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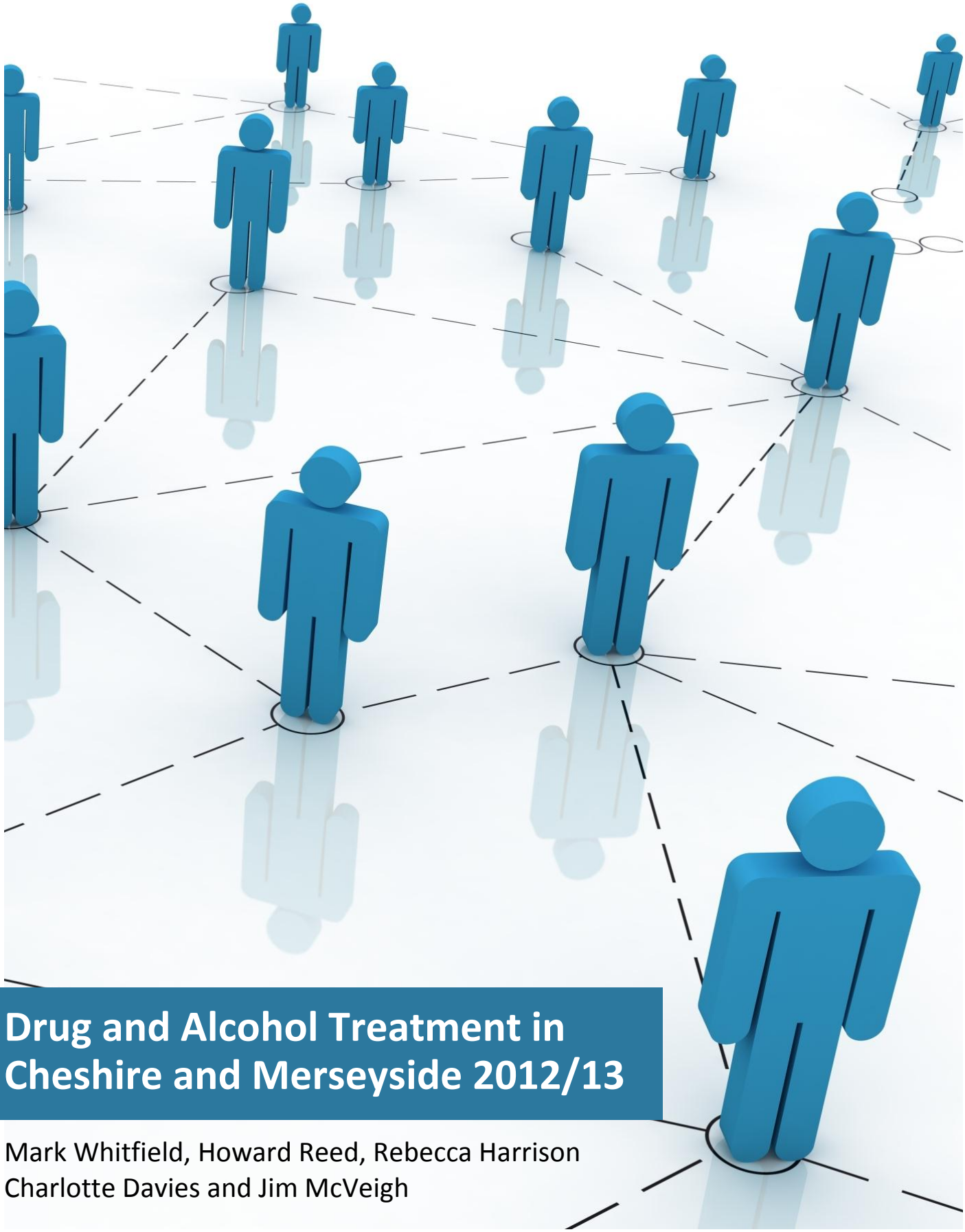

Drug and Alcohol Treatment in Cheshire and Merseyside 2012/13

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PREVIOUS REPORTS

The Alcohol Treatment in Cheshire and Merseyside report series

This *Drug and Alcohol Treatment in Cheshire and Merseyside 2012/13* report is adapted from a series of reports that highlight intelligence on alcohol treatment in Cheshire and Merseyside. The previous reports were:

- Alcohol Treatment in Cheshire and Merseyside, 2004/05 (Brown et al, 2006)
- Alcohol Treatment in Cheshire and Merseyside, 2005/06 (McVeigh et al, 2006)
- Alcohol Treatment in Cheshire and Merseyside, 2006/07 (McCoy et al, 2007)
- Alcohol Treatment in Cheshire and Merseyside, 2007/08 (McCoy et al, 2009)
- Alcohol Treatment in Cheshire and Merseyside, 2008/09 (McCoy et al, 2010)
- Alcohol Treatment in Cheshire and Merseyside, 2010/11 (Hurst et al, 2012)
- Alcohol Treatment in Cheshire and Merseyside, 2011/12 (Hurst et al, 2013)

All the reports above are available at: www.cph.org.uk/publications

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EXECUTIVE SUMMARY

This publication is the first combined report inclusive of both drugs and alcohol structured and non-structured interventions, which includes information previously reported in the "Alcohol Treatment in Cheshire and Merseyside" series of reports alongside information on drug use in the region. During the 2012/13 reporting period, 22 specialist drug and alcohol services from throughout the region reported attributable data (i.e., containing a client's initials, date of birth and gender). In total, 29,491 non-structured interventions delivered to 7,848 individuals, alongside a further 10,817 screenings delivered to both service users and the general public by pharmacies and agencies throughout the Wirral.

The treatment population for alcohol services as a whole (including structured services) was mainly male (62.1%), identified themselves as White British (95.7%) and over two in five were aged between 40-54 years. For drug services (including structured services), there were significantly more males attending (73.4%) with over half of individuals ages between 35-49 years, and again identifying largely as White British (95.6%). Illicit Heroin Illicit was the most commonly reported problem substance.

For non-structured services, the two hospital based LCAS (Liverpool Community Alcohol Service) services had the highest number of individuals reporting to the system (40.1% of the total). As a result, alcohol was the main problematic substance reported although there were also a significant number of heroin users reported to the monitoring system through the inclusion for the first time of GOLIATH based NSTMS (Non Structured Monitoring System) data. For the purposes of the time frame covered within this report NSTMS covers the Liverpool area but it has since been rolled out to other areas across the Merseyside and Cheshire region.

1. INTRODUCTION

This publication details the results of both the structured (NDTMS) and non-structured (ATMS/NSTMS) drug and alcohol monitoring systems within the Cheshire and Merseyside area during 2012/13, along with an overview of significant developments in terms of policy and publications in the field of drugs and alcohol research.

Box 1. The non-structured monitoring systems provided by CPH – ATMS (Alcohol Treatment Monitoring System), NSTMS (Non Structured Treatment Monitoring System) and IAD (Inter Agency Database) , which cover interventions delivered from low threshold drugs, alcohol and syringe exchange services will be unified into one dataset from 1st April 2014. More information on this can be found in the conclusion.

As this report is new in terms of its scope, Wirral AUDIT screening data are now included in a separate section. AUDIT screenings are mainly focussed on the general public, often through pharmacies (although some specialist drug and alcohol services are also included), and the population wide scope of the screening means that many individuals screened will not have an issue with any substance. Wirral is the only Local Authority in Cheshire and Merseyside currently comprehensively using the AUDIT (Alcohol Use Disorders Identification Test) screening tool developed by the WHO to identify persons with increasing risk or harmful/dependent use and the data is therefore invaluable as a measurement of alcohol use across the region.

With the transition for provision of NDTMS across England moving from local centres including theCentre for Public Health (CPH) to Public Health England (PHE), and public health departments moving from PCTs to local authorities, there has been a significant degree of upheaval to systems with uncertainties around funding and major changes of personnel creating ongoing challenges in maintaining the delivery of local monitoring systems. Consequently not all Local Authorities (LAs) within Merseyside and Cheshire contributed towards local monitoring systems for the 2012-13 financial year. However, the launch of a new Integrated Monitoring System (IMS) in April 2014 will bring together all non-structured monitoring within the region with representation from every area including Liverpool, Wirral, Sefton, Warrington, Knowsley, Halton, Cheshire East, Cheshire West & Chester and St.Helens.

1.1. SETTING THE SCENE (ALCOHOL)

Early key documents such as *Government Alcohol Harm Reduction Strategy for England* (Cabinet Office, 2004), *Choosing Health: Making Healthy Choices Easier* (DH 2004), *Prevention and Reduction of Alcohol Misuse (*HDA, 2003) and *Drinking Responsibly* (DCMS, ODPM and HO, 2005) recognised the challenge on policy makers to address alcohol-related issues and the burden that alcohol placed upon health services/health providers. This is a challenge that still presents a decade later.

Some key facts surrounding alcohol consumption, alcohol-related illness and treatment include:

- Alcohol-misuse spans all sectors of the economy such as alcohol-related disorders and disease; crime and anti-social behaviour; loss of productivity in the workplace and problems experienced by those who misuse alcohol and their families (NICE, 2011).
- Harmful use of alcohol is a major contributor of violence (Hughes, Bellis and Wood, 2009).
- In England, there has been a 73% increase in the number of items prescribed for the treatment of alcohol dependence in primary care settings or NHS hospitals and dispensed in the community (from 102,741 in 2003 to 178,247 in 2012). The Net Ingredient Cost (NIC) of these prescriptions has also increased by 70% from £1.72 million in 2003 to £2.93 million in 2012. (Health and Social Care Information Centre, 2013).
- It is estimated that alcohol-related harm costs the NHS approximately £2.7 billion per year (NHS Confederation, 2010). Despite this increasing burden, however, it is estimated that only 2% of NHS expenditure on alcohol-related harm is actually spent on specialist alcohol services (Department of Health, 2009).
- Anecdotal evidence suggests that 14 million work days per year are lost to hangovers, absenteeism or alcohol-related illness (http://www.theguardian.com/money/work-blog/2013/apr/23/workplace-alochol-testing-employees).
- The average amount of alcohol drunk per head (UK population aged 15 and over) has decreased from 11.6 litres of pure alcohol per head (2004) to 10.2 litres (2009) (British Pub and Beer Association, 2010)
- Between 2006 and 2011, in England, there was a decrease in the proportion of women drinking more than three units on the heaviest day's drinking in the last week (33% to 28%) and the proportion drinking twice the recommended amount (16% to 13%) (Health and Social Care Information Centre, 2012).
- In England in 2011/12, there were 200,900 admissions where the primary diagnosis was attributable to the consumption of alcohol (the narrow measure). This is a one per cent increase since 2010/11 when there were 198,900 admissions of this type and a 41 per cent increase since 2002/03 when there were around 142,000 such admissions (Health and Social Care Information Centre, 2012).
- In England, from 2002/03 to 2010/11 there was a 51% increase in the number of admissions related to alcohol consumption where an alcohol-related disease, injury or condition was the primary reason for hospital admission or a secondary diagnosis (from an estimated 807,700 admissions to an estimated 1,205,500 admissions)[1] (Health and Social Care Information Centre, 2013).

1.2. SETTING THE SCENE (DRUGS)

The 2010 Drug Strategy, *Reducing Demand, Restricting Supply, Building Recovery* (HM Government, 2010) sets out the Coalition Government's approach to tackling drugs, with an emphasis on recovery. In 2012, the expert group on recovery-orientated treatment published *Medications in Recovery* (NTA, 2012c), with the aim of coming to a consensus on providing recovery-orientated treatment for heroin users. The report, alongside the development of a suite of recovery resources, provides a new national framework of best practice for practitioners and effectively updates the *Models of Care* (NTA, 2006) document. A new model of commissioning services, Payment by Results is currently being piloted in 11 areas and a pilot of heroin assisted treatment is also underway. A commitment to harm reduction measures such as needle and syringe exchange, infectious disease testing and treatment continues the public health approach adopted in the UK since the 1980s. To address the increasing concern around the use of new psychoactive substances (NPS), an *Action Plan on NPS* was published in 2012 as part of the annual review of the Drug Strategy (HM Government, 2012).

Some key facts surrounding drug use, drug-related consequences and treatment include:

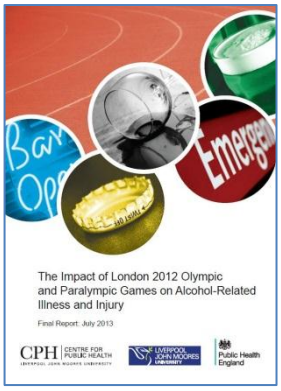
- There were 298,752 opiate and/or crack cocaine users aged 15 to 64 in England in 2010/11 and 93,401 injectors of these drugs (NTA, 2013).
- In 2011/12, 9% of adults aged 16 to 59 years old in England and Wales reported using drugs in the last year, a decrease from 12% in 2001/02 (Home Office, 2012). This decrease is primarily driven by a decrease in cannabis use (from 10.7% to 7.0%). Trends in stimulant use have fluctuated with a decline in amphetamines use since the turn of the century and an increase in cocaine powder use until 2008/09. Since then, cocaine powder use has stabilised but there has been growing concern about the use of Non-medical Prescription Stimulants (NPS). Nevertheless, reported use of most NPS apart from mephedrone is very low.
- In 2011/12, 197,110 adults and 15,289 young people aged under 18 received treatment for primary drug misuse in England (NTA, 2012a; 2012b). Just under two-thirds of opiate users are in treatment annually with 92% receiving prescribing treatment. Around two-thirds of primary opioid users in prescribing treatment during 2011/12 had been in prescribing treatment for more than 12 months.
- The number of individuals in treatment for primary cannabis use in England has increased by 41% since 2005/06 to 28,394 in 2011/12 (NTA, 2012a; 2012b) and the number of hospital admissions with a diagnosis of mental and behavioural disorders due to cannabinoids use has increased from 4,311 in 2007/08 to 13,034 in 2011/12. The most common primary diagnosis amongst admissions recording a secondary diagnosis of disorders due to cannabinoids in 2011/12 was mental and behavioural disorders due to alcohol (4.3%), schizophrenia (3.7%) and pain in the throat and chest (2.9%).
- In England in 2011/12, there were 6,227 NHS hospital admissions with a primary diagnosis of drug-related mental health or behavioural disorders and 57,852 admissions with a primary or secondary diagnosis. While the number of primary and secondary diagnosis admissions has increased substantially since 2002/03 (n=31,490), the number of primary diagnosis admissions has decreased (n=7,691).
- In addition, in 2011/12 there were 12,346 hospital admissions with a primary diagnosis of poisoning by illicit drugs, an increase since 2002/03 (n=7,011) (Health and Social Care Information Centre, 2012).
- There were 2,425 drug-related deaths in England and Wales in 2011, a decrease of 95 from 2010 (ONS, 2012). Just under one-third of drug-related deaths also involved alcohol. The number of deaths mentioning heroin decreased by 195 between 2010 and 2011 while deaths mentioning methadone increased by 131.
- The contribution of drug use disorders to premature mortality in the UK increased by 571% (95% CI: 71-942) between 1990 and 2010. Drug use disorders are now the 21st highest cause of years of life lost, up from 64th in 1990. Amongst those aged 20 to 54, drug use disorders are now the 6th highest cause of years of life lost, up from 32nd in 1990 (Murray et al., 2013).

- In England in 2011, the prevalence of HIV amongst people who inject drugs was 1.3%. Prevalence of hepatitis C infection was much higher at 45%, although there were marked regional variations with a rate of 60% in the North West compared to 33% in the East Midlands, West Midlands and North East (HPA, 2012). Sixteen per cent of people who inject drugs had markers of current or former hepatitis B infection in 2011, down from 29% in 2001.
    - Twenty-eight per cent of injecting drug users reported symptoms of an injecting site infection in 2011 (HPA, 2012). It is estimated that treating injecting site infections costs the NHS £15.6 million a year (Davies et al., 2012).
    - Just under 1.5 million adults are estimated to be affected by a family member's drug use (UKDPC, 2009) and 2%-3% of children aged under 16 are estimated to have a parent who is a problem drug user (ACMD, 2003). Just over half of the individuals in treatment in 2011/12 were parents or lived with a child (NTA, 2012d).

1.3. NATIONAL, REGIONAL AND LOCAL LITERATURE

This section aims to provide a brief (and by no means exhaustive) overview of the most recent national, regional and local guidance and policy relating to drugs and alcohol, as well as complimenting/updating literature found in the previous *Alcohol Treatment Monitoring* reports.

ALCOHOL



The impact of London 2012 Olympic and Paralympic games on alcohol-related illness and injury (Morleo et al, 2013)

The impact of London 2012 Olympic and Paralympic games on alcohol-related illness and injury is an evaluation that aims to assess any changes in alcohol-related illness and injury in London during the 2012 Olympic and Paralympic Games as well as exploring any factors and interventions that could mitigate alcohol-related illness and injury. The outcomes aim to inform future major event planning in London and the UK and elsewhere.

Overall the evaluation showed that there was minimal impact of the 2012 Olympic and Paralympic Games upon alcohol-related harm. It is unclear which interventions contributed to the success of the games in preventing these increases, however, published literature suggests that restricted advertising, appropriate service planning and pricing strategies that were in place for the Games would have played an important role in harm prevention.

Lessons learnt will inform future multi-agency practice – these include the opportunities that the Games presented through direct and indirect interventions provided in terms of advertising restrictions, prohibition of taking own alcohol into events, appropriate pricing strategies and the use of interventions to divert intoxicated people away from emergency departments where appropriate.

For recommendations, please see the report at: http://www.cph.org.uk/publication/the-impact-of-london-2012-olympic-and-paralympic-games-on-alcohol-related-illness-and-injury-final-report-2013/

Health First – An evidence-based alcohol strategy for the UK (Alcohol Health Alliance UK, University of Sterling and British Liver Trust, 2013)

Health First – An evidence-based alcohol strategy for the UK has been produced by an independent group of experts with no involvement from the alcohol industry. The report produced the following 10 key recommendations:

A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales, together with a mechanism to regularly review and revise this price.

At least one third of every alcohol product label should be given over to an evidence-based health warning specified by an independent regulatory body.

The sale of alcohol in shops should be restricted to specific times of the day and designated areas. No alcohol promotion should occur outside these areas.

The tax on every alcohol product should be proportionate to the volume of alcohol it contains. In order to incentivise the development and sale of lower strength products, the rate of taxation should increase with product strength.

Licensing legislation should be comprehensively reviewed. Licensing authorities must be empowered to tackle alcohol-related harm by controlling the total availability of alcohol in their jurisdiction.

All alcohol advertising and sponsorship should be prohibited. In the short term, alcohol advertising should only be permitted in newspapers and other adult press. Its content should be limited to factual information about brand, provenance and product strength.

An independent body should be established to regulate alcohol promotion, including product and packaging design, in the interests of public health and community safety.

The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml.

All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.

People who need support for alcohol problems should be routinely referred to specialist alcohol services for comprehensive assessment and appropriate treatment.

http://www.stir.ac.uk/news/news-archive/13/03/alcohol-pricing/

Stick to the facts. Alcohol advertising regulations that balances commercial and public interest (Alcohol Concern, 2013)

A report by Alcohol Concern, *Stick to the facts. Alcohol advertising regulations that balances commercial and public interest* claims that self-regulation of alcohol advertising is not working; and that high levels of alcohol brand recognition amongst children, increasing exposure to alcohol advertising among young people and numerous examples of inappropriate advertising content show the failings of the current system.

The report made five key policy recommendations:

- **Only advertise product characteristics** – images and messages should only refer to the characteristics of the product, e.g., its strength; promotion of 'lifestyle' images of drinkers or scenes depicting a drinking atmosphere should be prohibited.
- **Statutory and independent regulation** – regulation of alcohol should be statutory and independent of alcohol and advertising industries, paying particular attention to the difficulties that are experienced with regulating digital and online content.
- **Meaningful sanctions** – such as fines for serious non-compliance with marketing regulations. Fines should be dependent upon the size of the marketing budget and estimated children's exposure.
- **Prohibit sponsorship** – Sponsorship of sporting, cultural and music events by alcohol companies and brands should not be allowed
- **Restrict cinema advertising** – alcohol advertising at cinemas should be prohibited for all films that do not have an 18 rating.

http://www.alcoholconcern.org.uk/media-centre/news/stick-to-the-facts

The Government's Alcohol Strategy (HM Government, 2012)

The Government's Alcohol Strategy sets out the Government's proposals to crack down on 'binge drinking', alcohol related violence and the number of people drinking at harmful/damaging levels. Within the strategy, it includes commitments to:

- Introduce a minimum unit price for alcohol;
- Consult on a ban on the sale of multi-buy alcohol discounting;
- Introduce stronger powers for local areas to restrict opening and closing times, control the density of licensed premises (including making the impact on health a consideration for this) and charge a late night levy to support policing;
- Provide more powers to stop serving alcohol to people who are already drunk;
- Provide more powers to hospitals to tackle those who are drunk and turn up at the Accident and Emergency rooms as well as the clubs that are responsible for them being there;
- Pilot innovative sobriety schemes to challenge alcohol-related offending; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.

https://www.gov.uk/government/publications/alcohol-strategy

Government Alcohol Strategy – Government Response (HM Government, 2012)

The House of Commons Health Committee response to the *Government's Alcohol Strategy* recognised the concerns raised in the alcohol strategy around the impact of binge drinking, but also emphasised the importance of ensuring that the policy recognised and responded to the evidence of the increasing impact of excessive alcohol consumption upon health. The Committee welcomed the Government's decision to introduce a minimum unit price for alcohol.

http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/publications/?type=35&session=2&sort=false&inquiry=141

Can promotion of lower alcohol products help reduce consumption? A rapid review (Jones and Bellis, 2012)

Following the launch of the Government's Responsibility Deal, this short report, *Can promotion of lower alcohol products help reduce consumption? A rapid review* summarises the literature that is available looking at the impact of the promotion of lower alcohol products upon the consumption of alcohol. The report concluded that:

Lowering the alcohol contents of drinks offers health benefits for drinkers at a population level.

Policies that promote the production and consumption of lower alcohol products have the potential to contribute to reductions in alcohol-related harms.

From a public health perspective, of primary concern is the possibility that the introduction of lower alcohol products may actually increase the number of situations in which alcohol is consumed.

http://www.cph.org.uk/publication/can-promotion-of-lower-alcohol-products-help-reduce-consumption-a-rapid-review/

Substance use among 15-16 year olds in the UK (ESPAD, 2012)

The *Substance use among 15-16 year olds in the UK* report presents a summary of key results for the UK from the 2011 European Survey Project on Alcohol and Drugs (ESPAD) that was undertaken on behalf of the UK by the Centre for Public Health (Atkinson, Sumnall and Bellis, 2012). The ESPAD is conducted every four years and collects comparable data on trends in substance use among 15-16 year old school pupils across Europe. Of the 100,000 students from 36 countries that took part in the survey, 1,712 were from the UK. Key findings of the report included that when looking at comparable data across the last 16 years (the ESPAD began in 1995):

There has been a reduction in the level of smoking by school age children; while girls are still shown to smoke more than boys.

There has been a reduction in alcohol consumption, however, levels of heavy drinking (defined as consumption more than five drinks in one sitting) have not changed since 2003 and more girls than boys reported heavy drinking and drunkenness in the last 30 days.

Lifetime use of illicit drugs has decreased over time, however, boys still report greater use of all types of drug use than girls.

It is recommended that this report is read alongside the full ESPAD report (see www.espad.org), which contains further data on a range of associated substance use and risk taking behaviours.

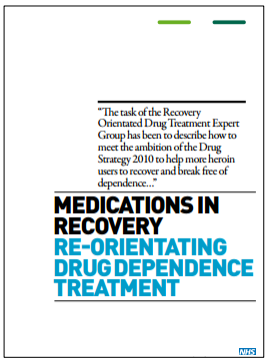
http://www.cph.org.uk/publication/substance-use-among-15-16-year-olds-in-the-uk/

Consideration of Naloxone (ACMD, 2012)

The Advisory Council on the Misuse of Drugs (ACMD) published a review of naloxone (ACMD, 2012) setting out its current legal status (a prescription-only medicine), its effects, methods of administration and a summary of its provision throughout the UK. The ACMD concluded that naloxone is safe and efficacious and any potential risks of using it are outweighed by its benefits. It suggests that provision of naloxone on its own is not enough to reduce drug-related deaths and that it should also be backed up by training of service users, peers and carers in other aspects of overdose response such as basic life support training. The report also states that naloxone's prescription-only status is limiting the opportunities for a range of people to intervene in a potential overdose situation, such as hostel staff.

The report contained three main recommendations:

- The availability of naloxone should be increased across the UK;
- Restrictions on who can be supplied with naloxone should be relaxed by the Government; and
- Effective training for individuals supplied with naloxone, in how to administer it and how to deal with overdose situations, should be investigated by the Government.



Medications in Recovery (NTA, 2012)

Medications in Recovery (NTA, 2012c) sets out practical steps to meet the 2010 Drug Strategy commitment that all those on substitute prescriptions should engage in recovery activities. Drawing upon expert advice, the Building Recovery in Communities (BRiC) consultation responses and a review of the evidence on opiate substitution treatment (OST), the report documents the consensus on providing recovery-orientated treatment for heroin users.

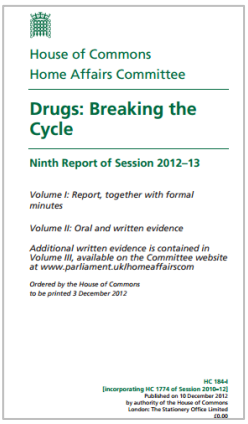
The report declined to set time limits on OST but advised medical and healthcare professionals to:

- Review all existing patients to ensure that they are working to achieve abstinence from problem drugs;
- Ensure treatment programmes are dynamic and support recovery, with the exit visible to patients from the moment they walk through the door; and
- Integrate treatment services with other recovery support such as mutual aid groups, employment services and housing agencies.

Charting new waters: Delivering drug policy at a time of radical reform and financial austerity (UKDPC, 2012)

The United Kingdom Drug Policy Commission (UKDPC, 2012a) published a report, *Charting new waters: Delivering drug policy at a time of radical reform and financial austerity*. Key findings were:

- There is a lack of understanding of how the National Health Service (NHS) structural reforms, the move to localism, austerity measures and the national drug strategy will fit together and how reforms in one area will affect other areas.
- While there may be opportunities to work more efficiently across sectors such as housing, employment and education and to integrate responses to alcohol and drugs, there are some concerns about the potential risks for disinvestment, fragmentation and bureaucracy.
- Although partnership working is valuable, the resources and staff required for such collaboration led around one-third of police respondents to report that they expected to work less with community groups and local councils in the next 12 months.
- There is a lack of robust evidence or detail underpinning the changes, a lack of knowledge about who is responsible for the collection of evidence to support the evaluation of policies and the implications for accountability systems.
- There is potential for groups perceived as 'undeserving', such as drug users, to be neglected given the removal of the ring-fence and assimilation into wider public health budgets.



Drugs: Breaking the Cycle (HAC, 2012)

The Home Affairs Select Committee carried out a review of drug policy in 2012 and reported its findings in in a report, *Drugs: Breaking the Cycle* (HAC, 2012). The review made reference to the findings of the previous Home Affairs Select Committee report on drugs policy carried out in 2002 and took oral and written evidence from a number of experts and individuals in the public eye. It also summarised the evidence available to support the different types of health and social services for drug users.

A number of recommendations were stated in the report including:

- The establishment of a Royal Commission to consider the best ways of reducing the harm caused by drugs.

- Giving the Home Secretary and Secretary of State for Health overall joint responsibility for coordinating drug policy to strengthen interdepartmental cooperation, and to acknowledge that the drug problem is as much of a public health problem as a criminal justice
- Expanding residential rehabilitation provision reviewing the guidance for referral to residential rehabilitation.
- Publishing an action plan to tackle prescription drug misuse as part of the next drug strategy update.
- Allocating ring-fenced funding for drug policy research to address the current knowledge gaps, particularly for prevention and recovery.

The Government's response to the report and its recommendations can be found here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/186345/breaking-the-cycle-government-response.pdf

Quality standard for drug use disorders (NICE, 2012)

A *quality standard for drug use disorders* was issued by NICE in November 2012 (NICE, 2012). Each of the 10 quality statements sets out the rationale for the statement, the quality measure, data source, what the quality measure means for each audience and definitions used in the statement. The standard recommends that services should be commissioned from, and co-ordinated across, all relevant agencies encompassing the whole drug use disorder care pathway. The 10 quality statements cover the following areas:

- needle and syringe programmes;
- assessment;
- families and carers;
- blood-borne viruses;
- information and advice;
- keyworking – psychological interventions;
- recovery and reintegration;
- formal psychosocial interventions and psychological treatments;
- continued treatment and support when abstinent; and
- residential rehabilitative treatment.

A Fresh Approach to Drugs (UKDPC, 2012b)

A Fresh Approach to Drugs (UKDPC, 2012b) pulls together findings from the United Kingdom Drug Policy Commission's six year work programme analysing the evidence for a range of different aspects of drug policy.

The report argues that while there have been policy successes, for example harm-reduction approaches have kept rates of HIV amongst injecting drug users low and the numbers of people receiving treatment has steadily increased, there remain large areas of expenditure, such as enforcement and much prevention, for which there is little evidence of effectiveness.

Some policies are viewed as having unintended negative consequences and drug policy is unable to fully address the problems caused by drugs because the debate has become polarised and 'toxic', with areas of evidence essentially off-limits. For example, there is no recognition of the perceived benefits of drug use.

It is argued that in this age of austerity, and in the light of the challenges posed by new psychoactive substances, there is a need for a fresh approach to drug policy.

United Kingdom drug situation: annual report to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2012)

The United Kingdom Focal Point on Drugs is based at the Department of Health and the Centre for Public Health, Liverpool John Moores University, It is the national partner of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and provides comprehensive information to the Centre on the drug situation in England, Northern Ireland, Scotland and Wales. The report details key topics including drug policy, drug use in the general population and specific groups, prevention, problem drug use, drug-related treatment demand and availability, health correlates and consequences, social correlates and reintegration, drug-related crime, prevention and prison, and drug markets. It also looks at developing trends including residential treatment for drug users and recent trends of drug-related public expenditure.

Human Enhancement Drugs – The Emerging Challenges to Public Health (CPH, 2012)

Public health faces a new kind of drug problem with the growing prevalence of so-called 'enhancement drugs' that have the potential to improve human attributes and abilities. The widespread availability of such drugs has generated a new and growing audience of users. People are seeking out enhancement drugs in a quest to improve their bodies and minds to look younger and more beautiful, to be stronger, happier and more intelligent. These types of drugs share a few similarities with recreational or addictive drugs such as heroin, cocaine, ecstasy and 'legal highs' but also attract people who do not necessarily perceive themselves as 'drug users' and are vulnerable to cultural pressures to optimise their bodies. Manufacturers and retailers around the world are tapping into the demand for such drugs by harnessing innovations in science and medicine, as well as improvements in transport and communication networks. Significantly, in the case of illicit markets, retailers are able to circumvent national laws and regulation with creative and persuasive marketing strategies via the Internet. Often their customers are duped or remain unaware of the considerable harms associated with usage of these drugs, a situation that presents a threat to public health and throws up challenges for healthcare systems around the world.

Residential Alcohol Detoxification Programme Facilitated by The Basement: Safety, Perceptions and Effectiveness (Duffy, Russell, McGee and McVeigh, 2011)

The report *Evaluation of a Residential Alcohol Detoxification Programme Facilitated by The Basement: Safety, Perceptions and Effectiveness* (Duffy, Russell, McGee and McVeigh, 2011), details the Centre for Public Health's rapid appraisal of the service delivery, residents' perceptions and steps taken to ensure safety at the residential detoxification programme facilitated by The Basement (a Liverpool based homeless support service). This included a two week residential stay in North Wales followed by six weeks of preparation sessions, which prospective residents had to attend. Conclusions of the rapid evaluation included that:

The residential filled a niche within treatment provision in Liverpool in that many of the clients attending the residential would have difficulties accessing other services.

The programme had a focus on long term recovery and the use of aftercare that has synergy with current national policy, however, that future funding difficulties present a substantial potential risk to the availability of aftercare spaces for clients exiting the residential.

http://www.cph.org.uk/publication/evaluation-of-a-residential-alcohol-detoxification-programme-facilitated-by-the-basement/

The Ellesmere Port Alcohol Enquiry: Talking Drink Talking Action (Our Life, 2012)

The Ellesmere Port Alcohol Enquiry: Talking Drink Talking Action was funded by NHS Western Cheshire in order to find out what action local people thought should be taken to tackle the negative impact of alcohol in Ellesmere Port. The overall aim of the enquiry was to empower and enable communities to articulate an informed view of the actions that individuals, communities, organisations and decision-makers should support and adopt to reduce alcohol related harm.

Of the 51 people who originally applied to be part of the inquiry, 30 people were invited to take part, while 21 people (aged 16-60 years) became regular attendees. Those taking part in the inquiry made a number of recommendations around the concept of "What needs to change for us all to have a healthier relationship with alcohol", which included:

- More informal education in youth centres.
- Minimum price – charge alcohol price by unit.
- Structured education about alcohol, its effects, how to enjoy responsibly – to be a gradual introduction from primary school onwards.

Further recommendations can be found at:
http://www.ourlife.org.uk/case-studies/the-ellesmere-port-alcohol-inquiry--talking-drink-taking-action/?keywords=alcohol

1.4. EXAMPLES OF CURRENT RESEARCH THAT IS TAKING PLACE WITHIN THE CENTRE FOR PUBLIC HEALTH

There are a number of drug and alcohol-related research projects that are currently on-going at the Centre for Public Health. Some of these projects are detailed below:

THE ADVERSE CHILDHOOD EXPERIENCES (ACE) STUDY

Evidence suggests that exposure during childhood to abuse (emotional, physical or sexual); household dysfunction and/or community dysfunction, which together are known as adverse childhood experiences (ACEs), can impact on people's lifestyle behaviour and disease in adulthood. Child maltreatment and other ACEs are major public health concerns, with large studies indicating that such exposures are relatively common. In the UK, the NSPCC reports that a quarter of all young adults were severely maltreated during childhood.

There are currently limited data on the relationship between ACEs and adult health and lifestyles in the UK. This large scale study will estimate the impact of ACEs in influencing lifestyle behaviours and diseases in the adult population. The study will provide data on the causes of poor adult health and lifestyle factors, giving vital information to local public services that assist with early intervention and prevention strategies and contribute to priorities in local Health and Wellbeing Strategies.

The objectives of the study are to measure:

- the prevalence of adverse childhood experiences at national level;
- adverse childhood experiences within a number of localities;
- the increased odds of morbidity and mortality in adulthood from the number of adverse childhood experiences.

In 2012, the Centre for Public Health (CPH) at Liverpool John Moores University, in collaboration with NHS Blackburn with Darwen, carried out the first ACE study in the UK using a representative sample of the Blackburn with Darwen Borough population. Fifteen hundred participants were successfully recruited through a door-to-door, face-to-face interviewing methodology. Data arising from this study demonstrated how social, emotional and medical problems are linked throughout the lifespan and are allowing researchers, commissioners and health professionals to gain an appreciation of the size of the association between ACEs and lifestyle behaviour and health disease at a population level (Bellis et al, 2013).

Building on the outcomes of this initial UK ACE study, a second ACE study will be the first to use a nationally representative household sample both in England and, to our knowledge, internationally. Results will be used to influence and develop national and local childhood and family-based policies and practices, thereby aiming to prevent future ACEs and influence the future development of family and early years interventions.

ALCOHOL RESEARCH UK (ARUK) - ALCOHOL CONSUMPTION

- '*Understanding the alcohol harm paradox in order to focus the development of interventions*'

This work being undertaken by the Centre for Public Health at Liverpool John Moores is being funded by ARUK and is a national telephone survey conducted as part of the overall project in order to maximise accurate understandings of alcohol consumption. The research team will carry out 6,000 telephone surveys from approximately June 2013 – April 2014. Landline and mobile telephone numbers from across England will be used in order to facilitate engagement with a wide range of population groups.

It is anticipated that the research findings will be available late 2014.

ALCOHOL RESEARCH UK – CONSTRUCING ALCOHOL IDENTITIES

– *'Constructing alcohol identities. How young people navigate and make sense of online intoxicogenic marketing and culture'*

The overall aims of this research project are to explore how young people (YP) interpret and incorporate industry and peer driven social media representations of alcohol use when constructing and negotiating their own on- and off-line identities; how this relates to their 'ideal' identities; and how this process might impact upon alcohol-related health and social behaviours. The researchers are particularly interested in the mediating role of gender and socioeconomic status in shaping identity, and how social media may influence this process. Through comparison with contemporary health promotion campaigns (which may also have industry involvement) the research will seek to understand the social and symbolic meanings of online industry and peer driven alcohol representations, and how these may conflict with, or support processes and values which are important to YP's identity construction.

It is hoped that this work will have useful policy and practice applications:

- It will provide a useful contribution to future development of the Advertising Standards Association Code of Non-broadcast Advertising, Sales Promotion and Direct Marketing code (CAP; Section 18 alcohol), which have previously focused on alcohol industry marketing messages rather than how consumers interact and manipulate those messages through social media.
- It will provide insights into young people's alcohol behaviours online and how these might be relevant to the development of evidence based health promotion.
- It will also contribute to public discussions on alcohol, exploring the view that alcohol marketing is no longer something which is simply delivered to consumers, but one in which they are active participants.

This project is ongoing.

NORTH WEST MENTAL WELLBEING SURVEY 2012/13

In 2009, the North West Public Health Observatory (NWPHO) conducted the North West Mental Wellbeing Survey; a regional survey to measure mental health and wellbeing across the region. It was the largest survey investigating mental wellbeing ever undertaken in the UK, consisting of 18,500 face-to-face interviews. Results were representative at the regional level and at local area level for a number of PCTs (and of sub groups or geographies within this). This project aims to repeat the survey in 2012/13 to provide updated information and allow comparison with the 2009 results.

2. ALCOHOL TREATMENT MONITORING SYSTEM (ATMS)

This section of the report examines the number of individuals in contact with both specialist and non-structured alcohol treatment services, identifying specific characteristics of the treatment population such as age, sex and ethnicity. Findings are reported for individuals across the whole of Merseyside and Cheshire by LA (Local Authority) of residence.

The Alcohol Treatment Monitoring System recorded 12,559 unique individuals between 1st April 2012 and 31st March 2013.

The data for all Local Authorities within Cheshire and Merseyside included 8,008 NDTMS clients (those in 'structured' treatment with alcohol as a primary problem substance), and 5,810 clients in non-structured treatment. The number of clients who were recorded with both NDTMS and non-structured treatment was 1,259.

2.1. PREVALENCE BY LOCAL AUTHORITY AREA

The local authority areas with the largest number of individuals reported to ATMS were Liverpool and Wirral with 4,430 (35.3%) and 3,060 (24.4%) respectively.

The total number of individuals reported in the remaining local authority areas was 5,069 (40.4%)

Local Authority	Individuals	Percentage
Liverpool	4,430	35.3
Wirral	3,060	24.4
Sefton	1,239	9.9
Cheshire West and Chester	915	7.3
Warrington	704	5.6
Knowsley	668	5.3
Cheshire East	567	4.5
St. Helens	501	4.0
Halton	475	3.8
Total:	**12,559**	

Table 1 - Alcohol Treatment by Local Authority

2.2. DEMOGRAPHICS OF THE ATMS TREATMENT POPULATION

GENDER

There are just over six male clients for nearly every four female clients. Within local authority areas this figure remains largely consistent with the local authorities with the highest number of males being Wirral (69.0%) and St Helens (62.3%) and the local authorities with the highest number of females being Knowsley (42.4%) and Liverpool (40.9%). When non-structured clients are split off from those captured by NDTMS, the figures for Males are 64.2% for non-structured and 60.8% for NDTMS.

Gender	Individuals	Percentage
Male	7,793	
Female	4,766	
Total:	**12,559**	

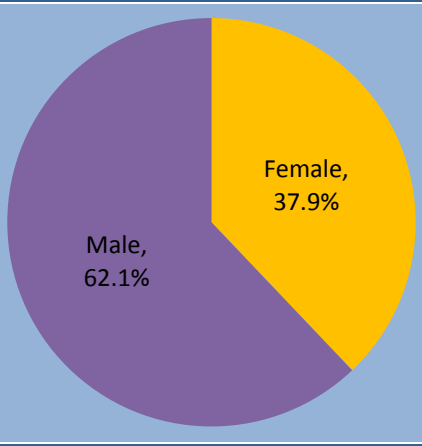


Table 2 - ATMS treatment population by gender

The majority of clients identify themselves as “White British” (73.9%) and this number rises to 95.7% when those not stating their ethnicity are omitted. The next largest groups identified are “Other White” (0.7%), “White Irish” (0.4%) and “Other Black” (0.4%) All other ethnic groups represent 0.3% or less each of the total.

Ethnicity	Individuals	Percentage
White British	9,281	73.9
Other White	93	0.7
White Irish	56	0.4
Other Black	50	0.4
African	43	0.3
Other Mixed	33	0.3
White and Black Caribbean	30	0.2
Other	29	0.2
Other Asian	14	0.1
White and Black African	11	0.1
Pakistani	11	0.1
Caribbean	8	0.1
White and Asian	8	0.1
Indian	6	0.0
Chinese	*	0.0
Bangladeshi	*	0.0
Not Stated	2,878	22.9
Total:	**12,559**	

Table 3 - ATMS treatment population by ethnicity

* Number of individuals suppressed where recorded by 5 or fewer people.

AGE

The largest number of individuals were in the 40-44 age band (14.9%), followed by the 45-49 age band (13.8%) and the 50-54 age band (12.3%), meaning just over two in five individuals were aged between 40-54 years. The age band with the lowest number was 18-19 year olds (3.0%) although this only represented two years, followed by under 18s (3.7%), 20-24 year olds and 60-64 olds, both representing 5.2% of the total and then those aged 65 and over who represent 5.4% of the total.

Age Group	Individuals	Percentage
Under 18	470	3.7
18 - 19	371	3.0
20 - 24	658	5.2
25 - 29	841	6.7
30 - 34	1,273	10.1
35 - 39	1,445	11.5
40 - 44	1,866	14.9
45 - 49	1,735	13.8
50 - 54	1,546	12.3
55 - 59	1,034	8.2
60 - 64	648	5.2
65 and over	672	5.4
Total:	**12,559**	

Table 4 - ATMS Treatment population by age group

2.3. NUMBER OF INDIVIDUALS BY POSTCODE AREA

This map illustrates the number of individuals in treatment by geographic area, the boundaries shown relate to postcode areas. The areas L4, L6, L8, L20, L36, CH41, CH42, CH44 each had greater than 300 individuals in treatment, when combined these eight postcode areas accounted for 25% of all individuals.

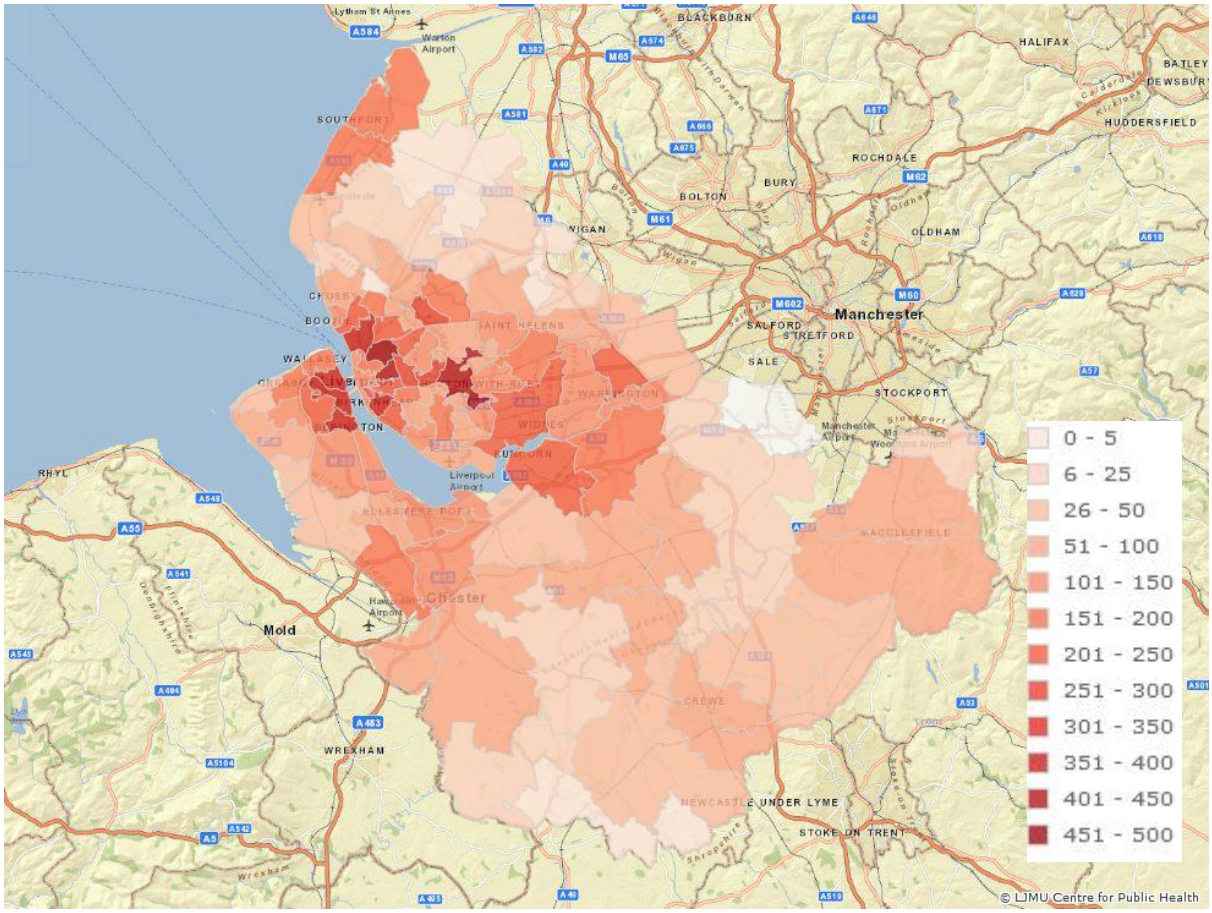


Figure 1 – Number of individuals in treatment by geographic area

3. DRUG TREATMENT MONITORING

The Drug Treatment Monitoring System recorded 15,502 unique individuals between 1st April 2012 and 31st March 2013. The data for all Local Authorities within Cheshire and Merseyside included 14,996 NDTMS clients (those in 'structured' treatment with a drug other than Alcohol as a primary problem substance), and 1,013 clients in non-structured treatment. However this number only includes individuals receiving non-structured treatment in the Liverpool area. The number of clients who were recorded with both NDTMS and NSTMS data was 507.

3.1. PREVALENCE BY LOCAL AUTHORITY AREA

The local authority areas reporting the largest number of individuals in Drug Treatment were Liverpool 5,357 (34.6%), Wirral 2,557 (16.5%) and Sefton 1,712 (11.0%) The total number of individuals reported in the remaining local authority areas was 5,876 (37.9%) It should be noted that at present only individuals resident in the Liverpool area contribute towards the non-structured component which has an inflationary effect on their figures in this table.

Local Authority	Individuals	Percentage
Liverpool	5,357	34.6
Wirral	2,557	16.5
Sefton	1,712	11.0
Cheshire West and Chester	1,309	8.4
Knowsley	1,240	8.0
St. Helens	1,010	6.5
Cheshire East	914	5.9
Warrington	737	4.8
Halton	666	4.3
Total:	**15,502**	

Table 5 - Drug treatment by Local Authority

3.2. DEMOGRAPHICS OF THE TREATMENT POPULATION

GENDER

The number of primary drug using male clients outnumbers female clients by a ratio of almost three to one, representing a client group substantially more skewed towards males than females than the alcohol client group. Within local authority areas this figure remains largely consistent with the local authorities with the highest number of males being Knowsley (76.5%) and St Helens (75.4%) and the local authorities with the highest number of females being Cheshire East (29.5%) and Wirral (27.7%). When non-structured clients are split off from those captured by NDTMS, the figures for Males are 71.3% for non-structured and 73.4% for NDTMS.

Gender	Individuals	Percentage
Male	11,384	
Female	4,118	
Total:	**15,502**	

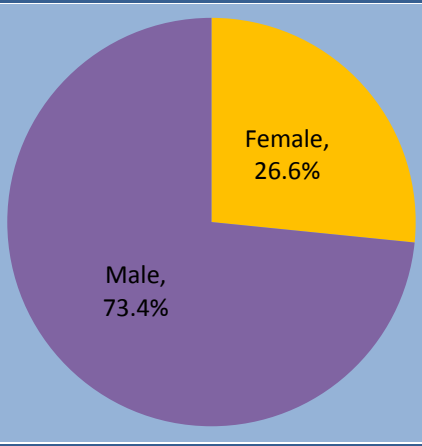


Table 6 - Drug treatment population by gender

The vast majority of clients identify themselves as “White British” (92.9%) and this number rises to 95.6% when those not stating their ethnicity are omitted. The next largest groups identified are “Other White, Other Black, Other and Other Mixed” all representing between 0.5% and 0.8%. All other ethnicities register less than half of one percent.

Ethnicity	Individuals	Percentage
White British	14,395	92.9
Other White	117	0.8
Other Black	111	0.7
Other	82	0.5
Other Mixed	70	0.5
White Irish	66	0.4
White and Black Caribbean	59	0.4
Other Asian	37	0.2
White and Black African	32	0.2
White and Asian	20	0.1
African	19	0.1
Caribbean	17	0.1
Chinese	8	0.1
Bangladeshi	8	0.1
Indian	7	0.0
Pakistani	3	0.0
Not Stated	451	2.9
Total:	**15,502**	

Table 7 - Drug treatment population by ethnicity

* Number of individuals suppressed where recorded by 5 or fewer people.

AGE

The largest number of individuals were in the 40-44 age band (20.6%), followed by the 45-49 age band (16.2%) and the 35-39 age band (15.3%), meaning just over half of all individuals were aged between 35-49 years. The age band with the lowest number was 65 and over (0.3%) followed by those aged between 60-64 years (0.9%) and those aged between 55-59 years (2.2%)

Age Group	Individuals	Percentage
0 - 18	879	5.7
18 - 19	503	3.2
20 - 24	1,163	7.5
25 - 29	1,394	9
30 - 34	1,925	12.4
35 - 39	2,371	15.3
40 - 44	3,197	20.6
45 - 49	2,513	16.2
50 - 54	1,019	6.6
55 - 59	341	2.2
60 - 64	144	0.9
65 and over	53	0.3
Total:	**15,502**	

Table 8 - Drug treatment population by age group

3.3. SUBSTANCE USE

The substance reported most often as the primary problem substance was *Heroin illicit* which was reported by 8,389 individuals (54.1%), this was followed by *Cannabis*[1] by 2,720 individuals (17.5%) and *Cocaine*[2] by 1,967 individuals (12.7%). Together these three substances accounted for over four fifths of all reported primary substances (84.4%).

Code	Primary Substance	Individuals
1101	Heroin illicit	8,389
5000[1]	Cannabis[1]	2,720
3200[2]	Cocaine[2]	1,967
1105[3]	Methadone[3]	953
3201	Cocaine Freebase (crack)	385
3100[4]	Amphetamines[4]	169
1204	Buprenorphine	125
9002	Methadone prescription	75
1111	Dihydrocodeine	68
1401	Other Opiates	63
3114	Mephedrone	56
1205	Codeine unspecified	51
9003	Buprenorphine prescription	48
2200	Benzodiazepines Unspecified	45
1201	Codeine Tablets	43
1000	Opiates unspecified	42
2201	Diazepam	32
1259	Tramadol Hydrochloride	27
4005	Ketamine	27
8799	Drug – not otherwise specified	27
1102	Diamorphine	23
8002	GHB/GBH	16
3406	MDMA	15
3400	Other Stimulants	14
9004	Codeine prescription	13
3000	Stimulants Unspec	11
8600	Steroids Unspecified	11
1103	Morphine Sulphate	10
6000	Solvents unspecified	8
9005	Other prescribed drugs	8
	Other Substances totalling 5 or fewer	61
	Total:	**15,502**

Table 9 - Primary substance reported for all individuals in drug treatment

[1] The figures shown here for 'Cannabis' includes those recorded using the following substance codes; 5000 Cannabis unspecified, 5001 Cannabis Herbal, 5002 Cannabis Resin and 5004 Cannabis Herbal (Skunk).

[2] The figures shown here for 'Cocaine' includes those recorded using the following substance codes; 3200 Cocaine unspecified and 3202 Cocaine Hydrochloride.

[3] The figures shown here for 'Methadone' include those recorded using the following substance codes; 1105 Methadone unspecified, 1106 Methadone Mixture, 1107 Methadone Linctus and 1108 Methadone Tablets.

[4] The figures shown here for 'Amphetamines' include those recorded using the following substance codes; 3100 Amphetamines unspecified, 3101 Amphetamine Sulphate and 3102 Amphetamine (pharmaceutical).

3.4. NUMBER OF INDIVIDUALS BY POSTCODE AREA

This map illustrates the number of individuals in treatment by geographic area, the boundaries shown relate to postcode areas. The areas L4, L6, L8, L11, L13, L20, CH41, CH42, CH44, WA8, WA9 each had greater than 330 individuals in treatment and when combined these eleven postcode areas accounted for 31.6% of all individuals.

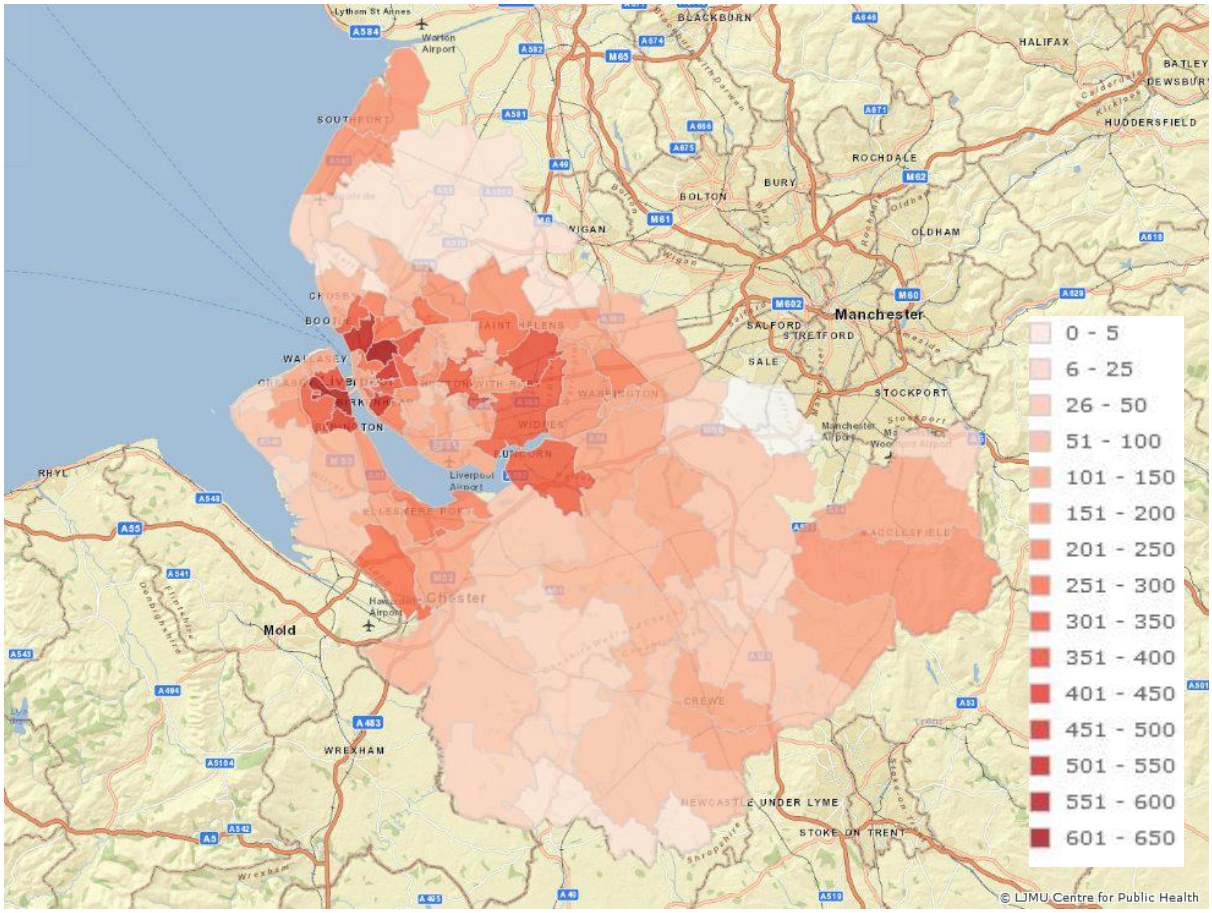


Figure 2 – number of individuals in treatment by geographic area

4. NON STRUCTURED TREATMENT MONITORING

4.1. NON STRUCTURED TREATMENT SERVICES

There were 22 non-structured services reporting to the ATMS (Alcohol Treatment Monitoring System) and NSTMS (Non Structured Treatment Monitoring Service) in the 2012/13 financial year, with 29,491 interventions delivered to 7,848 individuals, each individual receiving on average four interventions (3.76 per individual) but this figure varies considerably between services, from the Whitechapel Centre (26 interventions per individual) and Genie in the Gutter (19 interventions per individual) to Alder Hey and Knowsley ASK which both just record one intervention per individual; although this may be reflective of the kind of service which is delivered. LCAS at the Royal Liverpool University Hospital saw the most individuals (1,805) while the Whitechapel Centre delivered the most interventions (7,190).

Service Name	Number of individuals seen	Interventions delivered
Action on Addiction - SHARP Liverpool	376	2,039
Addaction Liverpool Recovery Services	85	311
Aintree Hospital – LCAS	1,343	3,448
Alder Hey Hospital	47	48
ARCH AIP Wirral	801	860
Armistead City	147	565
Armistead Street	49	550
Art & Soul Liverpool (Spider Project)	491	3,520
Brownlow Practice	197	972
Community Voice	151	518
Dare to Care	75	251
Genie in the Gutter	135	2,567
Knowsley – ASK	805	805
Response Wirral	37	162
Royal Liverpool University Hospital - LCAS	1,805	4,134
The Basement project	546	613
The Social Partnership - Birkenhead	132	147
The Social Partnership – Moreton	56	58
The Social Partnership – Rockferry	71	89
The Social Partnership - Seacombe	141	552
The Social Partnership - Woodchurch	77	92
Whitechapel Centre	281	7,190
Total:	**7,848**[5]	**29,491**

Table 10 - Non structured treatment services - individuals seen and interventions delivered

[5] Please note the total number of individuals seen is more than the total number of individuals within the dataset as an individual may have presented to more than one agency

4.2. DEMOGRAPHICS OF THE TREATMENT POPULATION

GENDER

Almost two thirds of the non-structured treatment population were male (65.3%) as opposed to just over a third female (34.7%), with almost identical percentages when split by the total number of interventions.

Gender	Individuals	Percent	Interventions	Percent
Male	4,461	65.3	19,331	65.5
Female	2,375	34.7	10,160	34.5
Total:	**6,836**		**29,491**	

Table 11 - Non structured treatment - all individuals and interventions by gender

ETHNICITY

Again, the majority of clients identify themselves as "White British" (57.9%) although a significant number do not have their ethnicity recorded (38%) – when this cohort is removed, the number identifying themselves as White British rises to 93.5%. The next largest groups identified are "Other White, Other Black, Other and White Irish" all representing between 0.5% and 0.7%. All other ethnicities register at half of one percent or less.

Ethnicity	Individuals	Percentage
White British	3,956	57.9
Other White	49	0.7
Other Black	44	0.6
White Irish	41	0.6
African	35	0.5
White and Black Caribbean	25	0.4
Other Mixed	22	0.3
Other	10	0.1
Other Asian	12	0.2
White and Black African	9	0.1
Not Stated	8	0.1
White and Asian	8	0.1
Caribbean	7	0.1
Pakistani	6	0.1
Chinese	*	0.0
Bangladeshi	*	0.0
Not Stated	2,596	38.0
Total:	**6,836**	

Table 12 - Non structured treatment - all individuals by ethnicity

* Number of individuals suppressed where recorded by 5 or fewer people.

AGE

The largest number of individuals were in the 40-44 age band (15.2%), followed by the 45-49 age band (12.5%), the 35-39 age band (10.7%) and the 50-54 age band, meaning just under half of all individuals (49%) were aged between 35-54 years. The age band with the lowest number was those under 18 (2.7%) followed by 18-19 year olds (4.1%) and 60-64 year olds (4.9%)

Age Group	Individuals	Percentage
0 - 18	185	2.7
18 - 19	280	4.1
20 - 24	527	7.7
25 - 29	485	7.1
30 - 34	631	9.2
35 - 39	731	10.7
40 - 44	1,037	15.2
45 - 49	855	12.5
50 - 54	725	10.6
.55 - 59	486	7.1
60 - 64	33	4.9
65 and over	561	8.2
Total:	**6,836**	

Table 13 - Non structured treatment - all individuals by age group

When interventions are factored into age groups instead of individuals, the age group with the largest percentage moves up from 40-44 year olds to 45-49 year olds (19.5%) and almost two thirds (63.5%) fall between the ages of 35-54 years. Less than 2.5% of the total number of interventions were delivered to those aged under 20 years.

Age Group	Interventions	Percentage
0 – 18	297	1.0
18 – 19	393	1.3
20 – 24	1,182	4.0
25 – 29	1,544	5.2
30 – 34	2,263	7.7
35 – 39	3,868	13.1
40 – 44	5,235	17.8
45 – 49	5,761	19.5
50 - 54	3,850	13.1
55 - 59	2,190	7.4
60 - 64	1,221	4.1
65 and over	1,687	5.7
Total:	**29,491**	

Table 14 - Non structured treatment - all interventions by age group

4.3. SUBSTANCE USE

Unsurprisingly since non-structured monitoring covered alcohol services over a wider geographical spread than drug treatment services, alcohol represented the primary substance for 85.4% of individuals and 74.1% of interventions. Significant numbers of primary alcohol clients however presented at services specialising in drug treatment which contributed to its numbers. *Heroin illicit* accounted for 6.0% of individuals and 13.1% of interventions, the average number of interventions per individual (9.3) being significantly higher than the average for primary alcohol users (3.7). The only other primary substances recorded for individuals at over 1% were for *cannabis*[6] (2.6%) and *cocaine*[7](2.5%), while when interventions are used; *cannabis* (3.2%), *cocaine* (2.9%), *cocaine freebase (crack)* (2.8%) and *methadone*[8] (2.6%) were the most reported substances. The drug with the highest number of interventions per individual was *methadone prescribed* (20.3) although this was derived from just 10 individuals – other substances with a high number of interventions include *cocaine freebase (crack)* (13.3 interventions per individual), *heroin illicit* (9.3) and *methadone* (9.0).

Code	Primary Substance	Individuals	Interventions	Average
7000	Alcohol (All)	5,944	21,852	3.7
1101	Heroin illicit	415	3,866	9.3
5000[6]	Cannabis[6]	182	945	5.2
3200[7]	Cocaine[7]	171	860	5.03
3201	Cocaine Freebase (crack)	61	813	13.3
1105[8]	Methadone[8]	62	563	9.08
9002	Methadone prescription	10	203	20.3
4005	Ketamine	20	102	5.1
8799	Drug – not otherwise specified	19	50	2.6
2200	Benzodiazepines Unspecified	*	42	>8.4
1205	Codeine unspecified	*	36	>7.2
8002	GHB/GBH	12	35	2.9
3100	Amphetamines Unspecified	22	33	1.5
3114	Mephedrone	6	17	2.8
1204	Buprenorphine	*	14	>2.8
1259	Tramadol Hydrochloride	*	12	>2.4
9003	Buprenorphine prescription	*	11	>2.2
2201	Diazepam	*	6	>1.2
3406	MDMA	*	6	>1.2
	Others with 5 or fewer instances	17	25	1.5
	Total:	**6,958**	**29,491**	**4.2**

Table 15 - Non structured treatment - all individuals by primary substance

* Number of individuals suppressed where the substance is reported by 5 or fewer people.

[6] The figures shown here for 'Cannabis' includes those recorded using the following substance codes; 5000 Cannabis unspecified, 5004 Cannabis Herbal (Skunk).

[7] The figures shown here for 'Cocaine' includes those recorded using the following substance codes; 3200 Cocaine unspecified and 3202 Cocaine Hydrochloride.

[8] The figures shown here for 'Methadone' include those recorded using the following substance codes; 1105 Methadone unspecified, 1106 Methadone Mixture.

4.4. REFERRALS

The NSTMS allows drug services to record referrals made to other organisations while the individual is in treatment as well as how the individual came into contact with the service in the first instance. While most referrals were recorded as "other," of the remaining referrals recorded, the highest number out to other organisations was to drug service non-statutory (15.2%), housing (9.6%) and GP (9.0%) Of referrals made in to organisations, the main referral type was drug service non-statutory (15.7%), housing (9.8%) and drug service statutory (9.2%)

Referral Detail	Number referrals made to	Number referrals received from
Other	1,120	1,170
Drug service non-Statutory	93	103
Housing Provider	59	64
Drug Service Statutory	53	60
GP	55	56
Job Centre Plus	51	53
Hospital General	49	52
Community Alcohol Team	45	50
Education Service	43	45
Social Services	27	27
Psychological Services	21	22
Employment Service	20	21
Psychiatry services	18	18
Concerned Others	13	14
Relative	7	8
A&E	7	7
Detox Service	7	7
ATR - Alcohol Treatment Requirement	6	7
Probation	6	7
DRR - Drug Rehabilitation Requirement	*	6
Local Non Structured Treatment Provider	*	*
Police Service (including specialist rape)	*	*
Community care assessment	*	*
Outreach	*	*
Peer / Other Service user	*	*
Employer	*	*
Rehab Service	*	*
Fire Service (Vulnerable Persons Team)	*	*
Sex Worker Project	*	*
Self	*	*
Total:	**1,732**	**1,824**

Table 16 - Non structured treatment referrals

* Number of referrals suppressed where the total is 5 or less.

4.5. EMPLOYMENT STATUS

While a significant number of individuals did not state their employment situation, the majority (67.8%) did indicate a status. Of those for whom a status was recorded , 61.7% were unemployed and seeking work, while 13.5% were long term sick or disabled. A further 8.9% were in regular employment while 8.3% indicated they were retired from paid work.

Employment Status	Count
Unemployed and seeking work	2,854
Not stated	2,115
Long term sick or disabled	624
Regular Employment	413
Retired from paid work	386
Other	163
Pupil / Student	120
Not Known	91
Not receiving benefits	55
Homemaker	8
Unpaid voluntary work	7
Total:	**6,836**

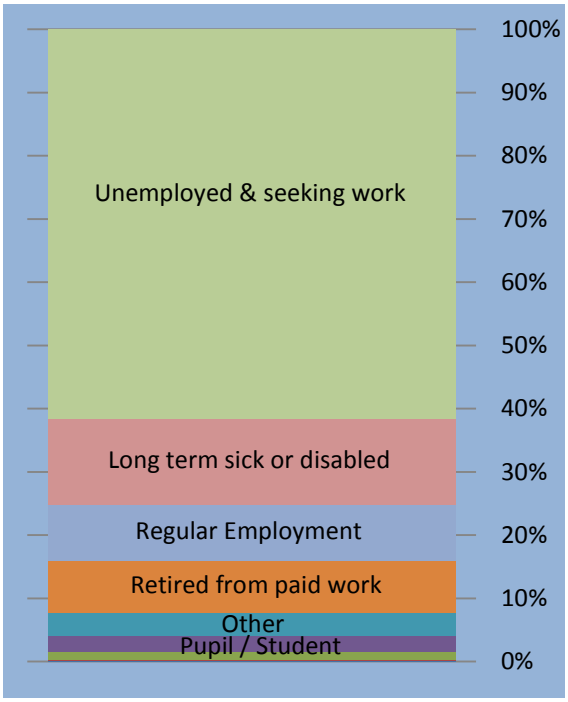


Table 17 - Non structured treatment - all individuals by employment status

4.6. PARENTAL STATUS

63% of the total number of individuals stated a parental status – of those who indicated a status, 62.7% were not a parent of a child under 18, while 29.7% indicated they were parents of children under 18 but that none of those children were currently living with them. Only 7.7% of individuals had any children under 18 living with them (either some or all).

Parental Status	Count
Not a parent of children under 18	2,695
None of the children under 18 live with client	1,275
All of the children under 18 live with client	265
Client declined to answer	68
Some of the children under 18 live with client	65
Not stated	2,468
Total:	**6,836**

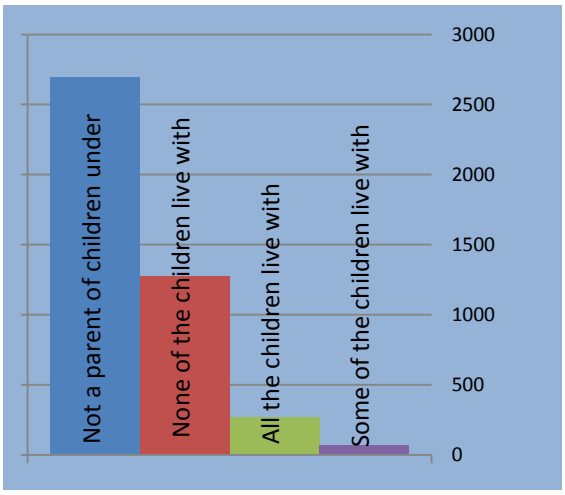


Table 18 - Non structured treatment - all individuals by parental status

4.7. ACCOMMODATION STATUS

Over two thirds of individuals (69.3%) who were asked the question reported their accommodation status. Of those who did, over three quarters identified they had no housing problem (78.4%), with 10% indicating they had a housing issue and a further 11.6% indicating they had No Fixed Abode (NFA) and therefore an urgent housing problem.

Accommodation Status	Count
No housing problem	3,717
NFA - urgent housing problem	548
Housing problem	474
Not stated	2,097
Total:	**6,836**

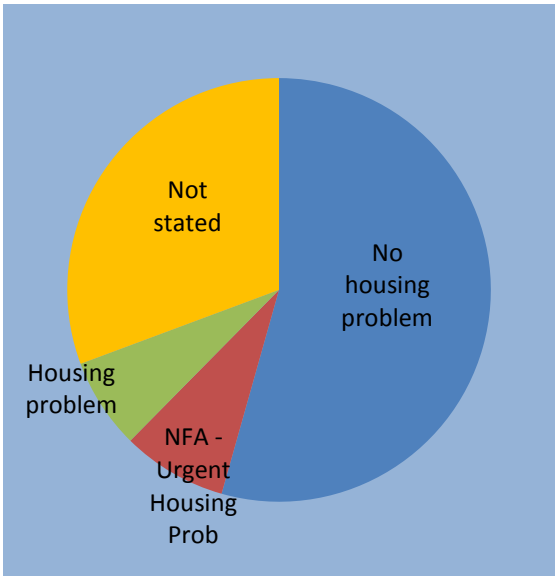


Table 19 - Non structured treatment - all individuals by accommodation status

4.8. NUMBER OF INDIVIDUALS BY POSTCODE AREA

This map illustrates the number of individuals in treatment by geographic area, the boundaries shown relate to postcode areas. The areas L1, L4, L6, L8, L36 each had greater than 280 individuals in treatment, when combined these five postcode areas accounted for 27.1% of all individuals.

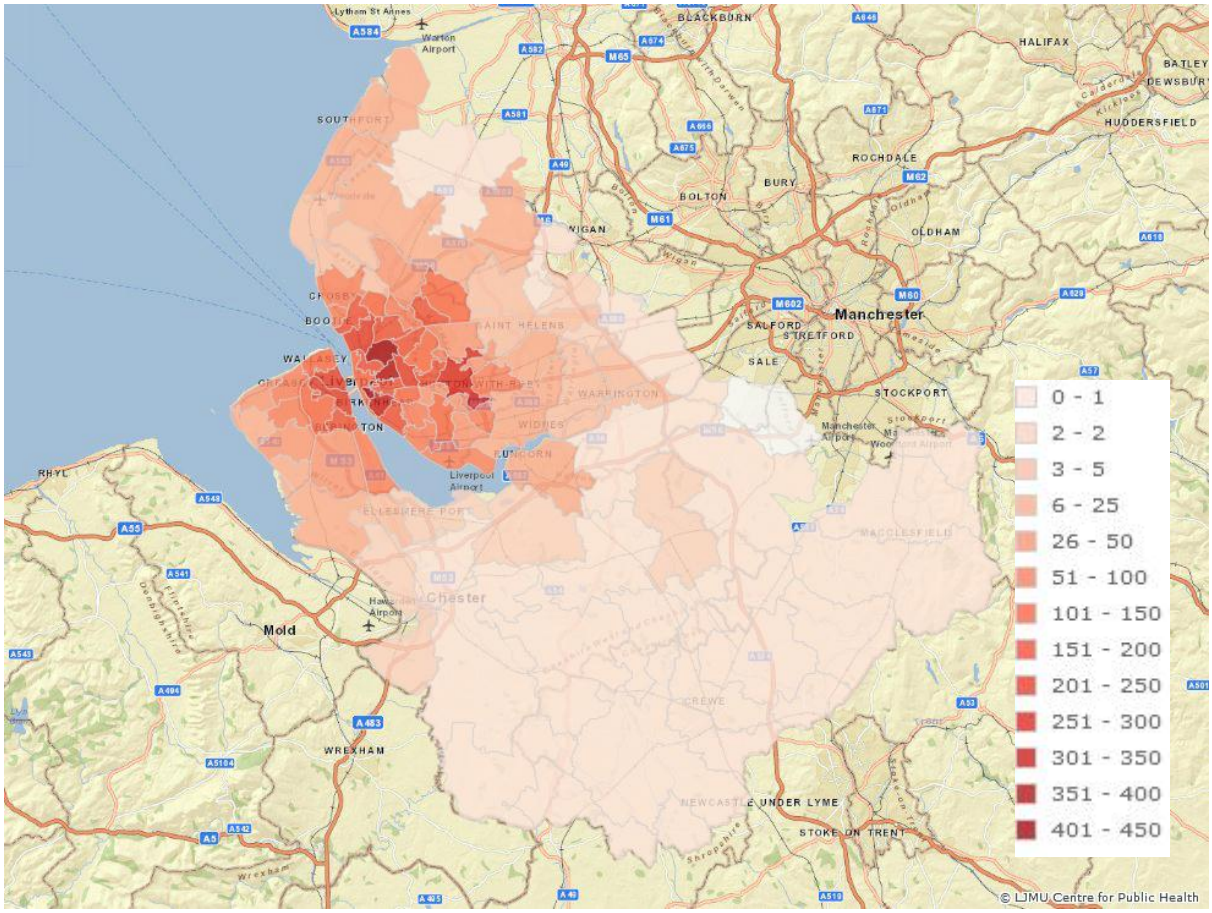


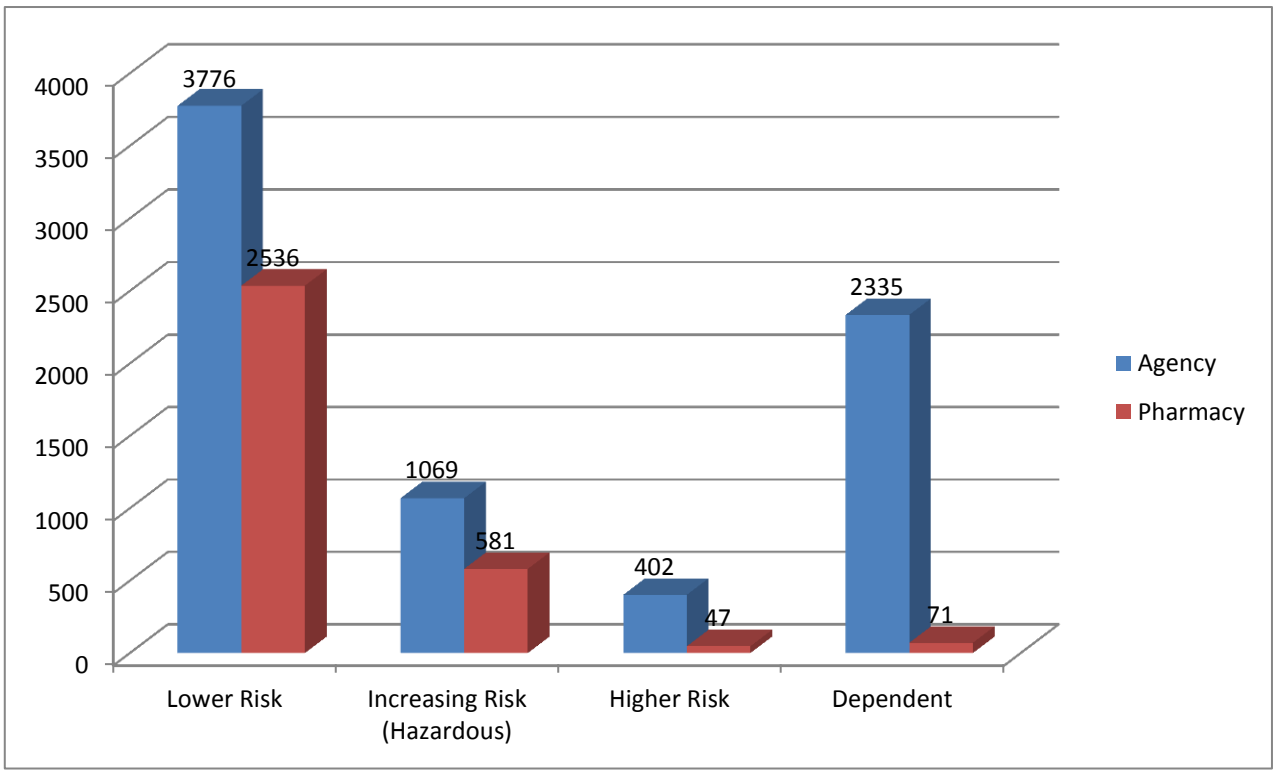
Figure 3 – number of individuals in treatment by geographic area

5. WIRRAL ALCOHOL SCREENINGS

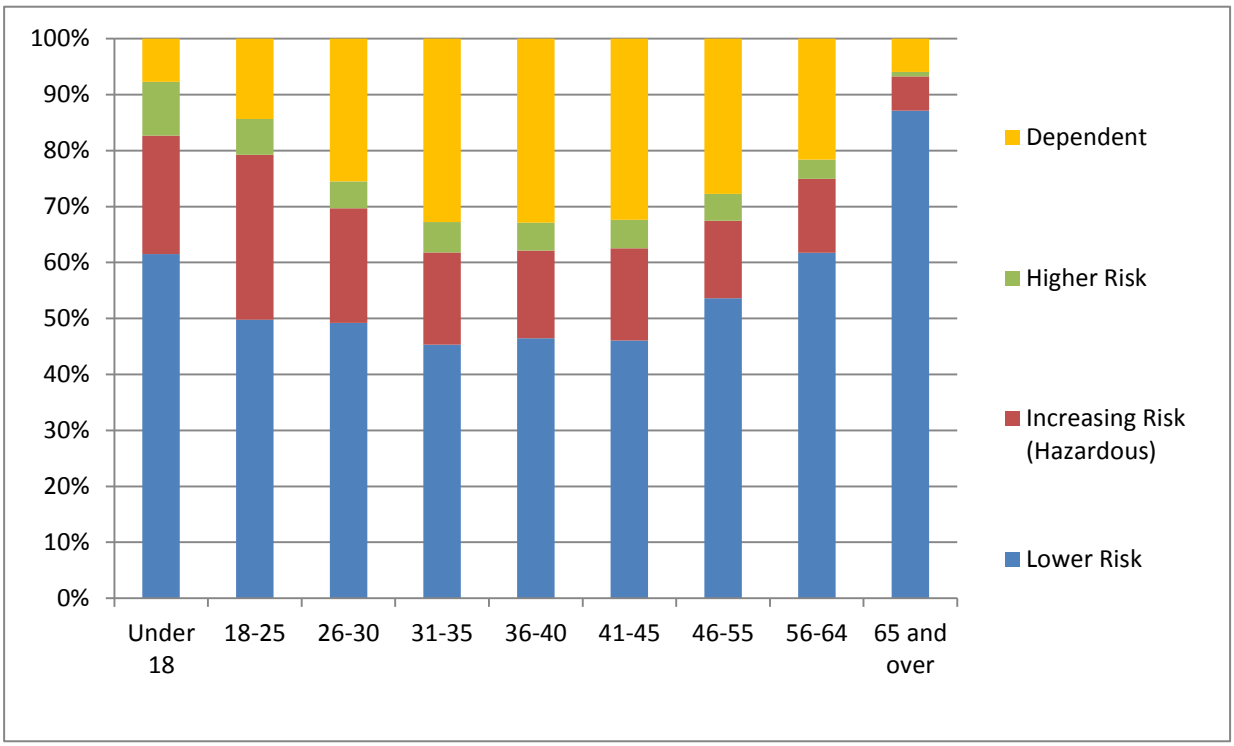
Wirral Council have commissioned CPH to report on their alcohol screening monitoring programme which has been running since 2008 and contributes towards key performance indicators around general population screening and the delivery of brief interventions where appropriate. A key component of the screening is delivered through use of the AUDIT tool by a range of pharmacies and agencies across the area – in 2012/13, 10,817 screenings delivered to 9,811 individuals were recorded through use of this tool, contributing to an overall figure of 38,428 screenings delivered using AUDIT between April 2008 and March 2013.

The majority of individuals presenting to agencies were male (58%) while the majority presenting to pharmacies were female (55%). There were some age differentials between those presenting to agencies and pharmacies, with those aged 65 and over (21.3%) being the largest group presenting to agencies (including those agencies providing services not directly related to substance or alcohol use) and those aged between 46-55 (20.4%) being the largest group presenting to pharmacies.

Box 2. Wirral Local Authority (previously PCT) began an extensive programme of alcohol screening in 2008 for both service users within existing drug/alcohol service as well as the general population, with AUDIT being the main tool used. AUDIT was developed by the WHO as a series of ten questions around an individual's alcohol use to pick up the early signs of hazardous and harmful drinking and identify mild dependence. CPH has produced regular reports on the screenings



Graph 1 - Breakdown of AUDIT score for HRT Screenings, 2012-13



Graph 2 - Breakdown of AUDIT score by age range, 2012-13

CONCLUSION AND THE LAUNCH OF IMS

When the Wirral AUDIT screening data is combined with the non-structured data, the total number of individuals screened for 2012-13 is 16,647, a 2.7% increase on the figure for 2011/12 (16,200). As this is the first report of its kind to include interventions for service users with both primary drug and primary alcohol presentations, it is not possible to compare data to previous years with any reliability. Alongside this, because of service provider changes and the move over from PCTs to LAs there was a drop in the number of areas reporting to the non-structured monitoring systems. However it is anticipated that this issue will be largely rectified for the 13/14 dataset as data flow issues with changes of provider have been resolved and GOLIATH (non-structured monitoring) has expanded beyond its original pilot area of Liverpool.

2014 sees the launch of the Integrated Monitoring System (IMS) which will bring together all non-structured monitoring systems including drugs (NSTMS), alcohol (ATMS) and syringe-exchange (IAD), covering over 70 agencies/pharmacies throughout Merseyside and Cheshire and when combined with NDTMS data providing the only comprehensive overview of treatment throughout the region and expanding the important area of wellbeing monitoring (a key PHOF indicator) to clients using alcohol and syringe exchange services.

The system is based on the NSTMS primarily which was introduced in April 2011 following the decommissioning of the Spider Project as a Tier 3 service, in order to capture the significant array of activity the service offered which would not be captured by the NDTMS. The system was rolled out across all Tier 2 drug services in Liverpool, covering 11 agencies initially and capturing activity via the bespoke GOLIATH database, covering areas such as wellbeing, substance use and referrals to other organisations. As noted in this report, the system allows agencies specialising in Tier 2 interventions to demonstrate activity which would otherwise not be collected in any other format and which they are required to provide back to the LA.

While the system will roll out a common dataset for the different services which previously reported to different existing monitoring systems, no significant fields will be dropped from the dataset and reporting will still be provided by agency type (syringe exchange, non-structured alcohol, etc.) or pharmacy within the overall reporting system.

There will be a formal launch of IMS during the early part of the 2014/15 financial year in which commissioners and providers will be given a chance to feed back on the new dataset. Commencement of development of a new web-based tool, IMSWeb, will also take place early within the financial year, with the intention of this being rolled out to services and pharmacies in the first quarter of the 15/16 financial year. This will allow providers to capture client information in a variety of settings and allow the database to be updated “on the fly” without the need to physically visit every site.

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