly. Fewer pupils reported binge drinking in 2010 than in 2007, but in 2010 over a third of 14 and 15-year-olds reported occasionally binge drinking, with one in 10 reporting to regularly binge drink.
- The lifestyle survey for 16-24 year olds in West Sussex showed that one in three males and one in four females regularly consume alcohol and a quarter of young adults admit to regularly binge drinking (29.8% of males and 18.8% of females).
- Public health data suggests there are 84 hospital admissions per annum in West Sussex due to under-age alcohol-specific conditions (based on data pooled from financial years 2008/09, 2009/10 and 2010/11). This translates to a local value of 50.8 per 100,000 population – not significantly different from the national average at 55.8.
- Whilst there are certain factors in young people's personality, development and environment which can predispose them both to drug and alcohol misuse and to antisocial behaviour, there also seem to be causal links from young people's alcohol and drug use to crime. Further, research suggests that reducing alcohol consumption can have a measurable impact on crime.
- Already vulnerable young people have an increased risk of drug use: 10 to 15 year olds are more likely to take drugs if they have experienced truancy, exclusion from school, homelessness, time in care, or serious or frequent offending.
- Of those young people accessing specialist services across England and Wales, the majority did so with problems for cannabis (68%) as their primary substance.
- Key facts from the 2012 to 2013 CSEW indicate that levels of any drug use in the last year were highest among young adults aged 16 to 19 (16.4%) and 20 to 24

(16.2%) and that Class A drug use was highest among 20 to 29 year olds (5.7% of 20 to 24 year olds and 5.4% of 25 to 29 year olds).

- Based on data from the Annual School Survey (2012) (and subject to usual limitations of population estimates), the report authors estimated that 6% of 11 to 15 year olds in England will have taken drugs (this includes the use of volatile substances, cannabis and Class A drugs) in the last month. Applied to the relevant population of West Sussex, this implies that around 2,750 11 to 15 year olds in the area will have taken drugs within the last month.
- Data from the local lifestyle survey reflected national trends showing that cannabis is the most frequently used drug amongst the 14 and 15 year olds polled, with 20.4% of pupils reporting that they had used cannabis at some stage. Similarly, cannabis is by far the most commonly used illicit drug amongst the 16 to 24 year olds who responded. There are noticeable differences in use between the sexes: half of males and a third of females have tried cannabis, with 10.9% of males stating they are regular users compared with only 2.5% of females.
- Young people more likely to be poly-drug users and are more likely to inject, not only opiates but amphetamine type stimulants as well, increasing risk of harms.
- Hospital admissions due to substance misuse (15-24 year olds) equates to an average of 46 a year in West Sussex (based on data pooled from financial years 2008/09, 2009/10 and 2010/11). This translates to a local value of 53.4 per 100,000 population aged 15-24, which is significantly better than the national average of 69.4.
- Research has shown that among 10 to 15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending.
- Problematic alcohol and drug use is more prevalent amongst some groups of young people within society. The risk factors for starting to take drugs include co-morbidity, disrupted family units, parental drug use, truancy, unemployment and social exclusion.

4.4 Demography of West Sussex

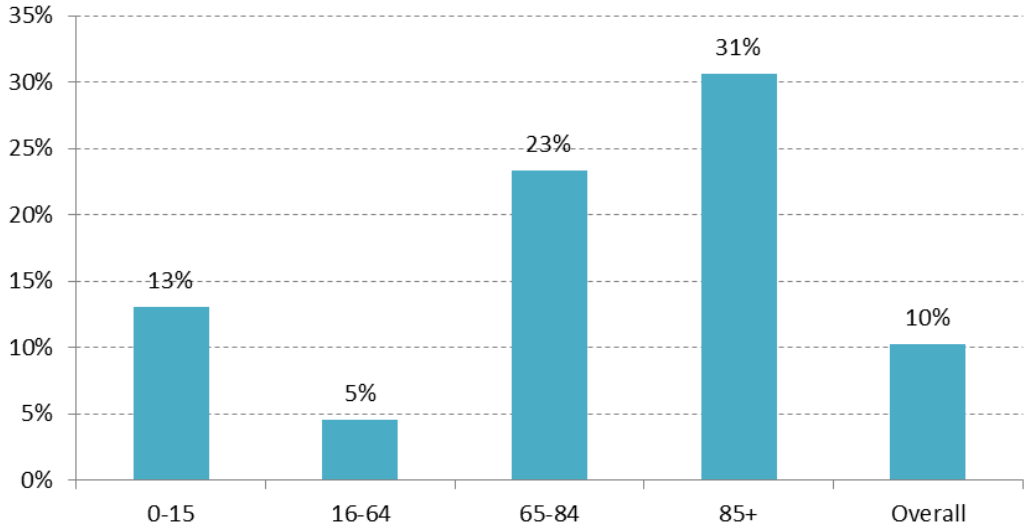
Present and future need for services and assets to address alcohol and drug misuse in West Sussex depends in part on the demography of the county. In this section basic population data is therefore briefly assessed as pertains to children and young people.

Of the 808,900 people resident in West Sussex, 145,200 are aged under 15 (18.0%).[242] Current population projections estimate an overall population increase of 10% over the

[242] All statistics taken from ONS Mid-Year Estimates 2011.

next ten years, but with a higher percentage increase for children and young people aged 0-15.[243]

Figure 4.1: Population 2011 (MYE) and 2021 Projected[244]



More specifically, projections for 2016, 2021 and 2016 are thus:

Figure 4.2: Population Projections 2016 – 2026 by age group[245]

Age Group	2016	2021	2026
0 – 4	44,200	47,600	48,500
5 – 9	46,100	45,700	47,600
10 – 14	45,500	47,200	45,700
15 – 19	47,900	46,400	47,100
20 – 24	53,900	50,000	46,300
25 – 29	52,200	58,000	50,000
30 – 59	309,600	312,900	306,900
60 – 79	175,700	187,300	198,600
80+	57,600	62,800	72,400
TOTAL	832,700	857,900	863,100

[243] Sub National Population Projections (SNPP) produced by ONS in 2013.

[244] Ibid.

[245] Source: Population Projections West Sussex. Projections to 2016 reflect policies in the approved West Sussex Structure Plan, 2001-2016; Projections for 2021 and 2026 reflect housing policies in the South East Plan final revision.

4.5 Prevelence of youth alcohol misuse in West Sussex

Drug statistics for 2012-13 from the National Drugs Treatment Monitoring System (NDTMS), reveal that 24% of those young people (under 18 years) accessing specialist substance misuse services in England during the year, did so with problems for alcohol as their primary substance (n=c.4,808).[246]

The number of young people accessing specialist substance misuse services in West Sussex is very small, so it is not possible to draw valid conclusions as to whether the national picture is replicated at a local level.[247]

It is however clear that the numbers accessing specialist services is not an accurate reflection of general prevalence when viewed in isolation. Therefore, in order to provide a prevalence estimate that is as accurate as possible, evidence from a variety of sources will be utilised below.

4.5.1 Alcohol Consumption: Level

In 2009 the Chief Medical Officer of England published the first official guidance on alcohol aimed specifically at young people.[248] This guidance recommended that the healthiest and safest option was for children to remain alcohol free up to the age of 15, and that older teenagers who did drink alcohol should do so infrequently and in a supervised environment. The guidance suggested that young people should drink on no more than one day per week and conform to the limits recommended for adults.

The guidance was based on a body of evidence that drinking at a young age, and particularly heavy or regular drinking, can result in physical or mental health problems, impair brain development, and put children at risk of alcohol related accident or injury. More broadly it is also associated with missing or falling behind at school,[249] violent and antisocial behaviour, [250] and unsafe sexual behaviour (including teenage pregnancy).[251]

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[246] Public Health England, Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2012 to 31 March 2013, December 2013. Accessed 10/12/2013. Available at http://www.nta.nhs.uk/uploads/annualypstatistics2012-13-final[0].pdf

[247] Public Health England, Alcohol and drugs: JNSA support data: Key data to support planning for effective young people's specialist substance misuse interventions: West Sussex, 2012-13.

[248] Department of Health, Guidance on the consumption of alcohol by children and young people. A report by the Chief Medical Officer, December 2009. Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110258. Accessed 10/12/2013.

[249] Phillips-Howard, P.A., et al, 'Wellbeing, alcohol use and sexual activity in young teenagers: findings from a cross-sectional survey in school children in North West England', *Substance Abuse Treatment Prevention, and Policy*. 2010;5 :27.

[250] See for example: Viner, R & Taylor, B., 'Adult outcomes of binge drinking in adolescence: findings from a UK national birth cohort', *J Epidemiol Community Health 2007;61:902–907.* Richardson A, Budd T. 'Young adults, alcohol, crime and disorder', Criminal Behaviour & Mental Health 2003; 135–16.16. Guo J, Chung I J, Hill K G. *et al* 'Developmental relationships between adolescent substance use and risky sexual behavior in young adulthood', Journal of Adolescent Health 2002.31354–362.362.

[251] In local authority wards with the highest level of alcohol-related hospital admissions, 15-17 year old girls are 20% more likely to get pregnant than in wards with the lowest level of alcohol-related hospital admissions. Bellis. M., et al., *Contributions of alcohol use to teenage pregnancy. An initial examination of geographical and evidence based associations*, Liverpool: North West Public Health Observatory, 2008.

Historically children in England have been more likely to drink alcohol than children in many other European countries.[252] Although the latest international comparisons suggest some improvement in the prevalence of alcohol consumption, the proportion consuming alcohol remains well above the European average. Furthermore, the UK continues to rank amongst countries with the highest levels of alcohol consumption for those who do drink, and British children are more likely to have 'binge drunk' or been drunk compared to children in most other European countries.[253] This led the Government to focus on binge and problem drinking in the 2012 Alcohol Strategy,[254] which had as a stated aim 'achieving a sustained reduction in both the numbers of 11 to 15 year olds drinking alcohol and the amounts consumed'.

Annual School Survey

The NHS Information Centre conducts an annual survey to monitor smoking, drinking and drug use among secondary school pupils aged 11-15. Key findings in relation to alcohol in the 2012 Annual School Survey[255] are as follows:

- Less than half of pupils (43%) had ever drunk alcohol. The proportion of pupils who have had an alcoholic drink increased from 12% of 11 year olds, to 74% of 15 year olds.
- One in ten pupils (10%) had drunk alcohol in the last week. This continues the downward trend since 2003, when a quarter (25%) of pupils had drunk alcohol in the last week.
- Pupils who had drunk in the last week had drunk an average (mean) of 12.5 units. Median consumption – which gives a more representative indication of how much pupils drink –was lower (8.0 units).
- Half (50%) of pupils who had drunk alcohol in the last four weeks said that they had been drunk at least once during that time. Although 61% of them said that they had deliberately tried to get drunk, 39% said they had not.
- Pupils were more likely to drink alcohol if someone they live with does: 83% of pupils whose households did not include anyone who drank alcohol didn't drink themselves.

[252] Hibell B, Guttormson U, Ahlstrom S, et al, 'The 2007 ESPAD report: substance use among students in 35 European countries', The Swedish Council for Information on Alcohol and Other Drugs, Stockholm, 2009.

[253] Hibell B, Guttormson U, Ahlstrom S, et al, 'The 2011 ESPAD report: substance use among students in 36 European countries', The Swedish Council for Information on Alcohol and Other Drugs, Stockholm, 2012.

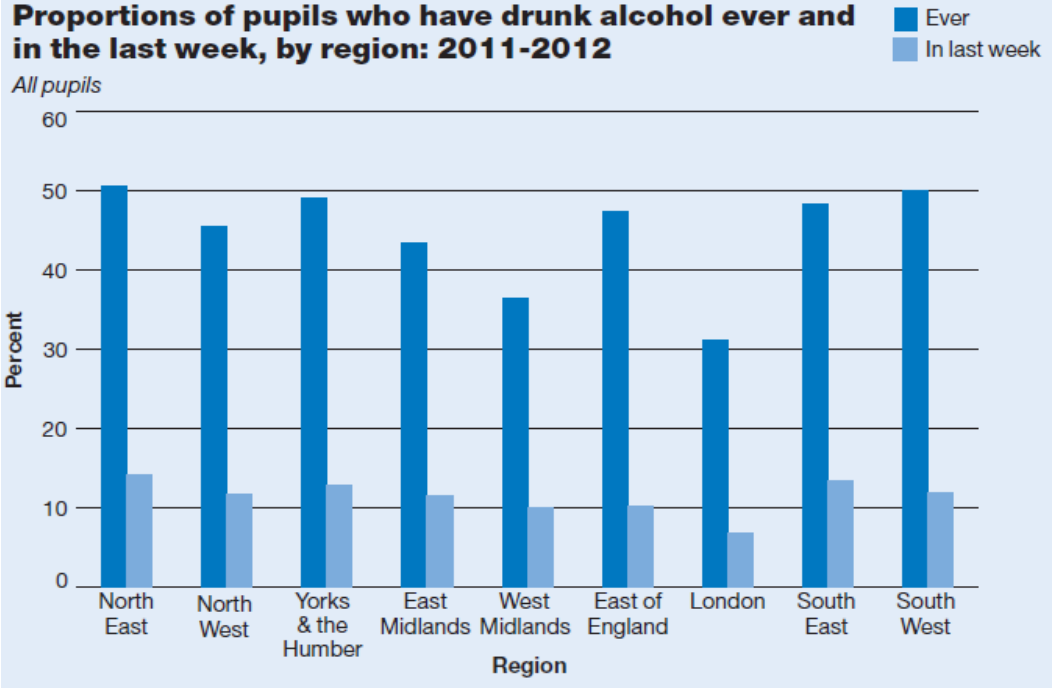
[254] Home Office, *The Government's Alcohol Strategy*, March 2012. Available at https://www.gov.uk/government/publications/alcohol-strategy. Accessed December 2013.

[255] National Centre for Social Research and the National Foundation for Educational Research, *Smoking, drinking and drug use among young people in England in 2012*, 2013, p.75-6. Available at http://www.wakefield.gov.uk/NR/rdonlyres/F20AE630-2DBF-456D-8E13-6B5050AE5D5E/0/SmokingDrinkingandDrugUseamongYoungPeopleinEnglandin2012NHS2013.pdf. Accessed 10/12/2013.

- The proportion of pupils who think it is OK for someone of their age to drink alcohol has fallen in recent years. In 2012, 28% of pupils thought that it was OK for someone of their age to drink once a week compared with 46% in 2003.
- There was a strong relationship between pupils' drinking behaviour and their parents' attitudes to their drinking. 87% of pupils who felt their parents would disapprove of their drinking had never drunk alcohol, compared with 28% who thought their parents wouldn't mind as long as they didn't drink too much.

Specific data is not available at the local level, however regional data indicates the prevalence of pupil drinking in the South East is higher than several other regions:

Figure 4.3: Proportion of pupils who have drunk alcohol ever and in the last week, by region: 2011-12[256]



Similarly, in terms of amount drunk, pupils in the South East consume more than those in London, Yorks & the Humber, the East and the South West:

[256] Source: Figure 6.1, *Smoking, drinking and drug use among young people in England in 2012*, p.199.

Table 4.4: Mean consumption of alcohol by pupils who drank in the last week, by region/sex: 2011-12[257]

Mean consumption of alcohol by pupils who drank in the last week, by region and sex: 2011-2012

Pupils who drank alcohol in the last week — *2011-2012*

Alcohol drunk in the last week	Region								
	North East	North West	Yorks & the Humber	East Midlands	West Midlands	East of England	London	South East	South West
	Units of alcohol								
Boys	17.1	14.4	9.6	11.1	13.1	9.6	a	12.5	13.2
Standard error of mean	2.86	1.84	0.92	1.13	1.82	1.89	a	1.64	2.10
Girls	14.3	16.8	10.0	9.5	10.5	10.9	[7.6]	8.6	8.5
Standard error of mean	2.10	3.04	1.57	1.02	1.59	1.95	[1.29]	0.80	0.97
Total	15.7	15.7	9.8	10.5	11.9	10.2	9.4	11.0	10.7
Standard error of mean	1.88	1.99	0.95	0.77	1.26	1.21	1.19	1.11	0.92
Unweighted bases									
Boys	*71*	*67*	*57*	*107*	*71*	*72*	*25*	*86*	*66*
Girls	*84*	*68*	*56*	*67*	*66*	*60*	*39*	*70*	*88*
Total	*155*	*135*	*113*	*174*	*137*	*132*	*64*	*156*	*154*
Weighted bases									
Boys	*37*	*88*	*67*	*71*	*71*	*71*	*55*	*163*	*70*
Girls	*38*	*101*	*73*	*45*	*62*	*68*	*65*	*106*	*79*
Total	*75*	*189*	*140*	*117*	*133*	*139*	*120*	*269*	*148*

[a] Because of the small bases, estimates are not shown for boys in London, and estimates for girls in London are shown in square brackets (see Section 1.1.5).

Based on the survey data (and subject to usual limitations of population estimates), the report authors estimated that 10% of 11 to 15 year olds in England will have drunk alcohol in the last week. Applied to the relevant population of West Sussex,[258] this implies that around 4,500 of 11 to 15 year olds in the area will have drunk alcohol in the last seven days.

More specific data is available from locally conducted lifestyle studies.

Local Report: Lifestyles of 14 to 15-year-olds in West Sussex 2010[259]

In 2007 the West Sussex Public Health Observatory reported the findings of a Lifestyle Survey, conducted in the summer term of 2006, of Year 10 pupils in West Sussex schools. Three years later the survey was repeated. The aims of the survey included:

- Establishing an overview of the health and wellbeing of young people in West Sussex schools;
- Estimating the prevalence of high-risk behaviours such as smoking, drug use and binge drinking.

This survey showed there was little difference between the drinking patterns of boys and girls. Around one third reported never or rarely drinking, just over half reported occasional drinking and the remaining 10% reported regular drinking. This pattern is similar to figures from 2007.

[257] Source: Table 6.5, *Smoking, drinking and drug use among young people in England in 2012,* p. 202.

[258] Population data from West Sussex County Council Public Health & Wellbeing Directorate.

[259] NHS West Sussex, *Lifestyles of 14 to 15-year-olds in West Sussex 2010,* available at http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media//publications/about_us/Publications/Lifestyles_of_14_to_15-year-olds_2010.pdf

Over 10% of pupils reported regularly drinking with the intention of getting drunk, a further one in three reported occasional binge drinking, and around one third claimed to never or rarely binge drink. As with moderate/low risk drinking, there was little difference between the habits of boys and girls. This pattern is similar to the 2007 figures, but an increase in those who never or rarely binge drink can be seen:

Table 4.5: Binge drinking by sex, 2007 vs 2010[260]

	Boys		Girls		All	
	2007	2010	2007	2010	2007	2010
Q. How often do you drink with the intention of getting drunk?	**Percentage (%)**					
Never/Rarely	53.0	58.7	49.0	53.1	51.0	56.0
Occasionally	35.0	30.7	38.0	35.6	37.0	33.0
Regularly	12.0	10.7	13.0	11.3	12.0	10.9

Local Report: Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008[261]

This lifestyle survey of 16 to 24-year-olds attending Further and Higher Education Colleges in West Sussex was conducted in the winter term 2006-2007. The aims of the survey included:

- Describing the health and social behaviour of young adults attending Further and Higher Education colleges in West Sussex;
- Estimating the prevalence of risk behaviour among young adults, such as cigarette smoking, the use of illicit drugs and alcohol consumption.

The report showed that 35.7% of males reported that they regularly consume alcohol compared with 22.7% of females. Around one in six students (17.4%) never or rarely consume alcohol.

The lowest rates of regular alcohol consumption were reported by Black (17.9%) and Asian students (21.7%).

The report also reflected an age effect with students aged 16 and 17 having lower levels of regular drinking (24.0% and 28.0% respectively) than those aged 19 and over (33.0%).

[260] NHS West Sussex, *Lifestyles of 14 to 15-year-olds in West Sussex 2010,* Table 4.2 p.18.

[261] West Sussex PCT, *Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008*, available at http://www.westsussex.nhs.uk/domains/westsussex.nhs.uk/local/media//publications/about_us/Publications/Lifestyles_of_16-_to_24-year-olds_in_West_Sussex_2008.pdf

A quarter of the students admitted to binge drinking regularly and a further 47.8% did so occasionally. Young men are more likely to regularly binge drink (29.8%) than young women (18.8%) as shown in the table below:

Table 4.6 Binge drinking by sex 16-24 year olds[262]

Binge drinking	Males		Females		All	
	N	(%)	N	(%)	N	(%)
Never/Rarely	364	25.2	303	29.5	667	27.0
Occasionally	649	44.9	531	51.7	1,180	47.8
Regularly	431	29.8	193	18.8	624	25.3
Total	1,444	100	1,027	100	2,471	100

4.5.2 Alcohol Consumption: Physical Health Harm

Young people's drinking carries immediate risks to their health; for example, underage drinkers are significant users of A&E and ambulance services. According to Alcohol Concern, alcohol contributes to 5% of young people's deaths – 1.4% more than in the adult population. In their strategy document, *Right time, right place* (2010) they noted that between 2002 and 2007 alcohol-related hospital admissions for under-18s increased by 32%, and that between 2004 and 2009, 28% more girls were admitted to hospital emergency departments for alcohol problems than boys. They acknowledge that data collection to accurately assess the scale of youth drinking remains 'a problem', but from the data that is available they estimate that the cost to health and ambulance services due to underage alcohol consumption is in the region of £19 million per annum.[263]

It does however appear that this measure of harmful drinking among young people has been falling. In 2010/11 there were 12,300 alcohol-related hospital admissions for under-18s[264] and 3,100 for under 16s[265] (for under-16s only conditions know to be

[262] West Sussex PCT, *Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008*, Table 4.2 p.18.

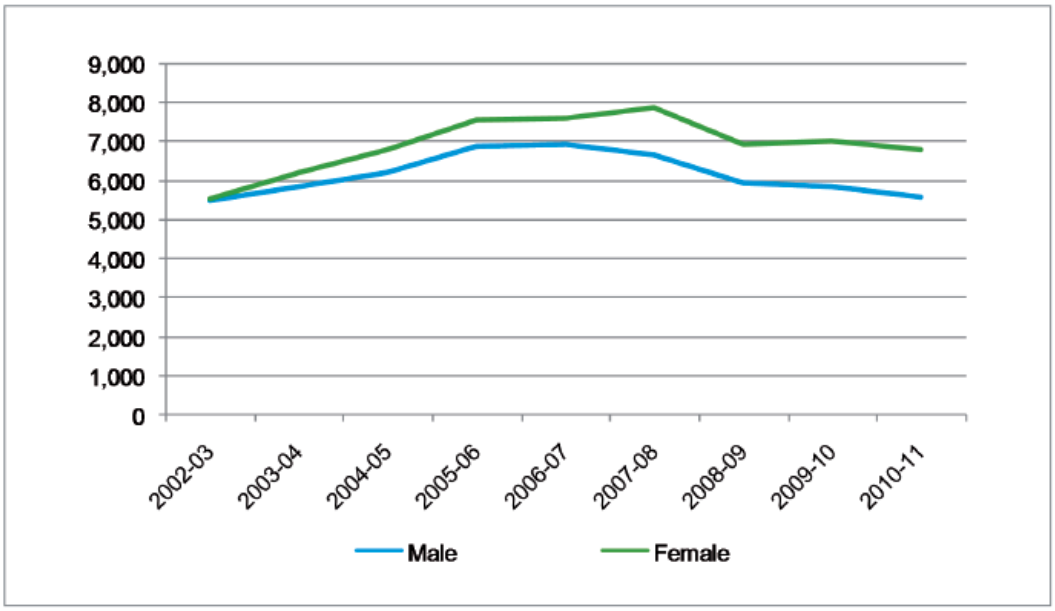
[263] Smith, T. and Curran, A., *Right time, right place: Alcohol-harm reduction strategies with children and young people*, Alcohol Concern, October 2010. Available at http://www.alcoholconcern.org.uk/assets/files/Publications/Right%20time%20right%20place%2023%20October%202010.pdf. Accessed 10/12/2013.

[264] Response to Parliamentary Question HC Deb, 18 June 2012, c780W. Cited in *Young people's drinking: health harms and NHS burden,* Mentor, January 2013, available at http://www.mentoruk.org.uk/wp-content/uploads/2013/01/30739_Alcohol_8pp_WEB.pdf. Accessed 10/12/2013.

[265] Health and Social Care Information Centre (2012) Statistics on Alcohol: England, 2012. Health and Social Care Information Centre. Cited in *Young people's drinking: health harms and NHS burden,* Mentor, January 2013, available at http://www.mentoruk.org.uk/wp-content/uploads/2013/01/30739_Alcohol_8pp_WEB.pdf. Accessed 10/12/2013.

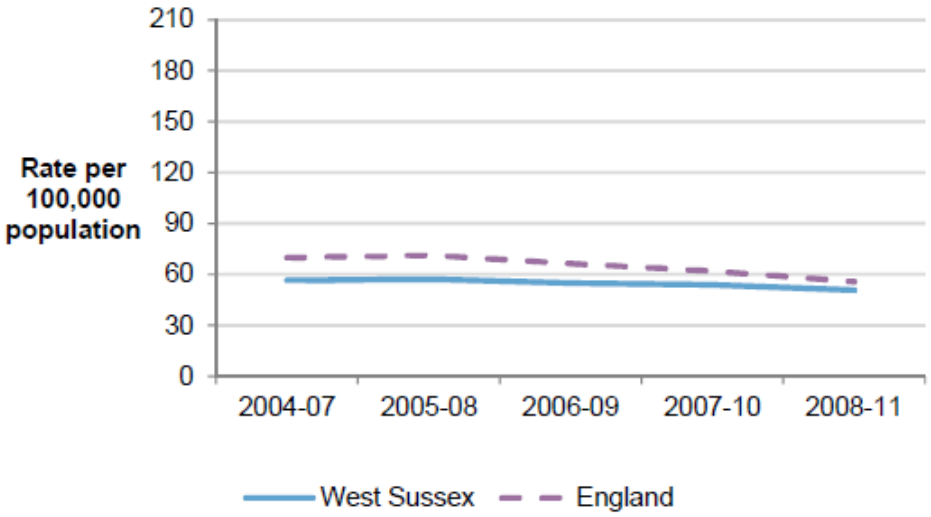
directly caused by alcohol are included). These figures continue the downward trend in evidence (to varying degrees) since 2007/8:

Figure 4.7: Trends in alcohol-related admissions to hospital for under-18s[266]



Similarly, at a local level, in West Sussex, in comparison with the 2004-07 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose remains broadly similar in the 2008-11 period:

Figure 4.8: Young people in West Sussex aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)[267]



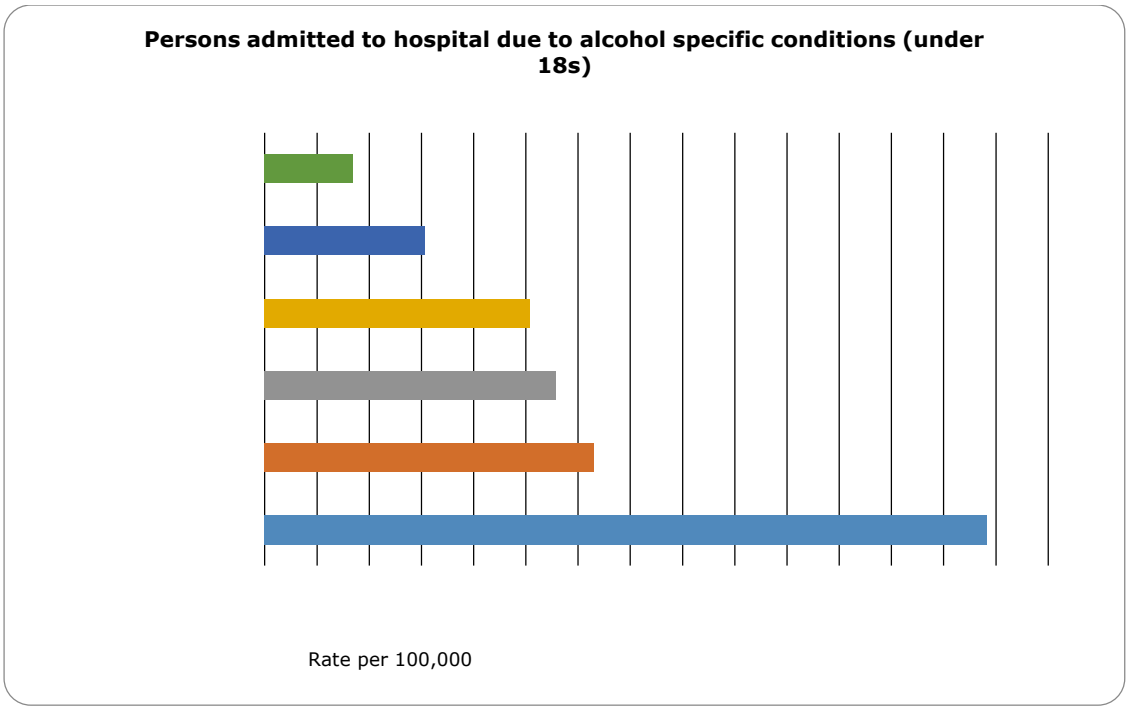
[266] Source: *Young people's drinking: health harms and NHS burden,* Mentor, January 2013, available at http://www.mentoruk.org.uk/wp-content/uploads/2013/01/30739_Alcohol_8pp_WEB.pdf. Accessed 10/12/2013, p.3.

[267] Child and Maternal Health Observatory, West Sussex Child Health Profile, March 2013.

However, it is noteworthy that whilst West Sussex's national ranking for most alcohol-related indicators is between 23 and 55 (out of 151, where 1 is the best local authority), for 'Alcohol-specific hospital admission – Under 18', West Sussex ranks significantly lower at 71 out of 151 (see Chapter 2 for further details).

That withstanding, public health data suggests there are 84 hospital admissions per annum in West Sussex due to under-age alcohol-specific conditions (based on data pooled from financial years 2008/09, 2009/10 and 2010/11). This translates to a local value of 50.8 per 100,000 population – not significantly different from the national average at 55.8. Likewise, numbers presenting in Devon are similar to the England average (63.0 per 100,000), however, at 30.7 per 100,000 population, Essex fares significantly better than the national average against this measure. [268]

Figure 4.9: New hospital admissions due to alcohol specific conditions (under 18) 2009-2011[269]



To get a more comprehensive picture locally, data was requested on NHS emergency admissions within West Sussex localities that had a record of alcohol in the diagnosis

[268] Child Health Profile snap-shot data, available at http://atlas.chimat.org.uk/IAS/dataviews/report. Accessed 28/11/2013.

[269] Data source: Child Health Profile snap-shot data, available at http://atlas.chimat.org.uk/IAS/dataviews/report. Accessed 28/11/2013.

codes.[270,271] The numbers involved are relatively small so caution should be used when attempting to identify trends; but in 2011/12, 151 young people aged 19 and under were emergency admissions with a record of alcohol in the diagnosis code,[272] and in 2012/13 the corresponding figure was 116. This equates to a crude rate of 81.8 and 62.4 per 100,000 head of population (aged 0-19) respectively,[273] it does therefore seem West Sussex is following the national trend.

Data from the *Lifestyle Survey for 14-15 year olds in West Sussex (2010)* shows a clear correlation between the level of alcohol consumption and a pupil's self-perceived health. Where alcohol consumption is rare, 58.3% of pupils reported good health. Where consumption is regular, the figure drops to 36.8%. Of those reporting 'not good' health, 13.6% were regular drinkers, compared to 3.2% who rarely drank. This survey also asked pupils who reported regular binge drinking how often they had experienced the following effects from alcohol: headaches, memory loss, vomiting, falling over and injuries resulting in hospital attendance. The figure below shows the prevalence of regular side effects on those who were regular binge drinkers:

Figure 4.10: Regular side effects of alcohol on those who are regular binge drinkers[274]

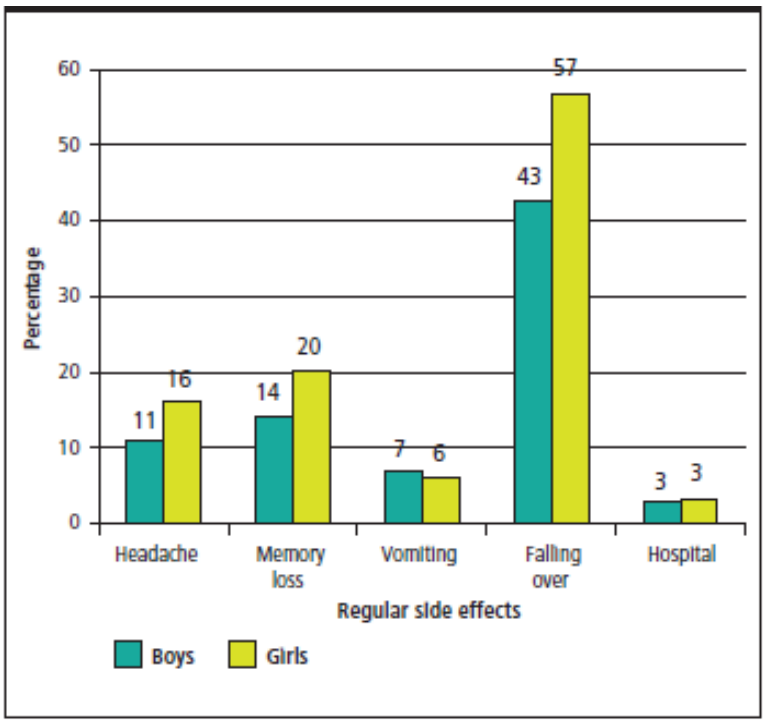
[270] Whilst the accuracy of this data relies on hospital staff noting alcohol misuse as a primary or secondary cause/factor in admission and thus will not capture all relevant incidents, the figures are presented to be appraised in conjunction with all other data to build up a comprehensive picture of prevalence in West Sussex. Please also note, some of the admissions tabulated below will have both alcohol and drugs in the diagnosis codes, there will therefore be some double counting between these statistics and the ones quoted in Section 4.5.1 pertaining to drug related harm in West Sussex.

[271] We also repeatedly requested alcohol/drug-related call-out data from South East Coast Ambulance Service NHS Foundation Trust. This data was not forthcoming.

[272] Data source: ICD 10 codes F10 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF ALCOHOL and T51 TOXIC EFFECT OF ALCOHOL; Admission Method = 2* (Emergency).

[273] West Sussex population statistics from West Sussex County Council Public Health & Wellbeing Directorate.

[274] Source: NHS West Sussex, *Lifestyles of 14 to 15-year-olds in West Sussex 2010,* Figure 4.3 p.19.


60
50
40
30
20
10
0
Percentage
11
16
14
20
7
6
43
57
3
3
Headache
Memory loss
Vomiting
Falling over
Hospital
Regular side effects
Boys
Girls

Young people who drink are also vulnerable to long-term damage from alcohol including appetite changes, weight loss, eczema, headaches, and sleep disturbance,[275] adverse effects on liver, bone, growth and endocrine development. They are also at risk of significant changes in brain structure. Alcohol use disorders can affect brain functions related to motivation, reasoning and other processes. Heavy drinking during adolescence may also affect normal brain functioning during adulthood.[276] Furthermore, whilst not inevitable, frequent drinking and binge drinking in adolescence increases the risk of alcohol problems, including dependence, in adulthood. Academic studies suggest that between 30% and 40% of moderate/heavy teenage alcohol users would develop alcohol misuse problems as adults.[277]

Early onset drinking can also contribute to chronic diseases associated with continuing over-consumption of alcohol, which can take a decade or more to emerge. Alcohol-related deaths have risen from 5,479 in 2001 to 6,775 in 2011.[278] Almost two-thirds of these deaths were from alcoholic liver disease. Among under 35 year olds (around four percent of this total) the causes are mainly acute consequences such as intentional self-harm and road traffic accidents.[279]

4.5.3 Alcohol Consumption: Social Harm

It is widely acknowledged that young people who drink regularly, smoke and/or take illegal drugs have a higher risk of becoming involved in anti-social behaviour and crime:

[275] *Young people's drinking: health harms and NHS burden,* Mentor, January 2013, available at http://www.mentoruk.org.uk/wp-content/uploads/2013/01/30739_Alcohol_8pp_WEB.pdf. Accessed 10/12/2013, p.2.

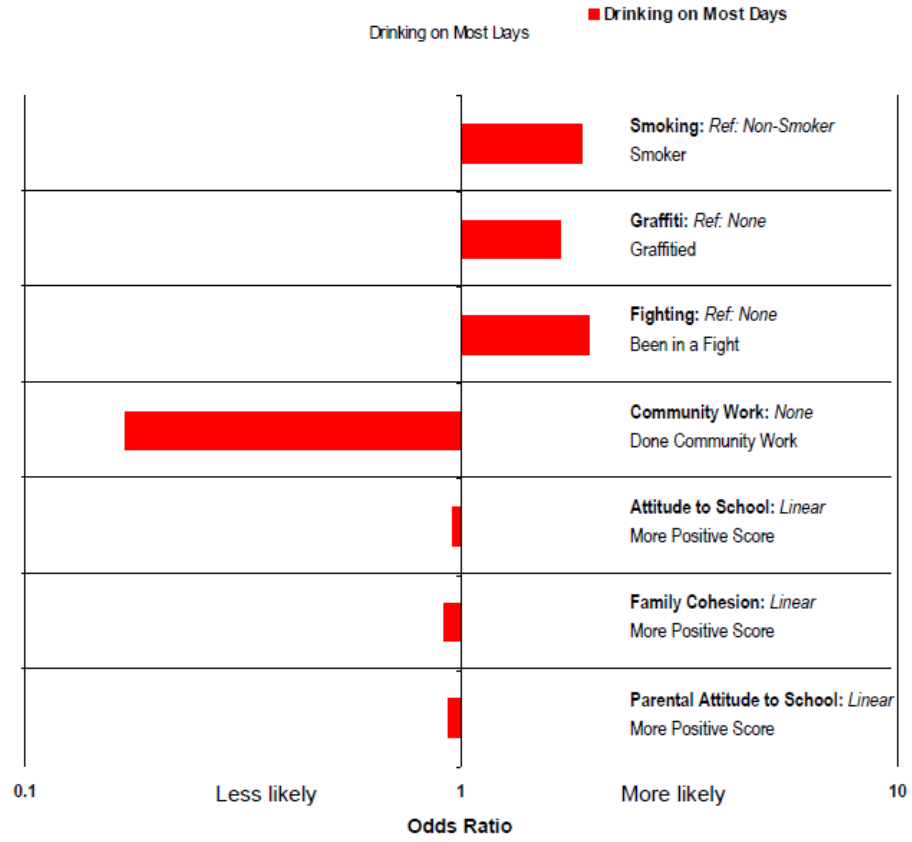
[276] Chief Medical Officer for England, *Guidance on the consumption of alcohol by children and young people*, December 2009. Available at http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110258.

[277] Frontier Economics, *Specialist drug and alcohol services for young people – a cost benefit analysis,* Department for Education, 2010.

[278] Source: Office for National Statistics, Alcohol-related deaths in the United Kingdom 2011, Reference tables. Available at http://www.ons.gov.uk/ons/rel/subnational-health4/alcohol-related-deaths-in-the-united-kingdom/2011/alcohol-related-deaths-in-the-uk--2011.html. Accessed 10/12/2013.

[279] *Young people's drinking: health harms and NHS burden,* Mentor, January 2013, available at http://www.mentoruk.org.uk/wp-content/uploads/2013/01/30739_Alcohol_8pp_WEB.pdf. Accessed 10/12/2013, p. 2.

Figure 4.11: Relationships between drinking on most days and other behaviours[280]



Research carried out for the Youth Justice Board into alcohol and drug misuse among children and young people in the secure estate (age 12-18) found that before coming into custody, 67% of the young people got drunk at least once a week, and 16% were getting drunk every day. Moreover, whilst the proportion of young people in custody who drank on a weekly or daily basis before they entered the secure estate fell from 74% in 2003 to 64% in 2006, the proportion who engaged in binge drinking at least once a week increased significantly from 59% to 66%.There is however a significant difference between genders, with more young females than young males reporting problematic alcohol use (females 73%; males 61%) and binge drinking (females 86%; males 78%).[281]

The incidence of crimes committed by those young people with the most severe substance misuse problems (i.e. those using drug and alcohol treatment services) varied by drug, and those treated for alcohol use are more likely to have assaulted

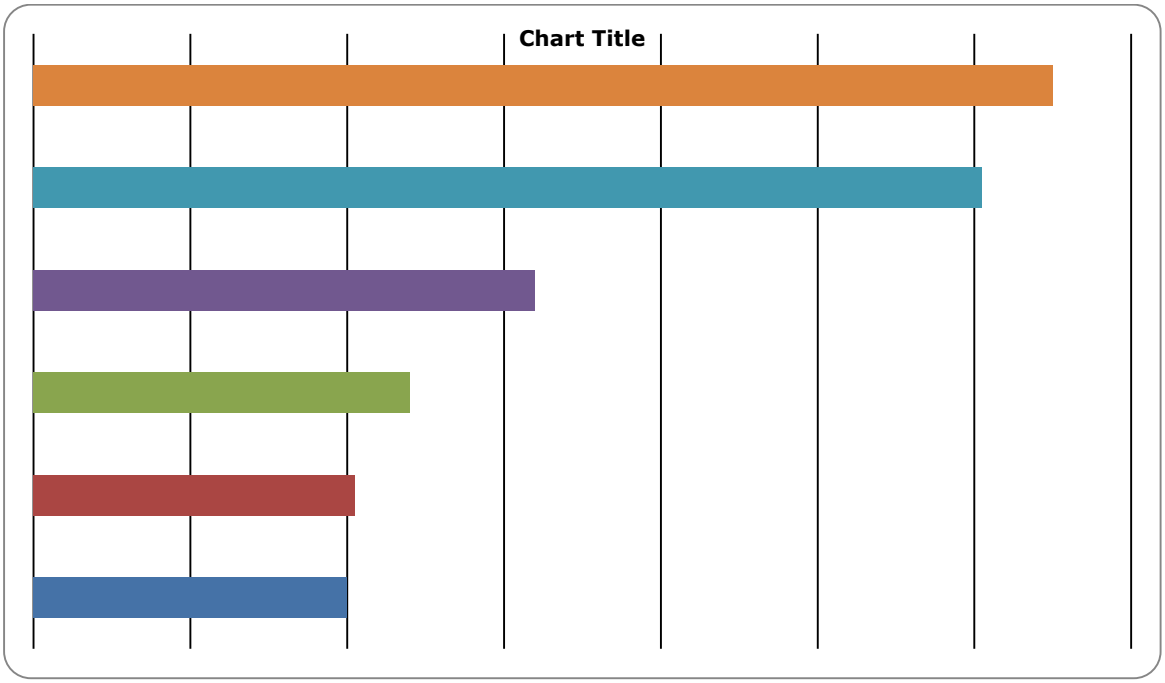
[280] Figure 5.8 Green, R. and Ross, A., *Young people's alcohol consumption and its relationship to other outcomes and behaviour. Department for Education*, 2010. Available at http://dera.ioe.ac.uk/87/1/DFE-RR005.pdf. Accessed 11/12/2013.

[281] Youth Justice Board, *Substance Misuse Service in the Secure Estate*, 2009. Available at http://yjbpublications.justice.gov.uk/en-gb/Resources/Downloads/Substance%20misuse%20services%20in%20the%20secure%20estate_summary_final.pdf. Accessed 11/12/2013.

someone, but less likely to have committed theft compared to cannabis users.[282] That said, amongst this cohort only a minority admitted to committing offences, yet these individuals seemed to be 'fairly prolific'.[283]

Whilst there are certain factors in young people's personality, development and environment which can predispose them both to drug and alcohol misuse and to antisocial behaviour, there also seem to be causal links from young people's alcohol and drug use to crime. A study following 15,000 young people from age 14 to 17 found that drinking alcohol was a strong predictor of an increase in criminal activity (graffiti, vandalism or shoplifting) in the following year.[284] The graph below illustrates this: even after adjusting for other factors, someone who drinks once or twice a week aged 15 is six times more likely to increase their criminal activity over the next year, compared to a non-drinker. There was little to no evidence that the reverse was true (criminal activity leading to an increase in drinking).

Figure 4.12: Odds of increased criminal activity a year later by drinking behaviour aged 15[285]



Moreover, research suggests that reducing alcohol consumption can have a measurable impact on crime. For example, in one study, young people in treatment for substance

[282] Mentor, *Drugs, alcohol and youth crime: Counting the cost*, January 2013. Available at http://www.mentoruk.org.uk/wp-content/uploads/2013/01/30739_Crime_4pp_WEB.pdf. Accessed 11/12/2013.

[283] Ibid.

[284] Green, R. and Ross, A., *Young people's alcohol consumption and its relationship to other outcomes and behaviour. Department for Education*, 2010. Available at http://dera.ioe.ac.uk/87/1/DFE-RR005.pdf. Accessed 11/12/2013.

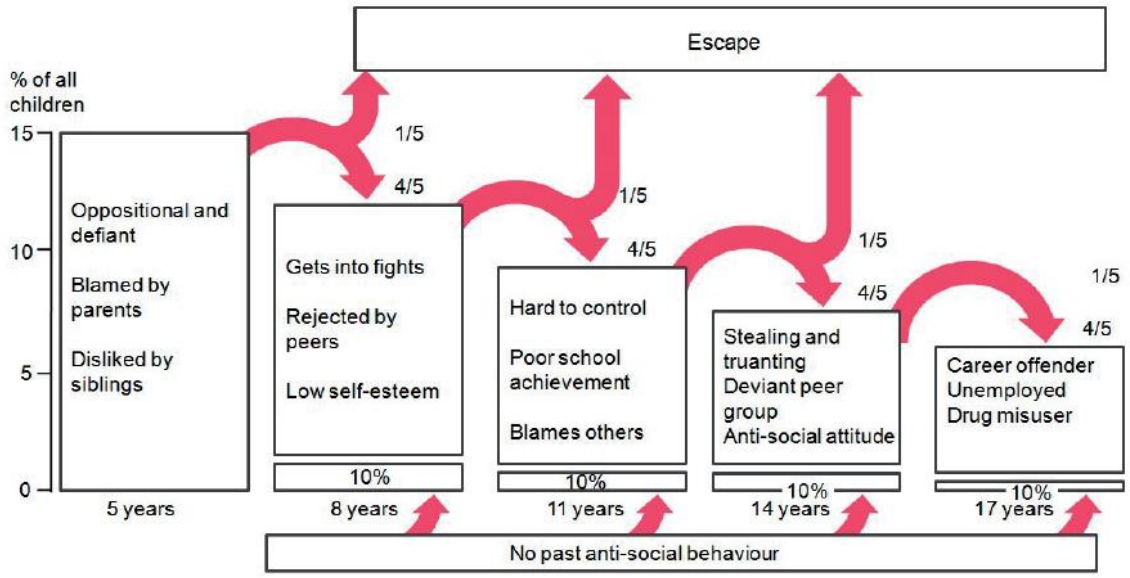
[285] Source: Mentor, *Drugs, alcohol and youth crime: Counting the cost*.

misuse were asked about any recent shoplifting, assault or theft. Self-reported offences fell on average by 55-65% after treatment for drug or alcohol addiction.[286]

Alcohol use may be a predictor of youth criminal or anti-social behaviour, but as with adults, a proportion of these offences occur whilst the young person is actually under the influence of alcohol. In a Europe-wide survey of 15-16 year olds, 22% of boys and 16% of girls in the UK said they had been in a physical fight when drinking, and 18% of boys and 13% of girls said they had been in trouble with the police after drinking alcohol. These self-reported rates were higher than in almost any other country in the survey.[287]

There is a wealth of research to support the view that a comprehensive prevention strategy is needed to address crime and anti-social behaviour linked to alcohol, one that starts in the early years, but also addresses the needs of young people already involved in risky behaviours. As noted in the *Every Child Matters*[288] strategy anti-social behaviour is a continuum and 'escape' becomes increasingly difficult with advancing age:

Figure 4.13: Continuity of anti-social behaviour from age 5 to 17[289]



4.6 Prevelence of youth drug misuse in West Sussex

Drug statistics for 2012-13 from the National Drugs Treatment Monitoring System (NDTMS), reveal that 20,032 young people (under 18 years) accessed specialist

[286] Op cit., Youth Justice Board, 2009.

[287] Cited: Mentor, *Drugs, alcohol and youth crime: Counting the cost*.

[288] HM Treasury, *Every Child Matters,* The Stationery Office: London, 2003. Available at https://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf. Accessed 11/12/2013.

[289] Diagram based on unpublished research by Stephen Scott for the Home Office, cited Mentor, *Drugs, alcohol and youth crime: Counting the cost*.

substance misuse services in England during the year. This is a decrease of 656 individuals (3.2%) since 2011-12 and a decrease of 1,923 individuals (8.8%) since 2010-11.[290]

Of those accessing specialist services, the majority did so with problems for cannabis (68%) as their primary substance.

The number of young people accessing specialist substance misuse services in West Sussex is very small, so it is not possible to draw valid conclusions as to whether the national picture is replicated at a local level.[291]

As with youth alcohol consumption, the numbers accessing specialist services is not an accurate reflection of general prevalence when viewed in isolation. Therefore, in order to provide a prevalence estimate that is as accurate as possible, evidence from a variety of sources will be utilised below.

4.6.1: Youth drug misuse: prevalence

The use of legal and illegal drugs by young people is associated with immediate and long term risks to their health and wellbeing and over time, drug users run the risk of dependence.[292] As with alcohol misuse, already vulnerable young people have an increased risk of drug use: 10 to 15 year olds are more likely to take drugs if they have experienced truancy, exclusion from school, homelessness, time in care, or serious or frequent offending,[293] and nearly three-quarters (74%) of those young people accessing specialist substance misuse services in 2012-13 did so reporting multiple vulnerabilities.[294]

Prevalence of opiate and/or crack use

Using 2011/12 data the NTA estimated national prevalence rates of opiate and/or crack use by age group and region:[295]

[290] Public Health England, Young People's Statistics from the National Drug Treatment Monitoring System (NDTMS): 1 April 2012 to 31 March 2013, December 2013. Accessed 10/12/2013. Available at http://www.nta.nhs.uk/uploads/annualypstatistics2012-13-final[0].pdf

[291] Public Health England, Alcohol and drugs: JNSA support data: Key data to support planning for effective young people's specialist substance misuse interventions: West Sussex, 2012-13.

[292] Advisory Council on the Misuse of Drugs, *Pathways to problems*, 2006. Available at https://www.gov.uk/government/publications/pathways-to-problems

[293] Becker J and Roe S, Drug *use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey,* 2005. Available at http://rds.homeoffice.gov.uk/rds/pdfs05/r254.pdf

[294] Op. cit. Public Health England, December 2013.

[295] Hay, G., Santos, A., and Millar, T., *Estimates Of The Prevalence Of Opiate And/Or Crack Cocaine Use 2010-11: A Summary of Key Findings*, National Treatment Agency for Substance Misuse, 2013. Available at http://www.nta.nhs.uk/uploads/prevalencesummary2013v1.pdf

Table 4.14: Opiate And/Or Crack Use Prevalence Rates Per Thousand Population, By Age Group And Region With 95% Confidence Intervals[296]

	15-24 years		
Region	Estimate	95% CI	
East of England	5.33	4.53	6.27
East Midlands	5.84	5.12	7.05
London	8.61	7.93	9.34
North East	7.58	6.89	8.58
North West	5.69	5.15	6.44
South East	4.41	3.93	4.90
South West	4.42	4.06	4.84
West Midlands	6.85	6.31	7.57
Yorkshire and the Humber	6.22	5.53	7.01
ENGLAND	6.04	5.80	6.28

It can be seen that the prevalence estimate is lowest in the South East at 4.41 per 1,000 head of population. Applying this prevalence estimate to the relevant population of West Sussex suggests that around 400 young people aged 16-24 will use opiate and/or crack.

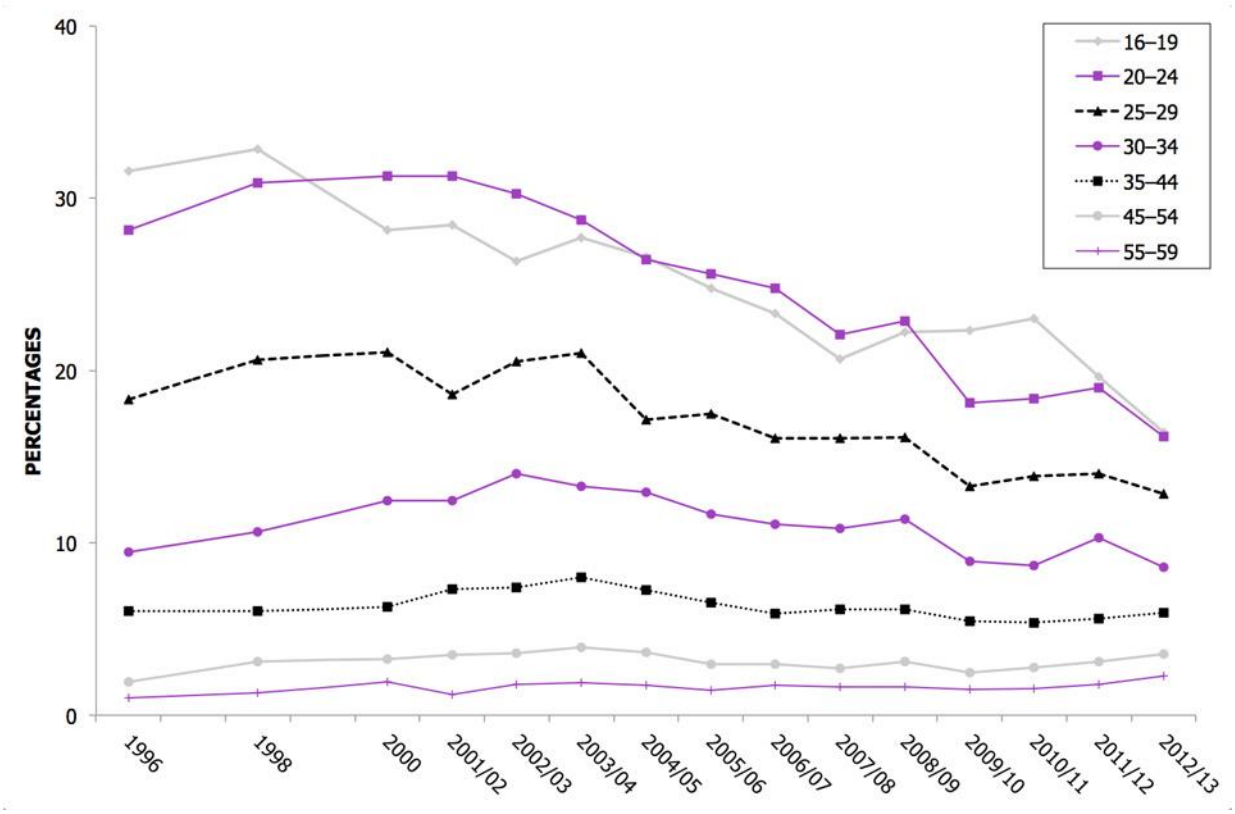
Crime Survey for England and Wales

The Crime Survey for England and Wales (CSEW) is an annual self-report study that provides perhaps the best insight into trends and patterns of drug use in Britain among those aged 16 and above. Key facts from the 2012 to 2013 CSEW indicate that levels of any drug use in the last year were highest among young adults aged 16 to 19 (16.4%) and 20 to 24 (16.2%) and that Class A drug use was highest among 20 to 29 year olds (5.7% of 20 to 24 year olds and 5.4% of 25 to 29 year olds).[297]

[296] Source: Hay et. al. 2013, Table 3.

[297] Home Office, *Drug Misuse: Findings from the 2012 to 2013 Crime Survey for England and Wales (CSEW),* 2013, Figure 3.1. Available at https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales#illicit-drug-use-by-personal-household-and-area-characteristics-and-lifestyle-factors. Accessed 11/12/2013.

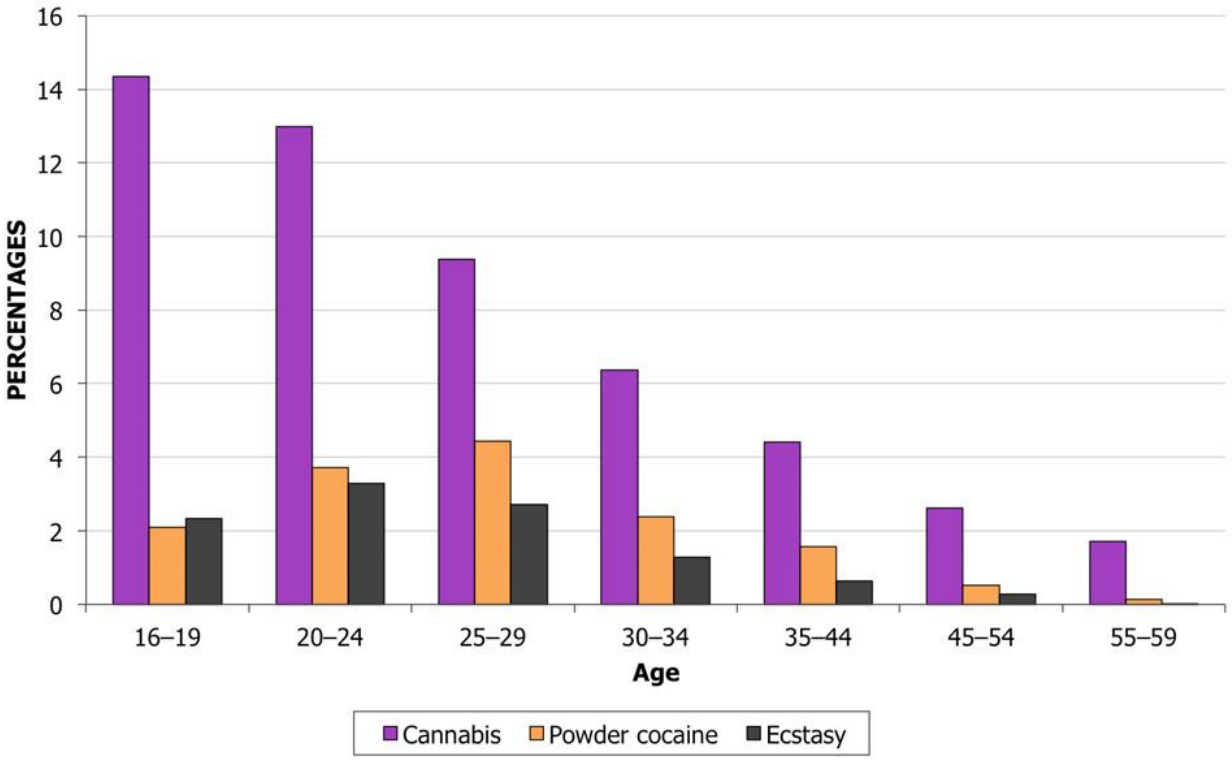
Figure 4.15: Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012 to 2013 Crime Survey for England and Wales[298]



Whilst still the most frequently used illicit drug, cannabis use has declined overall between 2011 to 2012 and 2012 to 2013 (from 6.9% to 6.4%) and, more specifically, use among 20 to 24 year olds fell from 15.7% to 13.0% over this period. Patterns of use for individual drugs vary by age group. While cannabis is the most prevalent drug across all age groups, use peaks among 16 to 19 year olds (14.3% used cannabis in the last year) and decreases with increasing age. Whereas, the prevalence of ecstasy use peaks among 20 to 24 year olds (at 3.3% in 2012 to 2013) and powder cocaine use peaks among 25 to 29 year olds (at 4.4% in 2012 to 2013). Ecstasy and powder cocaine use then decrease with increasing age.

[298] Source: Figure 3.1, *CSEW 2012-13,* 2013.

Figure 4.16: Proportion of 16 to 59 year olds reporting use of powder cocaine, ecstasy and cannabis in the last year by age group, 2012 to 2013 Crime Survey for England and Wales[299]



These prevalence figures are not adjusted for local conditions, but as a very crude measure they can be used to provide an indication of local need. Thus, based on current population statistics, in West Sussex (c. 83,489 young people aged 16-24[300]):

- 11,271 young people aged 16-24 are likely to have used cannabis in the last year (13.5%);
- 2,588 young people aged 16-24 are likely to have used cocaine in the last year (3.1%);
- 2,421 young people aged 16-24 are likely to have used ecstasy in the last year (2.9%).

New/Novel Psychoactive Drugs

As referenced in Chapter 2 of this report, reliable data on the prevalence of use and societal impact of Novel Psychoactive Substances (NPS) are difficult to obtain. Prevalence studies on NPS use tend to be from self-selecting samples and/or carried out in settings with high drug use occurrence such as music events and dance clubs, which are not representative of the general population. Furthermore, the problems

[299] Source: Figure 3.2, *CSEW 2012-13,* 2013.

[300] Based on population statistics at 31/03/2013, provided by West Sussex County Council Public Health & Wellbeing Directorate.

inherent to self-reported data may be magnified in the case of unknown drugs since substances sold under the same brand name can contain varying contents (Schmidt et al. 2011) and the supplier or user of the substance may not know what substance it actually contains. Despite these issues, prevalence of use surveys can give an indication of drug use behaviour although the ad hoc nature of some of the studies and different methodologies used mean that trend analysis should be treated with caution.[301]

Latest CSEW data for young adults aged 16 to 24 show decreased use of NSPs.[302] In the last year, use of the following 'other' drugs were statistically significant between 2011 to 2012 and 2012 to 2013:

- mephedrone (3.3% to 1.6% in 2012/13);
- ketamine (1.8% to 0.8% in 2012/13);
- magic mushrooms (1.2% to 0.6% in 2012/13);
- Methadone (0.4% to 0.0% in 2012/13).

Applying these rates to the population of West Sussex (with all the attendant caveats), it is possible 1,336 local young people aged 16-24 will have used mephadrone in the last year, and 668 will have used ketamine.

Annual School Survey

Key findings from the 2012 School Survey[303] pertaining to drug use include:

- The prevalence of illicit drug use was at similar levels to that in 2011. 17% of pupils had ever taken drugs, 12% had taken them in the last year and 6% in the last month;
- The prevalence of ever having taken drugs increased with age from 7% of 11 year olds to 31% of 15 year olds;
- Pupils who had taken drugs in the last year were most likely to have taken cannabis (7.5%);
- 2% of pupils said that they usually took drugs at least once a month (this survey's definition of frequent drug use);
- Pupils from minority ethnic groups were more likely to have taken drugs in the last year than White pupils.

[301] United Kingdom Drug Situation 2012 edition, *Overview of New Psychoactive Substances (NPS)*, pp.25-41. Available at http://www.nwph.net/ukfocalpoint/writedir/7839New%20%20psychoactive%20substances.pdf. Accessed 12/12/2013.

[302] Op. cit. *CSEW 2012-13,* 2013.

[303] National Centre for Social Research and the National Foundation for Educational Research, *Smoking, drinking and drug use among young people in England in 2012*, 2013, p.75-6. Available at http://www.wakefield.gov.uk/NR/rdonlyres/F20AE630-2DBF-456D-8E13-6B5050AE5D5E/0/SmokingDrinkingandDrugUseamongYoungPeopleinEnglandin2012NHS2013.pdf. Accessed 10/12/2013.

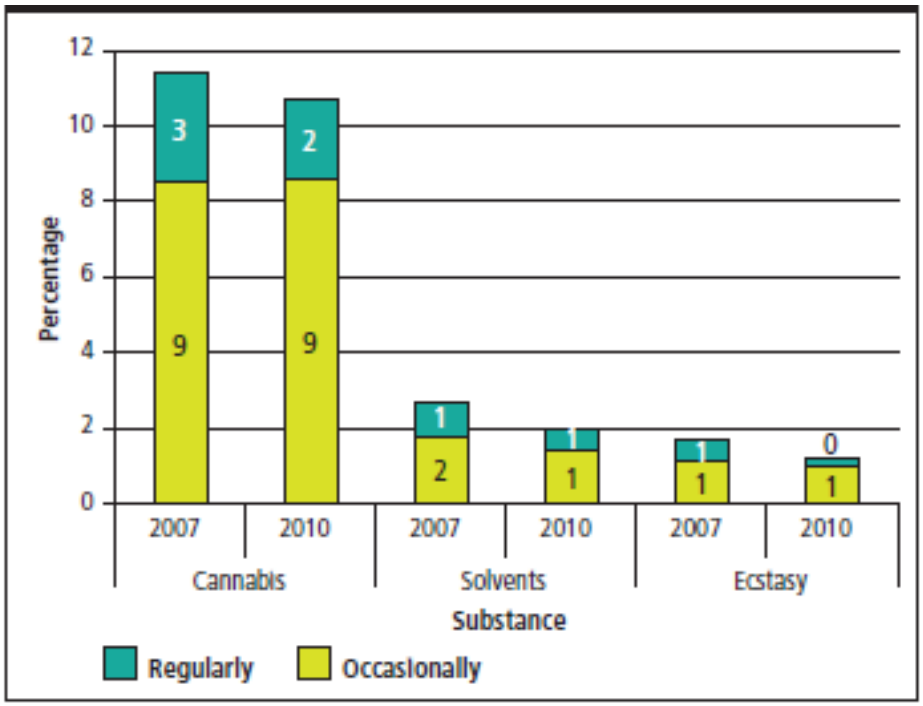
Based on the survey data (and subject to usual limitations of population estimates), the report authors estimated that 6% of 11 to 15 year olds in England will have taken drugs (this includes the use of volatile substances, cannabis and Class A drugs) in the last month. Applied to the relevant population of West Sussex,[304] this implies that around 2,750 11 to 15 year olds in the area will have taken drugs within the last month.

Local Report: Lifestyles of 14 to 15-year-olds in West Sussex 2010

Following national trends, the *Lifestyle Survey for 14-15 year olds in West Sussex (2010)* showed that cannabis is by far the most commonly used drug with 20.4% of pupils reporting that they had used cannabis at some stage. These results are similar to the recorded figures in the 2007 Lifestyle Survey. Pupils are much more likely to take cannabis as they get older. Of those who answered the question 'How old were you when you first tried cannabis?' (N = 607), less than 9% reported being 12 or younger, 19.3% first used it at 13 years old and 46.6% first used it at 14 years old.

The prevalence of drug use reported in this survey is summarised in the figure below:

Figure 4.17: Cannabis, ecstasy and solvent use in 2007 and 2010[305]



It can be seen that of those pupils who answered the questions, the proportion that has used cannabis and other drugs has decreased between 2007 and 2010.

[304] Population data from West Sussex County Council Public Health & Wellbeing Directorate.

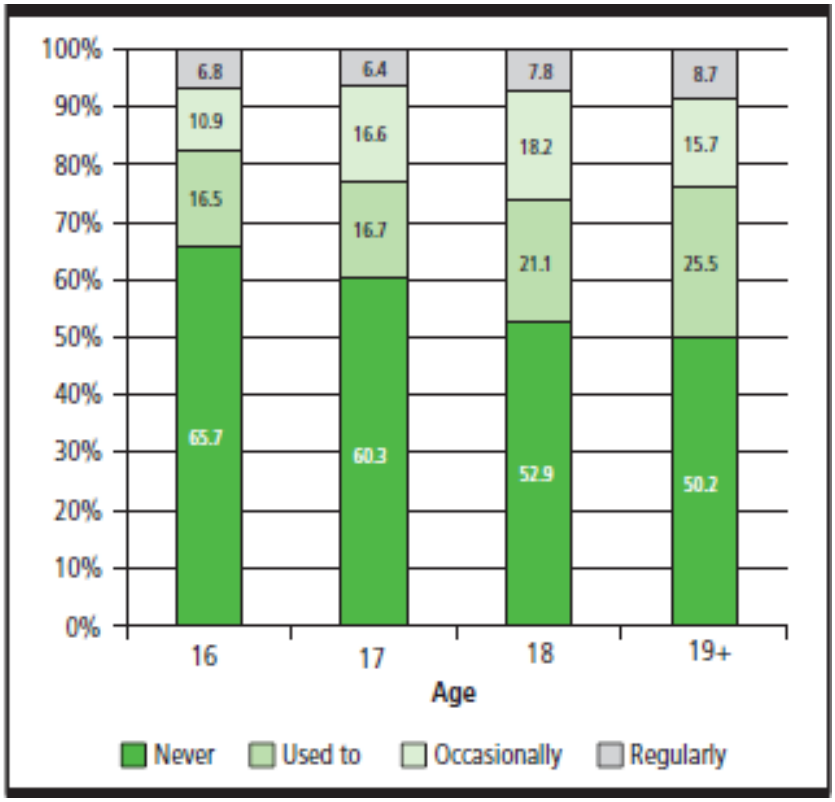
[305] Source: NHS West Sussex, *Lifestyles of 14 to 15-year-olds in West Sussex 2010,* Figure 5.1 p.21.

Local Report: Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008

Similarly, the most commonly used drug by students is cannabis. This survey showed that half of males and a third of females have used cannabis at least once. The difference between the sexes is particularly noticeable among the regular users of cannabis with 10.9% of males stating they are regular users compared with 2.5% of females.

Experience of cannabis was shown to increase with age, although it is the 18-year-old age group that has the highest proportion of current users (26.0%):

Figure 4.18: Cannabis experience by age[306]



The survey also asked whether students have ever taken a number of other drugs in their lifetime. In line with national figures, after cannabis, the most commonly used drug is cocaine (15.6% regular or occasional users) followed by ecstasy (13.1% regular or occasional users). A very small proportion (1.2%) of respondents classified themselves as regular class A drug users with 17.6% of students stating they are occasional class A drug users.

This report notes that for all drugs except amphetamines, a higher proportion of West Sussex HE and FE students have tried each drug compared with the national average

[306] West Sussex PCT, *Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008*, Figure 5.1 p.22.

(taken from the British Crime Survey 2006/7, see table below). The authors go on to state that the results are surprising as other indicators suggest that the prevalence of drug use in West Sussex is below national rates as will be further demonstrated below.

Table 4.19: Drug use in lifetime, local lifestyle data (2007) compared to BCS data 2006/7[307]

Drug	Local Lifestyle Survey Data 2008 (%)	British Crime Survey 2006/7 16-24 year olds (%)
Cannabis	42.6	39.5
Cocaine	15.6	11.2
Ecstasy	13.4	10.3
Amphetamines	9.1	11.2
Magic Mushrooms	9.9	7.0
LSD	3.7	3.2
Heroin	1.0	0.7

4.6.2 Youth drug misuse: physical health-related harm

Individuals who take illicit drugs face potential health risks, as the drugs are not controlled or supervised by medical professionals. As well as health risks, drugs can become addictive and lead to long term damage to the body. Illicit drug users are also at risk of being poisoned by drugs, and overdosing which can lead to a fatality. These risks are amplified for the, often highly vulnerable, young people who misuse drugs.

Intravenous drug use (IDU)

Whilst IDU still only represents a small proportion of drug use reported by under-18s overall, according to UNICEF, globally young people account for 2,500 new HIV infections every day.[308] Young people are also far more likely to be poly-drug users and are more likely to inject, not only opiates but amphetamine type stimulants as well, further increasing risk of harms.[309] Young people who inject drugs are also more unfamiliar with sterile equipment, more likely to use drugs in group environments where sharing of equipment occurs, and less likely to access health services due to stigmatisation by authorities and health care services.[310]

[307] West Sussex PCT, *Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008*, Table 5.3, p.23.

[308] Fletcher, A., and Krug, A., *Excluding Youth? A global review of harm reduction services for young people*, Chapter 3.2, 2012. Available at http://www.ihra.net/files/2012/09/04/Chapter_3.2_youngpeople_.pdf. Accessed 11/12/2013.

[309] EMCDDA, *Amphetamines, ecstasy and LSD: Drug situation*, Lisbon. European monitoring centre for drugs and drug addiction, 2007. Cited Youth Rise, *Harm Reduction and Young People*, 2011. Available at http://youthrise.org/sites/default/files/files/Harm%20Reduction%20and%20Young%20People.pdf. Accessed 11/12/2013.

[310] Op. cit., Youth Rise, 2011.

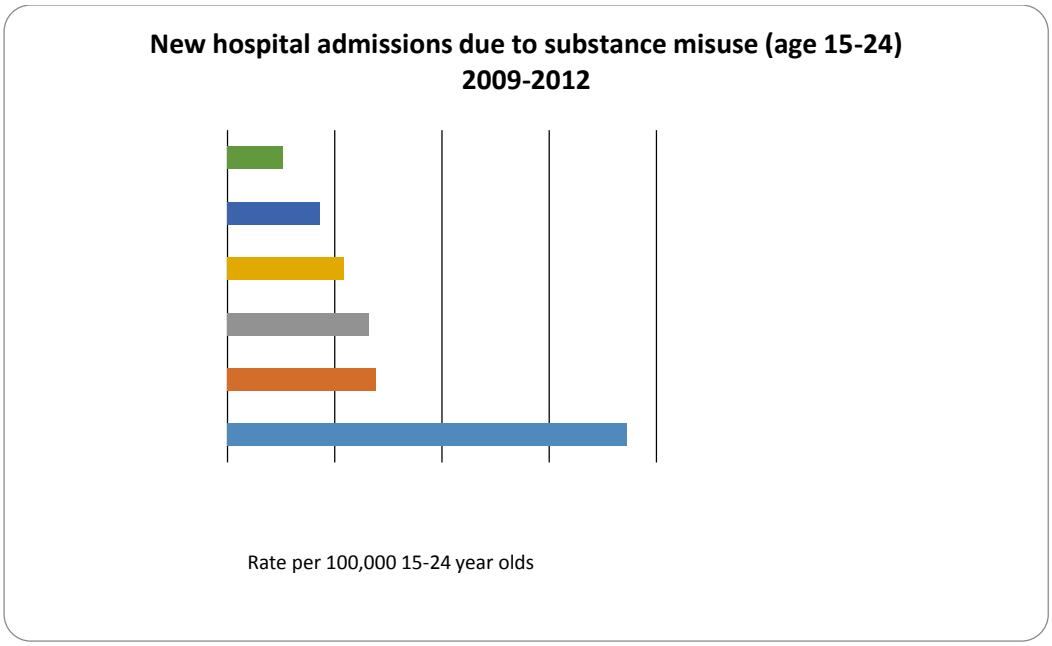
Hospital admissions – poisoning by drugs

In 2011/12, of the 12,344 hospital admissions with a primary diagnosis of poisoning by drugs, 3,612 (29.3%) related to those 24 and under. This was a reduction of 321 from the previous year, when admissions for the under-25s accounted for 31.2% of the total.[311]

Hospital admissions – due to substance misuse

Hospital admissions due to substance misuse (15-24 year olds) equates to an average of 46 a year in West Sussex (based on data pooled from financial years 2008/09, 2009/10 and 2010/11). This translates to a local value of 53.4 per 100,000 population aged 15-24, which is significantly better than the national average of 69.4. Likewise, numbers presenting in Essex are significantly lower than the England average (at 43.3 per 100,000), however, at 66.1 per 100,000 population, Devon is on a par with the national average for this measure.[312]

Table 4.20: New hospital admissions due to substance misuse (age 15-24) 2009-2011[313]



Emergency hospital admissions

To get a more comprehensive picture locally, data was requested on NHS emergency admissions within West Sussex localities that had a record of drugs in the diagnosis

[311] Source: The Health and Social Care Information Centre, *Statistics on Drug Misuse: England*, 2012, Table 3.7.

[312] Child Health Profile snap-shot data, available at http://atlas.chimat.org.uk/IAS/dataviews/report. Accessed 28/11/2013.

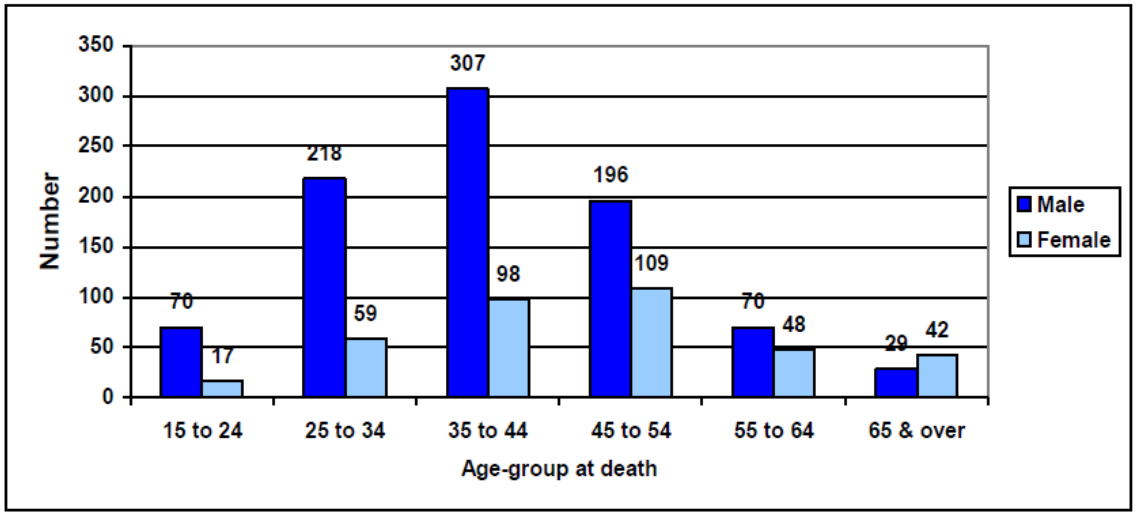
[313] Data source: Child Health Profile snap-shot data, available at http://atlas.chimat.org.uk/IAS/dataviews/report. Accessed 28/11/2013.

codes.[314,315] The numbers involved are small so caution should be used when attempting to identify trends, but in 2011/12, 37 young people aged 19 and under were emergency admissions with a record of drugs in the diagnosis code,[316] and in 2012/13 the corresponding figure was 45. This equates to a crude rate of 20.0 and 24.2 per 100,000 head of population (aged 0-19) respectively.[317] This appears to run counter to the national trend, but the numbers are so small that it is not possible to draw a valid conclusion.

4.6.3 Youth drug misuse: Drug Related Deaths

Most *np*-SAD drug-related deaths in England during 2011 occurred amongst those aged 35 years and over (71.2%), with 21.9% aged 25-34, and only 6.9% being 15-24 years old. These deaths were more likely than older cases to be attributed to accidental poisoning.[318]

Figure 4.21: np-SAD drug-related deaths by age and gender, England, 2011[319]



[314] Whilst the accuracy of this data relies on hospital staff noting alcohol misuse as a primary or secondary cause/factor in admission and thus will not capture all relevant incidents, the figures are presented to be appraised in conjunction with all other data to build up a comprehensive picture of prevalence in West Sussex. Please also note, some of the admissions tabulated below will have both alcohol and drugs in the diagnosis codes, there will therefore be some double counting between these statistics and the ones quoted in Section 4.4.2 pertaining to alcohol related harm in West Sussex.

[315] We also repeatedly requested alcohol/drug-related call-out data from South East Coast Ambulance Service NHS Foundation Trust. This data was not forthcoming.

[316] Data source: SUS; ICD 10 codes used: F11 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF OPIOIDS; F12 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF CANNABINOIDS; F13 MENTAL & BEHAVIOURAL DISORDERS DUE USE SEDATIVES/HYPNOTICS; F14 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF COCAINE; F15MEN & BEHAV DIS DUE USE OTH STIMS INC CAFFEINE; F16 MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF HALLUCINOGENS; F18 MENTAL & BEHAVIOURAL DISORDERS DUE USE VOLATILE SOLVENTS; F19 MENTAL & BEHAV'L DISORDERS DUE MULTIPLE/PSYCHOACT DRUG USE; Admission Method = 2* (Emergency).

[317] West Sussex population statistics from West Sussex County Council Public Health & Wellbeing Directorate.

[318] Op cit. *np*-SAD Report 2012.

[319] Source: Op cit. *np*-SAD Report 2012, Figure 1.1.

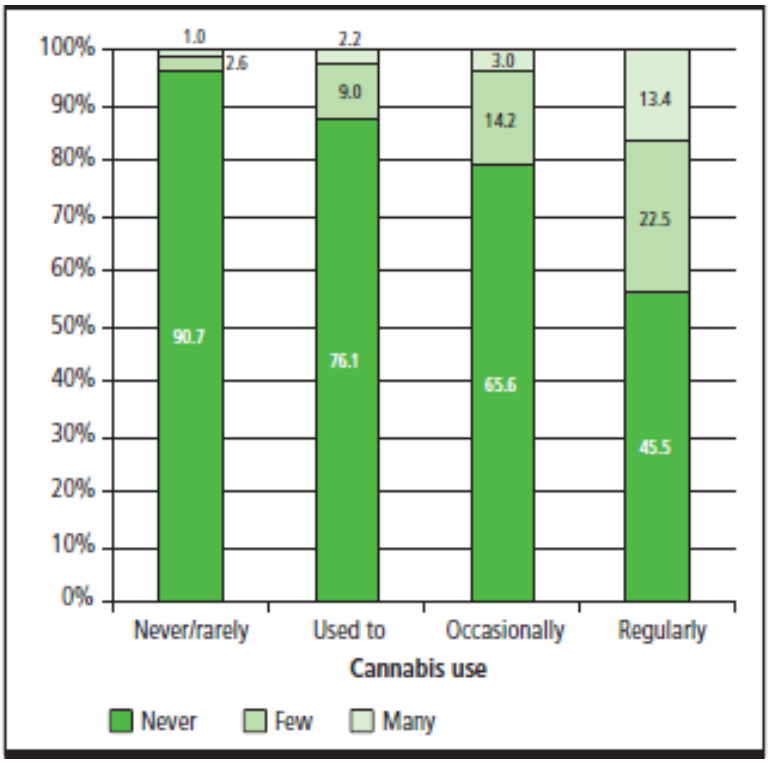
Statistics compiled by the West Sussex Reducing Drug Related Deaths Steering Group indicate np-SAD deaths in 2012 may number 18[320] (10 male; 8 female), of which only two were aged under 30 (25 and 27).

4.6.4 Youth drug misuse: Social Harm

Research has shown that among 10 to 15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending.[321]

Data from the *Lifestyle Survey of 16-24 year old in West Sussex (2008)* shows a clear relationship between drug use and crime. The figure below shows the correlation between the use of cannabis and how often in the previous 12 months respondents had vandalised someone else's property. Over half of the students who regularly use cannabis had vandalised in the previous 12 months with more than one in ten (13.4%) doing so many times. Class A drug users also showed a similar trend in vandalism as well as in other crime variables such as being arrested and spraying graffiti.

Figure 4.22: Vandalism by cannabis use[322]



Similarly, when asked if they had carried a weapon to college/university over the past 12 months, 2.6% of students who have never used any drug stated they had carried a

[320] This number is an estimation given time lags in some Coroner and Inquest verdicts.

[321] Becker J and Roe S, *Drug use among vulnerable groups of young people: findings from the 2003 Crime and Justice Survey*, 2005.

[322] West Sussex PCT, *Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008*, Figure 5.5, p.25.

weapon compared with 18.7% of regular cannabis users and 25.8% of regular Class A drug users.

Table 4.23: Drug use by carried a weapon to college[323]

	Number	Percentage (%)
Never used any drug	32	2.6
Occasional cannabis	39	9.8
Regular cannabis	35	18.7
Occasional class A	49	10.7
Regular class A	8	25.8

The lifestyle survey also showed that current drug users are more likely to be a victim of violent crime. Over a quarter (26.5%) of regular cannabis users stated they had been a victim of violent crime in the previous 12 months compared with just over one in ten (11.8%) of students who have never used any drug:

Table 4.24: Drug use by been a victim of violent crime[324]

	Number	Percentage (%)
Never used any drug	148	11.8
Occasional cannabis	70	17.5
Regular cannabis	50	26.5
Occasional class A	105	22.9
Regular class A	6	19.4

Youth drug possession and trafficking offences

The most recent statistics available from the Youth Justice Board which covers the workload of Youth Offending Teams (YOTs) in England and Wales notes that in 2011/12 there were 137,335 proven offences by young people on the YOT caseload which resulted in a formal disposal (either in or out of court). Of these, 8% (c. 10,997) were drugs offences. Between 2008/9 and 2011/12 there was a reduction of 27% in proven drugs offences by young people in England and Wales. [325]

[323] West Sussex PCT, *Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008*, Table 5.9, p.26.

[324] West Sussex PCT, *Lifestyles of 16-to-24-year-olds in Higher and Further Education Colleges in West Sussex 2008*, Table 5.8, p.26.

[325] Youth Justice Statistics (2011/12): England and Wales, Youth Justice Board/Ministry of Justice Statistics Bulletin, published 31 January 2013, pp. 27-8.

Of the offender records for drug possession and trafficking captured by West Sussex police between August 2010 and July 2013 which contained age information (n=6,290), 662 (11%) were for offenders under the age of 18.[326]

Substance misuse in the secure estate

Recent research across the secure estate in England and Wales suggests that up to 84% of this population could be considered problematic or potentially problematic substance misusers ('substance' includes drugs and alcohol). More specifically, use of the following drugs during the previous year was recorded[327]:

- Cannabis – 75% (down from 83% in 2003)
- Ecstasy – 38% (down from 44% in 2003)
- Cocaine – 33% (up slightly from 32% in 2003)
- Crack – 9% (down from 22% in 2003)
- Heroin – 1% (down from 13% in 2003)

Young females in the sample were significantly more likely to have been heroin and crack users than young males and significantly more females reported that they had overdosed at some stage in their life (females 34%; males 12%). Perhaps more worrying figures showed that, of those who had overdosed, over half of the females reported that they had done it deliberately (females 58%; males 19%). This speaks to the fact that the needs young people in custody stretch beyond substance misuse. Young people entering custody often have a number of problems that co-exist with their substance misuse such as: lack of secondary school education; the influence of close family members who use drugs; uncertainty about accommodation upon release from custody; drug dealing by young people; and mental health issues (addressed below).

4.7 Risk factors / Vulnerable Populations

Problematic alcohol and drug use is more prevalent amongst some groups of young people within society. The risk factors for starting to take drugs include co-morbidity, disrupted family units, parental drug use, truancy, unemployment and social exclusion.[328] In this section several such 'at risk' or vulnerable populations are examined.

4.7.1. Dual diagnosis

As noted by the Department of Health,[329] substance misuse is a major contributory factor in the development of mental health problems in the young. Indeed, "substance

[326] Source: Report prepared by West Sussex Police at behest of Lyn Williams August 2013.

[327] Op. cit. Youth Justice Board, 2009.

[328] See for example Zeitlin, H. (1999). Psychiatric co-morbidity with substance misuse in children and teenagers. Drug & Alcohol Dependence, 55, 225-234.

[329] Op cit. *Dual Diagnosis Good Practice Guide*, 2002.

misuse in young people is frequently associated with emotional and behavioural disorder not directly attributable to the effects of the substance."[330] A recent study from the University of Sydney's Brain and Mind Research Institute showed that one in 10 mentally ill teenagers reported frequent use of alcohol, cigarettes and cannabis. This pattern of substance use becomes more common as teens age, and likely heightens risk of poor physical and mental health outcomes, the study reports.[331]

Co-existing psychiatric disorder in young problematic substance users is the rule rather than the exception, and although UK research is patchy and restricted to custodial settings, there is strong evidence from the USA and elsewhere linking substance misuse with disruptive behaviours (e.g. ADHD), mood disorders, anxiety disorders and other associated disorders such as buliminia nervosa and emerging personality disorders.[332] Moreover, studies in Britain show that emotional and behavioural disorders are associated with an increased risk of experimentation with, misuse of and dependence on drugs and alcohol.[333]

Research shows that one in ten children aged between 5 and 16 years has a mental health problem,[334] and self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed).[335] Many of these young people will continue to have mental health problems into adulthood. Furthermore, half of those with lifetime mental health problems first experience symptoms by the age of 14,[336] and three-quarters before their mid-20s.[337]

Substance use is also prevalent during this developmental stage,[338] and young people with co-occurring affective and substance use disorders (SUD) consistently report greater levels of psychopathology as well as more psychosocial difficulties than those

[330] Zeitlin, H. (1999). Psychiatric co-morbidity with substance misuse in children and teenagers. Drug & Alcohol Dependence, 55, 225-234.

[331] Hermens, D., Scott, E., White, D. Et al, 'Frequent alcohol, nicotine or cannabis use is common in young persons presenting for mental healthcare: a cross-sectional study', *BMJ Open 2013;3:e002229.doi:10.1136/bmjopen-2012 002229.*

[332] Source: presentation by Vernon, J., *Dual Diagnosis in Young People*, 2009. Available at www.nypsmtf.org.uk/.../Dual_Diagnosis_In_Young_People.ppt

[333] Green, H., McGinnity, A., Meltzer, H., et al. (2005) *Mental Health of Children and Young People in Great Britain, 2004.* Basingstoke: Palgrave Macmillan.

[334] Op. cit. Green et al (2005).

[335] Hawton, K., Rodham, K., Evans, E., and Weatherall, R., 'Deliberate self harm in adolescents: self report survey in schools in England', *British Medical Journal,* 2002; 325: 1207–1211.

[336] Kim-Cohen, J., Caspi, A., Moffitt, T., et al., 'Prior juvenile diagnoses in adults with mental disorder', *Archives of General Psychiatry,* 2003; 60: 709–717; Kessler, R., Berglund P., Demler, O., et al., 'Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication', *Archives of General Psychiatry* 2005; 62: 593–602.

[337] Kessler, R. and Wang, P., 'The descriptive epidemiology of commonly occurring mental disorders in the United States', *Annual Review of Public Health,* 2007; 29: 115–129.

[338] Wittchen HU, Nelson CB, Lachner G., 'Prevalence of mental disorders and psychosocial impairments in adolescents and young adults', *Psychol Med*, 1998; 28:109-126.

with SUD alone.[339,340,341] For example, adolescents (aged 14 to 18 years) with an affective disorder and co-occurring SUD reported more academic problems, suicide attempts and impaired role functioning than those with a single diagnosis.[342,343] Young drug users (aged 16 to 22 years) with co-occurring depression have also been found to report greater family, housing and substance-related problems, as well as a poorer quality of life than those with SUD alone.[344] Despite this, it is estimated that in UK, of those adolescents with SUD in need of help for mental health, only about 9% receive treatment.[345]

Adolescents with co-occurring SUD and psychiatric disorders also appear to demonstrate poorer treatment outcomes at follow up.[346,347,348,349] For example, among adolescents admitted to an inpatient drug treatment programme, those with emotional problems reported higher rates of relapse at two year follow up than those with an SUD alone.[350] Similarly, Dobkin et al. reported that depressive symptoms at intake were predictive of non-improvement among those adolescents who completed a drug treatment programme.[351] For these reasons, among others, Vernon (2009) surmises that it is important to detect co-morbidity in young people with a SUD.

The aetiology of dual diagnosis in young people has not been systematically researched and it is unclear whether psychopathology precedes substance misuse disorders (SUDs), develops as a consequence of a SUD or whether both originate from a common vulnerability. It is however apparent that early onset of substance use (before the age of 13) increases the risk of developing mental health problems, as well as a range of other adverse outcomes (e.g., alcohol or drug dependence, educational underachievement, health problems, social difficulties) during late adolescence and

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[339] Lewinsohn PM, Rohde P, Seeley JR., 'Major depressive disorder in older adolescents: prevalence, risk factors, and clinical implications', *Clin Psychol Rev,* 1998; 18:765-794.

[340] Lubman DI, Allen NB, Rogers N, Cementon E, Bonomo Y., 'The impact of co-occurring mood and anxiety disorders among substance-abusing youth', *J Affect Disord,* 2007a; 103:105-112.

[341] Riggs PD, Baker S, Mikulich SK, Young SE, Crowley TJ., 'Depression in substance-dependent delinquents', *J Am Acad Child Adolesc Psychiatry,* 1995; 34:764-771.

[342] Op. cit. Lewinsohn et al 1998.

[343] Baker, K., Lubman, D., Cosgrave, E., Killackey, E et al., 'Impact of co-occurring substance use on 6 month outcomes for young people seeking mental health treatment', *Australian and New Zealand Journal of Psychiatry,* 2007; 41:896-902.

[344] Op. cit. Lubman et al 2007a.

[345] Source: presentation by Vernon, J., *Dual Diagnosis in Young People*, 2009. Available at www.nypsmtf.org.uk/.../Dual_Diagnosis_In_Young_People.ppt

[346] Dobkin PL, Chabot L, Maliantovitch K, Craig W., 'Predictors of outcome in drug treatment of adolescent inpatients', *Psychol Rep,* 1998; 83:175-186.

[347] Grella CE, Hser YI, Joshi V, Rounds-Bryant J., 'Drug treatment outcomes for adolescents with comorbid mental and substance use disorders', *J Nerv Ment Dis,* 2001; 189:384-392.

[348] Rowe CL, Liddle HA, Dakof GD., 'Classifying clinically referred adolescent substance abusers by level of externalising and internalizing symptoms', *J Child Adolesc Subst Abuse*, 2001; 11:41-65.

[349] Brown SA, Myers MG, Mott MA, Vik PW., 'Correlates of success following treatment for adolescent substance abuse', *Appl Prev Psychol,* 1994; 3:61-73.

[350] Ibid.

[351] Op. cit. Dobkin et al 1998.

early adulthood.[352] For instance, early-onset regular cannabis use has been associated with educational underachievement,[353] psychosis,[354,355] depression, and anxiety.[356,357] The existing evidence for developmental harm as a result of adolescent substance use therefore highlights the importance of prevention and early-intervention programmes that focus on: delaying the age of onset of drug experimentation; reducing the number of young people who progress to regular or problem use; and encouraging current users to minimise or reduce risky patterns of use.[358]

Poor academic attainment is one of the individual risk factors for dual-diagnosis highlighted by Vernon, and truancy is in fact one of the risk factors for starting to misuse substances in the first place as will be examined below.

4.7.2 Truancy

Truants have a significantly higher incidence of illegal drug use, underage drinking and smoking than non-truanting pupils and rates of substance misuse increase over time. Moreover, illegal drug use and smoking significantly predict truancy after controlling for a range of other explanatory variables, including school experience, victimisation, parenting and a range of personality characteristics such as self esteem and impulsivity.[359]

Frequent drinkers (age 15) are much more likely to increase both their truanting and their involvement in criminal activity over the following year compared to non-drinkers and less frequent drinkers, after accounting for other factors:

[352] Lubman, D., Hides, L., Yücel, M., and Toumbourou, J., 'Intervening early to reduce developmentally harmful substance use among youth populations', *Medical Journal of Australia*, 2007b, 187;7:22-25.

[353] Hall WD, 'Cannabis use and the mental health of young people', *Aust N Z J Psychiatry,* 2006; 40:105-113.

[354] Ibid.

[355] Arseneault L, Cannon M, Witton J, Murray RM., 'Causal association between cannabis and psychosis: examination of the evidence', *Br J Psychiatry,* 2004; 184: 110-117.

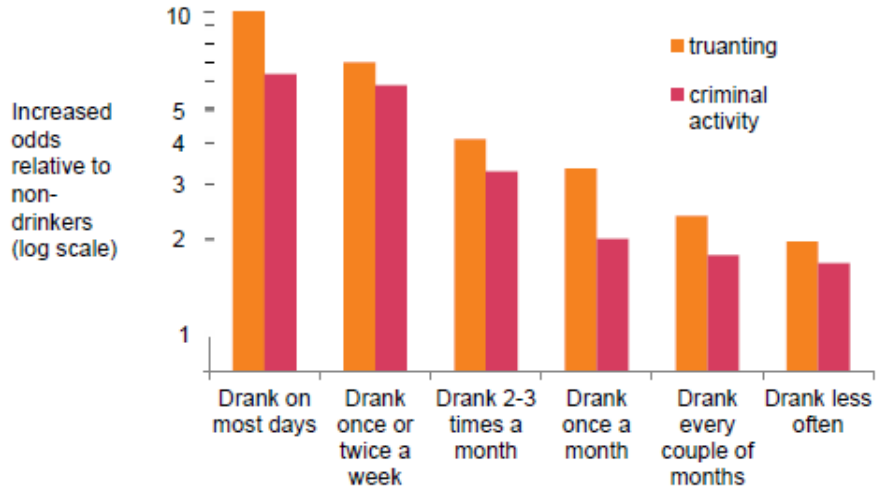
[356] Patton GC, Coffey C, Carlin JB, et al., 'Cannabis use and mental health in young people: cohort study', *BMJ*, 2002; 325: 1195-1198.

[357] Degenhardt L, Hall W, Lynskey M., 'Exploring the association between cannabis use and depression', *Addiction,* 2003; 98: 1493-1504.

[358] Lubman et al 2007b.

[359] McAra, L., *Truancy, School Exclusion and Substance Misuse*, The Edinburgh Study of Youth Transitions and Crime No. 4: Centre for Law and Society, 2004. Available at http://www2.law.ed.ac.uk/cls/esytc/findings/digest4.pdf

Figure 4.25: The link between alcohol, truancy and offending[360]



Data from the Longitudinal Study of Young People in England

Equally, data from a study in Edinburgh shows an extremely strong relationship between volume of truancy and all forms of substance misuse. Of particular note is the increased strength of the relationship between drug use and truancy over time. The closer the coefficient is to 1 the stronger the relationship:

Table 4.26: Correlations between Substance Misuse and Volume of Truancy[361]

	Primary School	First Year	Second Year	Third Year
Volume of Drug Use	.230***	.335***	.380***	.436***
Scale of Alcohol Use	.266***	.331***	.404***	.363***
Scale of Smoking	.315***	.405***	.486***	.470***

Correlations are non-parametric, Spearman's rho: *** significant at the 99.9% level of confidence

Annual School Survey

Data from the Annual School Survey also highlights a link between drinking and truancy, concluding that pupils who had played truant from school at least once were more likely to have drunk alcohol in the last week (odds ratio=2.00) compared with pupils who had never played truant.[362]

Similarly, the researchers concluded that pupils who had truanted from school were more likely to have taken drugs in the last year compared with pupils who had never truanted (odds ratio=2.71), and those who had been excluded from school were more

[360] Cited Mentor, *How 'risky behaviours' overlap in young people – messages for prevention*, March 2013. Available at http://www.kingsfund.org.uk/sites/files/kf/claire-james-mentoruk-poster-mar13.pdf. Accessed 11/12/2013.

[361] Source: Table 8 Op. cit. McAra, 2004.

[362] Op. cit. *Annual School Survey 2012.*

likely to have taken drugs in the last year compared with pupils who had never been excluded (odds ratio=1.77).

More specifically, the data showed that pupils who had ever truanted or had been excluded from school were more likely to report usually taking drugs at least once a month than those who had never truanted or had never been excluded (10% compared with 1%). This proportion is lower than in 2011 (12%) and maintains the overall decline in the prevalence of frequent drug use amongst this group of vulnerable pupils since 2003, when it was 21%.

Figure 4.27: Proportion of pupils who usually take drugs at least once a month, by truancy status[363]

Proportion of pupils who usually take drugs at least once a month, by whether ever truanted or excluded: 2003-2012[a,b]

All pupils *2003-2012*

Usually takes drugs at least once a month	Year									
	2003	2004	2005	2006	2007	2008	2009	2010[b]	2011[b]	2012[b]
	%	%	%	%	%	%	%	%	%	%
Truanted or excluded	21	17	18	11	14	11	14	8	12	10
Never truanted or excluded	3	2	2	1	2	1	1	1	1	1
Total[c]	7	5	6	4	5	3	4	2	3	2
Unweighted bases[b]										
Truanted or excluded	*2073*	*1896*	*1998*	*1920*	*1736*	*1499*	*1446*	*1226*	*1093*	*1271*
Never truanted or excluded	*7767*	*7470*	*6651*	*5926*	*5654*	*6011*	*5801*	*5790*	*4934*	*5993*
Total[c]	*10033*	*9497*	*8784*	*7949*	*7514*	*7589*	*7396*	*7153*	*6120*	*7377*

[a] The answer categories for usual frequency of drug use were slightly different in 2004. In every year shown, the question included the categories 'I take drugs most days' and 'I take drugs at least once a week'. In every year except 2004, there was an additional category, 'I take drugs once or twice a month'. In 2004, this category was replaced by two different categories: 'I take drugs two or three times a month' and 'I take drugs once a month'.

[b] Estimates since 2010 are based on weighted data (see Section 1.2.4). 2012 weighted bases are as follows: Truanted or excluded: n=1280; Never truanted or excluded: n=5988.

[c] Total includes pupils who did not say whether they had ever truanted or been excluded from school.

Pupils who had ever played truant or been excluded were also more likely to report taking Class A drugs in the last year (9%) than those who had never truanted or been excluded (1%). This is at a similar level to recent years, although lower than in 2003, when it was 14%.

Such findings reiterate the conclusions of Henry and Thornberry (2010) who surmised truancy appears to be a robust predictor of substance use. They believe the effect is likely to be, in part, a result of the deleterious effects of reduced school bonding and, in part, a result of the unsupervised, risky time afforded by truancy. That being so, they

[363] Source: Table 4.14 *Annual School Survey 2012* p. 174.

highlighted the importance of gaining a better understanding of how truancy may affect substance use for the development of prevention and intervention initiatives.[364]

In state-funded secondary schools in West Sussex, during the autumn term 2008 and spring term 2009 5.4% of enrolments were persistent absentees (defined as missing greater than 20% of all sessions due to authorised or unauthorised absences).[365] Moreover, during the 2008/2009 academic year, West Sussex County Council Education Welfare Officers and Sussex Police stopped or visited 218 children as part of truancy sweeps and returned 85 to school.[366]

The *Lifestyle Survey of 14 to 15 year olds in West Sussex* asked pupils whether they had played truant from or 'bunked off' school during the past year. Combining the responses of both boys and girls, 29% answered 'yes', which was slightly higher than the 27% from the 2007 Lifestyle Survey. In line with other studies, the survey found a strong relationship between truancy and high risk behaviours (see figure below). Pupils who regularly drank alcohol were six times more likely to have played truant than those who rarely drank. Those who regularly smoked were five times more likely to have played truant. Similarly, whilst 80% of pupils who regularly use cannabis had played truant during the previous year, it was only 21% for pupils who have never used cannabis. Of the three risk behaviours, regular cannabis use was the greatest risk factor for truancy.

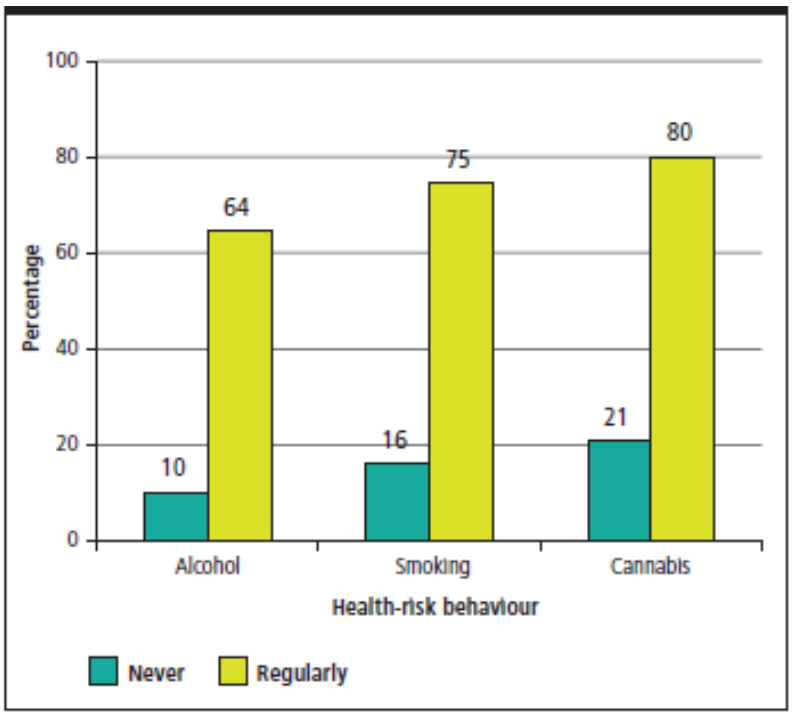
Figure 4.28: Truant in the last year by regularity of risk behaviour[367]

[364] Henry, K. And Thornberry, T., 'Truancy and Escalation of Substance Use During Adolescence', *J Stud Alcohol Drugs*, 2010; 71(1):115-124.

[365] Cited: NHS West Sussex, *Lifestyles of 14 to 15-year-olds in West Sussex 2010,* p.44.

[366] Ibid.

[367] Source: NHS West Sussex, *Lifestyles of 14 to 15-year-olds in West Sussex 2010,* Figure 10.2 p.45.



4.7.3. Those affected by parental substance misuse

Research cited in Dore, Doris and Wright (1995)[368] and more recently in Alcohol Concern's Report *Swept Under the Carpet (2010),*[369] suggests that children who live with substance misusing parents as part of their everyday life, may run a higher risk of having mental health problems themselves, a greater rate of drug and alcohol use in adolescence, impaired intellectual and academic functioning, higher levels of anxiety and depression and lower self-esteem.[370] Specifically, research has shown that children of drug abusing parents are seven times more likely to use drugs than those whose parents abstain.[371]

Annual School Survey

Data from the Annual School Survey (2012) indicates that whether pupils drink or not is strongly influenced by the behaviour and attitudes of their families. Pupils were more likely to drink alcohol if someone they live with does: 83% of pupils whose households did not include anyone who drank had never themselves drunk alcohol, compared with 30% of pupils who lived with three or more drinkers. The odds ratios increased with the number of drinkers in the home, from 1.64 for pupils who lived with one person who

[368] Dore MM, Doris JM, Wright P., 'Identifying substance abuse in maltreating families: a child welfare challenge', *Child Abuse Negl.,* 1995 May;19(5):531-43.

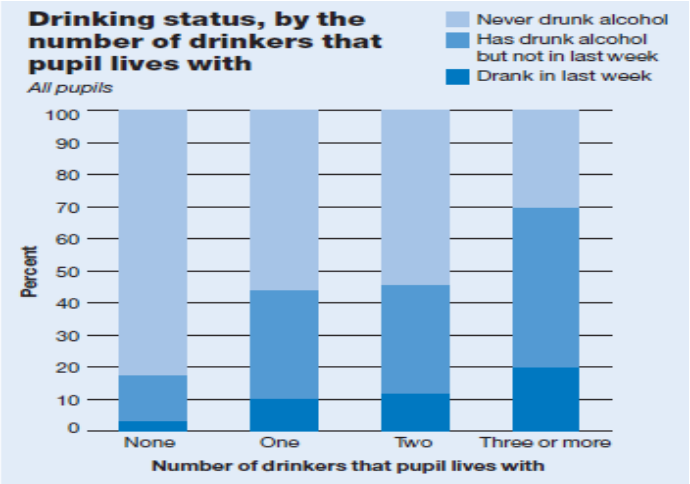
[369] Op cit. Delargy et al (2010).

[370] See also Cuijpers, P., Langendoen, Y. and Bijl, R. (1999) 'Psychiatric disorders in adult children of problem drinkers: prevalence, first onset and comparison with other risk factors', Addiction, Vol. 94, No. 10, pp. 1489–98; Advisory Council on the Misuse of Drugs (2003) Hidden Harm: Responding to the Needs of Children of Problem Drug Users. London: Home Office; Chalder, M., Elgar, F., & Bennett, P., 'Drinking and motivations to drink among adolescent children of parents with alcohol problems', *Alcohol & Alcoholism,* Vol. 41, No. 1, pp. 107–113, 2006.

[371] Cited Zurich Community Trust, 'Breaking the cycle of generational drug misuse'. Available at https://www.zurich.co.uk/zurichcommunitytrust/otprogrammes/breakingthecycleofgenerationaldrugmisuse/Thefacts.htm. Accessed December 2013.

drank alcohol to 2.15 for pupils who lived with three or more drinkers, compared with those who lived in homes where no one drank.

Figure 4.29: Drinking status, by the number of drinkers that pupil lives with[372]



Similarly, the attitudes of pupils' parents were also linked to whether or not a pupil drank. Pupils who thought their families didn't like them drinking were less likely to have drunk alcohol than those who thought their families didn't mind if they drank. Nearly 90% of pupils who felt that their parents would disapprove had never drunk alcohol, compared with 28% of those who thought that their parents wouldn't mind as long as they didn't drink too much (odds ratio 2.81).

Figure 4.30: When last drank alcohol, by perceived family attitude to pupil's drinking[373]

[372] Source: Table 3.15 *Annual School Survey 2012* p. 90.

[373] Source: Table 3.46 *Annual School Survey 2012* p. 135.

When last drank alcohol, by perceived family attitude to pupil's drinking

All pupils *2012*

Last drank alcohol	Perceived family attitude			
	Doesn't like pupil drinking	Doesn't mind pupil drinking if not too much	Lets pupil drink as much as he or she likes	Total[a]
	%	%	%	%
In the last week	2	18	49	10
Has drunk alcohol but not in the last week	10	54	30	31
Never	87	28	21	58
Unweighted bases	*3678*	*3386*	*100*	*7311*
Weighted bases	*3701*	*3378*	*98*	*7323*

[a] Total column includes pupils who did not answer the question about their parents' attitude to their drinking.

CHAPTER 5: PROFILE OF CURRENT SERVICE PROVISION

5.1 Introduction

This chapter sets out information on current service provision and is drawn from a variety of sources including data supplied within the West Sussex JSNA, DOMES statistics and information provided by managers of drug and alcohol services in West Sussex.

An online questionnaire was sent to all specialist drug and alcohol service managers in October 2013. Responses were received from 21[374] individuals and pertained to the following services:

- Addaction Chichester & Bognor Regis (3 surveys completed – results amalgamated)
- Addaction Crawley and Horsham Projects (2 surveys completed for Crawley – results amalgamated)
- Addaction Mid-Sussex
- Addaction Worthing (2 surveys completed – results amalgamated)
- Addaction (Generic)
- CRI Clock Walk
- CRI Crawley
- CRI (Generic)
- EXACT Central C.I.C
- Ravenscourt Trust
- Recovery Project / Sands Recovery Service – Stonepillow (2 surveys completed – results amalgamated)
- West Sussex Young Persons Substance Misuse Service

We also received a response from an Alcohol Specialist Nurse which is discussed at relevant points throughout this chapter.

A range of topics will be addressed including: demographic profile of client groups; nature and extent of contacts; nature of interventions provided; and capacity of services.

[374] Three only answered questions pertaining to service name and postcodes covered and have therefore been discounted in the following chapter.

5.2 Key findings

5.2.1 Service profile

- All groups of service users are catered for within the West Sussex area. However only one service has provision for the under 16 group, and only WSYPSMS and the Alcohol Specialist Nurse see clients aged between 16 and 17 years of age.
- The residential services are available for their service users 24 hours a day, seven days a week. Most of the rest operate within normal working hours. However, there are five services which currently provide limited out of hours service; and CRI Crawley plans to open a Saturday morning service in the future.
- All services use an appointments system. Stonepillow, the Alcohol Specialist Nurse and EXACT do not undertake home visits or offer a telephone helpline.
- The largest service in terms of staff is Addaction Crawley/Horsham which has 20 staff, although it should be noted that it is not known whether all posts are full time.
- There appear to be few limitations on methods of referral to specialist drug treatment services in West Sussex, with the exception of Addaction Chichester & Bognor Regis who can only accept referrals from CRI.
- The proportion of drug users waiting in excess of six weeks for treatment (from the point of initial referral) in West Sussex is in line with the national average at 1% of all initial waits. The proportion of primary alcohol users beginning treatment within three weeks in West Sussex is in line with the national average at 62%.
- Over half of all referrals for Alcohol treatment services in West Sussex came via self, family and friends in 2012/13. Similarly, at the national level, 40% of those who came into treatment for alcohol misuse in 2012/13 were self-referral.
- Clients of drug and alcohol services are referred onwards to a wide variety of services including mental health, housing and voluntary organisations.
- Each service provides a wide range of interventions to its service users including (but not limited to) detoxification, rehabilitation, peer support and group work.
- Of those offering detoxification services (n=9), seven offer home-based detoxification; four offer inpatient detoxification; and two offer out-patient detoxification.
- Of those offering substitute prescribing (n=6), all offer Subutex and Suboxone; Addaction Chichester/Bognor Regis, Mid-Sussex and Worthing and CRI Crawley also offer Methadone and Addaction Working have a Benzodiazepine service.
- It was not possible to calculate needle/syringe coverage for West Sussex due to inconsistencies with the figures.
- In 2012/13, only 29% of those eligible for a HBV vaccination accepted one in West Sussex compared to a national average of 47%. The rate of current injectors

eligible for a HCV test who received one in West Sussex is also lower than the national average at 67% compared to 73%.

- Of those offering rehabilitation services, many (n=10) offer 'Aftercare' and 'Group work' and nine services engage peer volunteers. Every type of service is available from at least five providers.
- Addaction Mid-Sussex and the Recovery Project both formally fed into the JSNA consultation and Addaction Crawley/Horsham and the Recovery Project engaged with the PCC through the Police & Crime Plan consultation. Several other projects have had informal engagement with the HWB and PCC.

5.2.2 Service user profile

- According to NTA figures, in 2012/13, 73% of clients in treatment for drug misuse across the nation were male. Similar results were seen across specialist services in West Sussex.
- According to the West Sussex Adult Alcohol Partnership Quarterly Performance Report 2012 / 2013 (Quarter 4), of the 942 clients in treatment year-to-date who had alcohol as the primary drug, 61.7% (n=581) were male and 38.3% (n=361) were female. The national average ratio for alcohol services is 64 male: 36 female.
- The majority of specialist drug service users in West Sussex are between the ages of 30 and 44 years old. Nationally, clients' median age at their first point of contact with drug treatment services in 2012-13 was 35.
- The mean age for both men and women in treatment for alcohol misuse locally is slightly higher than the national average (43.6 vs 42.3).
- The national picture is replicated locally with 'White British' accounting for the majority of service users.
- National trends are replicated at the local level, although there is a slightly higher than average proportion of adults receiving alcohol treatment living with children in West Sussex.
- Data reported in the West Sussex JSNA Alcohol report for 2012/13 shows a higher than average proportion of alcohol clients in West Sussex are either unemployed or in regular employment, with fewer drug and alcohol clients are long term sick or disabled. Data from the Management survey does however reveal that a higher proportion of clients appear to be long-term sick or disabled than reflected in the information above.
- Data collated from the Management survey shows that the majority of clients attending specialist substance misuse services in West Sussex were not subject to any legal proceedings.
- Data reported in the West Sussex JSNA Alcohol report for 2012/13 suggests that 18% of adults in alcohol treatment had a housing issue at the start of treatment. This is higher than the national average of 13%.

- The Adult Partnership Quarterly Performance Report 2012/2013 suggests that on average 14% of clients accessing specialist drug service have a dual diagnosis. However, estimates provided in the Management survey seem to indicate that significantly more than 14% of the client group do in fact have some sort of mental health condition, with anxiety and depression being particularly reported. It in not clear from survey responses as to the possible reasons for this.
- There is considerable variation between services with regard to the duration of service user contact. Overall, the modal class is 3-6 months which reflects national data provided by the NTA which notes that of all clients 18 and over in contact with treatment services during 2012-13, 94% were either retained for more than 12 weeks, or if leaving treatment before 12 weeks, were free of dependency. Data reported in the West Sussex JSNA Alcohol report for 2012/13 estimates the average length of time in alcohol treatment in West Sussex to be 234 days. This is compared to a national average of 183 days.
- For Alcohol Services, WSYPSMS, CRI Crawley, and CRI Chichester the majority of case closures were planned. For CRI Counselling, Addaction Crawley, Addaction Chichester and Addaction Bognor the majority of closures were deemed transfers (not in custody). No further breakdown of what constitutes a 'transfer' was provided by the agencies who were surveyed.

5.3 Service Profile

This section of the report provides factual data on specialist drug and alcohol services currently commissioned in West Sussex.

5.3.1 Range of clients provided for

The table below illustrates the range of service users catered for (by service):

Table 5.1: Profile of service user groups in West Sussex Drug and Alcohol services[375]

	SERVICE											
SERVICE USERS	**Add. Chichester/ Bognor**	**Add. Crawley / Horsham**	**Add. Mid-Sussex**	**Add. Worthing**	**Alcohol Specialist**	**CRI Clock Walk**	**CRI Crawley**	**EXACT**	**Ravenscourt Trust**	**Recovery Project***	**Stonepillow**	**WSYPSMS**
Under 16												✓
16-17					✓							✓
18-19	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
19-25	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
25+	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Both Sexes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Homeless/Street Drinkers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Offenders	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ex-offenders	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DIP Clients	✓	✓	✓	✓			✓	✓	✓	✓	✓	
Victims of domestic violence	✓	✓		✓	✓		✓		✓	✓	✓	✓
A10 migrants	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓
People from the Ascention States	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓
Undocumented migrants		✓		✓	✓	✓	✓					✓
Women or men involved in prostitution	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
People with a physical disability	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
People with a learning disability	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
People with dual diagnosis or complex needs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Families affected by drug and alcohol problems		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Those who don't speak English/require translator	✓	✓		✓	✓	✓	✓		✓	✓		✓

*The Recovery Project will accept any referral providing the client is eligible for housing benefit as this is their main funding stream.

[375] Source: Management survey conducted by Figure 8.

All groups of service users are catered for within the West Sussex area. However only one service has provision for the under 16 group, and only WSYPSMS and the Alcohol Specialist Nurse see clients aged between 16 and 17 years of age.

5.3.2 Hours of service provision

The table below details opening days/times and out of hours service provision within West Sussex.

Table 5.2: Opening hours of West Sussex Drug and Alcohol Services[376]

	Opening days/times	Out of hours service (please specify)
Add. Chichester / Bognor Regis	Monday – Friday 9am – 5pm	Late clinic fortnightly on a Monday 5pm to 7pm
Add. Crawley / Horsham	Monday – Friday 9am – 5pm	Thursdays open late to 7 pm
Add. Mid-Sussex	Monday – Friday 9am – 5pm	Tuesdays open late to 8 pm
Add. Worthing	Monday – Friday 9am – 5pm	Wednesdays open late to 8 pm
Alcohol Specialist Nurse	Monday – Friday 9am - 5pm	Nil
CRI Clock Walk	Monday – Friday 9am - 5pm	Late clinic fortnightly on a Monday 5pm to 7pm
CRI Crawley	Monday – Friday 9am - 5pm	Plan to open Saturday mornings soon
EXACT Central C.I.C	N/A	N/A
Ravenscourt Trust	24 hours a day	Telephone helpline
Recovery Project	24 hr residential service but core assessments and appointments are generally Monday – Friday 9am - 5pm	
Stonepillow	24 hours a day	N/A
WSYPSMS	Monday – Friday 9am - 5pm	Sometimes if required by YP

The residential services are available for their service users 24 hours a day, seven days a week. Most of the rest operate within normal working hours. However, there are five services which currently provide some sort of out of hours service; and CRI Crawley plans to open a Saturday morning service in the future.

5.3.3 Methods of service delivery

Table 5.3 below illustrates the means by which the services engage with service users:

[376] Source: Management survey conducted by Figure 8.

Table 5.3: Profile of service access methods in West Sussex Drug and Alcohol services[377]

Service	By appointment	Home visits	Disabled access	Telephone helpline	Other (please specify)
Addaction Chichester / Bognor Regis	✓	✓	✓		We do not have a helpline number, but we will always listen and offer advice, signposting, etc to anyone who calls the service.
Addaction Crawley / Horsham	✓	✓	✓	✓	We operate an open access policy as well where clients can attend without appointments and ask to be assessed with a view to coming into treatment services.
Addaction Mid-Sussex	✓	✓	✓	✓	
Addaction Worthing	✓	✓	✓	✓	
Alcohol Specialist Nurse	✓				Service is from 9-5 Monday-Friday. People come in via A+E as emergencies or via clinic by referral from the GP.
CRI Clock Walk	✓	✓	✓		Drop in five sessions a week, satellite in Middhurst and Selsey.
CRI Crawley	✓	✓	✓	✓	Open access drop in
EXACT Central C.I.C	✓				Open group meetings
Ravenscourt Trust	✓	✓	✓	✓	
Recovery Project	✓	✓	✓	✓	
Stonepillow	✓				Referral
WSYPSMS	✓	✓	✓	✓	

All services use an appointments system. Stonepillow, the Alcohol Specialist Nurse and EXACT do not do home visits or offer a telephone helpline.

5.3.4 Staffing levels

The table below sets out the staff composition of specialist drug and alcohol services in West Sussex. The largest services in terms of staff is Addaction Crawley/Horsham which has 20 staff, although it should be noted that it is not known whether all posts are full

[377] Source: Management survey conducted by Figure 8.

time. The same applies to all services polled. Addaction Worthing did not provide a response to this question.

Table 5.4: Profile of staff compostion in West Sussex Drug and Alcohol services[378]

STAFF COMPOSITION	Add. Chichester / Bognor*	Add. Crawley / Horsham†	Add. Mid-Sussex	Add. Worthing	Alcohol Specialist	CRI Clock Walk*	CRI Crawley	EXACT	Ravenscourt Trust	Recovery Project*	Stonepillow	WSYPSMS
Social Worker(s)		2		No response provided						1		
Project/Key/Support Worker(s)	5	4	3			7	7			5	5	4
Manager(s)	2	4	1			1	1	6	2	2	1	1
Medical Professional(s)	4	5	3		1				2			
Administrative Staff	3	3	1			1			1			1
Volunteer(s)		2										
Student placement(s)												
Counsellor(s)									5			
Care Staff									4			
Waking night worker(s)										2		
TOTAL	**14**	**20**	**8**		**1**	**9**	**8**	**6**	**14**	**10**	**6**	**6**

* "This is between the Chichester and Bognor Sites. I have included our Locality Manager in this number although he is responsible for three sites. We also have an area Manager and Quality and Governance Manager who are visible in our services on a weekly basis (minimum)."

†Please note, there is a discrepancy between returns for these services and it is possible that the Social Workers noted are in fact student placements – there may therefore be double counting.

¥ The Team is one nurse on each site. There are two sites.

5.3.5 Range of referral sources

Drug statistics from the National Drug Treatment Monitoring System indicate that of the 68,523 new presentations to treatment in 2012/13, 42% were self-referrals. The second most common source of referrals came from the criminal justice system (28%).[379]

There appear to be few limitations on methods of referral to specialist drug treatment services in West Sussex, with the exception of Addaction Chichester & Bognor Regis who can only accept referrals from CRI.

[378] Source: Management survey conducted by Figure 8.

[379] *Drug Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2012 to 31 March 2013*, Public Health England, November 2013. Available at http://www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf, p.18.

Table 5.5: Referral sources to drug treatment services in West Sussex[380]

	Any Agency	Self Referral	GP	Health Professional	Social Work	Court	Other
Addaction Chichester & B/Regis							All referrals must come through CRI as they care co-ordinate all of our clients apart from DIP clients.
Addaction Crawley & Horsham	✓	✓	✓	✓	✓	✓	
Addaction Mid-Sussex	✓	✓	✓	✓	✓	✓	
Addaction Worthing	✓	✓	✓	✓	✓	✓	
CRI Clock Walk	✓	✓	✓	✓	✓	✓	Probation, Police
CRI Crawley	✓	✓	✓	✓	✓	✓	
EXACT Central C.I.C	✓	✓		✓	✓		
Ravenscourt Trust	✓	✓	✓	✓	✓	✓	
Recovery Project	✓	✓	✓	✓	✓	✓	Prison, other homeless services and substance misuse services including residential
Sands Recovery Service - Stonepillow	✓	✓	✓	✓	✓	✓	
WSYPSMS	✓	✓	✓	✓	✓	✓	

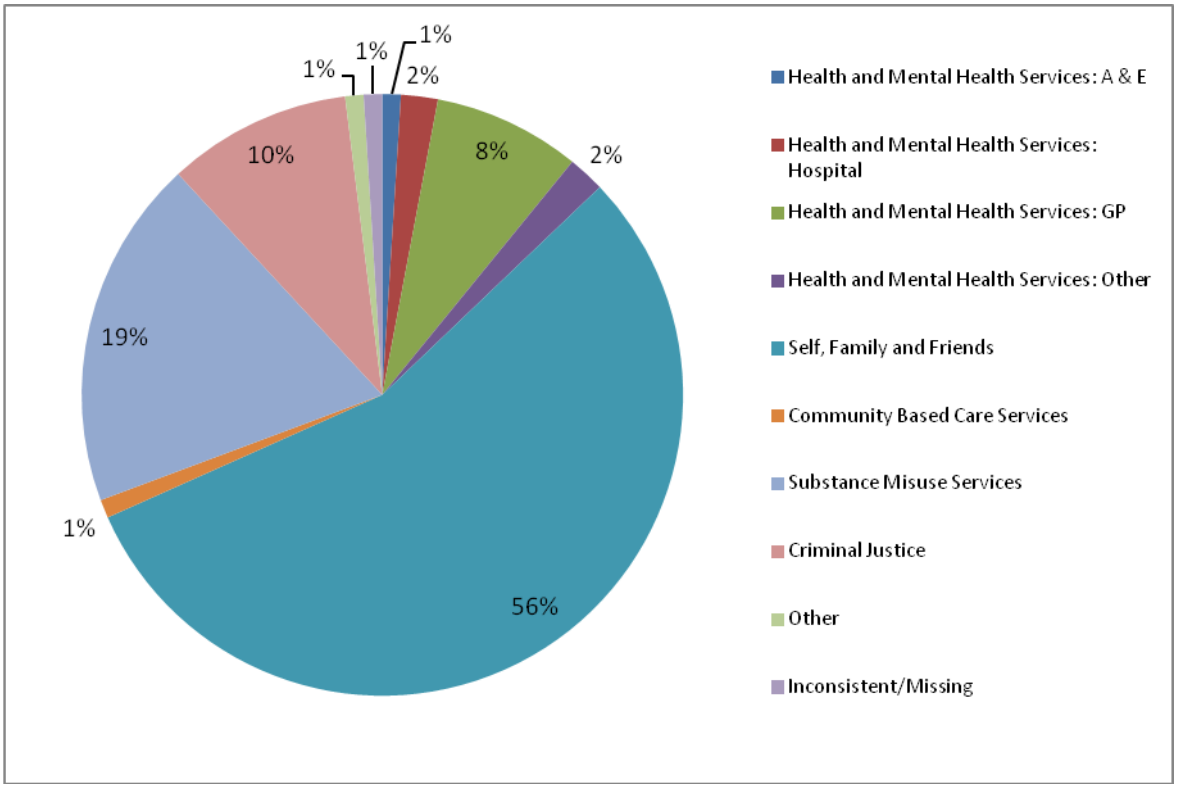
NTA data shows that in 2012/13 of all recorded referral sources for alcohol treatment, self-referral was the most common accounting for 40% of all recorded referrals. The second most common source of referral was from GPs (18%).[381]

Information provided in the Adult Alcohol Partnership Annual Performance Report shows that over half of all referrals for Alcohol treatment services in West Sussex came via self, family and friends in 2012/13. The second most common source of referral was from specialist substance misuse services which accounted for nearly a fifth of all referrals in this period:

[380] Source: Source: Management survey conducted by Figure 8.

[381] *Alcohol Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2012 to 31 March 2013*, Public Health England, October 2013. Available at http://www.nta.nhs.uk/uploads/alcoholstatisticalreport12-13.pdf, p.15.

Figure 5.6: Referral source into alcohol treatment of all new presentations in West Sussex 2012/13[382]



5.3.6 Waiting times

Health professionals recognise that drug and alcohol users need prompt help if they are to recover from dependence. Data reported under the JSNA framework therefore highlights the number of adults waiting in excess of six weeks to start treatment:

Table 5.7: Waiting times to start treatment (drug users) 2012/13[383]

	West Sussex		National	
	Number	As proportion of all initial waits	Number	As proportion of all initial waits
Adults waiting under three weeks to start treatment	546	98%	66,956	98%
Adults waiting over six weeks to start treatment	8	1%	439	1%

The proportion of drug users waiting in excess of six weeks for treatment in West Sussex is in line with the national average at 1% of all initial waits.

[382] Source: Adult Alcohol Partnership Quarterly Performance Report 2012 / 2013, Quarter 4.

[383] Public Health England (2013a). *Alcohol and Drugs JSNA Support Pack West Sussex: Adult Drug Treatment Data 2012/13*. Report supplied to authors by West Sussex County Council.

Table 5.8: Waiting times to start treatment (alcohol users) 2012/13[384]

	West Sussex		National	
	Number	As proportion of all clients in treatment during the year	Number	As proportion of all clients in treatment during the year
Adults waiting under three weeks to start treatment	589	62%	68,067	62%
Adults waiting over six weeks to start treatment	2	0%	2,711	2%

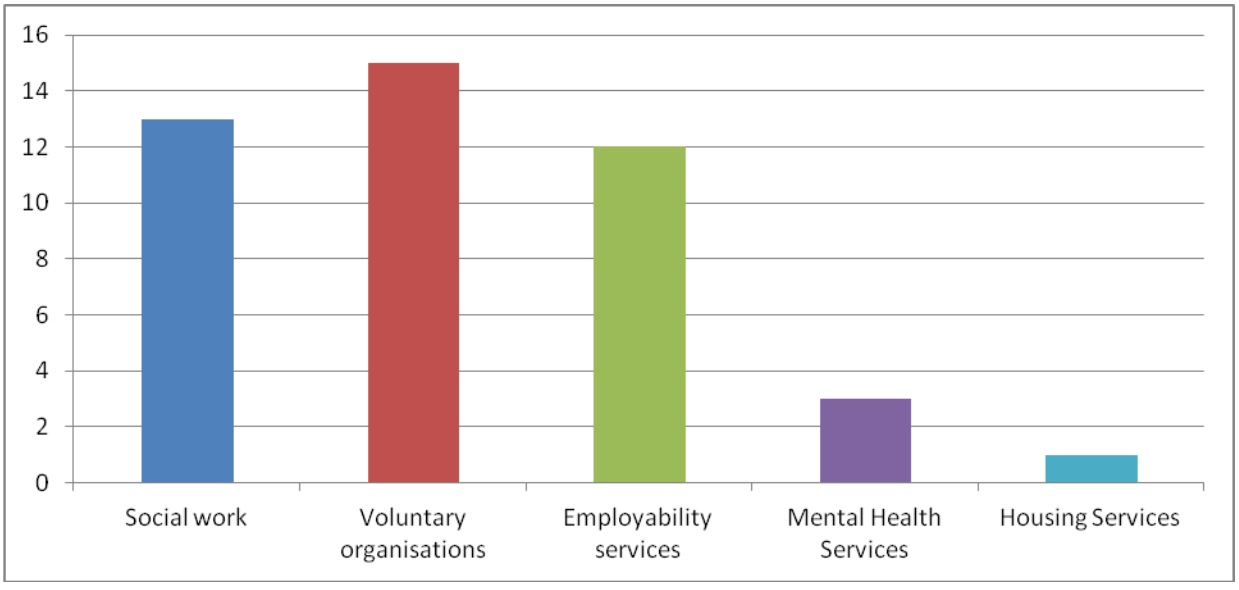
The proportion of primary alcohol users beginning treatment within three weeks in West Sussex is in line with the national average at 62%. Nearly all those accessing treatment for alcohol misuse in West Sussex are seen within six weeks.

5.3.7 Range of services referred to

Respondents were asked where they referred their clients on to. Two commented they would refer to *"Any agency we feel will benefit our service users."*

Voluntary organisations attracted the largest number of responses as shown in the figure below:

Figure 5.9: Range of services clients referred to[385]



[384] Public Health England (2013b). *Alcohol and Drugs JSNA Support Pack West Sussex: Alcohol Treatment Data 2012/13*. Report supplied to authors by West Sussex County Council.

[385] Source: Management survey conducted by Figure 8.

Specific voluntary services cited included the Friends and Family Scheme and EXACT:

Figure 5.10: Specific voluntary services referred to[386]

Voluntary service	Frequency of response
Friends and Families scheme	2
Addaction	1
Exact	1
Residential detox and rehab.	1
Lifecentre	1
Lifeworks	1
Worth project	1
Open house	1
Steps to well being	1
C.A.B	1
Shelter	1
The YMCA	1
Sussex oak leaf	1

5.3.8 Substances Treated

The Management survey asked respondents to select which substances they provide services to address. The table below sets out the responses. All services, with the exception of the Alcohol Specialist Nurse, would provide help for all the substances listed:

[386] Source: Management survey conducted by Figure 8.

Table 5.11: Substances clients are treated for by service[387]

Substances Treated	Add. Chichester/ Bognor	Add. Crawley / Horsham	Add. Mid-Sussex	Add. Worthing	Alcohol Specialist Nurse	CRI Clock Walk*	CRI Crawley	EXACT	Ravenscourt Trust	Recovery Project*	Stonepillow	WSYPSMS
Alcohol					✓							
Heroin/opiates/ opioids												
Psychostimulants												
Hallucinogens												
Benzodiazepines												
Over-the-counter medication												
Prescription medication												
Solvents/volatile substances												
'Legal Highs'												
All of the above	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓

* Also have a volunteer counsellor for gambling as they find there is often cross addiction to gambling.

5.3.9 Interventions provided

The table below illustrates that each service provides a wide range of interventions to its service users:

[387] Source: Management survey conducted by Figure 8.

Table 5.12: Profile of service provision within West Sussex Drug and Alcohol services[388]

SERVICES PROVIDED	Add. Chichester / Bognor	Add. Crawley / Horsham	Add. Mid-Sussex	Add. Worthing	Alcohol Specialist Nurse	CRI Clock Walk*	CRI Crawley	EXACT	Ravenscourt Trust	Recovery Project*	Stonepillow	WSYPSMS
Advice & Information	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Counselling		✓*	✓			✓	✓	✓	✓	✓	✓	✓
Detoxification	✓	✓*	✓	✓	✓		✓		✓	✓		✓
Day programme / structured daycare		✓*		✓		✓	✓		✓		✓	
Family Services		✓*	✓	✓			✓	✓	✓	✓	✓	✓
BBV Services	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓
Needle Exchange		✓*	✓	✓		✓	✓			✓		✓
Outreach	✓	✓*	✓	✓		✓	✓	✓		✓	✓	✓
Substitute Prescribing	✓	✓	✓	✓			✓					✓
Rehabilitation (Community)		✓*	✓	✓			✓	✓	✓		✓	✓
Rehabilitation (Residential)		✓*	✓						✓	✓	✓	
Other	✓		✓			✓						

* Offer onwards referral to these options as they are an integrated service provider.

Services listed under the 'Other' category were:

- Addaction Chichester/Bognor Regis - Although not provided by our staff, structured groups, family services, needle exchange are run from/use our building in Chichester. We support Tier 4 referrals with medical assessment for CRI clients whether they are alcohol or substitute prescribing clients. We provide community alcohol detox.
- Addaction Mid-Sussex – Referral to community rehabilitation
- CRI Clock Walk - we offer the psycho-social support whilst people undergo prescribing. We refer and do pre and post treatment work for both community and inpatient detoxes. We have other another provider who provides the family service for us from our premises.

[388] Source: Management survey conducted by Figure 8.

5.3.10 Range of Detoxification and Substitute Prescribing Services

The majority of services polled in the Management survey offer either detoxification and/or substitute prescribing services – the exceptions being CRI Clock Walk and EXACT who offer neither.

Of those offering detoxification services (n=9), seven offer home-based detoxification; four offer inpatient detoxification; and two offer out-patient detoxification.

Of those offering substitute prescribing (n=6), all offer Subutex and Suboxone; Addaction Chichester/Bognor Regis, Mid-Sussex and Worthing and CRI Crawley also offer Methadone and Addaction Working have a Benzodiazepine service.

Table 5.13: Profile of detoxification and substitue prescribing provision within West Sussex Drug and Alcohol services[389]

SERVICES PROVIDED	Add. Chichester/ Bognor	Add. Crawley / Horsham*	Add. Mid-Sussex	Add. Worthing	Alcohol Specialist Nurse	CRI Clock Walk*	CRI Crawley	EXACT	Ravenscourt Trust	Recovery Project*	Stonepillow	WSYPSMS
No detox service						✓		✓			✓	
Inpatient detox		✓			✓		✓		✓			
Out-patient detox		✓	✓									
Home-based detox	✓	✓	✓	✓			✓			✓		✓
No substitute prescribing service					✓	✓		✓	✓	✓	✓	
Methadone	✓		✓	✓			✓					
Subutex (Buprenorphine)	✓	✓	✓	✓			✓					✓
Benzodiazepines				✓								
Dihydrocodeine												
Suboxone (Buprenorphine + Naloxone)	✓	✓	✓	✓			✓					✓

* NB. It seems detox services are only provided in Addaction Horsham – the return completed solely for Addaction Crawley indicated that no detox services were provided.

According to 2012/13 statistics, West Sussex has a total of 63 sites providing a needle exchange programme. This includes 57 pharmacies, a variety of specialist substance misuse services such as Addaction Crawley, and Clockwalk Project Bognor, and two

[389] Source: Management survey conducted by Figure 8.

homeless services (St Clare's Worthing and Glassworks Chichester). Density of provision varies by area as shown in the table below:

Table 5.14: Sites offering needle exchange across West Sussex Q4 2012/13[390]

Area	Locale	Number of specific sites
North East	Crawley	11 x pharmacies 1 x substance misuse service
	Horsham & Chanctonbury	7 x pharmacies
	Mid Sussex	8 x pharmacies 1 x substance misuse service
NORTH EAST AREA TOTAL		26 x pharmacies 2 x substance misuse services **28 sites in total**
South East		18 x pharmacies 1 x substance misue service 1 x homeless service
SOUTH EAST AREA TOTAL		**20 sites in total**
Western		13 x pharmacies 1 x substance misuse service 1 x homeless service
WESTERN AREA TOTAL		**15 sites in total**
GRAND TOTAL		**63 sites across West Sussex**

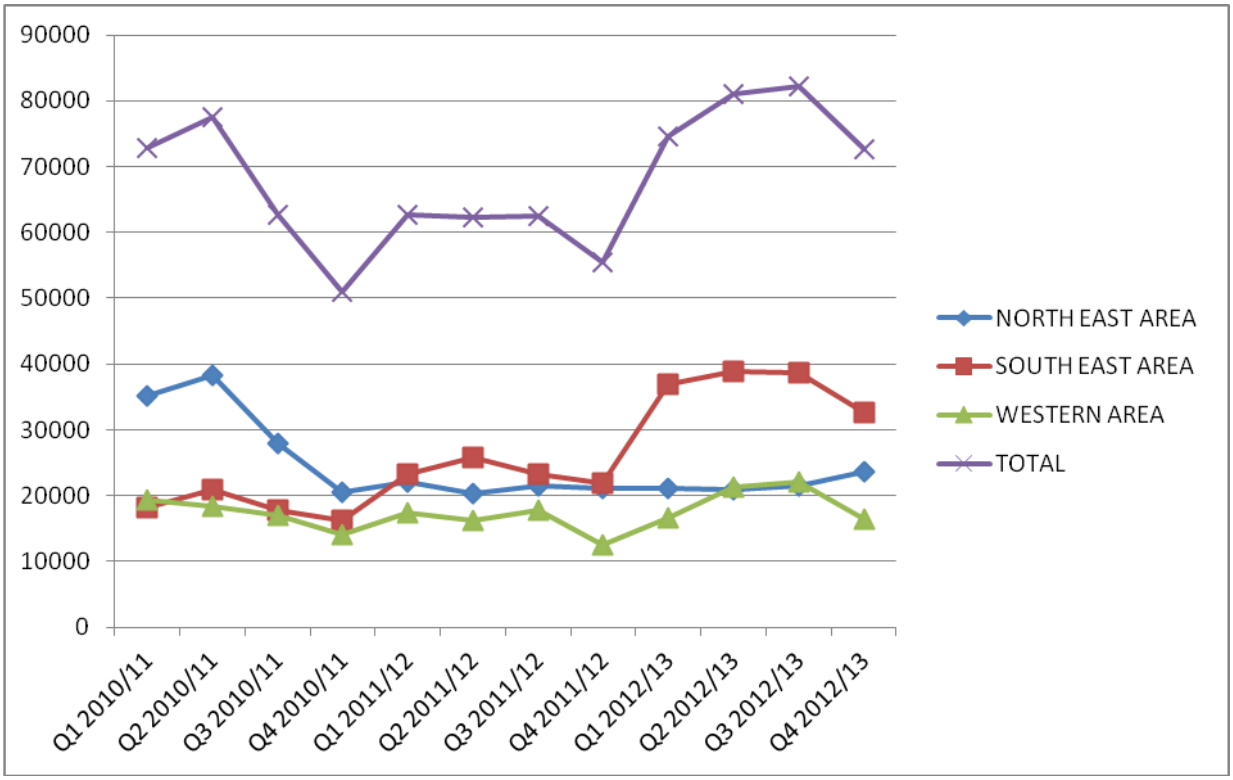
Figures suggest that the pharmacy sites are visited much more frequently than the other sites,[391] and comments made by the Public Health Programme Manager in West Sussex supports such a view since pharmacy sites consistently order more equipment which implies these sites consistently issue more needles and syringes etc.

Over the past three years locally compiled data suggests that the total number of needles distributed by the various sites across West Sussex has fluctuated. Over this period the South East has overtaken the North East in terms of total number distributed whilst the Western area has remained consistent and issued the fewest.

[390] Source: NX Statistics Tables provided by Public Health Programme Manager West Sussex.

[391] Source: NX Statistics Tables provided by Public Health Programme Manager West Sussex.

Figure 5.15: Number of needles/syringes issued by area in West Sussex[392]



The 'Harm Reduction Works' Campaign has created an online tool – a 'coverage calculator' – to help determine the extent to which the number of syringes being distributed to illicit drug users within an area compares to an estimate of the potential need for sterile injecting equipment. As noted on their website, "'coverage' is a term that is used to describe the extent to which healthcare interventions reach their target population. It is a particularly important issue for needle and syringe programmes because the provision of sterile injecting equipment has been shown to be an effective and cost effective intervention to reduce the spread of blood borne viruses."[393] The tool uses information on injecting drug use and the provision of injecting equipment within a specific area, and then calculates an estimate of coverage as 'the percentage of injections of illicit drugs for which a new needle and syringe has been provided' in a population. Coverage of over 100% is aimed for as this implies more than one syringe has been provided for each injection.

It has not been possible to calculate needle and syringe coverage for West Sussex because the numbers required for the calculation do not make sense when used in conjunction, and there are queries over the accuracy of the estimations:

The figures required are as follows:

- Number of illicit drug injectors – according to data reported in the West Sussex JSNA Drug report 2012/13 this figure is 651.

[392] Source: NX Statistics Tables provided by Public Health Programme Manager West Sussex.

[393] http://www.harmreductionworks.org.uk/5_web/coverage_calculator/index.php

- Number of people in opiate substitution treatment – this figure should be an estimation of the number of people in OST at any one time rather than the total number who pass through the treatment system in a year. According to Addaction, in early January 2013 there were 779 OST (methadone or buprenorphine) clients in West Sussex at the time. There is however an anomaly here. The formula in the coverage calculator does not work when the 'number of injectors in treatment' exceeds the 'total number of estimated injectors' as this is seen to be a very unlikely scenario.
- Average injections per day (out of treatment) – pre-populated at 3 as a 'best guess' for the UK.
- Average injections per day (in treatment) – pre-populated at 0.3 as an estimated average across those who have been stable in OST (and have not injected for years) through to those who are ambivalent about treatment (and may continue to inject daily).
- Total number of syringes given out per year – using NX Statistics Tables provided by the Public Health Programme Manager, this figure is estimated at 310,371. These tables rely on paper-based returns from individual sites which are then manually collated. This system therefore has a variety of limitations including:
- Not all sites regularly report activity thus it is possible this figure is an underestimate;
- Alternatively, this figure may be an exaggeration as paper records are less robust than electronic ones and in addition make analysis time consuming.
- Number of syringes given out to steroid injectors – the same statistics tables indicate that this number is 7,380 (the same limitations apply as above).

The coverage calculator is a useful tool it is therefore disappointing that it cannot currently be utilised to determine needle and syringe provision across West Sussex.

Whilst no specific data is available on the effectiveness and efficiency of supervised administration in the pharmacy, comments provided by the Public Health Programme Manager in West Sussex suggests that there are currently around 750 people in receipt of opiate substitution treatment and that dispensing and supervised administration provision in the area is good. Of the 163 community pharmacies in West Sussex, there are usually around 100 providing supervision at any one time, depending on demand. However, she went on to note that to date it has been impossible to comment on whether 'Orange Book' or NICE guidelines are met. The 'Orange Book' suggests all those new to opiate substitute programmes should be supervised for at least three months, whilst NICE guidelines suggest this period should be six months. A new system is currently being rolled out which will facilitate the monitoring of clients being dispensed to thus in the future it should be possible to measure compliance against these guidelines.

5.3.11 Harm Reduction

As part of the harm reduction agenda the number of drug users in treatment who have had a hepatitis B vaccination and current or past injectors who have been tested for hepatitis C is recorded. In this regard, West Sussex appears to lag behind the national average. Only 29% of those eligible for a HBV vaccination accepted one in West Sussex compared to a national average of 47%. The rate of current injectors eligible for a HCV test who received one in West Sussex is also lower than the national average at 67% compared to 73%:

Figure 5.16: Rate of HBV and HCV testing 2012/13[394]

	Local		National	
	Number	As proportion of eligible clients	Number	As proportion of eligible clients
Adults new to treatment eligible for a HBV vaccination who accepted one	132	29%	22,128	47%
Of those: the proportion who started a course of vaccination	25	19%	4,989	23%
Of those: the proportion who completed a course of vaccination	21	16%	4,403	20%
Previous or current injectors eligible for a HCV test who received one	569	67%	74,530	73%

5.3.12 Rehabilitation and Other Services

The table below illustrates the range of rehabilitation and other services offered by each project. It appears that only CRI Clock Walk do not provide a rehabilitation service. Many services (n=10) offer 'Aftercare' and 'Group work' and nine services engage peer volunteers. Every type of service is available from at least five providers.

[394] Public Health England (2013a), op.cit.

Table 5.17: Profile of rehabilitation and other services within West Sussex drug and alcohol services[395]

	SERVICES											
REHABILITATION & OTHER SERVICES	**Add. Chichester/**	**Add. Crawley / Horsham***	**Add. Mid-Sussex**	**Add. Worthing**	**Alcohol Specialist**	**CRI Clock Walk***	**CRI Crawley**	**EXACT**	**Ravenscourt Trust**	**Recovery Project***	**Stonepillow**	**WSYPSMS**
No rehabilitation service						✓						
Access to supported accommodation		✓†					✓		✓	✓	✓	✓
Aftercare		✓†	✓	✓	✓		✓	✓	✓	✓	✓	✓
Drop-in sessions		✓	✓	✓			✓	✓		✓	✓	✓
Education & training		✓†			✓		✓	✓	✓	✓	✓	✓
Engage peer volunteers	✓	✓	✓	✓			✓	✓	✓	✓	✓	
Group work	✓*	✓†	✓	✓			✓	✓	✓	✓	✓	✓
Structured day programme		✓†		✓			✓	✓	✓			
Other		✓								✓		

* CRI carry this role as care coordinators and PSIs

† These options are only provided in Addaction Horsham

Listed under the 'Other' category were:

- Addaction Crawley – We also provide referrals for clients to the other options not ticked.
- Recovery Project – Outreach cafe for residents that have moved on.

5.3.13 Representation at strategic level

To determine the level of representation at strategic level, respondents to the Management survey were asked whether they engaged with their local Health & Wellbeing Board and Police & Crime Commissioner. Addaction Mid-Sussex and the Recovery Project both formally fed into the JSNA consultation and Addaction Crawley/Horsham and the Recovery Project engaged with the PCC through the Police & Crime Plan consultation. Several other projects have had informal engagement with the HWB and PCC as demonstrated in the table below:

[395] Source: Management survey conducted by Figure 8.

Table 5.18: Engagement with HWB & PCC[396]

	Add. Chichester / Bognor	Add. Crawley /	Add. Mid-Sussex	Add. Worthing	Alcohol Specialist	CRI Clock Walk	CRI Crawley	EXACT	Ravenscourt	Recovery Project	Stonepillow	WSYPSMS
Engagement with local Health & Wellbeing Board (HWB)												
Yes - as members of the HWB board												
Yes - formally fed in via Joint Strategic Needs Assessment consultation			✓							✓		
Yes - via local Healthwatch										✓		
Yes - informally fed in (e.g. via HWB members)		✓	✓				✓				✓	✓
No					✓	✓		✓	✓			
Not sure	✓			✓								
Engagement with Police & Crime Commissioner (PCC)												
Yes, formally through Police and Crime Plan consultation		✓								✓		
Yes, through Safer Future Communities										✓	✓	
Yes, other (specified below)		✓				✓	✓				✓	
No			✓		✓			✓	✓			
Not sure	✓			✓								✓

Comments provided were thus:

- Addaction Chichester/Bognor Regis – "We invite the local wellbeing services to our service to offer wellbeing checks/assessments to our clients. This is usually monthly."
- Addaction Crawley – engagement with PCC through criminal justice drug intervention programme workers via meetings etc.

[396] Source: Management survey conducted by Figure 8.

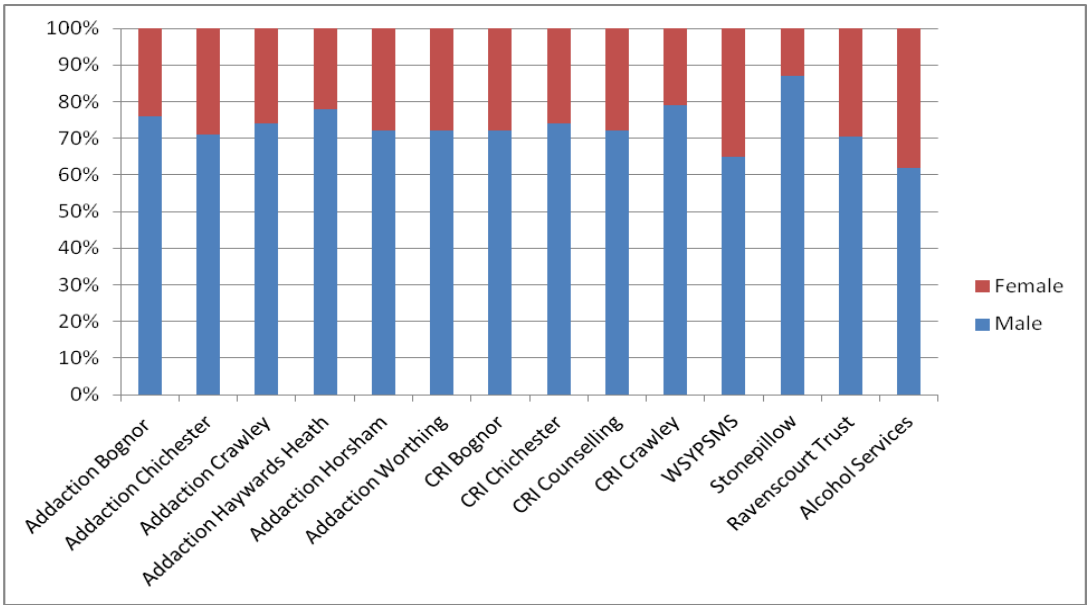
- CRI Clock Walk – engagement with PCC through joint working for Operation Accent.
- CRI Crawley – engagement with PCC at Director level.
- WSYPSMS – Mid Sussex Alcohol project is partly funded by HWB (this is small project managed by CRI).
- Addaction engage with the PCC through the Police Controlled Drugs Liaison Officer.

5.4 Service Users Profile[397]

5.4.1 Gender of Users

Figure 5.15 below shows how male: female ratio varies across all specialist drug services in West Sussex. According to NTA figures, in 2012/13, 73% of clients in treatment for drug misuse across the nation were male.[398] Similar results were seen across specialist services in West Sussex as demonstrated in the figure below. That withstanding, there are two notable exceptions: Stonepillow has fewer than average female clients (87:13);[399] and the young person's service has a greater proportion of female clients than the norm (65:35).

Figure 5.19: Profile of service users in West Sussex Drug services – by gender (2012/13)[400,401]



[397] As a service user group EXACT was unable to supply these statistics as they do not have 'case loads' as such.

[398] Cited *Statistics for drug treatment activity in England 2012-13 National Drug Treatment Monitoring System,* Available at http://www.nta.nhs.uk/uploads/statisticsfromndtms2012-13adultstatsreleasefinal.pdf

[399] Please note, statistics provided by Stonepillow are for both drug and alcohol clients.

[400] Source: Q4 Green Agency Reports 2012/13.

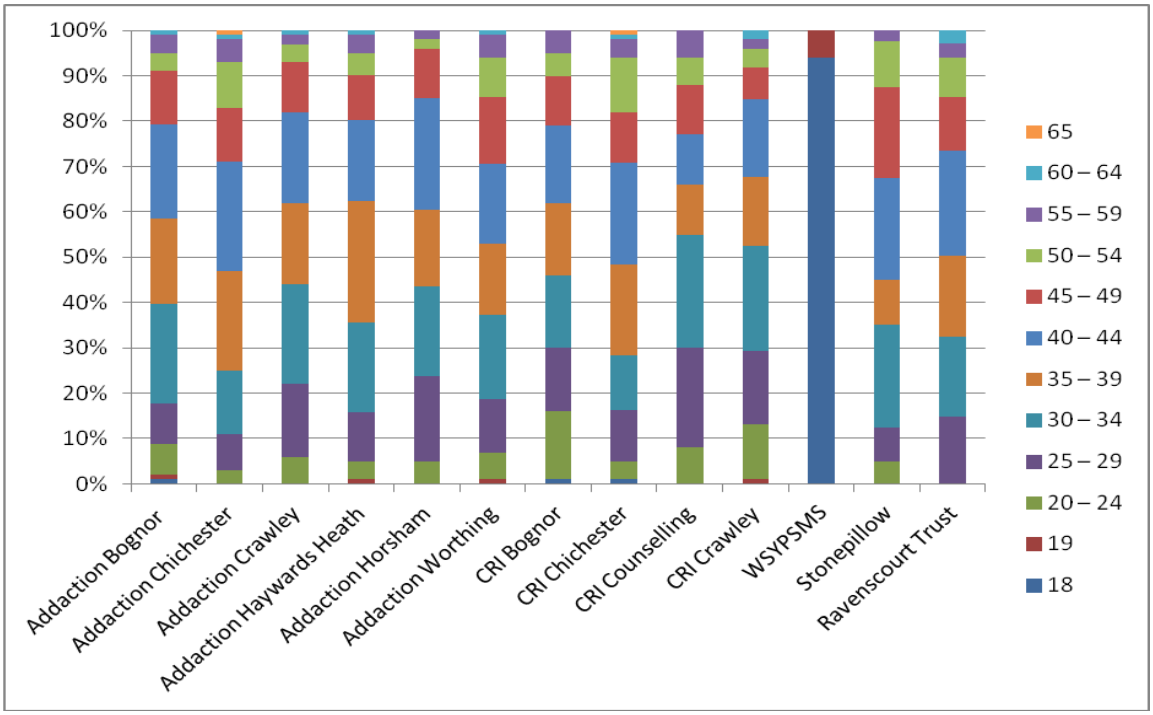
[401] Please note: figures provided by Ravenscourt Trust comprise both drug & alcohol clients.

According to the West Sussex Adult Alcohol Partnership Quarterly Performance Report 2012 / 2013 (Quarter 4), of the 942 clients in treatment year-to-date who had alcohol as the primary drug, 61.7% (n=581) were male and 38.3% (n=361) were female. The national average ratio for alcohol services is 64 male: 36 female.[402]

5.4.2 Age of Users

Figure 5.19 shows the age range distribution for all drug services in West Sussex. The majority of service users are between the ages of 30 and 44 years old, with the exception of the young person's service – 96% of whose service users were aged 18 on 30/09/2012. Nationally, clients' median age at their first point of contact with drug treatment services in 2012-13 was 35.[403]

Figure 5.20: Profile of service users in West Sussex Drug services – by age (Age group at mid point of the year (30/09/2012)[404,405]



Data reported in the West Sussex JSNA Alcohol report suggests that the national average age of clients in alcohol treatment is 42, and although there are more men than women in treatment, the age distribution for both genders is very similar.[406] This

[402] Cited *Statistics for alcohol treatment activity in England 2012-13 National Drug Treatment Monitoring System.* Available at http://www.nta.nhs.uk/uploads/alcohol1213statsrelease.pdf

[403] Cited *Statistics for drug treatment activity in England 2012-13 National Drug Treatment Monitoring System,* Available at http://www.nta.nhs.uk/uploads/statisticsfromndtms2012-13adultstatsreleasefinal.pdf

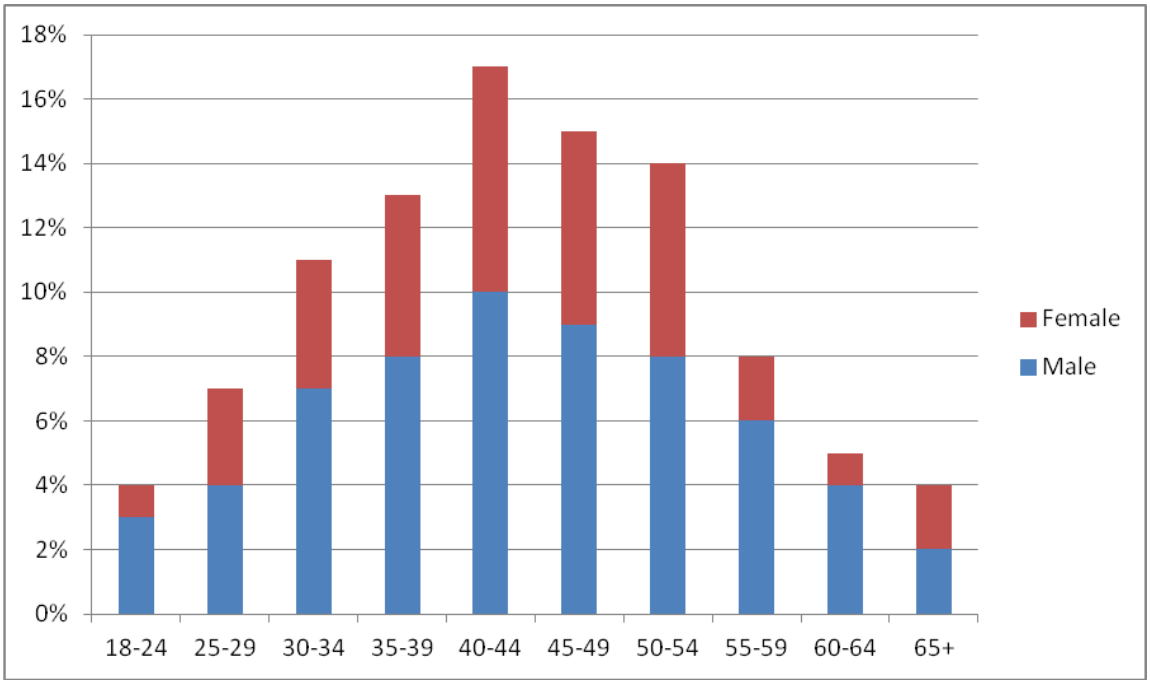
[404] Source: Q4 Green Agency Reports 2012/13.

[405] Please note: figures provided by Ravenscourt Trust and Stonepillow comprise both drug & alcohol clients.

[406] –Public Health England (2013b), op.cit.l

pattern is replicated at the local level within West Sussex as demonstrated in the figure below, although the mean age for both men and women in treatment locally is slightly higher than the national average (43.6 vs 42.3):

Figure 5.21: Profile of service users in West Sussex Alcohol services – by age 2012/13[407]



5.4.3 Ethnic Origin of Users

NTA data for 2012/13 shows that where reported, most clients in treatment for alcohol misuse were white British (87%). No other ethnic group accounted for more than 3%.[408] Similarly, most clients in contact with drug treatment providers were white British (83%); the next most common ethnicity was 'White – Other' (4%). No other ethnic group accounted for more than 2%.[409]

Table 5.21 provides details of the ethnic composition of service users in West Sussex. The national picture is replicated locally with 'White British' accounting for the majority of service users. However, the young person's service and CRI Crawley show greater ethnic diversity, with 'White British' only making up 82% and 75% of their clients respectively in 2012/13.

[407] Source: Adult Alcohol Partnership Quarterly Performance Report 2012 / 2013, Quarter 4.

[408] Cited *Statistics for alcohol treatment activity in England 2012-13 National Drug Treatment Monitoring System.* Available at http://www.nta.nhs.uk/uploads/alcohol1213statsrelease.pdf

[409] Cited *Statistics for drug treatment activity in England 2012-13 National Drug Treatment Monitoring System,* Available at http://www.nta.nhs.uk/uploads/statisticsfromndtms2012-13adultstatsreleasefinal.pdf

Table 5.22: Service users by ethnic origin 2012/13[410]

	Addaction Bognor	Addaction Chichester	Addaction Crawley	Addaction H/Heath	Addaction Horsham	Addaction Worthing	CRI Bognor	CRI Chichester	CRI Counselling	CRI Crawley	WSYPSMS	Stonepillow	Ravenscourt Trust[411]	Alcohol Services
White British	86 %	92 %	79 %	93 %	94 %	91 %	88 %	93 %	100 %	75 %	82 %	93 %	94 %	91 %
White Irish	1%		1%	1%						1%	6%			1%
Other White	11 %	3%	3%	2%		5%	7%	3%		4%	6%		3%	4%
White & Black Caribbean	1%		1%	1%		1%	1%			2%	6%	5%	3%	1%
White & Black African				1%	1%									
White & Asian	1%		1%					1%		1%				
Other Mixed	1%		2%	1%	1%		1%	1%		2%		2%		1%
Pakistani			1%							1%				1%
Bangladeshi		1%	1%		1%			1%						
Other Asian			2%							2%				
Caribbean	1%	1%	1%	1%	1%					1%				
African		1%		1%		1%		1%						
Other Black		1%	4%		1%		1%			5%				
Chinese										3%				
Other	1%	1%	2%				1%	1%		1%				
Not stated			1%		1%									1%

[410] Source: Q4 Green Agency Reports 2012/13 and Adult Alcohol Partnership Quarterly Performance Report 2012 / 2013, Quarter 4. Please note rounding error accounts for instances where percentages do not total 100%.

[411] Please note: figures provided by Ravenscourt Trust and Stonepillow comprise both drug & alcohol clients.

5.4.4 Percentage of Dependent Children

The data below is drawn from the West Sussex JSNA Drug[412] and Alcohol[413] reports for 2012/13 and shows the number of drug/alcohol users in treatment who live with children; users who are parents but do not live with children; and users for whom there is incomplete data. The last item is included highlight the possible hidden population(s) of drug/alcohol-dependent parents, or those with childcare responsibilities in contact with local treatment services.

Table 5.23: Percentage of service users who are parents/have families 2012/13[414]

	West Sussex		National	
	Number	**Proportion of treatment population (%)**	**Number**	**Proportion of treatment population (%)**
Adults receiving drug treatment who are in contact with children				
Living with children	466	33	64,862	33
Parents but not living with any children	309	22	41,532	21
Incomplete data	0	0	4,691	2
Adults receiving alcohol treatment who are in contact with children				
Living with children	334	55	32,113	52
Parents but not living with any children	268	45	27,197	44
Incomplete data	0	0	2,517	4

Higher than national average; Same as national average; Lower than national average

The table shows that national trends are replicated at the local level, although there is a slightly higher than average proportion of adults receiving alcohol treatment living with children in West Sussex.

5.4.5 Economic Activity

Evidence suggests that being in work or undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training.

[412] Public Health England (2013a), op.cit.

[413] Public Health England (2013b), op.cit.

[414] Source: JSNA Report West Sussex 2012/13 – Alcohol and Drugs.

The JSNA Alcohol report for 2012/13[415] shows a higher than average proportion of alcohol clients in West Sussex in the 'unemployed' category and in the 'regular employment' category, but fewer drug and alcohol clients are in the 'long term sick' or 'disabled' categories:

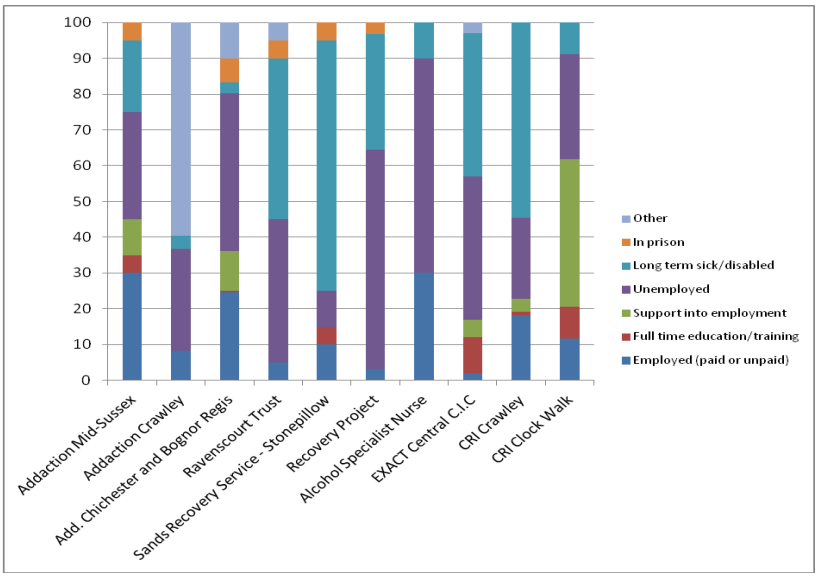
Table 5.24: Employment status at the start of treatment 2012/13

	West Sussex		National	
	Number	Proportion of eligible clients (%)	Number	Proportion of eligible clients (%)
Drug service data				
Regular employment	611	16	25,315	16
Unemployed	2007	53	90,704	58
Long term sick or disabled	111	3	17,147	11
Alcohol service data				
Regular employment	166	29	14,813	23
Unemployed	245	43	25,448	39
Long term sick or disabled	37	6	13,052	20

Higher than national average; Same as national average; Lower than national average

Data from the Management survey does however reveal that a higher proportion of clients appear to be long-term sick or disabled than reflected in the information above:

Figure 5.25: Percentage of service users by economic activity[416]



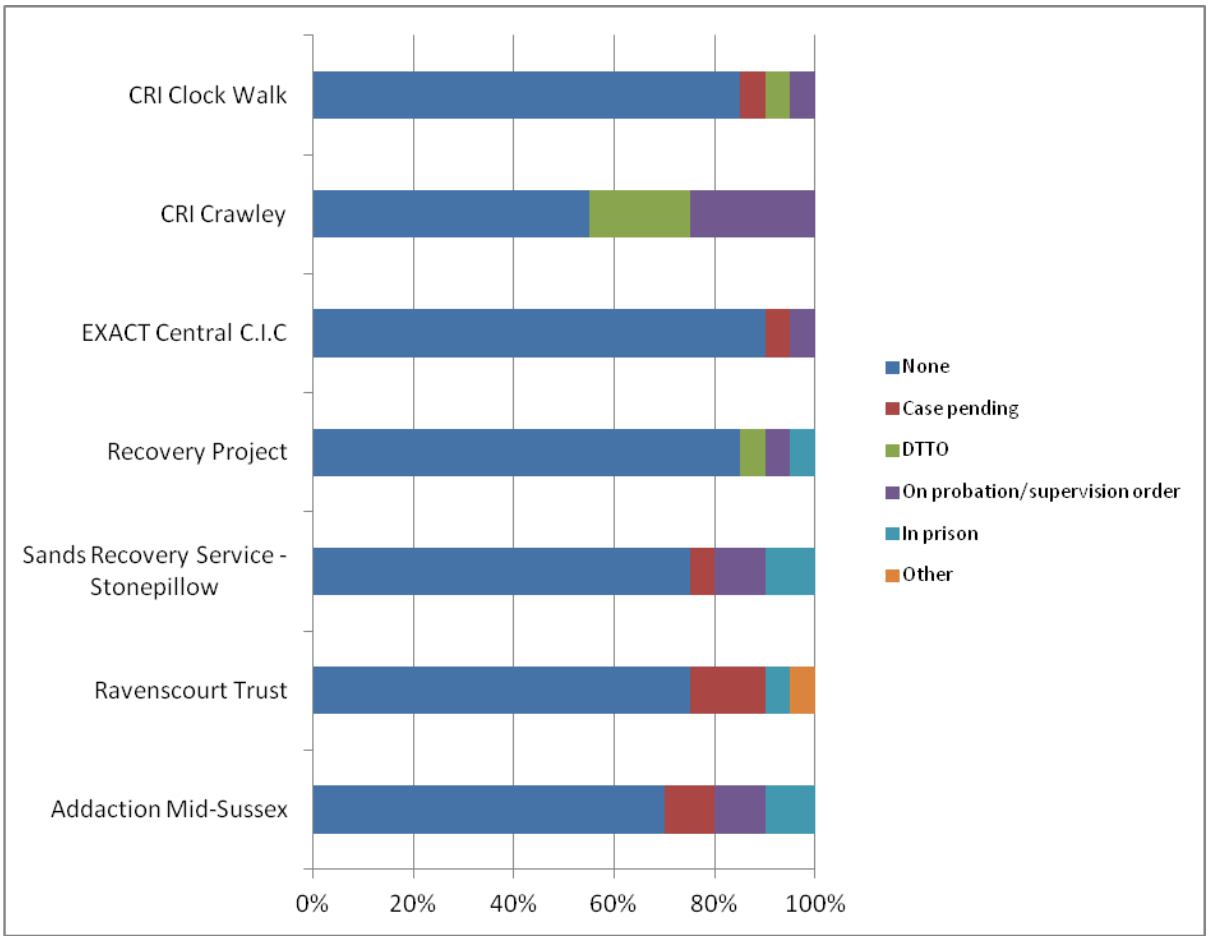
[415] Public Health England (2013b), op.cit.

[416] Source: Management survey conducted by Figure 8.

5.4.6 Legal Status of Users at First Contact

Data collated from the Management survey shows that the majority of clients attending specialist substance misuse services in West Sussex were not subject to any legal proceedings. However, it was estimated that 45% of clients from CRI Crawley were either on probation, a supervision order or a DTTO:

Figure 5.26: Profile of service users in Drug and Alcohol services – by legal status at first contact[417]



5.4.7 Accommodation Status of Users

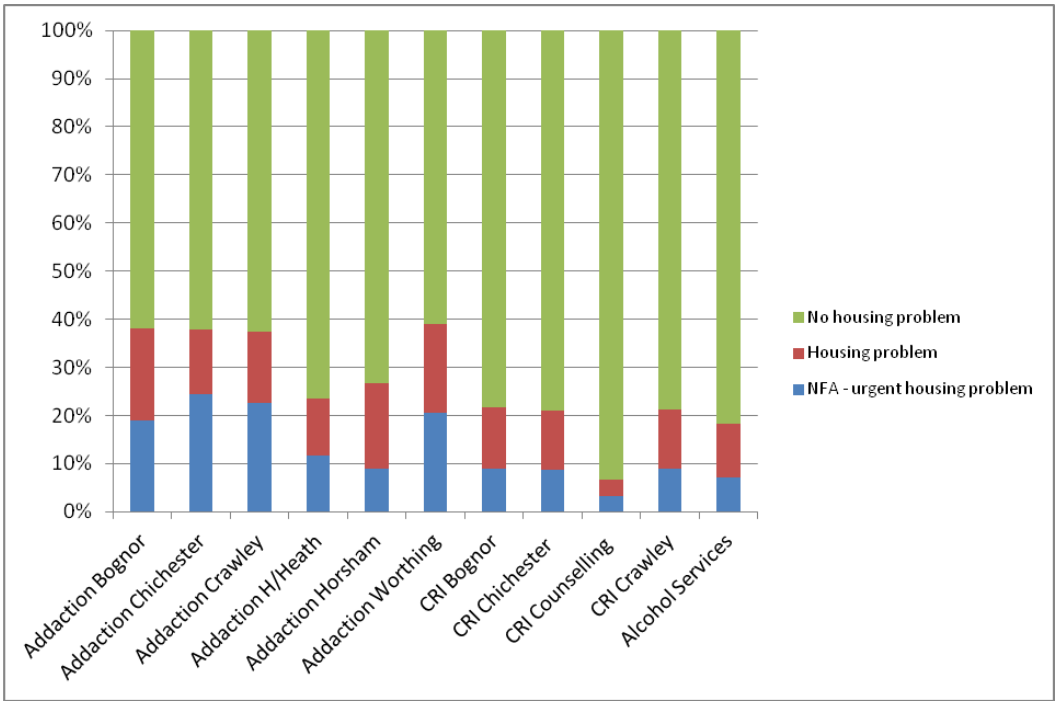
The data reported in the West Sussex JSNA Alcohol report for 2012/13 suggests that in West Sussex 18% of adults in alcohol treatment had a housing issue at the start of treatment. This is higher than the national average of 13%.[418]

That withstanding, agency performance reports for 2012/13 indicate that the majority of service users (between 62% and 93% depending on the specific service in question) are experiencing no housing problems:

[417] All figures provided were estimates.

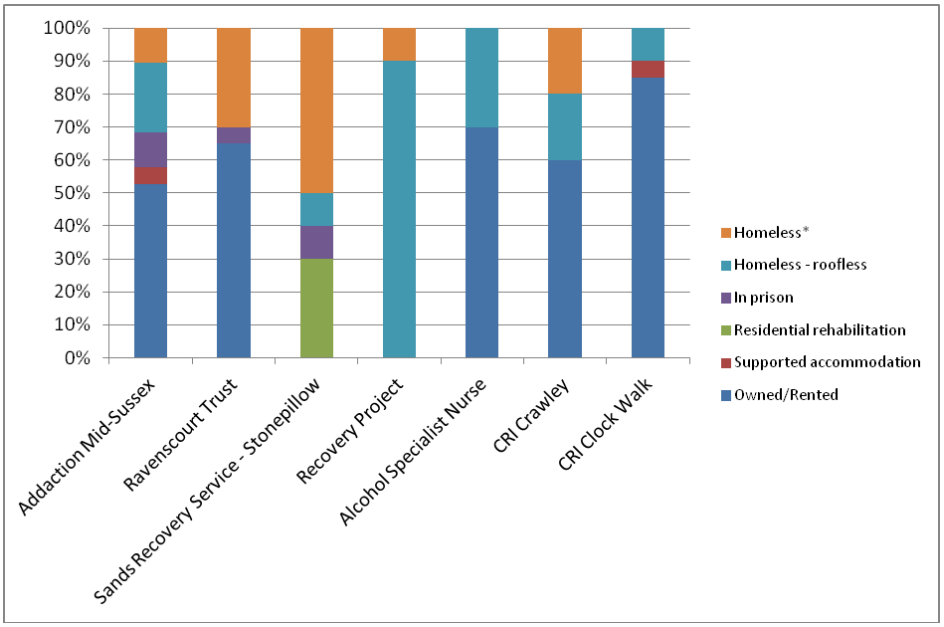
[418] Public Health England (2013b), op.cit.

Figure 5.27: Client Profile by Accommodation Need (YTD – new treatment episode)[419]



More specifically, the management survey enquired into the type of accommodation service users resided in. With the exception of Stonepillow and the Recovery project, the majority of clients owned or rented accommodation:

Figure 5.28: Profile of service users in Drug and Alcohol services – by accommodation status[420]



*hostel/temporary/unstable accommodation

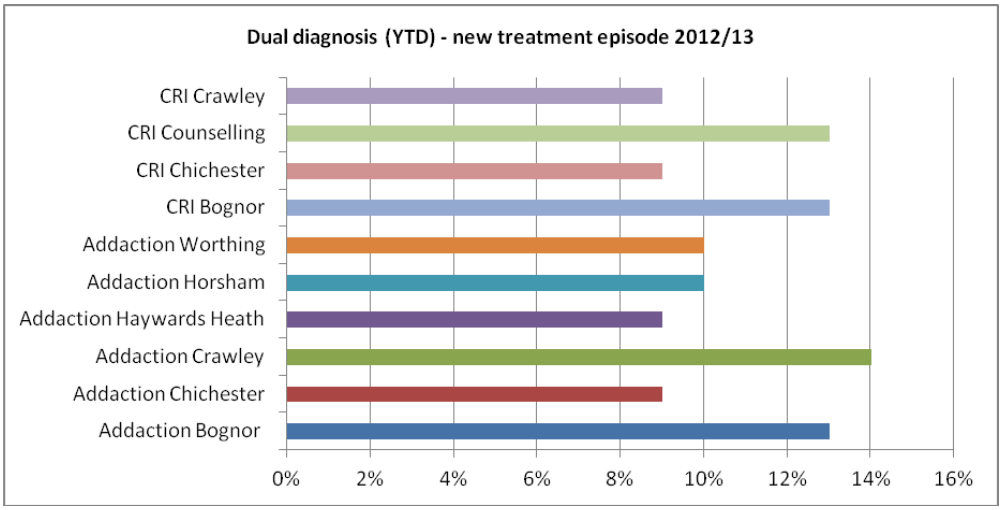
[419] Source: Adult Provider (By Residence) Quarterly Performance Report 2012 / 2013, Quarter 4.

[420] Source: Management survey conducted by Figure 8. All figure provided are estimates.

5.4.8 Percentage of Users with Mental Health Problem

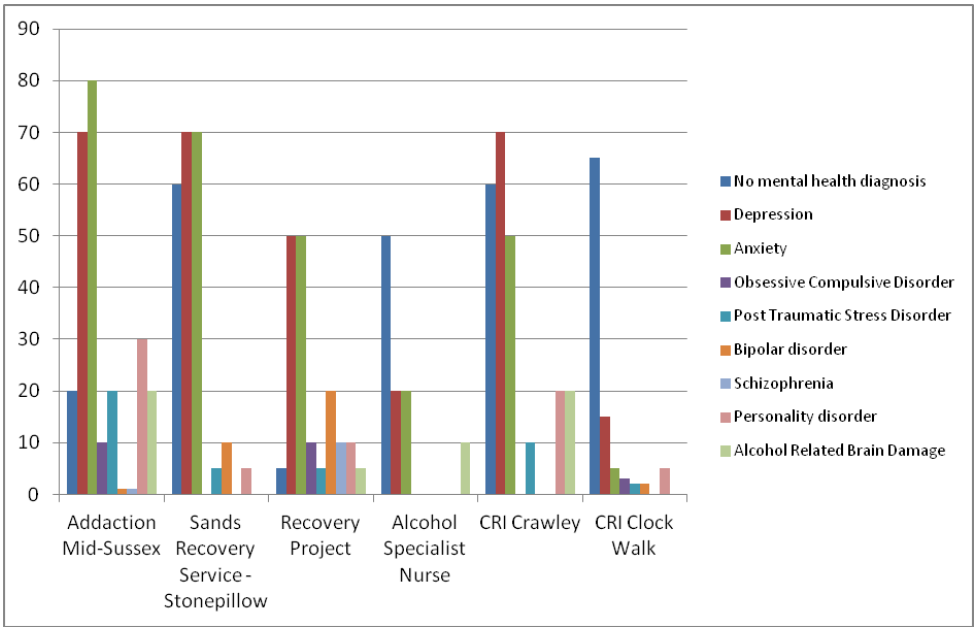
The Adult Partnership Quarterly Performance Report 2012/2013 suggests that on average 14% of clients accessing specialist drug service have a dual diagnosis. Specific data from the relevant agency reports is demonstrated in the figure below:

Figure 5.29:Percentage of service users with a dual diagnosis 2012/13[421]



However, estimates provided in the Management survey seem to indicate that significantly more than 14% of the client group do in fact have some sort of mental health condition, with anxiety and depression being particularly prevalent:

Figure 5.30: Percentage of service users with mental health problem[422]



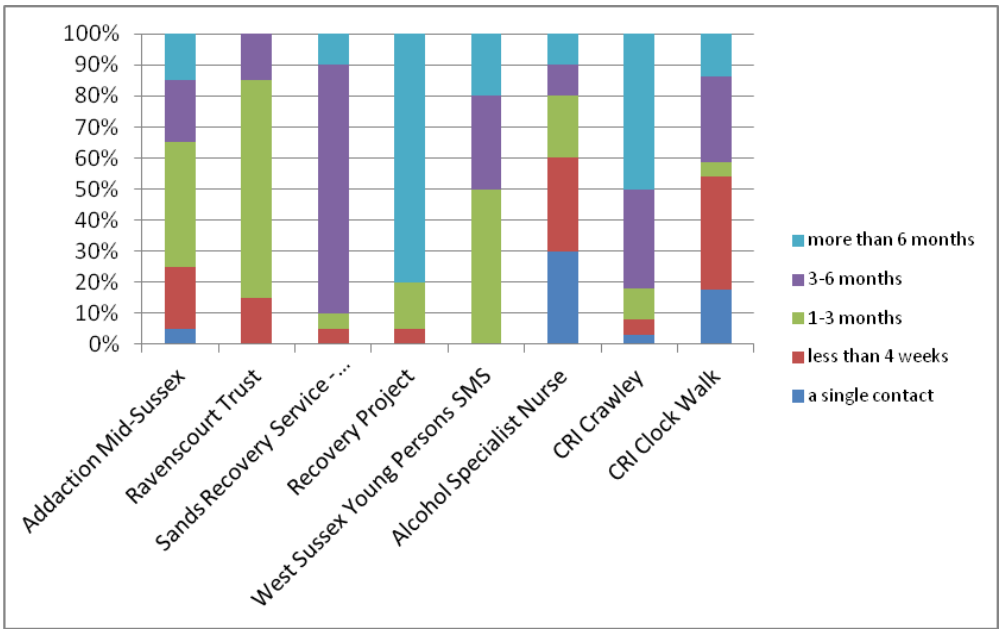
[421] Source: Adult Provider (By Residence) Quarterly Performance Reports 2012 / 2013, Quarter 4

[422] Source: Management survey conducted by Figure 8. All figure provided are estimates.

5.4.9 Duration of Service User Contact

There is considerable variation between services with regard to the duration of service user contact. Overall, the modal class is 3-6 months, although Ravenscourt Trust sees the majority of its clients for 1-3 months, and clients with the Recovery project often attend the service for more than 6 months as demonstrated in the figure below:

Figure 5.31: Profile of service users in West Sussex Drug and Alcohol services – by duration of service user contact



This is reflected in data submitted as part of the Adult Partnership Quarterly Performance Report 2012 / 2013 (Drugs) which suggests that 76% of new adult treatment journeys engaged in effective treatment for 12 weeks or more calendar year 2012. This compares to national data provided by the NTA which notes that of all clients 18 and over in contact with treatment services during 2012-13, 181,994 (94%) were either retained for more than 12 weeks, or if leaving treatment before 12 weeks, were free of dependency.[423]

Data reported in the West Sussex JSNA Alcohol report for 2012/13 estimates the average length of time in treatment in West Sussex to be 234 days. This is compared to a national average of 183 days as shown in the table below:

[423] *Drug Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2012 to 31 March 2013*, Public Health England, November 2013. Available at http://www.nta.nhs.uk/uploads/annualdrugstatistics2012-13-statisticalreport.pdf

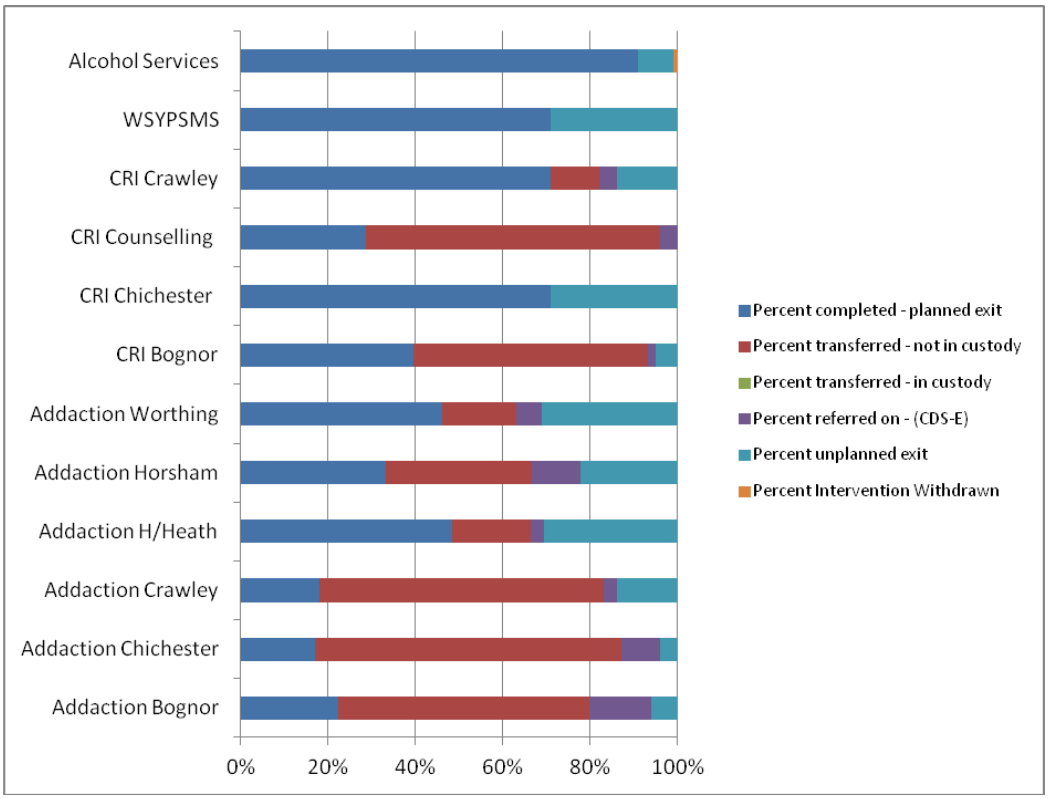
Table 5.32: Profile of service users (Alcohol) by length of time in treatment[424]

	Under 3m	3-6m	6-12m	Over 1 year	Average
Local	26%	28%	29%	17%	234 days
National	39%	26%	22%	13%	183 days

5.4.10 Reasons for Closed Contact

The figure below shows the range of reasons for case closures by service. For Alcohol Services, WSYPSMS, CRI Crawley, and CRI Chichester the majority of closures were planned. For CRI Counselling, Addaction Crawley, Addaction Chichester and Addaction Bognor the majority of closures were transfers (not in custody). Addaction Haywards Heath, Addaction Worthing, CRI Chichester and the young person's service saw around 30% unplanned case closures.

Figure 5.33: Adult Treatment Exits (YTD): 1st April 2012 to 31st March 2013[425]



[424] Public Health England (2013b), op.cit.

[425] Source: Adult Provider (By Residence) Quarterly Performance Reports 2012 / 2013, Quarter 4.

CHAPTER 6: VIEWS ON CURRENT SERVICE PROVISION AND PARTNERSHIP WORKING

6.1 Introduction and Aim

The purpose of this element of the research was to seek views from a range of individuals on current provision of specialist alcohol and substance misuse services across all areas of West Sussex. Specifically, there is illustration of what is working well, key issues, gaps and improvement areas and concerning service provision, linked to the underpinning system model, for children, young people and adults;.

Findings derive from a combination of methods, including a broad range of quantitative surveys[426]; interviews with young people and professional stakeholders; and focus groups with current and former service users, former service users, non service users including people in recovery as well as the lay; and family and friends affected by someone else's drinking and/or drug taking. This chapter also provides findings concerning partnership working between specialist alcohol and drug services; and other health and social care related services in West Sussex.

Semi-structured interview data were audio recorded and notes taken during and after the interviews. Focus groups were recorded by notes taken during and after each group. In order to ensure reliability the audio tapes were listened to and transcribed alongside all written notes, according to various topic headings (presented below), to allow for a comparative analysis. Some findings from this general chapter are supported by quotes from study informants.

Findings are presented, for brevity, in bullet point form given the large number of views collated across the range of research methods used.

6.2 Key Findings

This section outlines key findings derived from an extensive number and diverse range of informants.

- This study has observed, at first hand, that recovery from alcohol and drug problems at individual, partnership and family levels can and does happen.
- Relationships, partnership working and the general performance and standing of the specialist alcohol and drugs service for young people appear generally effective, despite a reported capacity issue.
- There is a requirement for greater priority and resourcing of prevention and education measures; particularly targeted at young people most at risk of becoming overwhelmingly involved in alcohol and drug use including those in care settings.

[426] Service user survey, Family/Carer survey, Specialist staff survey, Management survey, Pharmacy survey, GP survey.

- Much of the estate currently utilised for service provision is substandard and potentially unwelcoming and inhibiting for service users, staff and significant others. The buildings do not nurture an environment that is either welcoming or de-stigmatising. For many, such an environment creates a major blockage to engaging in quality treatment which would support lasting recovery.
- Notwithstanding some perceived practice shortcomings, as well as a few good examples of partnership working, a fundamental issue concerns the general lack of alliances and integration involving specialist alcohol and drug services; and linked services including GP, mental health, in patient/Tier 4, pharmacies, social work, housing and homelessness, employability, outreach, carer/family, mutual aid, recovery communities and generic services.
- The West Sussex treatment and recovery system model is predominantly ineffectual in its delivery of adult alcohol and services for a variety of reasons - a strategic review and rethink is already underway which should be underpinned by principles essential to the successful development of a recovery oriented system of care: co-production, integration, efficiency, innovation and outcome focus.

6.3 Working well

This section highlights examples of what is working well in respect of services for children, young people and adults.

6.3.1 Combined Children/Young People and Adult Services

- West Sussex Public Health has demonstrated a clear commitment to understanding local needs and implementing fit for purpose, sustainable solutions through a long-term appropriate alcohol and drug treatment and recovery orientated system of care.
- West Sussex Public Health has contracted an external consultant who is a specialist in alcohol, drug and recovery orientated care systems, as well as organisational review and development; with a focus on model and service re-design and related commissioning.
- There is a significant level of investment and a range of specialist alcohol and drug services for children and young people; and adults which are dedicated to supporting recovery from alcohol and drugs at an individual, community, regional and societal level.
- There is some evidence of effective transitioning between specialist alcohol and drug treatment service for young people and specialist alcohol and drug services for adults – where appropriate, the specialist alcohol and drug service for young people works for a sustained period beyond an individual's 18th birthday.
- On the face of it (despite the limited nature of evidence provided from various services, probation and the local prison), it appears that there are reasonably

good transitioning arrangements within the criminal justice system between penal establishments and community based services for young people and adults with offending and alcohol or drug problems.

'Reducing offending and reoffending remains a big priority.'

6.3.2 Children and Young People's Services

- There is consistent evidence from study informants that the specialist alcohol and substance misuse service for young people is working well.
- There is some evidence that the specialist alcohol and substance misuse service for young people is well integrated with other services such as social work (children and families) and mental health services.
- There is consistent evidence that staff in the specialist alcohol and substance misuse service for young people are caring, dedicated, flexible and responsive.
- Based upon organisational data, information; and feedback from staff, service users and a family member; client outcomes and satisfaction ratings appear good for the specialist alcohol and drug service for young people.

  'Young People service staff come with a package of enthusiasm and passion.'

6.3.3 Adult Services

- The empathy, commitment and general endeavour of staff volunteers, recovery champions, families, carers and other helpers for adults with alcohol/drug problems is apparent throughout West Sussex; based on service user, professional and other stakeholder feedback.

  'Impressed by resilience of staff.'
- There are some good examples of person centred schemes such as delivering home based alcohol detoxification services, delivering services in more local areas outwith the main adult specialist alcohol and drug service hub areas; and reimbursing client travel expenses.

  'The flexibility of the prescribing service is great.'
- There are developing recovery networks and communities throughout West Sussex; some of these are global mutual aid/self help movements such Alcoholics Anonymous, Narcotics Anonymous and SMART Recovery; some are organisational led enterprises, one is a statutory funded community led initiative (EXACT), others are ground level community initiatives and there are also hybrid models; one of which is underpinned by Recovery Coaching – although these initiatives are good and well intentioned, they would benefit from better understanding and coordination.

  'People have to gain recovery; this will not be given on a plate.'

  'It is confusing what is and is not happening with recovery led communities.'

- The leadership, training and mentoring demonstrated by some adult specialist alcohol and drugs service providers in respect of recovery or BBV championing (or equivalent) is commendable, despite apparent challenges such as duplication and lack of coordination.

  'There has been good investment in recovery champions.'

- What is described locally as 'medium level preparation' (6-8 one-to-one or group sessions over 3-4 weeks) by specialist alcohol and drug services for potential Tier 4 placement is good practice.
- There are specific outreach services in a few areas such as Worthing and Bognor which target ethnic minorities and Eastern Europeans and seem to work well, although throughput appears low.
- Despite the number of shelter, hostel, supported accommodation and housing options, coupled with some limiting eligibility criteria; there are good networks and relationships among key agencies including specialist adult alcohol and drug service providers, homeless service providers and housing providers (including District Councils, Housing Associations and Private Registered Landlords).
- The Family and Friends Network is going well, despite modest funding and a resource heavily reliant on volunteers.

  'The family and friends network is a much sought after service which requires a significant increase in funding to ensure families are more involved in care planning and delivery.'

- A shared client record system known as HALO is in place and continues to evolve and be more integrated and inclusive, although there is clear room for improvement.

  'HALO and NHS IT systems are incompatible.'

- The role of the community pharmacist has expanded beyond traditional dispensing to information, advice, brief intervention, needle exchange (in many cases) and information sharing including use of HALO.

  'Pharmacists could do drug testing.'

- The role of the Social Worker (Substance Misuse) is needed due to statutory cases – the role is diverse in nature but appears to be going reasonably well – it also appears to be under resourced based on the caseload size (n=30, potentially reducing to 15-20 and complexity of cases).

  'Staff teams feel over stretched due to massive caseloads (n=60-80).'

- The role of Alcohol Specialist Nurses appears to be going well, but would benefit from further expansion and resourcing.
- The role of Mental Health Liaison Nurses appears to be going well, which directly involves alcohol and drug misuse in many cases, but again could potentially be expanded.

'The substitute treatment provider is dealing with severe mental health issues, often beyond their scope, competence and wish.'

- Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ART) appear to be going well, with good links between the Probation Service and specialist adult and young people alcohol and drug services; based on positive feedback from service staff and DRR/ART individuals.

  'DRR's and ATR's are working well.'

- Harm reduction measures such as Needle Exchange are widely available in a variety of settings throughout West Sussex.

  'Could pilot drug testing at point of arrest.'

- The analysis of drug related deaths by multi-disciplinary stakeholders is being firmed up and given higher priority to support prevention, education, practice, learning and improvement.

- The focus on making communities safer through multiple partners often led by the police and District Councils is also commended by service users, family members and professional workers.

  'Reducing antisocial behaviour is a major priority as is reducing other harm such as domestic abuse.'

  'Community engagement is key including linkage with enhanced detached youth workers and community wardens.'

- Specialist services and initiatives such as assertive outreach and the Bognor Hub which target particularly vulnerable or disadvantaged groups such as minority ethnics, European citizens, rough sleepers and street drinkers are certainly needed and have received praise by service users.

  'The migrant community is a particular challenge for West Sussex.'

  'A real challenge is managing the influx of people from outwith West Sussex including foreign nationals.'

- Tier 4 residential rehabilitation / supported housing recovery services appear to be fulfilling the immediate needs and goals of their residents, according to residents, former residents and staff alike.

6.4 Key issues

This section highlights key issues identified by study informants in respect of service users (young people and adults), families/carers, the wider population, the system model and partnership working.

6.4.1 Service Users (Young People)

The key issues identified in respect of young service users are:

- Having practical and realistic knowledge and understanding about the risks of taking alcohol and drugs, particularly excessively – education needs to start from a young age and involve parents/carers.

  'Prevention needs to be higher up the priority list.'

  'Need greater focus on early prevention strategies.'
- Being resilient enough to cope with life pressures, make informed choices and to act responsibly.
- Avoiding peer pressure at a young age to take alcohol, drugs, have sex, wear designer clothes, etc.
- Feeling a sense of belonging and worth – having nice friends, going out, having fun and enjoying oneself without 'getting smashed' and behaving 'stupidly'.
- Getting and doing meaningful activities such as sport, music, hobbies, school or college education, training or work.

  'Creating meaningful activities in the community is the main priority.'
- Avoiding taking drugs or relapsing if helped.

6.4.2 Service Users (Adults)

The key issues identified in respect of adult service users are:

- Supporting abstinence as a viable and realistic goal of treatment.

  'Services need to be honest with clients, stop holding them but facilitate abstinence and recovery.'
- Improving one's health status including mental health status – overcoming stress/anxiety/depression.

  'Mental health is a big problem.'

  'Some people who bounce between alcohol/drug and mental health services receive only limited help.'
- Getting a stable living arrangement; a safe, comfortable and homely place to live.

  'Many failings come down to lack of support for people living independently.'

  'There is a lack of move on accommodation arrangements.'

  'Local housing eligibility criteria is a major inhibitor.'

  'A missing link is a wet hostel.'
- Sorting out and improving relationship issues.
- Getting one's life back on track – maybe helped through a volunteer or paid job.

  'There are some volunteer opportunities which can be expanded.'

  'Holistic approaches, including employability are crucial.'

'Better support is needed to help people with alcohol and drug problems to remain in employment, as well as to gain employment.'

'Employability resources are scare and more capacity is required to meet client demand.'

- Supporting and encouraging individuals to 'give back' – i.e. helping and encouraging other people with substance misuse problems to achieve recovery.

  'Lack of motivation to change from some individuals is an issue.'

  'People need to be more enthused about recovery.'

6.4.3 Families and Carers

The key issues identified in respect of families and carers are:

- Providing better education for families about the dangers of alcohol and drugs including new market drugs such as mephedrone (commonly known as meow meow), risk indicators and symptoms of problems – this will not only indirectly help the individual affected by the problem but family members too.
- Providing better support for families affected by someone else's alcohol or drug problem.

  'Need more family support.'
- Reducing the stigma against the individual as well as the family member/significant other.
- Increasing family involvement in the individual's care package; including jointly participating in interventions and activities, where appropriate. Currently family members are not routinely involved in the process and as a result become marginalised.

  'There needs to be wider family interventions.'

  'Need family key workers.'
- Increasing funding for the Family and Friends Network – more appropriate distribution of the specialist alcohol and drugs service budget to support families.

  'More equitable resourcing is required.'
- Creating a higher local and national profile for families, most of whom hold fundamental and pivotal roles in their loved one's recovery from alcohol and/or drug problems.

6.4.4 Wider Population

The key issues identified in respect of the wider population are:

- Better advertising and campaigning on the dangers associated with alcohol and drugs – something more potent than the current 'please drink responsibly' campaign which is seen as appeasing the drinks industry.

  'Previously, substance misuse had a much bigger profile.'

- Persuading retailers to stop selling really cheap and really strong alcohol.

  'Need to encourage retailers to sell alcohol more responsibly.'

- Stopping to think about our own attitudes, beliefs and behaviour – how tolerant are we ourselves - do we stigmatise people with drug or even drink problems – we actually need to look at ourselves before judging others.

  'The future requires more leadership and self management from individuals.'

- Taking a 'wider society' approach to identifying, understanding and tackling the alcohol and drug problem – currently most people turn a blind eye despite knowing somebody with this type of problem – that someone might be a family member, a friend, a neighbour, a colleague; that someone might be oneself.

- A challenge rests with media and press coverage which largely sensationalises the lifestyles and substance related mishaps of celebrities – the young generation can be influenced by what these people wear, how they look and; of course, how they act.

- People who use drugs and alcohol excessively can commit crime, cause fear to residents, unsettle areas and undermine safety – society doesn't want people breaking into houses, stealing cars, robbing people, behaving anti-socially and generally causing a nuisance to fund their addiction – these people should get help and live responsible lives.

  'There is a huge wealth of support but the trick is to make people aware of such.'

6.4.5 System Model

All study informants were asked to comment specifically on any issues concerning the current system model; both design and delivery. The key issues are:

- The integrated specialist alcohol and drug treatment model in practice is overwhelmingly seen by most stakeholders consulted as flawed, no longer fit for purpose or even 'salvageable' – the model supports not just competition but rivalry, opposition and even antagonism; it endorses a blame culture and does little to promote professionalism, effective partnership working or accountability – in short, it is evident that at least the delivery of the system model is ineffective.

  'It will be disappointing for West Sussex if the current model continues in the same format in the future.'

  'The West Sussex model in practice is like 'a hospital without an ambulance'.'

  'There are lots of no's: no simple map, no overseer, no monitoring, no accountability as well as a confusing model.'

'The integrated or split model equals a blame culture.'

'Need to address multiple issues such as vested interest, lack of inspiration and short term-ism.'

'The UK recovery agenda has made everyone freak out especially statutory services which focused on substitute treatment and reducing crime.'

'You get what you pay for and let's not forget that quality costs money.'

'West Sussex is not championing recovery.'

'Aspiration for recovery could be higher in West Sussex.'

- The West Sussex alcohol and drug treatment system is generally viewed as fragmented by most study informants.

  'Services are fragmented and are not joined up or cohesive' 'West Sussex does not embrace the care coordination system and practice is inconsistent across the county including a north/south split.'

  'Services are predictably unpredictable.'

  'There are a sufficient number of services but the configuration is not right.'

  'There is not a lack of services but a lack of integration.'

  'There is massive duplication as well as massive gaps.'

  'Simply put, current services do not meet the aggregated needs, especially older people.'

  'There are many small pockets of commissioned services which is sometimes duplicative or problematic.'

- The specialist alcohol and drug service model for adults is confusing to service users, potential service users, professionals and other key stakeholders; especially but not solely concerning integrated models involving the two main specialist adult alcohol and drug service providers.

  'The lack of a consistent model across West Sussex is confusing for all stakeholders, especially clients.'

  'The system is confusing and can only work for people within the system.'

  'Clients are confused and adversely affected.'

6.4.6 Partnership working

All study informants were asked to comment specifically on any issues concerning partnership working. The key issues are:

- Partnership working between the two main specialist alcohol and drug service providers has deteriorated further in recent years as a consequence of commissioner driven system changes which saw business won or lost by the two 'rival' specialist adult alcohol and drug service providers.

'Relationships between the two main specialist providers are not good at any level.'

'Providers are competitors so it is difficult to work effectively.'

'The two main specialist providers are overt competitors.'

- Partnership working is inconsistent and generally requires improving, particularly but not only between the two main specialist alcohol and drug service providers.

  'There is no joint assessment, care planning or review.'

  'Achieving reconnections requires specialised skills, experience and networks.'

- Linkage with primary care (GPs) is severely lacking based upon feedback from multiple stakeholders including service users, former service users, family members, specialist adult alcohol and drug service providers, a GP and other stakeholders.

  'Contact by the prescriber agency with GPs is limited.'

- Linkage with adult mental health services could also be improved based on feedback from multiple stakeholders including service users, specialist service staff and a mental health nurse.

  'A specialist substance misuse provider employs mental health nurses but they do not do mental health work.'

  'There are inadequate resources including doctors, prescribing nurses and non prescribing nurses: 5 years ago, there were 30 nurses; now there are 9 due to the high number of Project Workers.'

  'There is a huge barrier between adult social work services, substance misuse services and mental health services.'

- Partnership working with other specialist alcohol and drug services including in-patient settings, community pharmacies, Tier 3 structured day services and Tier 4 services is sporadic, with good and bad examples cited by study informants.

  'Pharmacists are not fully integrated in the system.'

  'The alcohol liaison nurse at the hospital is an important resource.'

  'Specialist service providers should provide hospital in-reach services.'

  'We spend so much money and time getting people well in hospital but it falls down on discharge.'

  'We are increasingly seeing more people under 40 with advanced liver disease.'

- Partnership working with homelessness services is also patchy, based on mixed feedback from stakeholders.

- Partnership working with generic services such as employability, criminal justice, counselling services, family services is also irregular, based on diverse feedback from consultees.

- Partnership working with mutual aid organisations and community led recovery initiatives is also random, based on feedback from recovery champions, mutual aid groups, service users a, former service users and other contributors.
- From the perspective of some staff from the two main specialist alcohol and drug service providers, as well as other substance misuse providers; partnership working with the West Sussex commissioner is variable, whilst recognising recent policy and structural changes.

  'The DAAT needs more resources.'

  'There is little contract monitoring from commissioners.'

  'Need a single committee overseeing all commissioning.'

6.5 Gaps in Service Provision

This section identifies gaps in service provision.

6.5.1 Combined Children/Young People and Adult Services

- Targeted training on specific drug types such as Novel Psychoactive Substances ('legal highs') and overdose training could be expanded into recovery communities, schools, prisons, custody suites, youth services, Tier 4 services, the Family and Friends Network; and GP practices.

  'First Aid for Overdose training for front line workers and service users is vitally important and can save lives.'

  'There is a need to broaden overdose training to other staff including A&E, custody/police and teachers, as well as recovery communities.'

  'There is a lack of general substance misuse training in West Sussex.'
- Alcohol Identification and Brief Advice Interventions do not appear to be widely available.

  'There is a lack of brief interventions.'

6.5.2 Children and Young People's Services

- According to service users and staff (including senior management), the specialist alcohol and drug service for young people is under resourced. If resources were increased, it is perceived by relevant study informants, that more young people would be targeted, access and benefit from the service. The range of interventions and activities would also be increased including family/carer engagement.

  'The young people service has capacity issues.'
- There could be better links between prevention/education initiatives and the specialist alcohol and drugs service for young people – there is a gap for earlier

intervention before the onset of problems caused by overwhelming involvement of drinking and/or drug use.

'The key gap is lower level intervention to sit between education programmes and specialist substance misuse service for young people.'

'A significant proportion of young people have experience of the care system.'

6.5.3 Adult Services

- Specialist alcohol and drug services for adults do not always fit people; rather people generally need to adapt to fit services.

  'Many services at the moment are about fitting into a box.'

- Specialist alcohol and drug services for adults are not universally seen as person centred but sometimes service or organisational centred.

  'Need to strike better balance of treatment into recovery.'

  'Clients have said it takes a long time to reduce their substitute treatment, despite their goals to do so.'

  'Specialist service providers are hoarding their clients and not referring them to other services such as the day service.'

- Specialist alcohol and drug services for adults are largely inaccessible with limited opening times at evenings and weekends – staff views sometimes contradict service user views in terms of needs.

  'Opening times need to be looked at as weekend and evening sessions are minimal.'

  'The accessibility of services needs to be widened to encourage family, friends and significant others to accompany individuals.'

- Based on feedback from service users, families and multi-agency staff, services in rural and remote areas are limited, despite positive endeavours to tackle this issue through locality based activities (see bullet point immediately below).

  'Accessibility is an issue in rural areas.'

- With a few exceptions, specialist alcohol and drug services for adults are generally locality hub centric, whereby interventions are delivered by office based staff within service premises. The main exceptions are the at-home alcohol detoxification service, local community based clinics in key places such as health centres or community centres, and some outreach work.

  'Solutions include assertive outreach, community based teams, home working, multi disciplinary working (including within GP practices) and employing specialist workers e.g. reducing violence.'

  'More satellite and outreach based work is required, particularly in outlying areas.'

- Based on multiple stakeholder feedback (including former service users and family members), there is virtually no home based service provision for adults with alcohol and drug problems, except for alcohol detoxification. This is a particular problem for people who are disabled, elderly, severely ill (physically and/or mentally), with severe and complex problems or who are simply unsuitable to travel or engage in hub based services.

  'Detox options are limited; whether in hospital, at home or in the community.'

- Services are not adequately marketed, targeted or necessarily attractive to service users, potential service users and significant others - for example, some families/carers do not see much attraction, opportunity or involvement happening or in the pipeline within specialist alcohol and drug services for adults or Tier 4 services; whilst people with alcohol issues (including those in denial or who under estimate their problem), especially older people and women, have negative, sometimes stigmatised views concerning what they sometimes perceive as 'drug services for people with heroin problems'.

  'There needs to be greater emphasis on alcohol problems for older people.'

- Assertive outreach services are very limited and are provided outwith the main commissioned specialist alcohol and drug service contracts.
- There is a lack of detoxification options within West Sussex for people with more severe alcohol and drug problems including in-patient, at home, Tier 4 services or via a GP/GP Shared Care arrangement – some study informants (specialist staff only) also highlighted concerns regarding detoxification and general substitute treatment practice in West Sussex.
- Based on feedback from several current and former service users as well as some staff, it appears that West Sussex does not traditionally have a culture of offering or providing detoxification as an upfront treatment choice except in exceptional circumstances (A&E hospital admission, abstinence based Tier 4 residential detoxification and rehabilitation service). There is some evidence from professionals and service users alike that detoxification and reduction programmes are actively discouraged by the treatment system itself. There is also conflicting evidence that detoxification, or at least reduction rather than maintenance programmes, are increasing [NB: the authors have not rigorously tested this assertion].
- Naltrexone is an opioid receptor antagonist used in the UK and globally, primarily in the management of alcohol dependence and opioid dependence. However, despite its common use and benefit in maintaining an abstinent state following patient detoxification, the drug is rarely used in West Sussex due to licensing restrictions, concerns regarding effectiveness and perceived expensive cost.
- Where motivated to do so, in the sense of further specialist input rather than conventional primary health care, GPs could contribute more to the treatment of patients with alcohol and drug problems. This study is aware of a particularly proactive GP who is committed to doing more to help individual patients, families and communities to recover from alcohol and drug problem.

'A major problem concerns the specialist provider not touching general health needs whilst GP's do not touch substance misuse needs.'

'The prescribing service was designed as a GP led model; however, the service does not resemble this in practice.'

- The West Sussex pharmacist prescribing pilot got little chance to prove itself as a supplementary option for people with severe alcohol and drug problems. It is unclear to the study authors whether the evaluation findings of the pilot are in the 'public domain'; therefore, the question remains whether this model could potentially be consolidated and rolled out across West Sussex (several Pharmacy Managers consulted during this study expressed general pharmacy profession as well as well as personal interest in fresh exploration).

  'The pharmacy prescribing pilot scheme was successful but quickly stopped for no known reason.'

- There is no West Sussex based dual diagnosis service for adults with co-occurring mental health problems and substance misuse problems which is seen as a priority issue by several study informants (specialist staff).

  'The 'Options' dual diagnosis service was lost about 5 years ago.'

  'There are no dual diagnosis services, so patients are normally led down a mental health route.'

- The West Sussex based Tier 4 residential detoxification and rehabilitation service and a linked structured day service for people with alcohol or drug dependency can both be under-utilised, mainly due to lack of 'headline' referrals and placements from within the county; despite there being clear client demand for this type of service, and a proportionally high 'out of area' placement trend.

  'There is a need for the day service to continue and to be expanded in other West Sussex areas e.g. Crawley.'

- Naloxone (brand name, Narcan), an opioid antagonist drug used to counter the effects of opiate overdose does not appear to be widely utilised in West Sussex.

- Recovery is individualistic and aspirational. Unless avoidable, the individual needs to be and remain at the centre of 'all' decision making processes about their treatment and own recovery. This requires carefully balancing of treatment and support with discharge – services should not hog clients; nor should services discharge clients prematurely. The right balance should be sought, underpinned by a person centred approach. Based on the general evidence collated and analysed by the research team, there are gaps or deficiencies in respect to several of these important areas.

  'Clients are not involved in decision making.'

  'Individuals deserve greater empowerment.'

  'There is a need for more abstinence based services as well as mutual aid.'

6.6 Improvement Areas

6.6.1 Children and Young People's Services

- No improvement areas have been identified in addition to the three gaps highlighted in the relevant 'Children and Young People' section on 'Gaps' above.

6.6.2 Adult Services

- All the gaps highlighted in the relevant Adults' section above also represent areas for improvement.
- In addition to previous issues and gaps identified earlier in this chapter, some informants reported a number of other potential service programme, intervention and practice related issues which may require further analysis and potential service improvement.

  'Clinical practice is an issue.'

  'Prescribing practice is ineffectual.'

  'Prescribing services are not gelling with psychosocial interventions.'

  'Programme quality assurance is lacking.'

  'There should be more group work within services.'

  'Overdose training should be written into relevant care plans.'
- There would be benefit in reproducing a care pathway illustration for distribution in key localities.

  'Need a diagram of the care pathway for clients.'
- Many stakeholders reported concern over high staff turnover rates amongst specialist adult alcohol and drug treatment service providers. This requires monitoring and abating, where appropriate; as this has caused work pressure as well as disquiet among several stakeholders and can be open to inaccurate interpretation.

  'Staff turnover in Tier 2 and 3 specialist services is high.'

  'Locums are expensive and do not have the same loyalty.'
- Many of the buildings currently operated throughout West Sussex by specialist alcohol and drug service providers, as well as primary homelessness service providers (which also provide residential/supported housing recovery services for people with alcohol and drug problems) are unwelcoming, substandard and un-inspiring. Significant investment, and possibly in some cases, relocation is required. Some staff and volunteers are also working in these inferior conditions.

  'Specialist provider premises are horrible and inaccessible, particularly for females and elderly people.'

'The standard of accommodation used by specialist providers is inadequate.'

'The revenue budget seems okay but the capital budget is lacking.'

- There are largely untapped 'new media' opportunities within West Sussex for modern, efficient and responsive solutions to help facilitate recovery from alcohol and drug problems.
- The Tier 4 panel which assesses individuals for potential entry to Tier 4 services does so in the absence of the individual at the centre and significant others. Furthermore, referrals for panels appear to be of sporadic quality.
- Tier 4 services should be considered more as a feasible treatment option at the start of a treatment journey, rather than as a last resort.
- West Sussex can learn from recovery orientated systems of care and specific elements of such from elsewhere – although these are still developing and the evidence base for recovery models is still largely in its infancy, there is no doubt an improved system is required to meet the aggregated needs of the relevant population.

CHAPTER 7: THE GAP BETWEEN NEED AND ACCESS

7.1 Introduction

This phase of the study uses data derived from Chapter 2 on the prevalence of alcohol and drug dependence in West Sussex, combined with the estimated access to treatment to assess the gap between the two.

The ratio of need to access is defined by Oyefeso et al (1997) as the Prevalence-Service Utilisation Ratio (PSUR).[427] The PSUR provides a numeric estimate of the local or national gap between need for and access to treatment. This can also be expressed in terms of specifics such as age, gender or ethnic group.

The key data from the agency survey for this gap analysis is the number of people that can access the service at any one time; this is termed as the capacity of services. In some cases capacity might be higher than current activity (e.g. due to staff sickness or absence) or lower than current activity (e.g. when services are involved in contingency measures such as overtime to address waiting times). The capacity of services in each area is set out in the following sections.

The *Alcohol Needs Assessment Research Project* (ANARP)[428] established from the agency survey that, across England, 8.2% of people accessing treatment were referred by other alcohol treatment agencies. This 'double counting' provided an over-estimate of the total number of people accessing treatment. We have replicated the ANARP methodology and have therefore adjusted the estimated access to services in West Sussex by -8.2%.

7.2 Key Findings – Gap Analysis

- In West Sussex the target annual performance (capacity) for treatment services has been set as 500 (alcohol), 1250 (OCU) and 500 (Non-OCU) treatment places (2014-15).
- The PSUR ratio of need for alcohol services in relation to the provision of services is 1:12.6. This is equivalent to 7.9% of people in need accessing service. This is significantly better than the national rate of 5.6% (or 1:18).
- The PSUR ratio of need for drug services in relation to the provision of services is 1:1.46. This is equivalent to 68.5% of people in need accessing services.

[427] Oyefeso, A., Ghodse, H., Goldfinch, R., Keating, A., Marshall, F. and Miller, J. (1997) *Consultative Report of Drug and Alcohol Services in Merton Sutton and Wandsworth*. Report submitted to Merton Sutton & Wandsworth Health Authority.

[428] Drummond (2005) op.cit.

- The medium (mean) level of access to drug services, according to National Audit Office guidance[429], would be a PSUR of 1:2, or 50% access rate. By comparison West Sussex has a high level of current access to its drug services.

7.3 Benchmarking

Previous studies have shown that at any given time, the number of people who need alcohol treatment greatly exceeds the number who actually access treatment. In North America a 'low' level of required capacity is considered to be 10% or one in ten people in need accessing treatment per annum. Fifteen percent (or 1 in 7.5 poeple in need) is considered to be a 'medium' level of required capacity; and 20% (or 1 in 5 people in need) is considered to be a 'high' level of required capacity (Rush, 1990).[430]

However, it should be noted that in the drug misuse field which has seen a large increase in availability of treatment in recent years, through considerable investment in expanding services in England, the level of treatment access for 'problem drug misusers' per annum is approximately 50% equating to a PSUR ratio 1:2 (National Audit Office, 2008).

The level of access and PSUR should be used to compare relative levels of access in different areas or countries, and between different demographic groups. They are of only limited value in studying or applying the absolute levels to service planning or development.

The ANARP[431] and SANA[432] reports set out adjusted alcohol dependence factors as a percentage of populations across UK regions. The adjusted alcohol dependence factors were endorsed by the Scottish Government and are now used in all prevalence calculations. Table 7.1 below sets out the adjusted alcohol dependence rates for each English region:

Table 7.1: Adjusted prevalence of alcohol dependence by region[433]

Region	Adjusted prevalence of alcohol dependence factor (%)	Number
North East	7.2	83,356
North West	12.6	145,054
Yorkshire and Humber	14.2	163,889
East Midlands	3.7	42,656
West Midlands	11.0	126,658
East of England	8.3	95,808

[429] NAO (2008), op.cit.

[430] Rush, B. (1990) A systems approach to estimating the required capacity of alcohol treatment services. *British Journal of Addiction*, 85: 49-59.

[431] Drummond (2005), op.cit.

[432] Drummond (2009), op.cit.

[433] Drummond (2009), op.cit.

London	18.8	217,429
South East	**15.9**	**183,611**
South West	8.3	95,257

The estimated number of people in the population with alcohol or drug dependence is compared to the number accessing treatment. This can be expressed in two ways. First, in terms of the prevalence-service utilisation ratio (PSUR), a ratio of the number of people needing treatment compared to the number actually accessing treatment, which for England as a whole is 18:1 (Alcohol) and 2:1 (Drugs). Second, this can be expressed as a percentage of the alcohol or drug dependent population that is accessing treatment which for England as a whole is 5.6% (Alcohol) and 50% (Drugs).

7.4 Percentage Accessing Treatment

This section sets out the PSUR for alcohol and drug treatment in West Sussex.

7.4.1 Capacity of alcohol and drug services in West Sussex

Table 7.2 displays the capacity[434] (or target performance) of the specialist drug and alcohol services across West Sussex as laid down in the West Sussex Adult and Young People reporting documents (Performance Activity Reports)[435].

Table 7.2: Target performance (capacity) of alcohol and drug services in West Sussex

Service	Target performance (Capacity)			
	Total	Drugs clients (opiate)	Drugs clients (non-opiate)	Alcohol clients
Adults	3250	1250	500	1500
Children & Young People	170	n/a	n/a	n/a
TOTAL	**3420**	**n/a**	**n/a**	**n/a**

7.4.2 PSUR - Alcohol

Table 7.3 sets out the PSUR for alcohol services in West Sussex. The total population has been adjusted to reflect the age ranges appropriate to specialist alcohol services (16-64, 65+).[436] The gender ratio of alcohol dependence is drawn from the ANARP[437]

[434] Capacity refers to the number of unique clients that a service can accommodate at any one time. This may be greater than current activity levels.

[435] Performance Activity Report spreadsheets supplied by Philippa Gibson, Commissioning Manager, Drug & Alcohol Action Team, Joint Commissioning Unit , West Sussex County Council (12th December 2013).

[436] Office for National Statistics (ONS) Mid-Year Estimate (2011)

[437] Drummond (2005) op.cit.

and SANA reports.[438] The raw number accessing treatment was provided by the West Sussex Performance Activity Reports as set out in Table 4.2 above. From this a calculation has been done to compensate for double-counting, i.e. clients attending more than one service at a time. The PSUR is calculated between the adjusted prevalence figure and the adjusted access figure.

Table 7.3: Prevalence Service Utilisation Ratio – Alcohol

	Total Population	Adjusted prevalence alcohol dependence		Adjusted by age 61.3% 20.8%		Target performance (capacity)	Adjusted number accessing treatment (-8.2%)	PSUR Ratio	Percent accessing treatment
	Number	%	Number	16-64	65+	Number	Number		%
All	808,900	15.9	17,363	10,644	3612	1500	1377	1:12.6	7.9%
Male %		75	13,022	7,982	2,709	(62%)	854	1:15.2	6.6%
Female %		25	4,341	2,661	903	(38%)	523	1:8.3	12.0%

These calculations show a PSUR ratio of 1.12.6, meaning that 7.9% of alcohol-dependent people in West Sussex are accessing specialist alcohol services as defined earlier in this report. This is a significantly higher rate of access than the English rate of 5.6% (or 1 in 18)[439]. It is also worth noting the significant difference in gender based PSUR ratios. Based on international guidance[440] the male PSUR ratio (1:15.2) represents a 'medium' level of access to treatment, whereas the female PSUR ratio (1:8.3) represents a 'medium to high' level of access to treatment.

7.4.3 Variables

Assuming that there was no overlap between services, i.e. that no individual person was attending more than one service at a time; the PSUR would be calculated on a total of 1500 clients (assuming all are alcohol dependent). The PSUR would reduce slightly to 1:11.6 (8.6%).

7.4.4 PSUR - Drugs

The calculation for PSUR for drug services is similar to that of alcohol services except in calculating the age adjusted prevalence figure, and is presented in Table 7.4 below. The standard age range commonly accepted for drug prevalence is 16-64 years. Age adjustment is taken from the ONS mid-year population figures (2011).[441] The prevalence rate of Opiate and/or Crack Users (OCU – previously defined as 'problem

[438] Drummond (2009) op.cit.

[439] Drummond (2005), op.cit.

[440] Rush (1990), op.cit.

[441] ONS (2011), op.cit.

drug use') for West Sussex is taken from the JSNA 2012-13[442]. The gender ratio of OCU prevalence is drawn from the 'Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2010/11' report[443] and the local gender profile is drawn from the full year figures contained within the 'West Sussex Adult Partnership Quarterly Performance Report (Drugs), Quarter 4, 2012-13'.

Table 7.4: Prevalence Service Utilisation Ratio – Drugs

	Total Population adjusted by age (16-64)	Prevalence of OCU (previously defined as 'problem drug use')		Target performance (capacity)	Adjusted number accessing treatment (-8.2%)	PSUR	Percent accessing treatment
	Number (61.3% of total population of 808,900)	%	Number	Number	Number	Ratio	%
All	495,856	0.47	2331	1750	1596	1:1.46	68.5%
Male %		76.7	1788	(74%)	1181	1:1.51	66.1%
Female %		23.3	543	(26%)	415	1:1.31	76.4%

It can be seen from these calculations that the percentage accessing drug treatment (68.5%) is significantly higher than those accessing alcohol services (7.9%) in West Sussex. The expectation based on the NTA guidance in England and the SACDM report in Scotland is that access to drug services should be 50%. In this regard, it could be argued that there is an overprovision in the ratio between the prevalence of problem drug use in West Sussex and the capacity of available services.

[442] JSNA (2013a), op.cit.

[443] Hay (2013), op.cit.

CHAPTER 8: WHAT THIS MEANS FOR WEST SUSSEX

The publication of the Government's 2010 Drug Strategy *Reducing Demand, Restricting Supply, Building Recovery* [444] signalled a fundamental shift in the way we think of problem drug use and in the approach to the types of interventions that are appropriate to address it. In particular, the switch to a recovery model represented the recognition that the resolution of addiction problems involves not only the substance user, but also their family and their community. It also recognises that recovery is a complex process likely to endure over a number of years after the point of stabilisation or abstinence, one that is likely to involve fundamental changes in an individual's social functioning and personal wellbeing, as well as in their place in their community and society. This shift in emphasis is also acknowledged in relation to alcohol treatment in the Government's 2012 Alcohol Strategy.[445]

There are a number of different definitions of recovery within policy, strategy, academic and clinical writings; however these can be distilled into three key common aspects:

- remission of the substance use disorder;
- enhancement in global health (physical, emotional, relational, occupational and spiritual); and
- positive community inclusion.[446]

The impact of this approach is the need to consider not just whether there is sufficient capacity within alcohol and substance misuse services to meet demand (and therefore avoid lengthy waiting times) but also to consider how these services work together to the benefit of the individual, how they engage with and support families and how the care and support of people with alcohol and drug problems is interlinked with a wide range of health and social care providers.

This chapter identifies the extent to which these elements are in place across West Sussex and makes comment on the appropriateness and effectiveness of current resources and the systems within which these are deployed.

The conclusions and recommendations have been developed through a systematic review of the evidence gathered through Chapters 2-7. Each member of the Research Team has reviewed the report independently and drawn together conclusions and recommendations (using the headings listed in Section 1.3 'Objectives') which have then been collated and cross-checked prior to inclusion in the final report.

[444] HM Government (2010), op.cit.

[445] HM Government (2012), op.cit.

[446] White, W (2007) 'Addiction Recovery: Its Definition and Conceptual Boundaries', *Journal of Substance Abuse Treatment*, Vol. 33, No. 3, pp229-241.

8.1 Conclusions

Evidence from the Gap Analysis (Chapter 7.4) suggests that West Sussex is currently well provided for in terms of alcohol services - the ratio of need for alcohol services in relation to the provision of services is 1:12.6, which is significantly better than the English average of 1:18. There is also a wide variety of other services that play a legitimate role in responding to the needs of people who get into problems with alcohol, although links between specialist services, non-specialist services and community assets/groups/resources have significant room for improvement.

In relation to the current service provision for those with drug problems, evidence from the Gap Analysis (Chapter 7.4) suggests that West Sussex may have an over-provision of specialist service capacity. However, there is concern over the accuracy of prevalence data pertaining to injecting in West Sussex which does not seem to correlate with the number of needles and syringes issued across the county, nor with the numbers presenting at specialist services. The Gap Analysis should therefore be seen as an indication rather than hard evidence upon which commissioning decisions can be made.

There is a paucity of data in relation to current service provision for those with co-occurring disorders (or dual diagnosis). The evidence gathered through the qualitative interviews as part of this review suggests that dual diagnosis service provision needs significant development. However, the data provided by services is mainly estimated, with no certainty provided as to the consistency of assessments available across West Sussex around dual diagnosis.

One of the major challenges in conducting this Needs Assessment has been the lack of service engagement in seeking the views of service users and carers. Insufficient service user and carer questionnaires were returned to give any credible voice to these important groups. Because of this, the findings of this report are poorer and less robust than they would otherwise have been. The poor engagement of services in this regard may be a sign of anxiety (within services) as to the relative importance placed upon service user views in commissioning processes.

Evidence gathered throughout this review indicates that mutual-aid and self-help groups are not well publicised/engaged with across West Sussex.

Little appears to be understood about the concept of recovery to support and sustain change for those who want to end their dependency upon alcohol and/or drugs. Recovery is not simply about providing person-centred care – it places users of services as experts in their own recovery. Services do not appear to have grasped this shift in emphasis.

8.2 Recommendations

The following set of recommendations are structured around the key objectives of the study.

8.2.1 To describe the epidemiology of drug and alcohol use in West Sussex including prevalence, risk factors, drivers and impact.

1. We are aware of moves to improve data collection systems and we would particularly encourage collection of more longitudinal data to track changes over time. This will enable trends to become more visible, especially in mapping against wider changes, such as improvements in HCV testing rates.
2. We would further suggest that local analysis to interpret and comment on data collected would be a useful tool for planners, managers, services and those who use services. Narrative summaries will help the universal application of data to assess gaps, map trends and highlight improvements for all concerned. An annual summary of data and accompanying narrative for wide distribution is suggested.
3. West Sussex is becoming more ethnically diverse (11% ethnic minority in 2011 Census; 6.5% in 2001 Census), although there is significant local variation across the county. We therefore suggest close monitoring of ethnic diversity is maintained, with attention to those who may be underrepresented in presentations to local services e.g. seasonal or migrant workers.
4. West Sussex is a large county with a variety of large towns and many smaller, scattered villages. In 2011, the population of rural wards on West Sussex accounted for 24% of the county total. Residents of rural West Sussex generally have to travel further to access services than in rural areas across the country. Whilst there is no strong evidence this prevents people accessing services, we suggest a 'watching brief' is maintained on rural and remote access to services. There may be options for utilising pharmacy and other resources to increase access to some local support services in future.

8.2.2 To assess current and estimate future health and social care needs of adults and children and young people with Opiate & Crack Use (OCU), non–OCU and Alcohol use.

5. West Sussex Commissioners and Services should continue to ensure that alcohol and drug treatment and recovery services are identifying their clients' employment related aspirations and needs as well as looking at strengthening the links between education, training, volunteering and employment services and treatment/recovery services.
6. There appears to be limited integration with mental health services and work with people with dual diagnosis. Current services and their responses appear fragmented and/or limited. Consideration should be given to ensuring that all staff and volunteers working with those who have alcohol and/or drug problems have access to regular training in mental health issues and receive specialist advice and training from the Community Mental Health Service.
7. Consideration should be given to mapping the existing provision (and gaps in provision) of self help services such as AA/NA/SMART Recovery and the local EXACT service; and to identify ways to support the development of mutual aid

and self help; to ensure that it is an integrated part of the treatment and recovery system.

8. Consideration should be given as to how best to promote the evidence base for recovery which demonstrates that recovery is possible. This can be achieved via staff training and workforce development opportunities.

8.2.3 To understand the issues which are important to service users, their families and the wider population.

9. The evolution, planning and development of recovery assets, services, and commissioning processes should be built around the ambitions of service users and their families within a recovery-orientated system of care. Developing services in this way will provide benefits to people who use the service but will also help develop community based mutual aid and peer support networks, thereby enhancing the ability for people to move on from services. Consequently consideration should be given to developing a clear framework for how service users and their families should be involved in the delivery, development and commissioning of drug/alcohol services. The first step should be to develop a meaningful county-wide consultation system which would enable service users and families to work in collaboration with commissioners and services to develop a long-term inclusion and involvement strategy, and would be consistent with the principles of Recovery Oriented Systems of Care.

10. In order to address this objective fully in the longer term, we suggest that a 'Recovery Resource Centre' is established in West Sussex, staffed and run by service user-educators and linked to the delivery of the local recovery strategy. The centre would train and support people with lived experience of drug and alcohol problems to tell their stories and to promote awareness of recovery principles among staff and other service users. It would also begin to train people as 'peer professionals' to provide direct care within the services. It would need to work with local education providers to ensure that the training is of a consistently high standard and begin to offer accredited courses. A beneficial offshoot of this development would be the general promotion of an 'educational', rather than a 'therapeutic', model within the services, which would place an emphasis on learning from one another and assist in promoting self-determination and self-management.

8.2.4 To assess the health and social care needs of adults and young people with dual diagnosis.

11. Annual Partnership returns suggest that in 2012/13, 14% of new clients accessing specialist drug misuse services in West Sussex had a dual diagnosis. This is significantly lower than rates suggested by research and indications provided in the Management Survey conducted as part of this study. Therefore, given the apparent discrepancy between perceptions of prevalence, consideration

should be given to evaluating and developing staff skills and confidence in identifying mental health issues and recording details.

12. Co-occurring mental health problems and substance misuse problems are typically managed in a way which addresses the primary problem, followed by the secondary problem; regardless of equity of condition – co-occurring problems are not effectively managed simultaneously. This requires further detailed analysis.

13. Our findings highlight the absence of a specific dual diagnosis service is regarded as a significant gap by key stakeholders in West Sussex. Joined up working between specialist mental health services and specialist alcohol and drug services for adults also appears sporadic. These merit further detailed analysis, including exploring options to strengthen and improve delivery, particularly treatment pathways and better inter-agency working.

8.2.5 To assess the needs of children and young people whose parent or guardian is at risk of drug and or alcohol misuse.

14. Specialist services which support young people affected by parental alcohol and drug misuse, including their own alcohol or drug misuse, should support whole family interventions to ensure a holistic approach is maintained in West Sussex.

15. Prevention/education services and the specialist young people substance misuse service should seek ways to include those affected by parental alcohol and drug misuse.

16. The training needs of those who work with children and young people affected by parental alcohol and drug misuse should be ascertained to ensure evidence based and effective approaches are being applied, consistent with the rapidly changing trends in drug use by young people.

17. Treatment and interventions for young people with alcohol and drug misuse problems, including those affected by parental alcohol and drug misuse, need to be not only well targeted, responsive, flexible and individually tailored; but also linked to prevention/education and earlier support interventions.

18. Expanding targeted training on specific drug types such as NPS should be considered as part of a future West Sussex training strategy.

19. Similarly, expanding Alcohol Identification and Brief Advice Interventions for both young people and adults should be explored and considered alongside a range of other low level early interventions.

20. Our findings highlight a paucity of data on the number of children and young people in West Sussex who are affected by parental/guardian substance misuse. Given national estimates, there are potentially a large number of children and young people so affected who are currently unknown to services, and who may therefore have unmet needs. Consideration should be given to identifying the

prevalence of children affected by parental substance misuse across the county in order to mitigate both current and future issues this group might encounter.

8.2.6 To summarise existing treatment provision and resources for adults, children and young people presenting with drug and alcohol misuse and other preventative services and activities.

21. Although it is acknowledged that the specialist substance misuse service for young people is accessible and effective, there appears to be limited low level early interventions for children and young people at the earliest stages of problematic substance misuse. A multi-agency response to coordinate low threshold early interventions should be considered, especially involving education, police, and children and family services.
22. Improved coordination of school education work is necessary to respond to deliver consistent key messages in schools and encourage multi-agency low level intervention options. Lessons learned from the now ceased 'Healthy Schools Team' approach should be part of a suggested review of school education work, particularly leadership and coordination. The Healthy Schools Team was a major strength in coordinating and leading schools work and Sussex Police (for example) are calling for its return.
23. Our qualitative findings suggest further exploration of rural and home based provision (except alcohol detoxification) is required to establish the efficacy of current provision and identify gaps, especially in those who are unable to travel or engage in hub based services. The role of pharmacy services as an access point and resource in rural locations should be included in this exercise.
24. The profile and advertising of services and other community based assets and groups should be improved and targeted to different stakeholders, in order to increase understanding of the role each has as part of a network of helping services. This should include mutual aid and emerging recovery communities.
25. Consideration should be given to providing assertive outreach services as part of future mainstream provision, especially for those who rarely or never engage with services.
26. Consideration of the evaluation findings and dialogue with those Pharmacy Managers involved in the West Sussex pharmacist prescribing pilot should be undertaken to establish if this model is viable for further roll out across the County.
27. West Sussex should further investigate the reasons for the apparent under use of local residential Tier 4 detoxification and rehabilitation service for people with alcohol or drug dependency and take steps to improve its use as a local (and probably more cost effective) resource.

8.2.7 To understand where local services are working well and where improvements are needed.

28. The Structured Day Service (Ravenscourt) is clearly under-utilised (approx.. 50% capacity over the last year) across West Sussex. We suggest the reasons for this are further explored in order to maximise the effective and efficient use of this service.
29. West Sussex should also investigate the reasons for the apparent under-use of the local residential Tier 4 detoxification and rehabilitation service (Ravenscourt), and take steps to improve its use as a local (and possibly more cost effective) resource.
30. Future contract arrangements should monitor and address attrition rates among staff in specialist alcohol and drug treatment service providers. This has caused work pressure as well as disquiet among several stakeholders and can be open to inaccurate interpretation.
31. Many of the buildings currently operated throughout West Sussex by specialist alcohol and drug service providers, as well as primary homelessness service providers (which also provide residential/supported housing recovery services for people with alcohol and drug problems) are unwelcoming, substandard and un-inspiring. Significant investment to upgrade and possibly relocate may be required for some services whose building is not fit for purpose.
32. The Tier 4 panel which assesses individuals for potential entry to Tier 4 services does so in the absence of the individual at the centre and lacking the involvement of significant others in the process. Furthermore, referrals for panels appear to be of sporadic quality. A review of the Tier 4 assessment panel's process and quality should be undertaken, ensuring that individuals and significant others are fully involved in this process.
33. Tier 4 services should be considered more as a feasible treatment option at the start of a treatment journey, rather than as a last resort. We suggest the criteria for Tier 4 be examined to ensure that access to Tier 4 services remains an option at any stage of an individual's recovery journey.

8.2.8 To understand how substance misuse treatment services are working with other health and social care services (including VCS services), in particular links with mental illness treatment for adults and children and links with prevention and treatment for infectious diseases such as HIV and Hepatitis.

34. We are aware of the efforts that are underway to improve rates of HBV vaccinations and HCV tests across West Sussex, and we would encourage these efforts to continue.
35. West Sussex should draw upon the considerable experience of its specialist staff in its move towards establishing recovery orientated systems of care. For example, the impact of recovery could be made more visible by drawing upon the knowledge of existing specialist staff with personal experience.

36. Good links to homeless, pharmacy and probation services are evident in West Sussex. Further efforts to draw upon the assets of many other agencies should include mutual aid groups. The apparent lack of linkages with maternity services, specialist alcohol and drug inpatient services, and some adult social work services should be urgently explored.

37. Whilst staff are largely positive about team spirit, support and communication, the apparent low morale is concerning. Strengthening management and peer support systems should be encouraged to mitigate against the impact of wider changes. Attention to staff wellbeing, sickness and stress levels is suggested.

38. Additionally, further attention should be considered to bolster informal and formal supervision structures to support staff in their work with alcohol and drug issues.

8.3 In summary

In summary, this study has a number of limitations in common with other health needs assessments. However, the assumptions and limitations have been clearly described in the body of the report, and due caution should be exercised in interpreting the findings. It will be for future research to address the limitations of the current study. In particular, there is concern over the accuracy of prevalence data pertaining to injecting in West Sussex which does not seem to correlate with the number of needles and syringes issued across the county, nor with the numbers presenting at specialist services. However, the work done for this assessment has highlighted a number of areas that could benefit from further consideration.

APPENDICES

APPENDIX I: List of stakeholders consulted during the consultation phase

Table AI.1 Stakeholder Interview List

Stakeholder name	Job Title	Service/Dept	Organisation
Caroline Adams*	Youth Safety & Intervention Officer	Youth Safety & Intervention Team	Sussex Police
Charlotte Agent*	Alcohol Specialist Nurse	Worthing Hospital	West Sussex Hospitals Trust
Andy Biddle	Integrated Services Manager	West Sussex	CRI
Ian Bradshaw*	Team Leader	CARAT, HMP Ford	CRI
Jane Brown	Locality Manager	West Sussex	Carers Support West Sussex
Pam Bushby	Communities Intervention Manager	Community Safety	Chichester District Council
Helen Carey*	Pharmacist		Boots the Chemist
Joel Corey	Chairman	Chichester EXACT	EXACT
Derek Corrigan	Manager	Day Centre	Ravensourt
Bec Davison	Director	Operations	CRI
Chis Dunn-Coleman	Service Manager	Day Centre	Worthing Churches Homeless Project
Mark Eyre*	Partnership Manager	Community Safety	Sussex Police
Vicky Fenwick	Harm Reduction Programme Manager	Public Health	WSCC
Kayleigh Foster	Outreach & Recovery Project Worker	Outreach	CRI
Rhian Francis	Partnership Coordinator	Safer Communities Team	WSCC
Stuart Gibbons	Head of Client Services	Glenlogie Hostel	Stonepillow
Joanne Goodchild	Assistant Service User Recovery Assistant	Sands	Stonepillow
Jez Graves*	Detective Superintendent	CID	Sussex Police
Jonathan Harmin	Director	Executive	Ravenscourt Trust
Kathryn Harries	Pharmacist		Paydens
Alan Hendry	Recovery Champion		
John Holmstrom@	Chief Executive	Executive	Worthing Churches Homeless Project

Colleen Homan	Area Manager	West Sussex Area	Addaction
Clive Jones	Team Leader	Hostels	Stonepillow
Helen Keats*	Rough Sleeping Advisor	Independent (Police link)	Helen Keats Associates
Sophie Kinnaird	Project Worker	Sands Residential Recovery Service	Stonepillow
Beverly Knight	Lead Professional	Community Safety	WSCC
Gill Livingstone	Quality & Governance Manager	Quality & Governance	Addaction
William Lloyd	Pharmacy Manager		Kamsons
Holly Margetts	Quality & Development Manager	Public Health Directorate	WSCC
Neil Mooney	Assertive Outreach Officer	Outreach	Stonepillow
Matthew Moore	Project Worker	Day Service	Addaction
Kevin Muncey	Trainee Project Worker	Day Centre	Ravensourt
Ellie Newton	Project Worker	The Old Glassworks (& Sands)	Stonepillow
Tom Packer*	Business Manager		Broadreach House (Devon)
Sarah Piper*	Mental Health Liaison Nurse	Worthing Hospital	Sussex Partnership NHS Foundation Trust
Amanda Radley	Director	Probation	Surrey and Sussex Probation Trust
Niall Reid	Project Manager	Residential Recovery Service	Worthing Churches Homeless Projects
Sue Rowden	Recovery Lead	Recovery	Addaction
Cathy Salisbury	Social Worker	Social Worker	WSCC
Dr Charles Shlosberg*	GP		The Lawns Surgery
Pamela Spalding*	OD Trainer	Sussex Homeless Training Service	St John Ambulance
Cheryl Spittal	Recovery Lead	Bognor & Chichester	CRI
Rosa Srodkoska	Outreach & Recovery Project Worker	Outreach	CRI
Jennifer Talbot	Project Worker	The Old Glassworks (and Sands)	Stonepillow
Miranda Tatarek	Team Manager	Day Service	Addaction
Hayley Territ	Senior Counsellor	Residential Detoxification & Rehabilitation Service	Ravenscourt Trust
Martin Territ	Service Manager	Sands Residential Recovery Service	Stonepillow

Maxine Thomas*	Specialist Vocational Support	Central Management Team	Impact Initiatives
Catrina Tranquille*	Alcohol Specialist Nurse	St. Richard's Hospital, Chichester	Western Sussex Hospitals Trust
Katherine Wadbrook*	Team Manager	Young People	CRI
Paul White*	Practitioner Nurse	Chichester	Addaction
Sophie Whitehouse	Partnership Coordinator	Safer Communities Team	WSCC
Sinead Wileman	Social Worker (Substance Misuse)	Adults	WSCC
Brenda Williams*	Business Change Manager		Avanta
Robin John Woznicki	Treatment Manager	Residential Detoxification & Rehabilitation Service	Ravenscourt Trust

KEY: * interviewed by telephone; @ interviewed by email

Table AI.2 List of Focus Groups and Attendees

FOCUS GROUPS CONDUCTED			
No.	**Location**	**Attendees**	**Organisation / Project**
1	Worthing	Anonymous	Addaction
2		Anonymous	Addaction
3		Anonymous	Addaction
4		Anonymous	Addaction
5		Anonymous	Addaction
6		Anonymous	Addaction
No.	**Location**	**Attendees**	**Organisation / Project**
1	Lancy	Anonymous	Carers Support West Sussex
2		Anonymous	Carers Support West Sussex
3		Anonymous	Carers Support West Sussex
4		Anonymous	Carers Support West Sussex
5		Anonymous	Carers Support West Sussex
6		Anonymous	Carers Support West Sussex
7		Anonymous	Carers Support West Sussex
8		Anonymous	Carers Support West Sussex
9		Anonymous	Carers Support West Sussex
10		Anonymous	Carers Support West Sussex
11		Anonymous	Carers Support West Sussex
12		Anonymous	Carers Support West Sussex

No.	Location	Attendees	Organisation / Project
1	Bognor	Anonymous	CRI
2		Anonymous	CRI
3		Anonymous	CRI
4		Anonymous	CRI
5		Anonymous	CRI
6		Anonymous	CRI
7		Anonymous	CRI
8		Anonymous	CRI
No.	**Location**	**Attendees**	**Organisation / Project**
9	Telephone Interview	Anonymous	CRI
10		Anonymous	CRI
11		Anonymous	CRI
No.	**Location**	**Attendees**	**Organisation / Project**
1	Chichester	Anonymous	EXACT
No.	**Location**	**Attendees**	**Organisation / Project**
1	Bognor	Anonymous	Ravenscourt
2		Anonymous	Ravenscourt
3		Anonymous	Ravenscourt
4		Anonymous	Ravenscourt
5		Anonymous	Ravenscourt
6		Anonymous	Ravenscourt
7		Anonymous	Ravenscourt
8		Anonymous	Ravenscourt
9		Anonymous	Ravenscourt
10		Anonymous	Ravenscourt
11		Anonymous	Ravenscourt
12		Anonymous	Ravenscourt
13		Anonymous	Ravenscourt
14		Anonymous	Ravenscourt
15		Anonymous	Ravenscourt
16		Anonymous	Ravenscourt
17		Anonymous	Ravenscourt
18		Anonymous	Ravenscourt

No.	Location	Attendees	Organisation / Project
1	Bognor	Anonymous	Stonepillow
2		Anonymous	Stonepillow
3		Anonymous	Stonepillow
4		Anonymous	Stonepillow
5		Anonymous	Stonepillow
6		Anonymous	Stonepillow
7		Anonymous	Stonepillow
8		Anonymous	Stonepillow
9		Anonymous	Stonepillow
10		Anonymous	Stonepillow
11		Anonymous	Stonepillow
No.	**Location**	**Attendees**	**Organisation / Project**
1	Worthing	Anonymous	Worthing Churches Homeless Project
2		Anonymous	Worthing Churches Homeless Project
3		Anonymous	Worthing Churches Homeless Project
4		Anonymous	Worthing Churches Homeless Project
5		Anonymous	Worthing Churches Homeless Project
6		Anonymous	Worthing Churches Homeless Project
7		Anonymous	Worthing Churches Homeless Project
8		Anonymous	Worthing Churches Homeless Project
9		Anonymous	Worthing Churches Homeless Project