

# **Substance Misuse Needs Assessment**

**North East Lincolnshire  
2017**

# SUBSTANCE MISUSE

in North East Lincolnshire



In the last 4 years  
**65 babies**  
were admitted to  
NICU as result of  
maternal drug use

**58%** of drug and alcohol  
admissions were male...



...**42%** were female

## HOSPITAL ADMISSIONS

**76%**  
of drug admissions  
were via A&E  
in the last 3 years



**Alcohol** admission rates are  
significantly higher in NEL than nationally



The number of **drug** related  
deaths have reduced in NEL

**60%** of suicides in NEL had  
a history of alcohol and/or drugs  
abuse



## MORTALITY



**45%** of suicides had involved alcohol...  
...**32%** involved drugs



## AMBULANCE DATA



**812** drug related calls for an ambulance last year

**358** patients taken to hospital for drug related incident

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### **Report Authors**

Hazel Stevens	North East Lincolnshire Council
Angie Webster	North East Lincolnshire Council
Philip Huntley	North East Lincolnshire Council
Mike Hardy	North East Lincolnshire Council

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## **1. Introduction**

This substance misuse needs assessment has been compiled using a variety of local and national data sets and information sources, to assess the impact of substance misuse in the borough, and to evaluate current specialist substance misuse service provision and recovery services within North East Lincolnshire.

The aim of this needs assessment is to provide insight into the population impact of drug and alcohol use within North East Lincolnshire that will inform a future Substance Misuse Strategy.

This needs assessment will be used to identify gaps or needs within the current treatment system and incorporate and implement changes into the re-procurement of specialist drug and alcohol services, to meet the needs of North East Lincolnshire residents.

The misuse of drugs and alcohol can have a profoundly damaging impact on individuals, their families, the community and the economy, often leading to family breakdown, poverty and crime. Partnership working is essential for effective prevention, early intervention, treatment and support into recovery, to improve the health, wellbeing and future prospects of those misusing drugs and/or alcohol, and their families.

### **Definition of substance misuse**

Substance misuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state (World Health Organization, 2017).

### **Needs Assessment Surveys**

As part of the needs assessment process, three surveys were carried out from individuals accessing treatment services, partner agencies who work alongside treatment agencies and the general public to ascertain their views in respect of drug and alcohol misuse in North East Lincolnshire. Reference is made to these surveys throughout the needs assessment; the full reports can be seen in the appendix.

## 2. Summary

Key points from local data, to go to the relevant section click on the heading.

### Substance Misusers in Treatment

- The majority of users in treatment are primarily opiate users.
- Overall numbers in treatment for opiates are decreasing.
- Clients under 30 are most likely to be non-opiate users, those aged 30-44 are most likely to use opiates and the older age groups are most likely to be in treatment for alcohol.
- New clients entering treatment in the younger age groups are decreasing whilst the over 30s are increasing.
- Nationally 78% of clients waited less than 3 weeks for an appointment following a referral to treatment services, locally however for all drug users 100% received an appointment within 3 weeks of referral and 99% of those in treatment for alcohol received an appointment within 3 weeks.
- The number of clients in treatment for mephedrone has increased, however the numbers in treatment for other New Psychoactive Substance (NPS) are currently low.

### Complexity of clients *(For definition please click on the title)*

- The proportion of clients with complex needs is increasing while the proportion of clients successfully completing treatment is decreasing.
- There is a high proportion of clients in treatment with very high complexity in NEL.
- Clients with high complexity are less likely to successfully complete treatment so PHE have suggested alternative ways to measure success.
- Clients with high complexity are more likely to have higher physical and mental health needs and are at higher risk of drug-related death.

### Hospital Admissions

- 65 babies were admitted to neonatal intensive care as a result of maternal drug misuse over 4 years, 2011/12 to 2014/15, Grimsby Hospital ( 16 per year on average).
- Males were more likely to be admitted to hospital as a result of drug and/ or alcohol misuse.
- Those living in the most deprived wards were significantly more likely to be admitted to hospital for drug-related conditions than the NEL average.
- The majority of drug-related admissions were via A&E (76.4%, 2036 admissions over 3 years, 2013/14-2015/16).
- NEL were significantly higher than the England average for alcohol-related hospital admissions. Males in particular were considerably higher.

### Drug related deaths & Suicide

- Nationally drug-related deaths are at an all-time high, locally the rate has fluctuated but the overall trend line shows a decline.
- Those most at risk of dying from a drug-related cause were males, those aged 34-44 and those living in the 2 most deprived wards in NEL.

- 59.7% of people from NEL who died from suicide had misused drugs and/or alcohol at some point in their life, the most commonly used drug was cannabis.
- Of those who died from suicide, 45.2% were found to have alcohol in their system at the time of their death and 32.3% were found to have drugs in their system, however overdose was not a common method of suicide.

### **Children**

- There were 206 child referrals to social services where alcohol or drugs were a related factor in 2015/16 in North East Lincolnshire.
- There are 455 children known to be living with users of Foundations drug and alcohol service.
- A local survey of drug and alcohol service users showed that 28.5% had children living with them.

### **Drug-related calls for ambulance**

- In 2016/17 there were 812 calls in NEL for an ambulance where the chief complaint directly related to drugs, 358 resulted in the patient being taken to hospital.
- The highest proportion of calls for drug related complaints were to Croft Baker ward, followed by Park and East Marsh (location of incident, not residence).
- Females aged 20-24 and Males aged 25-29 were those most likely to need an ambulance for a drug related complaint.

### **Data gaps**

**A&E** - Data obtained from A&E doesn't reflect the actual number of drug and alcohol related attendances, in reality the numbers are significantly higher based on the number of admissions to a ward via A&E for drug and alcohol related conditions and the number of calls to the Ambulance service for drug related conditions.

**Ambulance Data** – Access to data from East Midlands Ambulance Service (EMAS) is limited, currently the only available data relates to the chief complaint code. Further data is recorded by EMAS including an initial assessment and clinical impression, however EMAS have not responded to requests for this data. Therefore it has not been possible to obtain ambulance data relating to alcohol as there is no chief complaint code relating to alcohol.

**New Psychoactive Substances (NPS, previously known as 'legal highs')**– Whilst anecdotal evidence suggests the use of NPS is increasing and that its use is linked to problematic behaviour, particularly patients admitted to acute mental health wards, however data only shows low numbers of usage.

**Mental Health – Poor** mental health and drug use are undoubtedly linked, our survey alone showed over half of substance users have mental health problems and 65% have thought about suicide. However it has been difficult to obtain detailed data from services to show this.

**Prevalence of drug users** – The most recent, available prevalence data is out of date and may not be representative of the 2016/17 prevalence of drug users.

**Problematic alcohol users not in treatment** - There is a higher proportion of drug users to alcohol users in treatment and this was reflected in our survey, however it is likely that the number of problematic alcohol users is far larger than the number in treatment.

### **Key Points – Surveys**

Three surveys were carried out as part of this needs assessment, for the full report please see **Appendix**, for the highlights see below.

**User survey** (*The following responses are from users of drug and alcohol services in North East Lincolnshire, including users of the needle exchange*).

- Most started using drugs in adolescence and cannabis was the most commonly used first drug.
- Two thirds of those who inject drugs use the needle exchange.
- 73% of those who have stopped using drugs said being in treatment helped them stop.
- 40% of drug users have overdosed and 46% of alcohol users have been admitted to hospital as a result of their drinking.
- 59% have been arrested as a result of their drug use and 44% of drinkers have been arrested as a result of drinking.
- Of those who misuse alcohol, 74% said alcohol was around in the home growing up, 65% said someone at home drank a lot and 44% said their childhood had influenced their drinking.
- 55% have educational qualifications and 50% have vocational qualifications, however 71% are unemployed.
- 14% are homeless or living in a hostel.
- People who misuse alcohol or drugs are more likely to engage in other risky health behaviours, 85% said they smoke tobacco and 13% had an unplanned pregnancy as a result of substance use.
- Furthermore, users are more likely to have poor mental health, 54% said they have mental health problems and 63% have thought about suicide.

### **Community Survey**

- 65% think money on drug use prevention is money well spent.
- 80% think drug treatment should be available to addicts.
- 40% have tried cannabis.
- 90% think drug use is a problem in North East Lincolnshire.

### **Provider Survey**

- Only 28% of providers think it is easy to access substance treatment services, however 76% of service users said it was easy to access treatment services.

- 83% said they know where to find information about local drug and alcohol treatment services.
- 67% have been affected by others use of drugs and/ or alcohol.

#### **Key points- Current Treatment Services**

- Budget availability for substance misuse continues to reduce annually by 2.6%.
- Since 2013 drug and alcohol treatment services became the responsibility of local authorities.
- There is a good spread of pharmacies offering supervised consumption and needle exchange across NEL.
- Drug and alcohol treatment is currently provided by Foundations and is centrally located in Grimsby.
- Foundations is open Monday to Friday and it's direct access hours are 9am till 4:30pm. Additionally there is a service provided seven days a week in the police custody suite.
- An additional annual grant is received from the office of the Police and Crime Commissioner for engagement with individuals alongside the criminal justice system.
- Of those in custody and eligible for class A screening, 49% tested positive, of those who tested positive 95% needed a further intervention.
- Of those arrested for alcohol related offences, 93% were referred to the Alcohol Intervention Programme.
- In addition to Foundations North East Lincolnshire Drug and Alcohol Treatment NELDAT is offered by Grimsby Practices in Partnership (GPIP). The GPIP service is based on payment by results.
- A needle exchange service operates from pharmacies across North East Lincolnshire supplying needles, syringes and other preparation equipment to the public who use drugs.
- The needle exchange aims to reduce sharing of needles and therefore reduce the risk of blood-borne diseases such as HIV, Hepatitis C and Hepatitis B. It also reduces drug litter.

### 3. Background

#### National context

Tackling substance misuse is an important area of public health. Many people use drugs at some stage of their lives and combined with the increase in alcohol consumption; it is becoming an increasing public health challenge. Access to quality substance misuse treatment and recovery services is vital in improving the health and wellbeing of both individuals and populations.

#### Drugs

New strategy:

On the 14<sup>th</sup> July 2017 The Government released The Drug Strategy 2017 which sets out how the government and its partners, at local, national and international levels, will take action to tackle drug misuse and the harms it causes.

The aims of the strategy are:

Our ambition is for fewer people to use drugs in the first place, but for those that do - and who then experience problems - we want to help them to stop and to live a life free from dependence. Our overall aims therefore remain to reduce **all illicit and other harmful drug use, and increase the rate of individuals recovering from their dependence**. But we want to go further, and achieve our greater ambition both for progress against these aims as well as against a broader set of indicators which reflect the partnership approach that needs to be taken to tackle drug misuse and its harms (HM Government, 2017) .

The strategy is divided into four sections:

#### 1: Reducing Demand

We will take action to prevent the onset of drug use, and its escalation at all ages, through universal action combined with more targeted action for the most vulnerable. This includes placing a greater emphasis on building resilience and confidence among our young people to prevent the range of risks they face (e.g. drug and alcohol misuse, crime, exploitation, unhealthy relationships).

#### 2: Restricting supply

We will take a smarter approach to restricting the supply of drugs: adapting our approach to reflect changes in criminal activity; using innovative data and technology; taking coordinated partnership action to tackle drugs alongside other criminal activity.

#### 3: Building recovery

We will raise our ambition for full recovery by improving both treatment quality and outcomes for different user groups; ensuring the right interventions are given to people according to their needs; and facilitating the delivery of an enhanced joined-up

approach to commissioning and the wide range of services that are essential to supporting every individual to live a life free from drugs.

#### **4: Global Action**

We will take a leading role in driving international action, spearheading new initiatives e.g. on new psychoactive substances, sharing best practice and promoting an evidence-based approach to preventing drug harms (HM Government, 2017).

The strategy received a mixed response from those involved in the commissioning and delivery of substance misuse services.

In his response to the Government's new drugs strategy, Cllr Izzi Seccombe, Chairman of the LGA's Community Wellbeing Board said:

"Local government will continue to play its part in working with national government to deliver on our shared ambition to support those individuals and their families devastated by the harm caused by drug misuse.

"We have long argued that reductions by central government to the public health grant in local government that is used to fund drug and alcohol prevention and treatment services is a short-term approach and one that will only compound acute pressures for criminal justice and NHS services further down the line.

"Leaving councils to pick up the bill for new national policies while being handed further spending reductions cannot be an option. Pressure will be placed on already stretched local services if the Government fails to fully assess the impact of their funding decisions." (Local Government Association, 2017)

Local commissioners and providers have a responsibility to develop services that enable the guidelines to be applied. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in these guidelines should be interpreted in a way that would be inconsistent with compliance with those duties.

#### Highways and Buyways: A snapshot of the UK drug scenes 2016 – Drugwise 2017

Drugwise completed some analysis in 2016 into the changing drug scenes within the UK. The key findings are as follows:

- Unprecedented street purity levels for heroin, crack, powder cocaine and ecstasy.

- Headline goals for Psychoactive Substances Act<sup>1</sup> achieved but new forms of SCRA (synthetic cannabinoid agonists) street dealing and distribution putting vulnerable groups at risk as rough sleeping numbers increase.
- Some reports of young people using heroin to self-medicate from synthetic cannabinoid receptor agonists SCRA.
- Extension of drug distribution system known as county or country lines (where a gang from a major city moves into an area to take over the dealing network).
- Increasing numbers coming forward to agencies with cannabis as a primary problem.
- Continued reporting of widespread non-medical use of prescription and Over the Counter (OTC) drugs not necessarily confined to traditional drug treatment service groups.

## Alcohol

The risk of alcohol harm is addressed through the governments Alcohol Strategy 2012 (HM Government, 2012).

The Alcohol Strategy focuses on the following key aims:-

- changing behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- reducing the number of young people aged 11 to 15 drinking alcohol and the amount they drink;
- reducing the level of alcohol-fuelled violent crime;
- reducing the number of adults drinking above the lower-risk guidelines;
- reducing the number of people binge drinking; and
- reducing the number of alcohol-related deaths.

### Estimates of alcohol dependence in England based on APMS 2014, including children living in a household with an adult with alcohol dependence

Alcohol is the most commonly used psychoactive substance in the UK, with 58% of the population reporting drinking in the last week (ONS). While many people drink alcohol without experiencing harms, at a population level, alcohol is responsible for a million hospitalisations and 6,500 deaths in England per year (HSCIC). Overall, alcohol harms are estimated to cost £21 billion per year, including £3.5 billion in NHS Costs (HSCIC).

Alcohol dependence not only affects the individual, but also has important consequences for those around them; particularly the children of the individuals (SchARR, University of Sheffield & Institute of Alcohol Studies, 2015). Children of parents with alcohol and other substance use problems are more likely than children in general to have a range of adverse childhood experiences such as being taken into care, witnessing or be a victim of domestic abuse, and family separation. Such children are also more likely to demonstrate behaviour problems and perform less well at school. In later

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<sup>1</sup> The Psychoactive Substances Act 2016 makes it an offence to produce, supply, offer to supply, possess with intent to supply, possess on custodial premises, import or export psychoactive substances; that is, any substance intended for human consumption that is capable of producing a psychoactive effect.

life, they are at a greater risk of themselves developing substance use and/or mental health problems.

### Alcohol-related deaths in the UK: registered in 2015

The Office for National Statistics definition of alcohol-related deaths includes underlying causes of death regarded as those being most directly due to alcohol consumption. The definition is primarily based on chronic conditions associated with long-term abuse of alcohol and, to a lesser extent, acute conditions.

- In 2015, there were 8,758 alcohol-related deaths in the UK, an age-standardised rate of 14.2 deaths per 100,000 population
- For the UK as a whole, alcohol-related deaths have not changed in recent years, but the rate in 2015 is still higher than that observed in 1994
- The majority of alcohol-related deaths (65%) in the UK in 2015 were among males
- For both males and females, rates of alcohol-related deaths were highest in those aged 55 to 64 years in 2015

### Marketing and Alcohol<sup>2</sup>

The Institute of Alcohol Studies completed a study looking at the correlation of marketing and alcohol. Alcohol is one of the most significant ‘fast moving consumer goods’ (FMCGs) marketed today.

- It is estimated that each year more than £800 million is spent on advertising alcoholic beverages in the UK, with the global estimate approximating \$1 trillion
- Alcohol marketing uses the “four Ps” – product, price, place and promotion, which have been found to increase alcohol consumption
- Research shows that exposure of children and young people to alcohol marketing materials leads them to drink at an earlier age and to drink more than they otherwise would
- The World Health Organisation states “the extent and breadth of commercial communications on alcohol and their impact, particularly on young people’s drinking, should not be underestimated”

### **New Psychoactive Substances (NPS)**

In May 2016, the government introduced the Psychoactive Substances Act. The primary purpose of this Act was to close high street retail outlets for NPSs both those known as head shops and other NPS outlets such as newsagents, petrol stations and fast food outlets. The Act made it an offence to manufacture, import, and in anyway supply and distribute any substance deemed to be psychoactive with a list of exemptions such as alcohol, tobacco, food and medicines – while at the same time not enacting a possession offence. To date the Act has largely achieved its primary purpose, as NPS is

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<sup>2</sup> <http://www.ias.org.uk/Alcohol-knowledge-centre/Marketing/Factsheets/What-is-Alcohol-Marketing-The-Four-Ps.aspx>

not now blatantly sold on the high street and various agencies report a significant reduction in incidents and referrals.<sup>3</sup>

Over 1,600 young people (aged under 25 year old) gave their views and experiences of New Psychoactive Substances (NPS) to inform a new report<sup>4</sup> (March 2017) from Addaction, mainly through an on-line survey. The main findings of this report identified:

- Young people are continuing to use NPS, despite the change in classification, and many of them use a range of other illegal substances.
- Nitrous Oxide and synthetic cannabinoids were the most commonly reported NPS being used, but some young people said they used ecstasy imitations.
- 66% of the young people who completed the online survey had used NPS at some point in their life.
- Many young people reported that they took NPS 'to have fun' and said they enjoyed the effects of NPS.
- A number of young people said they used NPS as a method of coping with a difficult situation. These young people often used in isolation and therefore this was less visible to their support networks.
- Young people reported that there were significant adverse effects of NPS both in terms of physical health and emotional wellbeing, with 'delusions, hallucinations, panic or anxiety' reported as the most common effects that had been experienced.
- Bad experiences of NPS use often led the young person to stop their NPS use, but they didn't seek help with stopping and instead went 'cold turkey'. They said this was because they didn't know about the support available or worried that they would be stigmatised for their NPS use.
- Young people who had stopped their NPS use reported that withdrawal symptoms could continue for a significant period of time.
- A substantial number of individuals stated that the reason they started was not why they continued and described feeling 'addicted'.

#### Accessing information about NPS

- Some young people had researched NPS before using them, through watching documentaries or visiting websites that provide advice on dosing.
- Other young people got their information through word of mouth, from people they knew who previously used NPS.
- Young People clearly stated that they want credible and reliable information about NPS.

#### Engaging with services

- Young people overwhelmingly asserted that they would not approach a mainstream drug service for support for NPS use.

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<sup>3</sup> Highways and Buyways; a snapshot of drug scenes – Drugwise 2017

<sup>4</sup> Novel psychoactive substances insight report: "The view from young people" – Addaction 2017

- This reluctance to attend a face-to-face service was attributed to: fears about the stigma associated with problematic NPS use; anxiety around confidentiality; and not wanting to be aligned with other drug users.
- Young people said they would prefer to access support anonymously, particularly in the first stage of their contact with a service, so they could build up a sense of trust. This anonymous support could happen through online chat or email facility or over the phone/text message.
- Social media was highlighted as an effective tool for advertising support services.
- Young people repeatedly stated that they wanted to receive support from someone with lived experience of drug misuse.
- Young people also told us that they want balanced information from keyworkers that recognises the pros and cons of NPS use and they want advice on how to use NPS safely rather than a judgemental 'just say no' approach.
- It was felt that both group work and one-to-one interventions could be useful in helping young people to change their NPS use and that this support should be provided as part of a holistic approach to their full range of needs, including general wellbeing, education and employment.
- The importance of diversionary activities was emphasised, particularly activities that 'concentrate on the people and not make it look to them like you're concentrating on the addiction' (male, 22-23)

#### Conclusions and recommendations from the report:

Providers of services need to do much more to reach this group of young people and provide them with effective information and support. Key learning points for treatment services are:

- Use social media, internet and phone tools to reach young people, promote the help that is available and offer them anonymised support
- Work to reduce the stigma that young people increasingly feel subject to because of their NPS use.
- Develop NPS harm reduction messages and ensure that these can be delivered in a credible way by a range of agencies as part of the support that they provide to young people. These messages should be incorporated into wider health and wellbeing support rather than activities that focus solely on the substance use.
- Consider how to reach young people as they are reaching a decision to stop their use and provide support to help them deal with any withdrawal symptoms.

#### **Public Health Outcomes Framework (PHOF)**

The Department of Health has developed a Public Health Outcomes Framework (PHOF). The framework is focused on the two high-level outcomes to be achieved across the public health system and beyond:

- Increased healthy life expectancy; and
- Reduced differences in life expectancy and healthy life expectancy between communities.

Alcohol and drug misuse have significant health and social costs; the impact of which can lead to social, physical, or mental health problems, as well as increased crime and inequalities in health.

Strong links exist between deprivation, prevalence of substance misuse, drug and alcohol related hospital admissions, and mortality. There are also certain groups of young people that are at greater risk of substance misuse, the consequences of which permeate homes, schools and workplaces, affecting not only the individuals and families, but also the wider community.

### **Public Health England (PHE)**

The PHE White Paper 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' highlights a commitment to work towards an fully-integrated, recovery-orientated and outcome focused model of service delivery to allow easy access to confidential, non-judgemental substance misuse services (including drug education, health promotion and prevention).

Local authorities have the responsibility to commission alcohol and drug prevention, treatment and recovery services for adults and young people. For those people that have become dependent on alcohol and/or drugs, the aim is for them to recover from their dependency, to be in employment, have stable accommodation, look after their families, and, where applicable, cease committing crime. These aims are now part of the overall public health agenda to improve the health of the citizens of North East Lincolnshire and reduce health inequalities, reflecting national priorities.

## 4. Demographics

### North East Lincolnshire

North East Lincolnshire (NEL) is a small unitary authority covering an area of 192 km<sup>2</sup>. The majority of the resident population live in the towns of Grimsby and Cleethorpes with the remainder living in the smaller town of Immingham, surrounding villages and rural areas.

Figure 1 Map of North East Lincolnshire



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NEL has a distinctive economy, built on expertise in manufacturing, engineering, ports and logistics, and food processing. The local area has some significant advantages stemming from its location,

labour force, and transport infrastructure that position it for growth in renewables, chemicals, advanced manufacturing and the food and drink sector.

Census figures classify 94.2% of the population of North East Lincolnshire as living in an urban environment, however North East Lincolnshire has a wide variety of parks and open spaces.

The total population of North East Lincolnshire (NEL) is estimated at 159,827. Approximately 97% of all individuals within North East Lincolnshire for whom ethnicity was recorded are British.<sup>5</sup>

The percentage of the local population who are of working age, (16 to 64), is slightly below national and regional comparator estimates at 62.1% (99,276). 18.9% (30,145) of the local population are of pensionable age. The percentage of children and young people, (0 to 15), is in line with national average at around 19% (30,406) of the population.

For further statistics regarding North East Lincolnshire please visit the council's data observatory <http://www.nelincsdata.net>.

North East Lincolnshire Council's priorities are: 'Stronger economy and stronger communities'. Stronger Economy focusing upon skills and employability, business support and innovation, local employment and sustainable environment and Stronger Communities focusing on independence, sustainable housing, active citizens and healthy lives.

The Council's stronger economy / stronger communities priorities are underpinned by a key strategic framework comprising the following:

- health and wellbeing strategy
- economic strategy
- prevention and early intervention strategy
- financial strategy
- safeguarding

The Council's commissioning outcomes framework states that North East Lincolnshire will be a place where people start, develop, live, work and age well. Substance misuse services link directly and contribute to the following indicators within the Council's outcome framework:

**All people in NEL feel safe & are safe**

- Domestic abuse rates
- Incidences of abuse
- Crime rates
- % of residents who feel safe
- % reduction in harm caused by drugs and alcohol

**All people in NEL enjoy good health & wellbeing**

- Number of opiate users aged 15-64 years

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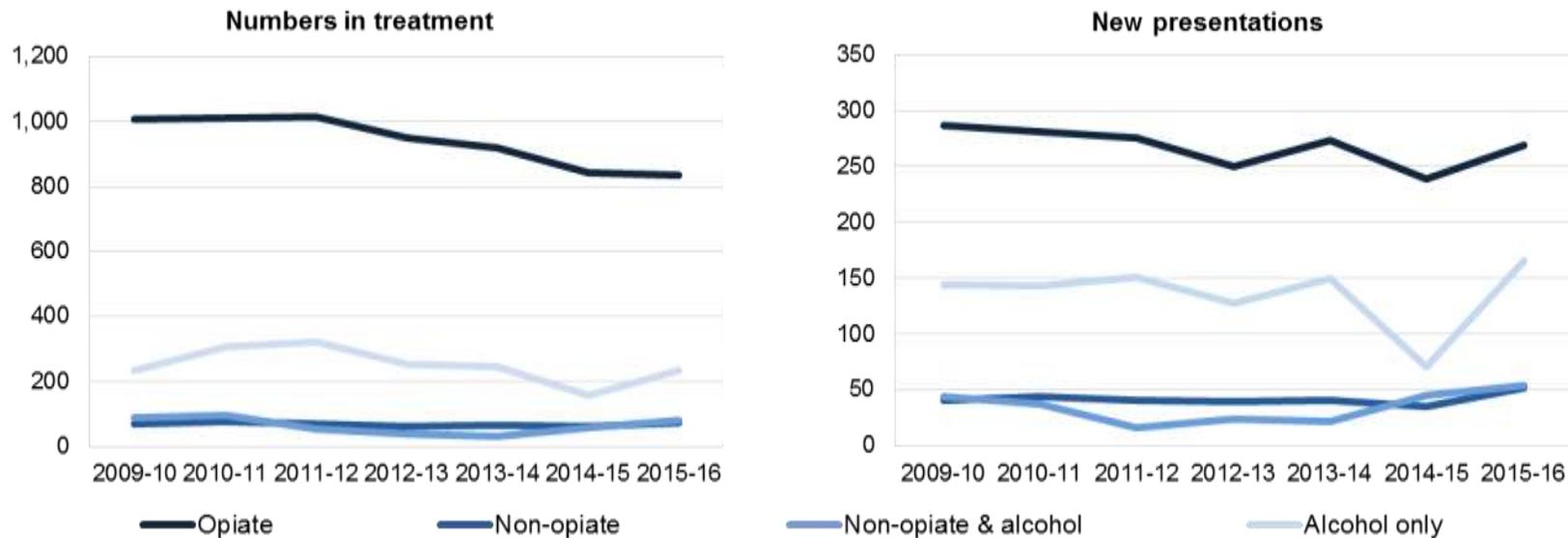
<sup>5</sup> NEL Data Observatory 2015

## 5. Data

### Substance Misusers in Treatment

Nationally the proportion of individuals in treatment for opiate use has gradually decreased, of drug users in treatment 55% in 2009/10 were opiate users, by 2016 this reduced to 52%, the proportion in treatment for other substances has remained relatively stable. In North East Lincolnshire 68% of users in treatment are opiate users, this is lower than the 2009/10 figure of 72%, however the figure has fluctuated over the years. Other substances have remained stable. The overall number of opiate users in treatment has decreased from 1008 in 2009/10 to 834 in 2015/16, the number of alcohol and non-opiate drug users have remained fairly static.

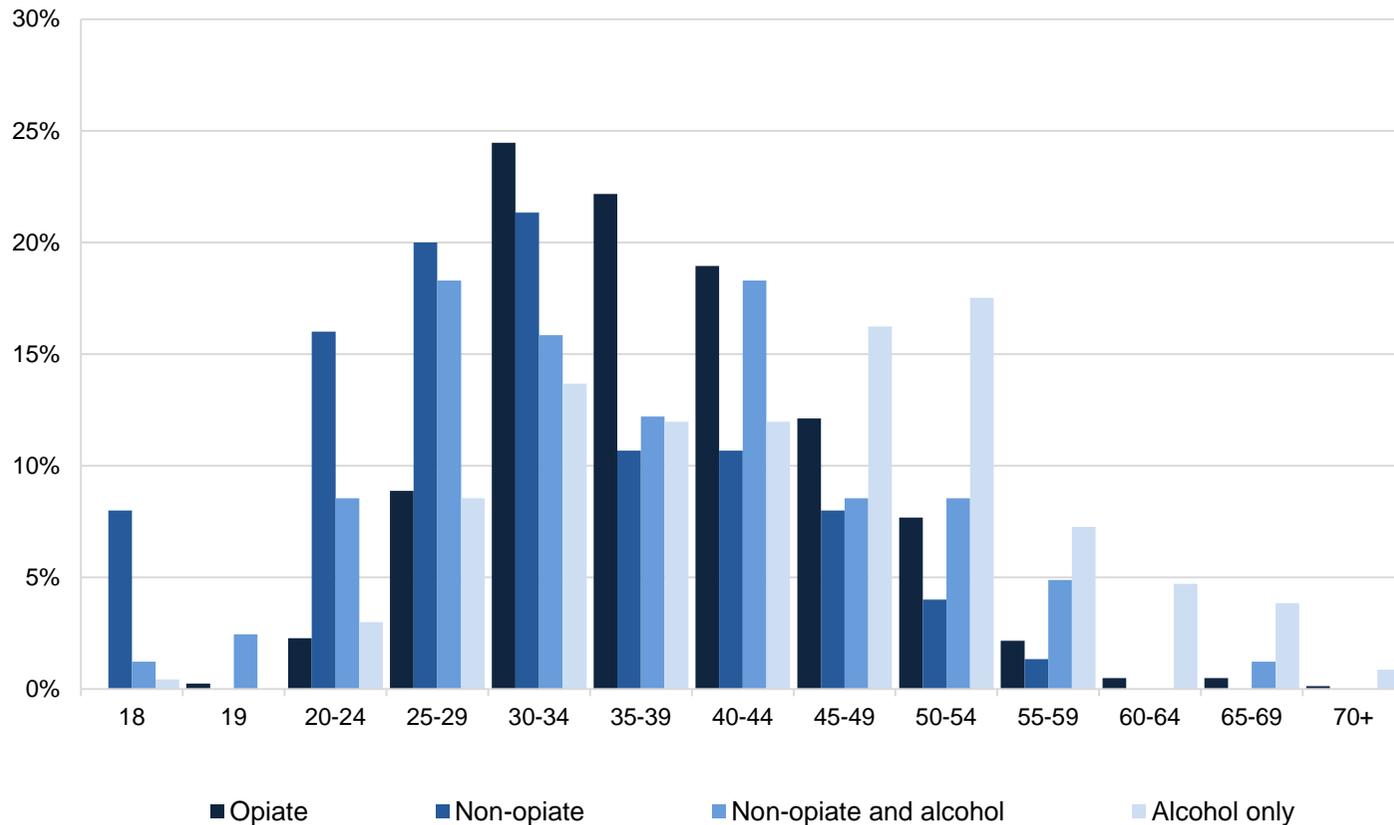
Figure 2 Trends in numbers in treatment by main substance group, North East Lincolnshire



Source: Public Health England Local Area Trend Report

Clients aged under 30 are most likely to be in treatment for non-opiate drug use whilst those aged 30-44 are most likely to be in treatment for use of opiate drugs, alcohol only is the most common reason for treatment in the older age groups.

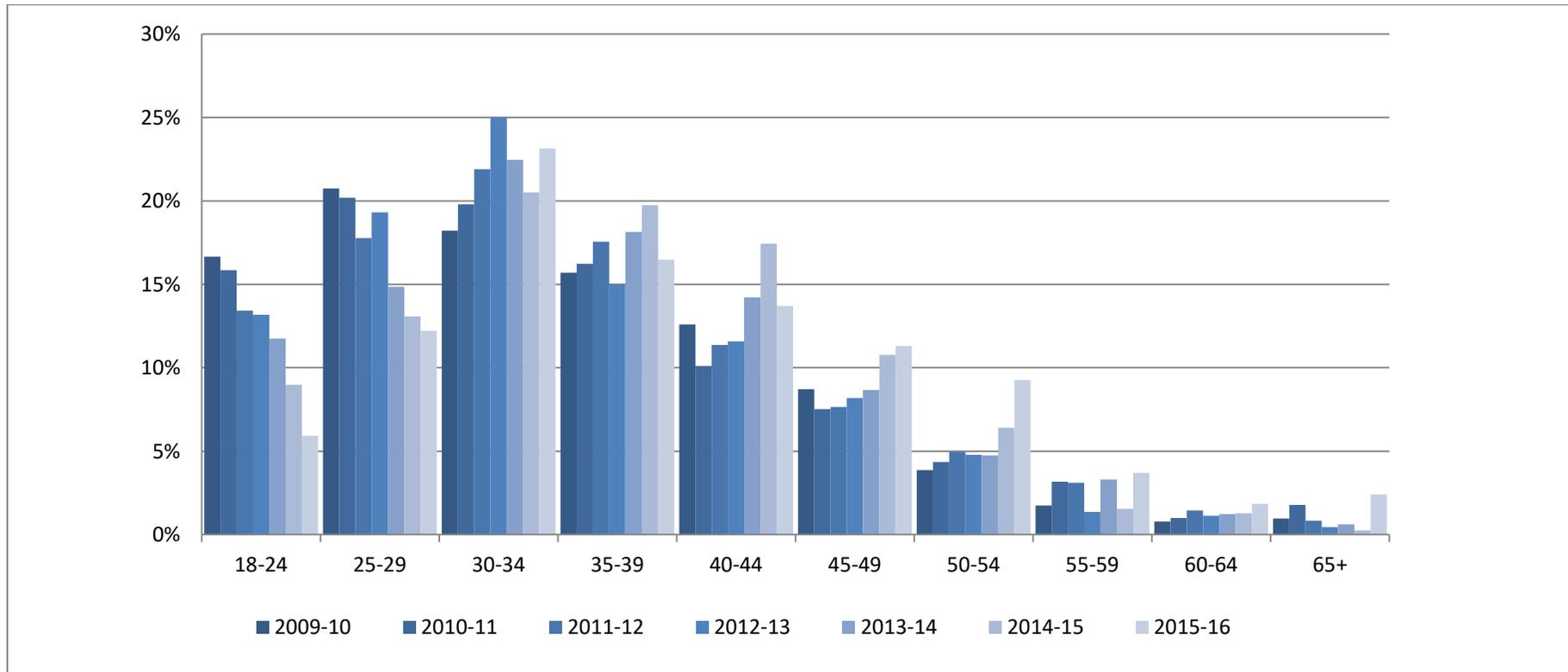
Figure 3 Age distribution of all clients in treatment 2015/16, North East Lincolnshire



Source: Public Health England Local Area Trend Report

The age profile of new clients entering treatment has changed since 2009/10, the proportion of younger people entering treatment has significantly reduced from 17% to 6% in 2015/16, the 25-29 age-group has also reduced from 21% to 12%. The proportions of those aged over 30, have generally increased, particularly 45-54 year olds. The local ageing in treatment population reflects national trends of those entering treatment being older.

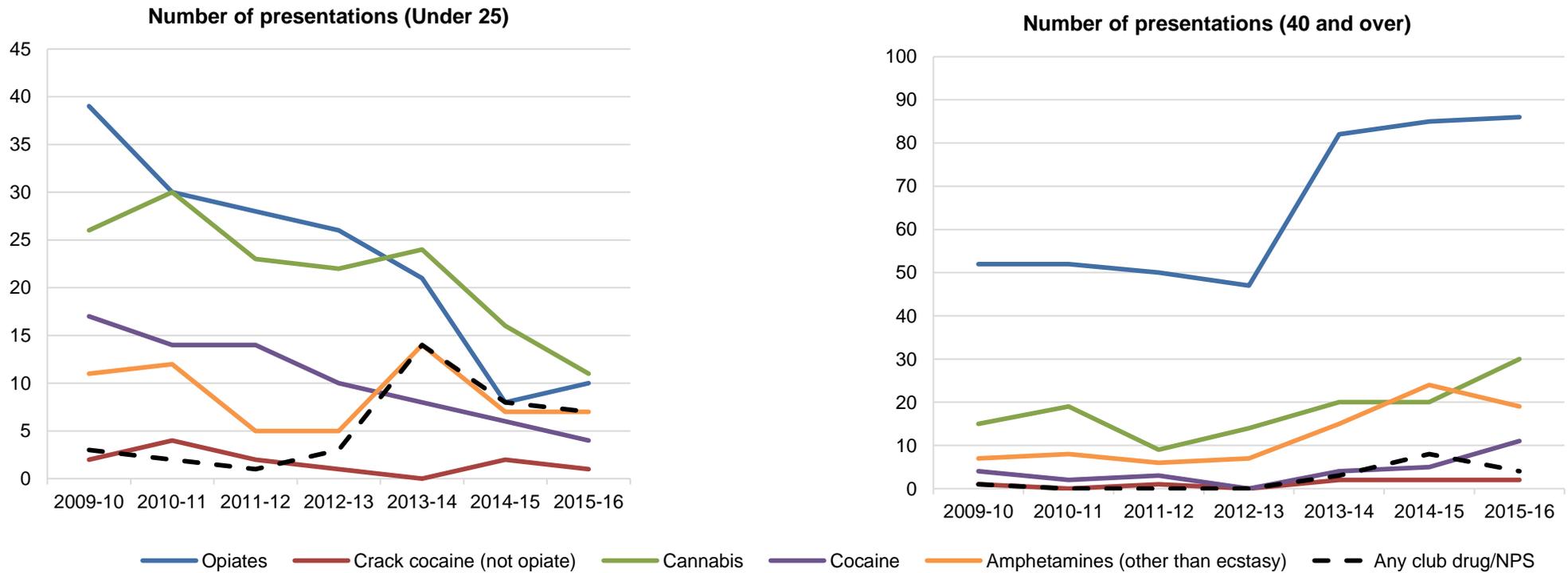
Figure 4 Trends in the age distribution of new presentations to treatment, North East Lincolnshire



Source: Public Health England Local Area Trend Report

The number of people aged under 25 entering treatment for use of opiates has significantly reduced since 2009/10 from 39 to 10, however the number of new presentations from those aged 40 and over has increased. New clients under 25 presenting with club drug/ NPS use has increased overall, presentations for amphetamines has fluctuated but presentations for other drug use generally has declined.

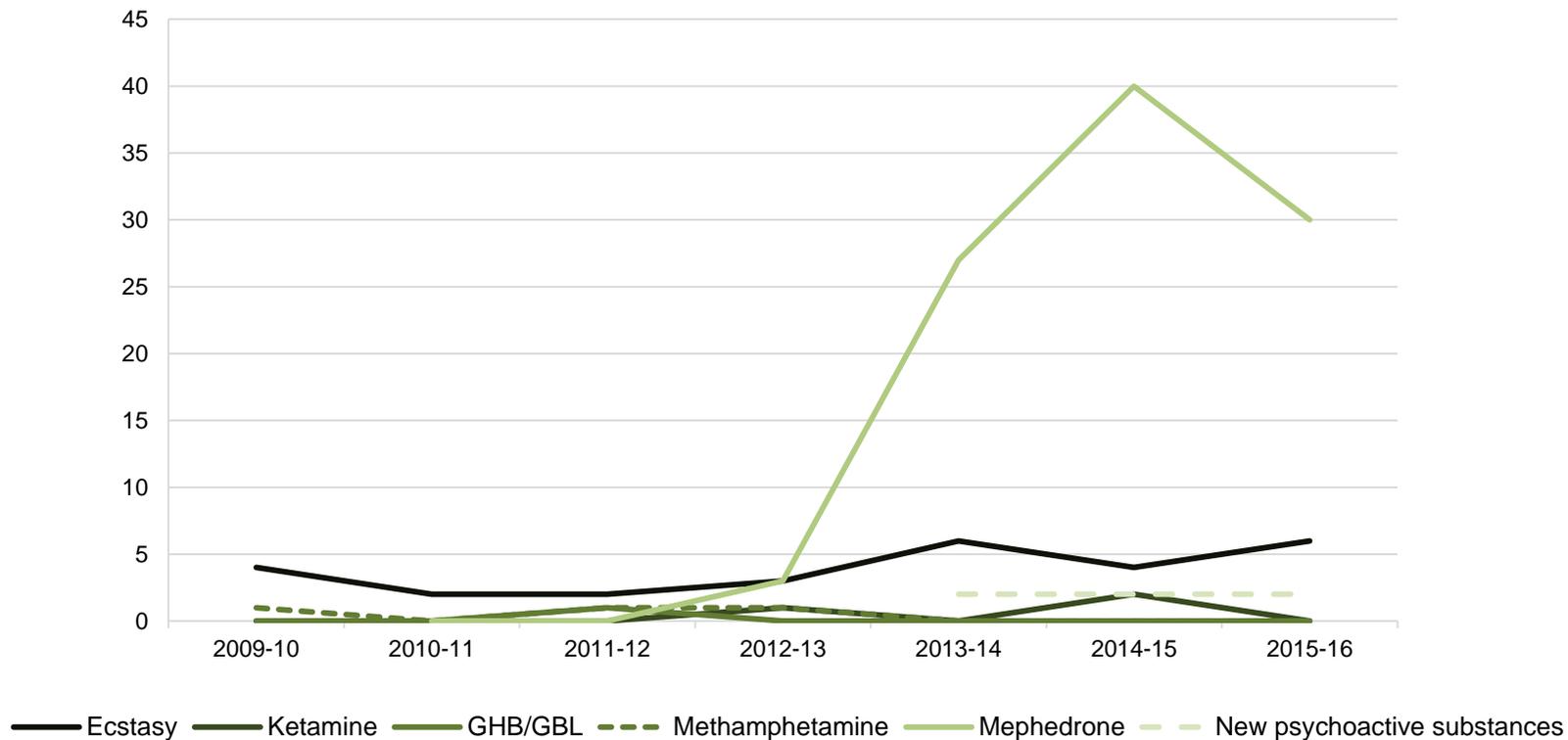
Figure 5 Trends in presenting substances of under 25 and 40 and over, North East Lincolnshire



Source: Public Health England Local Area Trend Report

Nationally, the number of individuals citing club drug or NPS use has been increasing, the largest increase being in NPS use and the most significant decrease in ecstasy. In North East Lincolnshire anecdotal evidence suggests that NPS use is a problem, however currently there is no local data available due to there being no standardised testing processes in place and no standardised tracking recording of NPS use in partner agencies. There has been a significant increase locally in the number of presentations to treatment for Mephedrone, from 3 in 2012/13 to 40 in 2014/15 and 30 in 2015/16, see Figure 6. A code for mephedrone was added to the NDTMS core dataset in 2010-11. Codes for NPS were added to NDTMS core dataset in 2013-14.

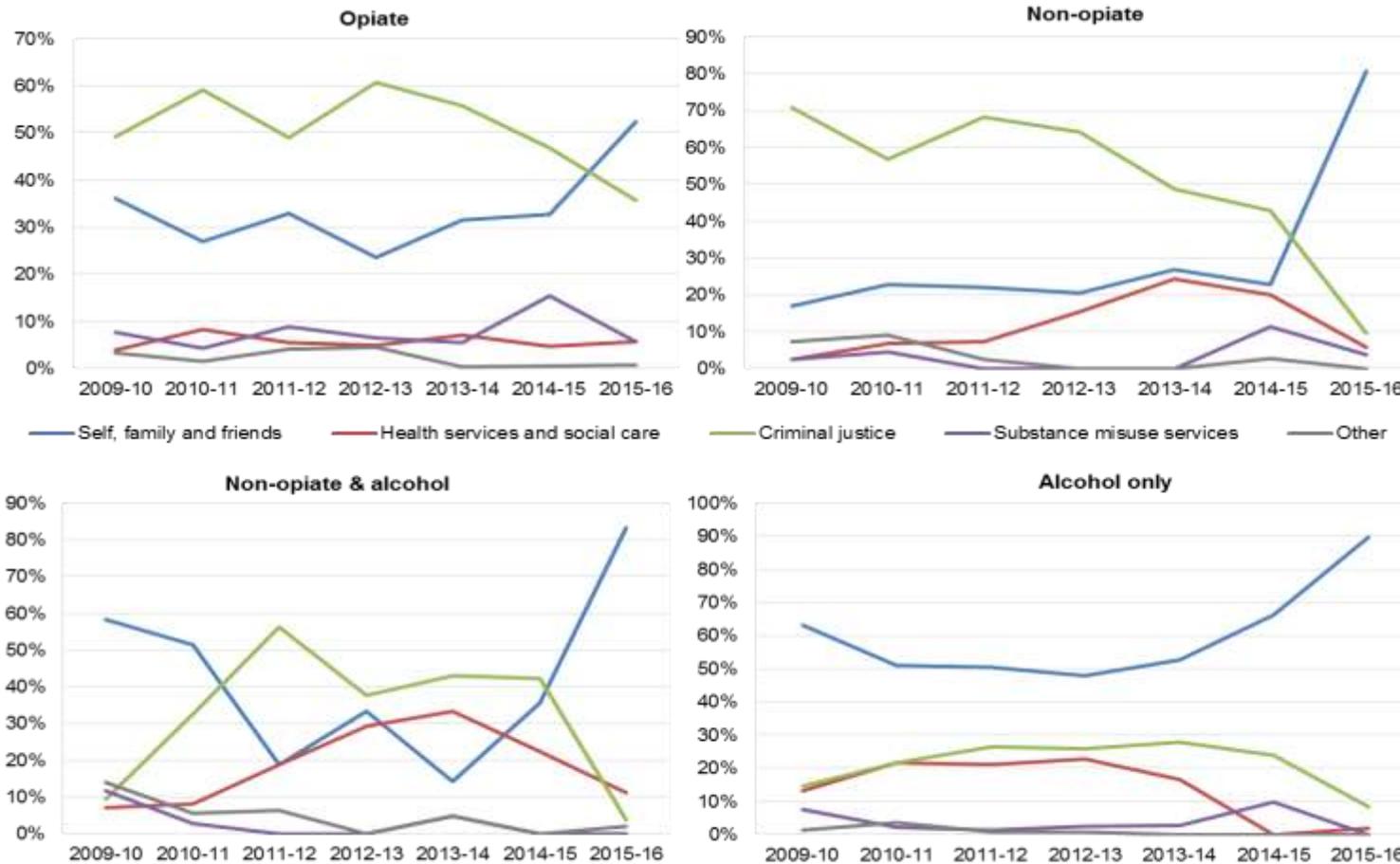
Figure 6 Trends in number of new presentations to treatment citing club drug use, North East Lincolnshire



Source: Public Health England Local Area Trend Report

Locally trends in referrals have seen changes in the last year; there has been a significant reduction in referrals by the police and an increase in self-referrals (including family and friends). Since the new provider was commissioned in 2014 criminal justice is no longer recorded as a referral as it is one provider that provides criminal justice and non-criminal justice services. Therefore those who access on-going treatment/recovery services are not registered as a referral but are “signed up” for treatment “there and then” as part of the Foundations provision.

Figure 7 Trends in source of referral into treatment, new presentations



Source: P

The tables below show the main substances used by clients in treatment, since many clients use more than one substance totals exceed 100%. Clients in treatment for alcohol only are not included below. In North East Lincolnshire the majority of clients are in treatment for opiate use (44%), almost a quarter use both opiates and crack cocaine and 38% of those in treatment for drug use also use alcohol.

**Table 1 Substance breakdown of clients in treatment 2015-16**

<b>Opiate Users</b>	<b>n</b>	<b>%</b>
Alcohol	148	18%
Amphetamines (not ecstasy)	125	15%
Benzodiazepine	225	27%
Cocaine	57	7%
Cannabis	172	21%
Opiate and crack cocaine	292	35%
Opiate (not crack cocaine)	542	65%
Total	834	100%
<b>Non-opiate users</b>	<b>n</b>	<b>%</b>
Crack cocaine (not opiate)	8	11%
Cannabis	38	51%
Cocaine	9	12%
Benzodiazepine	9	12%
Amphetamines (not ecstasy)	26	35%
Other	<5	*
Ecstasy	<5	*
NPS	<5	*
Hallucinogen	<5	*
Total	75	100%
<b>All non-opiate and alcohol users</b>	<b>n</b>	<b>%</b>
Alcohol	82	100%
Ecstasy	<5	*
Other	<5	*
Amphetamines (not ecstasy)	17	21%
Benzodiazepine	6	7%
Cocaine	15	18%
Cannabis	48	59%
Crack cocaine (not opiate)	<5	*
Total	82	100%
<b>All clients in treatment</b>	<b>n</b>	<b>%</b>
Alcohol	464	38%
Amphetamines (not ecstasy)	168	14%
Benzodiazepine	240	20%
Cocaine	81	7%
Cannabis	258	21%
Opiate and crack cocaine	292	24%
Opiate (not crack cocaine)	542	44%
Total	1,225	100%

Nationally, 78% of those in treatment waited less than 3 weeks for an appointment from referral, locally 100% of clients for opiate, non-opiate and non-opiate and alcohol treatment were offered an appointment and 99% of alcohol clients were offered an appointment within 3 weeks.

Injecting behaviour has remained fairly stable across the main substance groups, those using opiates were far more likely to have injected/ still be injecting compared to the other substance groups. Of those using opiates, 36% are currently injecting and 43% have injected previously. 4% of non-opiate users currently inject and 16% have previously, see Table 2.

The needs assessment survey of substance users found that 35% of drug users injected drugs, this reflects current injecting behaviour data. Of those who said they inject drugs, the majority (90%) always use clean needles and two thirds use the needle exchange.

56% of those surveyed said they had injected at some point in their lives, of these 43% have had an infection as a result of injecting.

Table 2 Injecting Behaviour, North East Lincolnshire, 2015-16

Substance	Currently Injecting (%)	Previously Injected (%)
Opiate	36%	43%
Non-opiate	4%	16%
None-opiate & Alcohol	0%	6%
Alcohol only	0%	2%

Source: Public Health England Local Area Trend Report

## Complexity of clients in treatment

Complexity is assigned to clients individually using a scoring system. In this, a score is assigned to an individual based on variables collected in Treatment Outcome Profile (TOP) and National Drug Treatment Monitoring System (NDTMS). There are separate scores for "new clients", i.e. clients that started treatment in the year and "existing clients", i.e. where the person was already in treatment at the start of the year - see table below. These are summed up for each individual and the resulting scores are then grouped into the five complexity groups shown from very low through to very high.

If the person is a new client then a combination of the start TOP and NDTMS triage information from the first episode is used to determine a client's complexity. Where if the person is an existing client the most recent available TOP data (providing there is a TOP within the 12 months for the person) is used as a proxy for their circumstances at the start of the year. Opiate use is a significant factor in this calculation and for this reason data is only provided for all clients and not broken down by opiate/non-opiate.

Nationally and locally, the proportion of clients in drug treatment services with complex needs has increased, this means that the proportion of successful completions has decreased and will continue to do so as the proportion of complex clients continues to rise. The increase in complex cases is largely due to the aging cohort of heroin users, aged 40 plus who started using drugs in the 1980's and 1990's. This complex cohort of clients in treatment have been using drugs for decades and are therefore far more likely to have multiple physical and mental health conditions relating to their long term drug use. This makes it very challenging to achieve abstinence orientated recovery and many

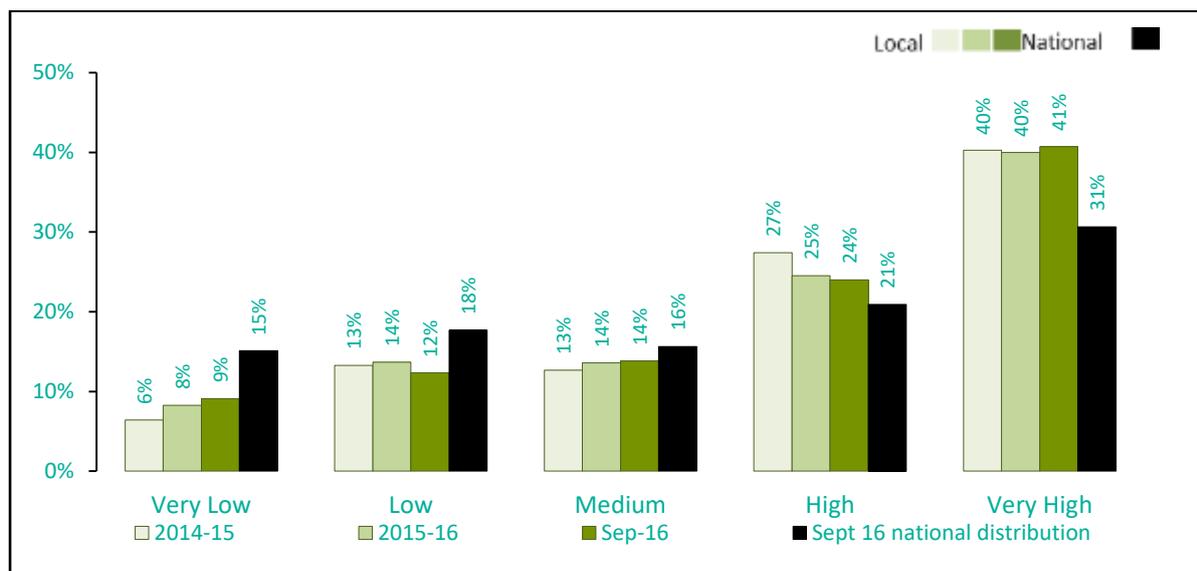
will never complete treatment drug free, this group are also more susceptible to overdose (Public Health England, 2017).

Currently successful completion of treatment is used as a measure to assess how well treatment services and local authorities are performing, however as the proportion of successful completion of treatments will continue to fall it may not be the best way of monitoring success. Public Health England suggest other ways of monitoring success:

- % in need of treatment in treatment
- Good treatment access
- Blood borne viral infection rates
- Longer-term re-presentation rates
- Treatment entry rates following release from prison
- Access to employment and housing support services (Public Health England, 2017).

Figure 8 shows the distribution of complexity groups across the population in treatment in North East Lincolnshire compared to the national average. The proportion of clients in the high and very high complexity groups is higher in North East Lincolnshire compared to the national average. The most recent data shows 41% of clients in North East Lincolnshire are high complexity (equating to 415 people) compared to 31% nationally.

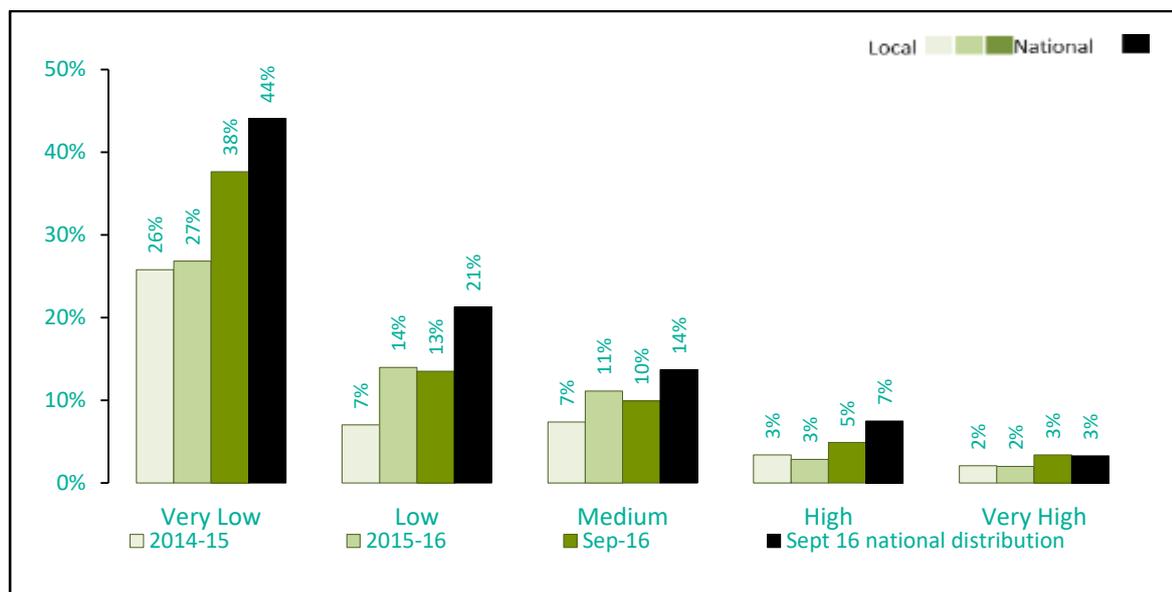
Figure 8 Treatment population by complexity group, October 2015 to September 2016



Source: Public Health England, Recovery Diagnostic Toolkit

Clearly those in the high risk groups are less likely to successfully complete treatment. Only 3% of those with very high complexity will successfully complete treatment both locally and nationally. Locally, 38% with very low complexity successfully completed treatment.

Figure 9 Completions by complexity group, North East Lincolnshire compared to England



Source: Public Health England, Recovery Diagnostic Toolkit

It is thought that the increase in drug-related deaths is likely to be as a result of this cohort of complex clients who are at higher risk of drug-related deaths. As this cohort of complex clients continues to age drug treatment services will need to adapt to their needs as co-morbidities from chronic conditions associated with ageing and drug use become more prevalent (Health Scotland, 2017).

## Successful completion of treatment

One of the measures used to assess how well a local treatment system is delivering outcomes is the successful completion and re-presentation rate. This shows how many individuals have successfully completed treatment and have not returned in the six months post completion. In the financial year 2014/15 opiate users in North East Lincolnshire ranked worst in the Yorkshire and Humber region for the proportion of successful completions of treatment. With a rate of 3.41% North East Lincolnshire had a statistically significantly worse rate than both the regional (5.77%) and national (6.72%) averages. These figures considered in isolation would indicate that the treatment system during that period was under-performing however in considering this data it should be noted that NE Lincolnshire had and still has a high proportion of complex clients, see section **complexity of clients in treatment**. The current (2016/17) successful completion rate for opiates is 5.5%.

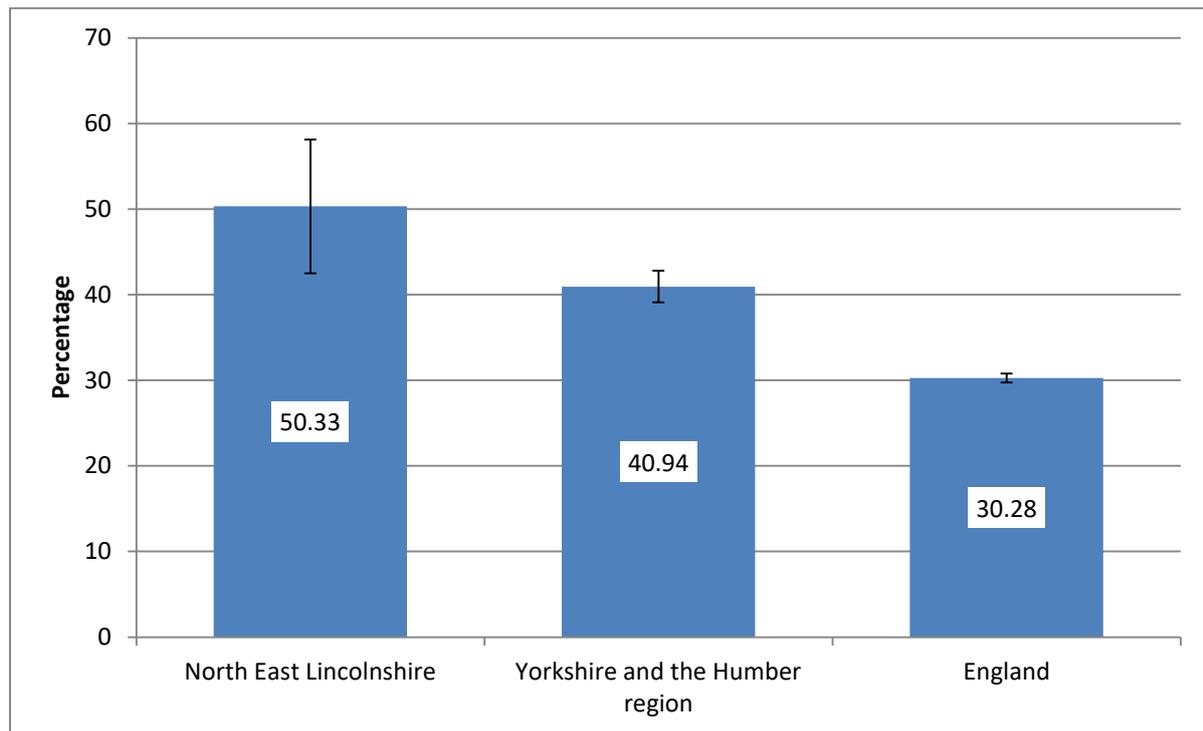
North East Lincolnshire has a statistically significantly higher (better) rate of adults with a substance misuse treatment need in community-based treatment following release from prison, see Figure 10. In 2015/16 North East Lincolnshire had the third highest rate in the region after North Lincolnshire and East Riding.

A number of studies have found an increased risk of death following prison release, an effect which can last for up to a month after release. This is primarily due to reduced tolerance to opiates. Recently released prisoners who return to substance misuse after a length of time without using, in

this instance opiates, whilst imprisoned may go back to the dosage they were using before being imprisoned. Due to the reduced tolerance, this can result in a fatal overdose (Merrall, 2010).

Between November 2016 and January 2017, there were 59 appointments booked with Foundations for prisoners due to be released, the majority from HMP Hull. Only 23 out of the 59 who were due to be released were actually released from prison. Out of these 23 19 (82.6%) attended their appointment.

**Figure 10 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison, 2015/16, 18 years and over, with 95% confidence intervals**



Source: Public Health Outcomes Framework

## Drug-related Calls for Ambulance

Between 1<sup>st</sup> April 2016 and 31<sup>st</sup> March 17 there were 812 calls in North East Lincolnshire for an ambulance where the chief complaint code directly related to drugs. All chief complaint codes relating to drugs were used in this analysis and are as follows:

- Overdose/ Poisoning
- Heart problems AICD – cocaine
- Convulsions/ Fitting.

Two thirds of the calls were stopped and did not progress to hospital, this was for many reasons seen in the table below. The majority of calls stopped were duplicate calls, 10.5% were treated on scene and 4.9% were treated by the clinical assessment team over the phone.

Table 3 Reason call relating to drugs was stopped, ambulance data, North East Lincolnshire, 2016/17

Reason call stopped	No.	%
Taken to hospital	358	44.1%
Duplicate Call	172	21.2%
Treated on Scene	85	10.5%
Hear and Treat by phone by CAT	40	4.9%
Cancelled pre-arrival (AMPDS coded)	37	4.6%
No Patient Found On Scene	33	4.1%
Police Dealing	24	3.0%
Refused treatment & won't sign form	15	1.8%
Refused any treatment & signed form	12	1.5%
Patient Said Making Own Way	11	1.4%
Hoax Call - No Resource Required	6	0.7%
Cancelled Before AMPDS Code	5	0.6%
Refer and Treat (referred to other provider) by CAT	5	0.6%
OCP 3 and above (for CAT use only)	<5	*
Certified dead on scene	<5	*
Police Convey a Patient (usually as a result of a response delay)	<5	*
Fire Service Dealing	<5	*
Referred to Intermediate Care (e.g. Walk In Centre) by attending resource	<5	*
Total	812	100.0%

\*percentages are not shown where data is less than 5

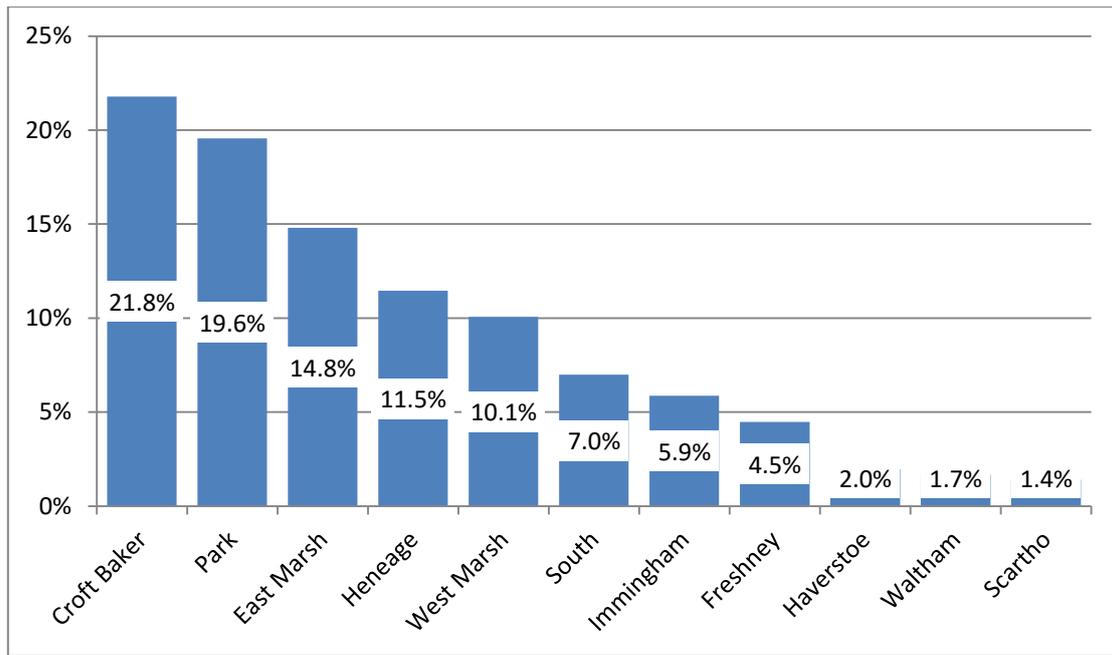
CAT (Clinical Assessment Team)

Source: EMAS

94% of those taken to hospital were taken to the Emergency Department.

The highest proportion of calls were from Croft Baker ward followed by Park and East Marsh ward, this relates to the location of the incident and not necessarily their ward of residence.

Figure 11 Ward of incident location, ambulance data, North East Lincolnshire, 2016/17.

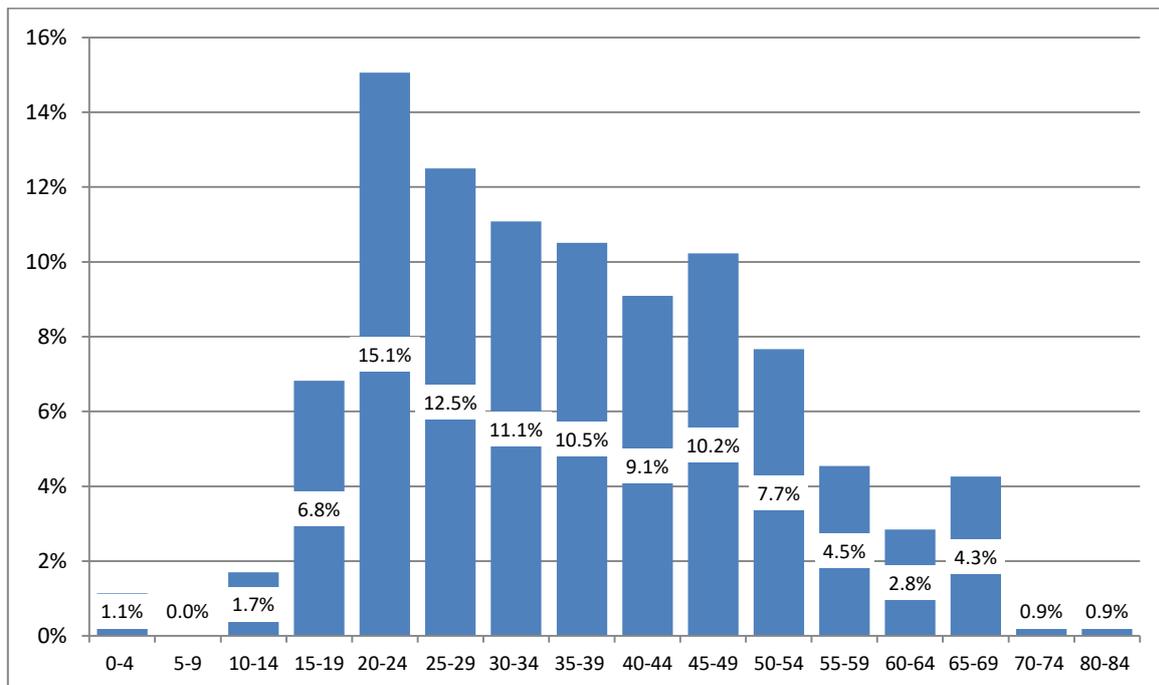


Source:EMAS

Those aged 20 to 24 accounted for 15.1% of all patients with a drug related complaint. Children and the older groups unsurprisingly accounted for much smaller proportions. For females 20.4% were in the 20-24 year old age group and for males the largest group were those aged 25-29 (17.3%). 55.5% of calls were for females and 44.5% were for males.

99% of all drug related calls were classed as overdose/ poisoning, this equated to 354 people.

Figure 12 Age of patient, drug related calls for an ambulance, North East Lincolnshire, 2016/17



Source: EMAS

Data from EMAS has only recently become available to analyse through NEL CCG, previously it hasn't been available to the NEL Public Health Department. Whilst it has been valuable to have this data, there are still some gaps as only certain fields are provided. It wasn't possible to include data on alcohol related calls because there is no field in the chief complaint field. Further information from the clinical impression and initial assessment fields may have been helpful in providing more information as these codes record the suspected use of alcohol and/ or drugs, additionally whether the patient is intoxicated and if an overdose was intentional. EMAS were contacted, however did not reply to a request for this data.

## Accident and Emergency Department

Because of the way that A&E data is coded it has not been possible to establish how many attendances to A&E are related to use of drugs and alcohol, only the main reason for treatment is recorded, therefore if a patient attended A&E to receive treatment for a fractured arm after a fall caused by intoxication (being drunk), this would be recorded as a fracture with no indication of alcohol involvement. Two codes that indicate drugs and/ or alcohol could be the cause are 'poisoning (including overdose)' and 'social problem including chronic alcoholism and homelessness'.

Five years' worth of data (2011/12 to 2015/16) were extracted where the primary reason for attending A&E was poisoning (including overdose) or a social problem (including chronic alcoholism and homelessness). There were 52 cases of poisoning and 32 attendances for a social problem, it is highly likely that this under represents the number of attendances to A&E for drug and alcohol related issues (Data Source NEL CCG). Our local admissions data alone shows over 3 years, 2036 (76.4%) drug-related admissions were via A&E, see section **hospital admissions related to substance misuse**. Furthermore, there were 358 people taken to hospital by ambulance in just one year (2016/17) in North East Lincolnshire for drug related codes, 354 of those were for overdose/poisoning, see section on **ambulance data**.

A national study found that 9 out of 10 A&E departments are failing to identify young people with alcohol problems. The study found that A&E departments don't routinely ask young people or the over 65's about their drinking habits potentially missing out on identifying patients with alcohol problems (Alcohol Policy UK, 2017).

## Hospital admissions related to substance misuse

A local survey of substance users found that 41% of drug users and 46% of alcohol users had been admitted to hospital as a result of their substance use. 40% of drug users surveyed had overdosed at some point in their life see **Appendix 1**.

Hospital admissions related to substance misuse have been extracted from the Secondary Uses Service (SUS) using ICD10 codes (International Classification of diseases 10<sup>th</sup> Revision<sup>6</sup>) seen in the table below. Hospital admissions can have up to 12 reason codes for admission. Records were extracted where at least one of the codes in the table below were in any of the 12 reasons for admission.

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<sup>6</sup> The ICD10 is a system used by medical professionals to classify and code all diseases and health problems, it is used on health records and death certificates and is the standard diagnostic tool used in epidemiology.

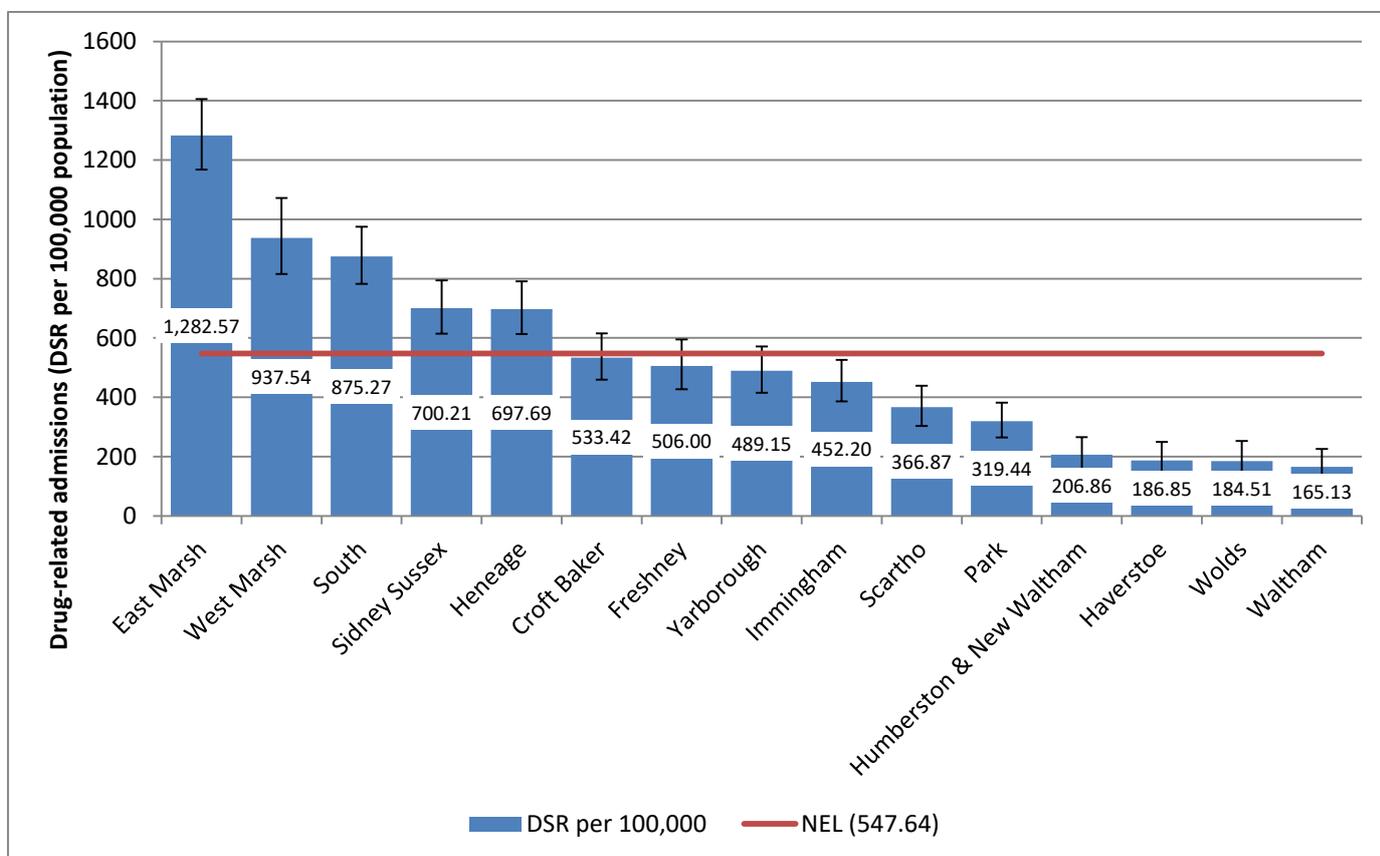
ICD 10 Code	Description
X40-X44	Accidental poisoning by drugs, medicaments and biological substances
X60-X64	Intentional self-poisoning by drugs, medicaments and biological substances
Y10-Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent
X85	Assault by drugs, medicaments and biological substances
F11-F16, F18-F19	Mental and behaviour disorders due to drug use (excluding alcohol and tobacco)

Source: ONS

Data were extracted over 3 years from 1<sup>st</sup> April 2013 to 31<sup>st</sup> March 2016 resulting in 2666 admissions to hospital for persons with a usual residential postcode in North East Lincolnshire equating to 1426 individuals (47% had been admitted more than once in the three year period), 58% of admissions were male and 42% female.

The most deprived wards had the highest admission rates for drug related-admissions, East Marsh, West Marsh, South, Sidney Sussex and Heneage wards all had admission rates statistically significantly higher than the North East Lincolnshire average. Those living in the East Marsh ward were almost 8 times as likely than those living in Waltham to be admitted to hospital as a result of drugs. The N E Lincolnshire rate for males (632.56/100,000) is significantly higher than the female rate (462.22/100,000).

Figure 13 Admissions to hospital for drug-related conditions, 2013/14-2015/16 (3 years pooled), by North East Lincolnshire ward



Source: SUS, provided by NEL CCG

By far the most common admission method was by emergency via A&E with 76.4% of all admissions, admission methods are in the table below.

**Table 4 Admission method for drug related admissions, North East Lincolnshire residents, 2013/14-2015/16**

Admission Method	No.	%
Emergency via A&E	2036	76.4%
Daycase	316	11.9%
Maternity	106	4.0%
Emergency via GP	82	3.1%
Elective	70	2.6%
Emergency Other	56	2.1%
<b>Total</b>	<b>2666</b>	<b>100.0%</b>

Source: SUS, provided by NEL CCG

#### *Primary reason for admission*

The table below shows the primary reason for admission based on ICD10 Chapter for all drug-related admissions, the main primary reason for admission was for injury, poisoning or other external causes. Where a drug related cause is not the primary reason for admission it will be a contributory factor in at least one of up to 12 reasons for admission.

**Table 5 Primary cause for admission to hospital for all drug-related admissions, North East Lincolnshire residents, 2013/14-2015/16**

Primary Cause for admission	No.	%
Injury, poisoning and certain other consequences of external causes (S00-T98)	1272	47.7%
Diseases of the digestive system (K00-K93)	406	15.2%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	153	5.7%
Diseases of the circulatory system (I00-I99)	144	5.4%
Mental and behavioural disorders (F00-F99)	123	4.6%
Pregnancy, childbirth and the puerperium (O00-O99)	99	3.7%
Diseases of the skin and subcutaneous tissue (L00-L99)	94	3.5%
Diseases of the respiratory system (J00-J99)	77	2.9%
Neoplasms (C00-D48)	61	2.3%
Diseases of the genitourinary system (N00-N99)	40	1.5%
Diseases of the musculoskeletal system and connective tissue (M00-M99)	36	1.4%
Factors influencing health status and contact with health services (Z00-Z99)	35	1.3%
Diseases of the nervous system (G00-G99)	32	1.2%
Endocrine, nutritional and metabolic diseases (E00-E90)	27	1.0%
Certain infectious diseases (A00-B99)	26	1.0%
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	23	0.9%
Diseases of the eye and adnexa (H00-H59)	18	0.7%
<b>Total</b>	<b>2666</b>	<b>100.0%</b>

Source: SUS, provided by NEL CCG

### *Secondary reason for admission of this cohort*

Almost all (99.7%) drug-related admissions had more than one reason for admission, 10% had all 12 reason codes completed.

Additional to the primary cause of admission, the secondary cause for admission was analysed. 40.6% had a secondary reason for admission coded as external causes of morbidity and mortality, the majority of which were because of poisoning, 788 (29.7%) secondary reason codes were for intentional self-harm/ poisoning. It is not possible to identify the drug used in all cases of poisoning, for some the codes specifically mentioned the drug taken for example 'heroin', 'paracetamol', however some codes were less specific such as 'other opioids', 'other synthetic narcotics'.

### *Naloxone*

Naloxone is a life-saving drug that temporarily blocks the effects of drugs like heroin and methadone in the event of an overdose. Recent changes in the legal status of naloxone have made it easier for commissioned substance misuse services to provide naloxone to service users, their family and carers and services that interact with substance misusers, such as accommodation services for homeless people.

The suitability of the provision of a take-home naloxone service has been assessed, taking into account factors such as:

- An estimated rate of opiate use far above the national average
- High rates of individuals in substance misuse treatment
- Socioeconomic patterning of opiate overdose and drug-related deaths

We are piloting the use of naloxone in local homelessness accommodation centres, to assess the suitability of a larger scale take home naloxone programme (For full report see Appendix 7).

## **Hospital admissions relating to alcohol**

A range of conditions relating to alcohol contribute to hospital admissions and mortality. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and costs society £21 billion. The indicators below aim to promote measurable, evidence based prevention activities at a local level, and supports the national ambitions to reduce harm set out in the Government's Alcohol Strategy. This ambition is part of the monitoring arrangements for the Responsibility Deal Alcohol Network. Alcohol-related admissions can be reduced through local interventions to reduce alcohol misuse and harm. Reducing alcohol-related harm is one of Public Health England's seven priorities for the next five years (from the "Evidence into action" report 2014) (Public Health England, 2017).

## HOSPITAL ADMISSIONS RELATED TO ALCOHOL

Indicator	NEL		England Average	Regional Average	England Range	Data Period
	Number	Value				
10.01 Admission episodes to hospital for alcohol-related conditions (narrow) (Persons)	1132	728	647	701		2015/16
10.01 Admission episodes to hospital for alcohol-related conditions (narrow) (Male)	723	963	830	880		2015/16
10.01 Admission episodes to hospital for alcohol-related conditions (narrow) (Female)	409	514	483	541		2015/16

The persons rate for hospital admissions for alcohol-related conditions (narrow) is statistically significantly higher than the England rate, this is largely due to the high rate of male admissions. Males in North East Lincolnshire are twice as likely to be admitted to hospital for alcohol-related conditions than females.

**Definitions:** Directly age-standardised rates per 100,000 population. Children under 16 years have only been included for alcohol specific-conditions and for low birth weight. **Alcohol-related** conditions include persons admitted to hospital where the primary or any of the secondary diagnoses are an alcohol-attributable code. **Alcohol-specific** conditions include conditions where alcohol is causally implicated in all cases of the condition. **Broad:** All codes that are recorded in relation to the patients admission are included where an alcohol-attributable fraction is mentioned. **Narrow:** only the primary code is included. For more information on understanding alcohol related admissions see [Public Health Matters](#). **Source:** Local Alcohol Profiles for England, Public Health England.

## MORTALITY RELATED TO ALCOHOL

Indicator	NEL		England Average	Regional Average	England Range	Data Period
	Number	Value				
2.01 Alcohol-specific mortality (Persons)	83	17.7	11.5	31.9		2013-15
2.01 Alcohol-specific mortality (Male)	61	26.5	15.9	17.1		2013-15
2.01 Alcohol-specific mortality (Female)	22	*	7.3	8.3	Insufficient values for spine chart	2013-15
3.01 Mortality from chronic liver disease (Persons)	92	19.7	11.7	11.8		2013-15
3.01 Mortality from chronic liver disease (Male)	63	27.4	15.4	15.5		2013-15
3.01 Mortality from chronic liver disease (Female)	29	12.3	8.2	8.2	Insufficient values for spine chart	2013-15

For alcohol specific mortality, the main concern is the high mortality rate found in males in North East Lincolnshire. The rate for males is 3 times higher than for females and is statistically significantly higher than the England rate. Mortality from chronic liver disease is also significantly worse in males in NEL compared to the national average and males are twice as likely to die from chronic liver disease than females in North East Lincolnshire.

**Definitions:** All mortality indicators are for all ages, directly age-standardised rates per 100,000 population.

Alcohol-specific conditions include conditions where alcohol is causally implicated in all cases of the condition. Alcohol-related conditions include alcohol-specific conditions as well as those where alcohol is implicated in some but not all cases of the outcome.

**Source:** Local Alcohol Profiles for England, Public Health England.

## Drug related Mortality

Drug related deaths in this section are defined as:

“Deaths where the underlying cause is poisoning, drug abuse or drug dependence and where any of the substances listed in the Misuse of Drugs Act 1971, as amended, were involved.” (Advisory Council on the Misuse of Drugs.)

Immediate or virtually immediate deaths arising from the pharmacological action of the drug, including “normal” dosage, accidental or deliberate overdose.

Nationally, drug related deaths are on the increase, and are now at an all-time high. Drug misuse is the third most common cause of death for those aged 15 to 49 years in England (Public Health England, 2017).

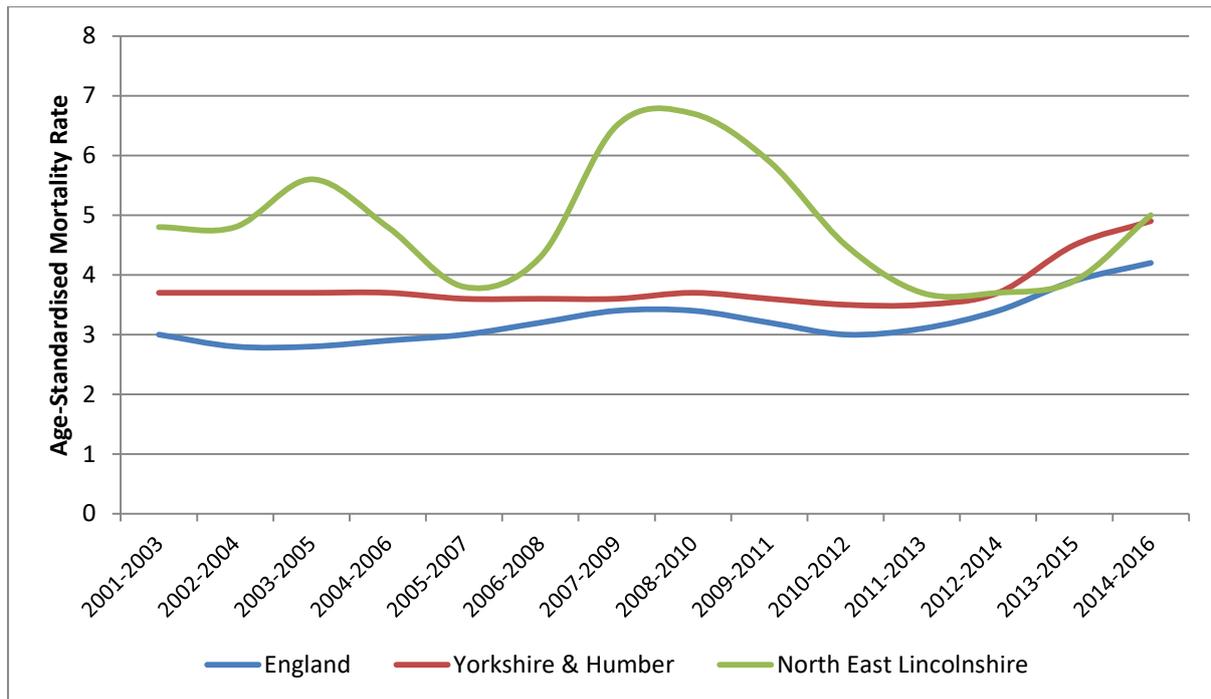
National and regional trends are increasing and the most recent data shows an increase in North East Lincolnshire, however the numbers are small and so the rate fluctuates. 2014-16 data shows North East Lincolnshire has a higher rate than the national but similar to the regional average. There were 21 drug related deaths in North East Lincolnshire between 2014-2016, 7 deaths per year on average.

The definition for this indicator only includes specific codes, seen below, the majority relate to poisoning and do not include deaths from long term substance abuse, therefore there may be additional deaths classified as drug-related deaths by the coroner that are not included in the national figures, additionally there will be deaths from long term drug use from conditions such as liver disease that do not go to the coroner and are not included in the figures.

**Table 6 ICD 10 Codes used for national drug-related death indicator**

ICD-10 Codes	Description
F11–F16, F18–F19	Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)
X40–X44	Accidental poisoning by drugs, medicaments and biological substances
X60–X64	Intentional self-poisoning by drugs, medicaments and biological substances
X85	Assault by drugs, medicaments and biological substances
Y10–Y14	Poisoning by drugs, medicaments and biological substances, undetermined intent

Figure 14 Drug deaths, trend in England, Yorkshire and Humber and North East Lincolnshire



Source: Public Health England

Local analysis was carried out on drug-related deaths data from the Primary Care Mortality File (PCMD) see Figure 15.

- No seasonal or monthly trends were observed in the number of DRD's registered in 2013-15. Similarly, no trends were observed regarding type of substances leading to DRDs.
- 58.6% DRDs were aged 35 to 44 years and 72.4% were male.
- 82.8% of all DRDs lived in the two most deprived local deprivation quintiles and 24% lived in the East Marsh.
- 79.3% were acute deaths and 20.7% were chronic deaths.
- 37.9% involved the use of illegal drugs with the most commonly used drug being heroin .
- 34.5% used prescription drugs, 17.2% used non-prescription drugs and less than 5 used both prescribed and non-prescribed medication.
- 31% of DRDs had poly use which also included alcohol.
- 79.3% of DRDs were categorised as “accidental poisoning by and exposure to noxious substances” and 20.7% were categorised as either “ mental and behavioural disorders due to psychoactive substances” or “intentional self-harm”.

Figure 15 Summary of key findings relating to the DRDs in the North East Lincolnshire:

Source: ONS PCMD

## Suicide

Those who misuse substances (alcohol and/or drugs) are amongst those at highest risk of suicide (Mental Health Foundation , n.d.), people who misuse substances are 6 times more likely to attempt

suicide compared to those who don't misuse substances (Psychiatric Times, 2011). Substance misuse along with other risk factors found in the general population such as depression indicate those most at risk (Psychiatric Times, 2011).

The National Confidential Inquiry into Suicide and Homicide (NCISH) found that 45% of patients who died from suicide had a history of alcohol misuse and 32% had a history of drug misuse, over half (54%) had misused alcohol and/or drugs at some point in their life. 7% of patients had been under drug services and 7% under alcohol services at the time of their death (NCISH, 2015).

A local suicide audit was carried out pooling 5 years' worth of data from 2010 to 2014 (year of inquest) for suicides in North East Lincolnshire, it found that although the actual method of suicide was less likely to be from drugs and/ or alcohol (overdose) it was found that a large proportion had substances in their system indicating use prior to their death, additionally many had misused substances at some point in their life.

Local trends are similar to national trends, although a slightly higher proportion (59.7%) had misused either alcohol or drugs at some time in their life. Locally 19.4% had used drugs and 19.4% had misused alcohol in their life, the table below show the proportions who used both drugs and alcohol together.

**Table 7 Drug and alcohol misuse**

History of alcohol/ drug use	Total	
	Count	%
Not misused alcohol or drugs	25	40.3%
Misused both drugs and alcohol	13	21.0%
Alcohol misuse only	12	19.4%
Drug misuse only	12	19.4%
<b>Total alcohol or drug misuse</b>	<b>37</b>	<b>59.7%</b>

Source: North East Lincolnshire coroner case notes, 2010-2014

The most commonly used drug used locally was cannabis, 64.0% of all drug users had used cannabis (25.8% of all those who died from suicide). Cocaine and Amphetamine use were the next most commonly used drug.

- 45.2% had alcohol in their system at the time of death.
- 32.3% had drugs in their system at the time of death.

A local substance misuse survey found that over half substance misusers (54%) surveyed have mental health problems. 61% said they thought that their drug/ alcohol use had a harmful effect on their mental health, furthermore 63% said they had thought about suicide at some point in their life. Of those who said they had thought about suicide 61% had attempted suicide, equating to 38% of respondents overall.

## Mental Health

Obtaining data relating to mental health and drug and alcohol use, also known as dual diagnosis has been challenging; partly because of the way mental health conditions are recorded by Foundations and the way that substance use is recorded by mental health services. In both cases reading through

client records was the only way to access the data rather than there being a code or tick box to make it easier to extract the data.

Additional to the numbers of clients with dual diagnosis, the local needs assessment survey found, as stated above, that over half (54%) of those who responded to the user survey said they had mental health problems. Furthermore 63% said they had thought about suicide and of those who had thought about suicide 61% had attempted it, this equated to 38% of all respondents. Whilst many alcohol and drug users may not have a diagnosed mental health condition or be known to the dual diagnosis team, it is clear that there is a link between substance misuse and poor mental health. See section on **Suicide** for more information.

#### *Foundations Data – Dual Diagnosis*

39 clients in treatment at Foundations Drug and Alcohol Service have a dual diagnosis of drug/alcohol addiction and a mental health condition, 54% were male and 46% were female. 10 clients didn't have a diagnosis recorded at the time the data were extracted. The most common recorded conditions for those in dual diagnosis were anxiety, depression and mental and behavioural disorders. Post-Traumatic Stress Disorder, Bipolar and Emotionally Unstable Personality Disorder (EUPD) were also commonly recorded conditions. 31% had more than one mental health disorder diagnosed.

The age group of the clients in dual diagnosis is shown below, the largest proportion of clients in dual diagnosis are those ages 40 to 49 years.

**Table 8 Age of clients in dual diagnosis**

<b>Age-group</b>	<b>No</b>	<b>%</b>
<b>20-29</b>	7	18%
<b>30-39</b>	11	28%
<b>40-49</b>	15	38%
<b>50-59</b>	6	15%

Source: Foundations

#### *Navigo Data – NPS Users*

Data on NPS use recorded by Navigo may not reflect the actual number of mental health clients using NPS; currently there is no standardised method of testing or recording of NPS use. Client records held by Navigo identified 21 who had disclosed NPS use over the last 3 years. In 2016/17 the 21 clients known to mental health services who disclosed NPS use accounted for 25 crisis referrals and 25 approved mental health practitioner referrals. 44% led to a formal section. There were 21 adult acute admissions (6.5% of all adult acute admissions) for a total length of stay of 359 days and an average stay of 18 days per admission. It is not possible to say if the use of NPS caused the referral.

Of those who have disclosed use of NPS to Navigo, 81% have had a crisis referral over the last 3 years, on average 4 crisis referrals over the three year period, the highest amount of crisis referrals was 15 over three years. 71% of clients who have disclosed NPS use have had an admission to an acute mental health ward in the last 3 years, again it is not possible to say whether or not NPS was the cause of admission.

## Children living with an alcohol or drug user

The proportion of referrals to social services where alcohol and/or drug misuse is a factor has remained at 12% for the last 3 years as shown in the table below. The numbers have decreased from 371 to 206, however this is reflected in the total number of all referrals also decreasing. A possible reason for this is that fewer referrals reach the Child in Need stage and instead, receive an early intervention.

**Table 9 Number of referrals to social services for where substance misuse is a factor, North East Lincolnshire, 2013/14 to 2015/16**

Year	Number	% of all new referrals	All referrals Total
2013/14	371	12%	3126
2014/14	237	12%	1997
2015/16	206	12%	1725

Source: Northern Lincolnshire Business Connect

In the financial year 2016/17 43% (433) out of all individuals accessing treatment in substance misuse services in NE Lincolnshire lived with children under the age of 18, the national average is 24% . A local survey of substance users found that 29% of respondents had children living with them.

Children who have stressful experiences in childhood that directly harm or affect the environment they live in are at risk of developing health-harming behaviours in adulthood, these are known as adverse childhood events (ACEs). ACEs include households where there is domestic violence, mental illness, drug use, alcohol abuse, incarceration; have separated parents and children who have suffered verbal, physical or sexual abuse. Children who experience 4 or more ACEs are 4 times more likely to be a high risk drinker, 11 times more likely to smoke cannabis, 16 times more likely to use crack cocaine or heroin and 20 times more likely to be incarcerated at some point in their life (Public Health Wales NHS Trust , 2015).

Women who abuse drugs and/ or alcohol or live in a home where alcohol and/ or drugs are abused are at high risk of repeated pregnancies resulting in the child being removed from their care. A local study of women who had children removed from their care in the last 2 years and whose children were still in care showed that over half (55%) of the women had children removed from their care because of drug or alcohol issues in the home (Provisional data from the Pause Project) (Omonubi, 2017). Additionally our Needs Assessment Survey of substance users found that 13% of respondents said they or their partner had unplanned pregnancies as a result of their drink/ drug use.

## Neonatal Admissions to Hospital

Many females using drugs in NEL are of child bearing age, the health risks for both the mother and baby are increased in those who don't access general health services until late into their pregnancy (NICE, 2010). Drug use in pregnancy is a significant risk factor whether or not the person is accessing maternity or drug services but the outcomes are far worse for those pregnant and not accessing services.

Over the last 4 years there were 65 admissions to neonatal intensive care (babies to mothers with a usual residential address in North East Lincolnshire) for conditions related to drug use in pregnancy. The main underlying reason for admission was for neonatal withdrawal from maternal use of drugs. The withdrawal of substances caused by maternal drug addiction is known as Neonatal Abstinence Syndrome (NAS). This table shows the main reason for admission only, in many cases there were more than one reason for admission, all babies were withdrawing from drugs but in some cases this was not recorded as the underlying cause but as an additional cause.

**Table 10 Admissions to neonatal intensive care of babies born with withdrawal from maternal drug use, North East Lincolnshire, 2011/12 to 2014/15**

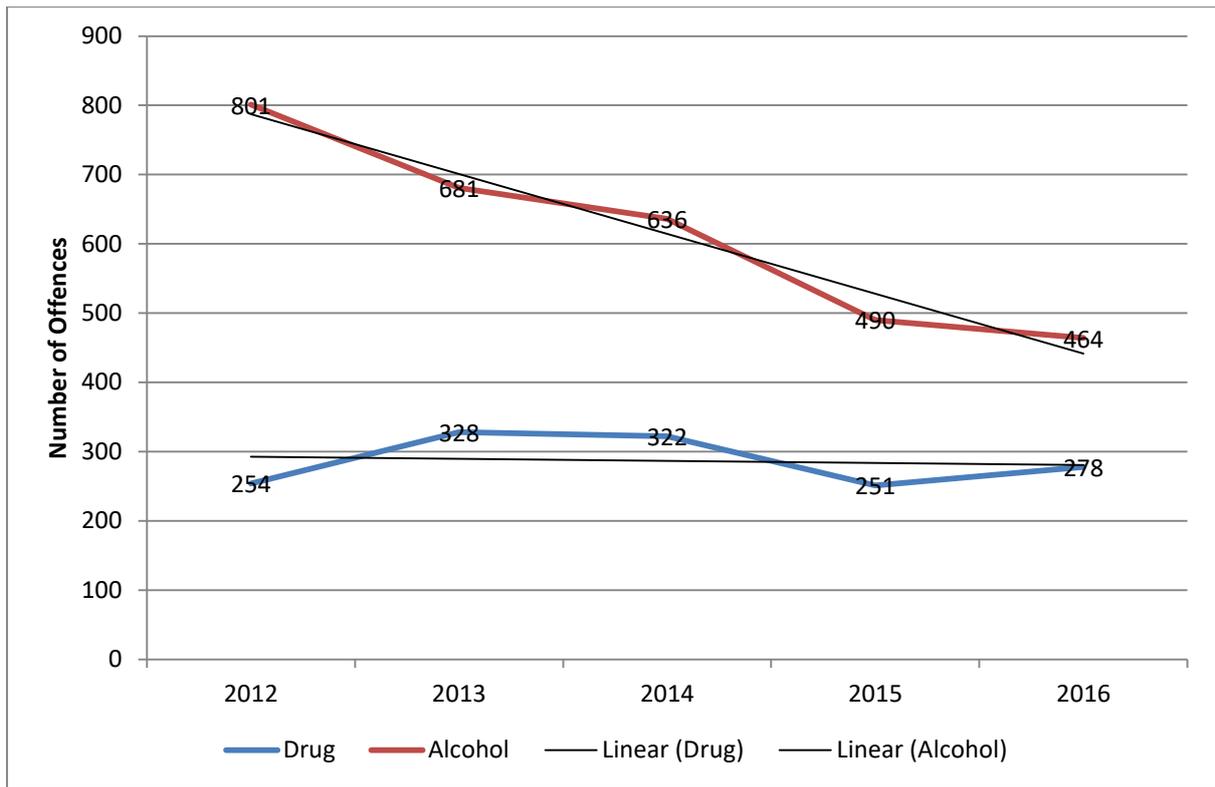
<b>Underlying reason for admission</b>	<b>Number</b>	<b>%</b>
Neonatal withdrawal symptoms from maternal use of drugs of addiction	43	66%
Withdrawal symptoms from therapeutic use of drugs in newborn	8	12%
Other low birth weight	7	11%
Hypothermia of newborn	<5	*
Feeding problem of newborn	<5	*
Other preterm infants	<5	*
Neonatal jaundice, unspecified	<5	*
Intrauterine hypoxia first noted during labour and delivery	<5	*
<b>4 year Total</b>	<b>65</b>	<b>100%</b>

Source: NEL CCG

## **Drug and alcohol related Crime**

The number of offences relating to alcohol have declined over the last 5 years from 801 in 2012 to 464 in 2016. The number of offences relating to drugs have fluctuated slightly but the overall trend shows there hasn't been much change.

**Figure 16 Number of drug and alcohol offences in North East Lincolnshire, 2012-2016**

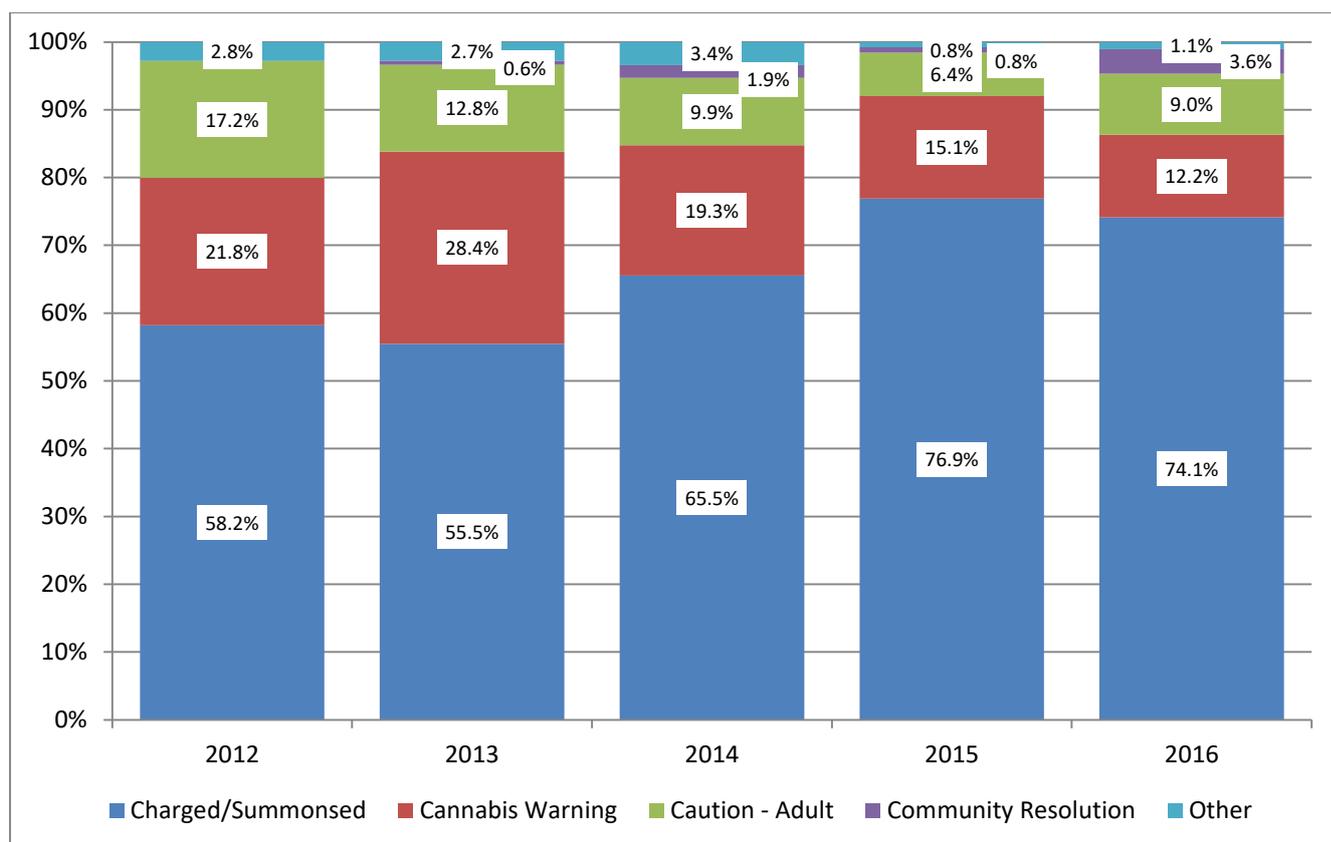


Source: Humberside Police

The proportion of people arrested for drug offences being charged or summonsed has increased over the 5 years show in Figure 17 from 58.2% in 2012 to 74.1% in 2016. There has been a decrease in the proportion of cannabis warnings and adult cautions and an increase in cases resulting in community resolution<sup>7</sup>.

<sup>7</sup> Community resolutions are an out of court disposal the police can use to deal with antisocial behaviour and low-level crime

Figure 17 Outcome of drug offences, North East Lincolnshire, 2012-2016



Source: Humberside Police

Males are far more likely to be arrested for drug related offences than females, in 2016 87% of those arrested for drug related offences were male, 13% were female.

Those arrested for drug related offences were most likely to be in the 21-30 year old age-group, followed by the 31-40 year old age-group.

Table 11 Age-band of people arrested for drug offences in North East Lincolnshire, 2012-16 pooled data

Age-band	Female	Male	Persons
Under 16	0.5%	2.0%	1.8%
16 - 20	10.3%	17.5%	16.5%
21 - 30	35.8%	42.1%	41.2%
31 - 40	32.4%	22.5%	23.8%
41 - 50	16.2%	12.0%	12.6%
51 - 60	3.9%	3.2%	3.3%
over 60	1.0%	0.8%	0.9%
Not Specified	0.0%	0.2%	0.2%

Source: Humberside Police

East Marsh and West Marsh wards had by far the highest number of offences (relating to where the crime took place), together accounting for 41.2% of all drug related crime.

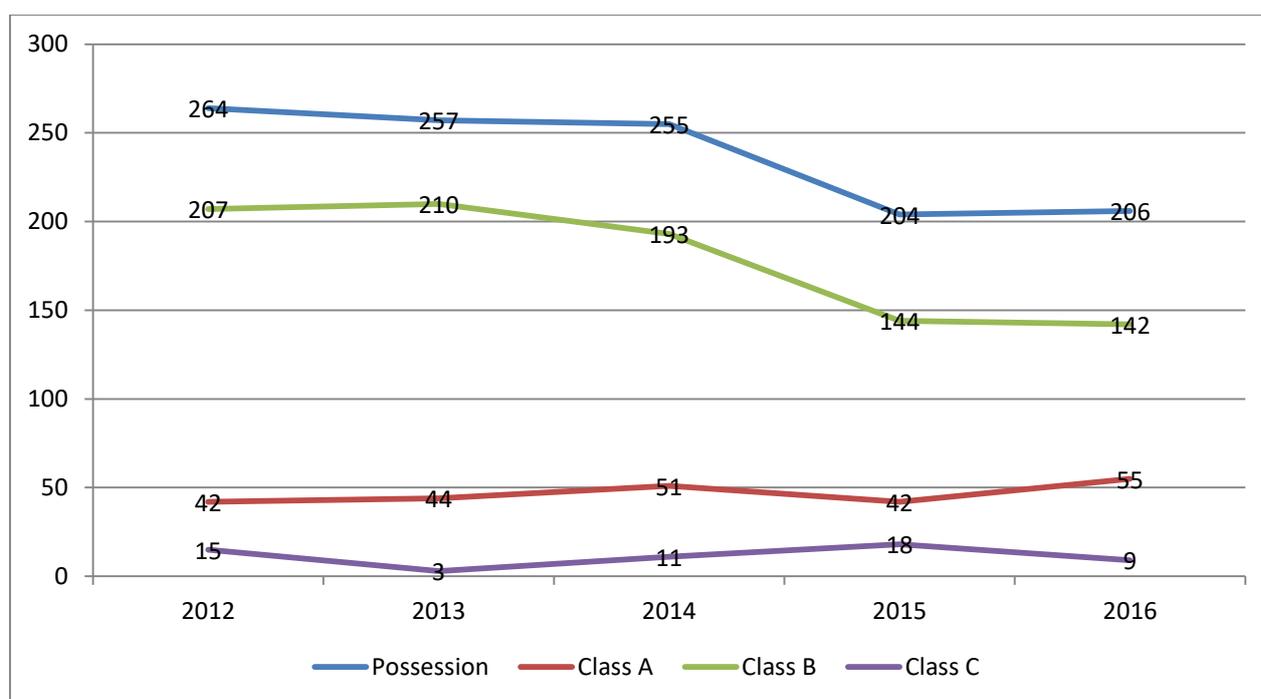
Table 12 Location of drug-related crime, by ward, 2012-2016

Ward	2012-2016	
	No.	%
East Marsh	338	22.1%
West Marsh	293	19.1%
Sidney Sussex	156	10.2%
South	133	8.7%
Heneage	118	7.7%
Croft Baker	115	7.5%
Park	90	5.9%
Yarborough	71	4.6%
Immingham	60	3.9%
Freshney	41	2.7%
Wolds	37	2.4%
Humberston & New Waltham	25	1.6%
Scartho	25	1.6%
Haverstoe	20	1.3%
Waltham	9	0.6%
<b>NEL Total</b>	<b>1531</b>	<b>100.0%</b>

Source: Humberside Police

Overall the number of crimes for possession of drugs has declined; possession of class B drugs remains the highest. A smaller number of crimes for possession are made up of crimes from class A and C.

Figure 18 Possession of drugs by class in North East Lincolnshire, trend 2012-2016



Source: Humberside Police

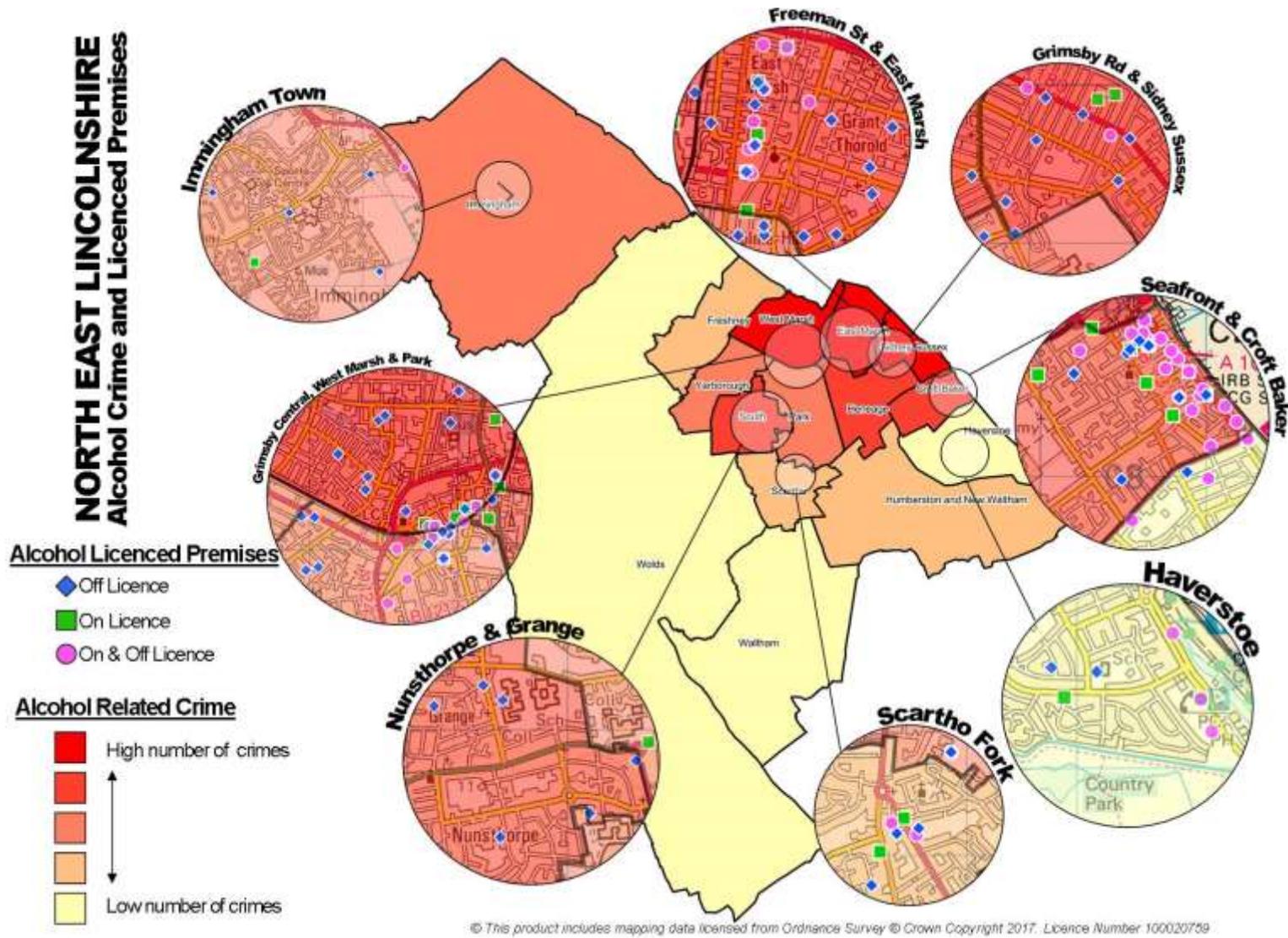
The needs assessment survey of substance service users found that 59% of drug users had been arrested as a result of their drug use, of those who had been arrested, 51% said it was for a drugs only offence additionally 69.8% said it was to fund their drug use. Of all those surveyed 21% have been convicted as a result of drug use and 18% have served a custodial sentence.

44% of alcohol users had been arrested as a result of their alcohol use and most of those who had been arrested (82%) were convicted.

## **Alcohol-related Crime**

Figure 19 shows that the highest number of alcohol related crimes occur in East Marsh, West Marsh and Sidney Sussex wards. These wards also have a high number of alcohol licenced properties; particularly off licenced premises in the West Marsh and Freeman Street area of the East Marsh. Similarly, Sidney Sussex ward had a greater number of licenced premises compared to other areas of North East Lincolnshire that had lower numbers of alcohol related crime. Despite the greatest density of licenced premises, particularly around the Cleethorpes seafront area, lying within Croft Baker, this area was only in the fourth highest local quintile for alcohol related crime. Conversely, South ward, including the Nunsthorpe and Grange, had relatively high numbers of alcohol related crime despite only having low numbers of licenced premises.

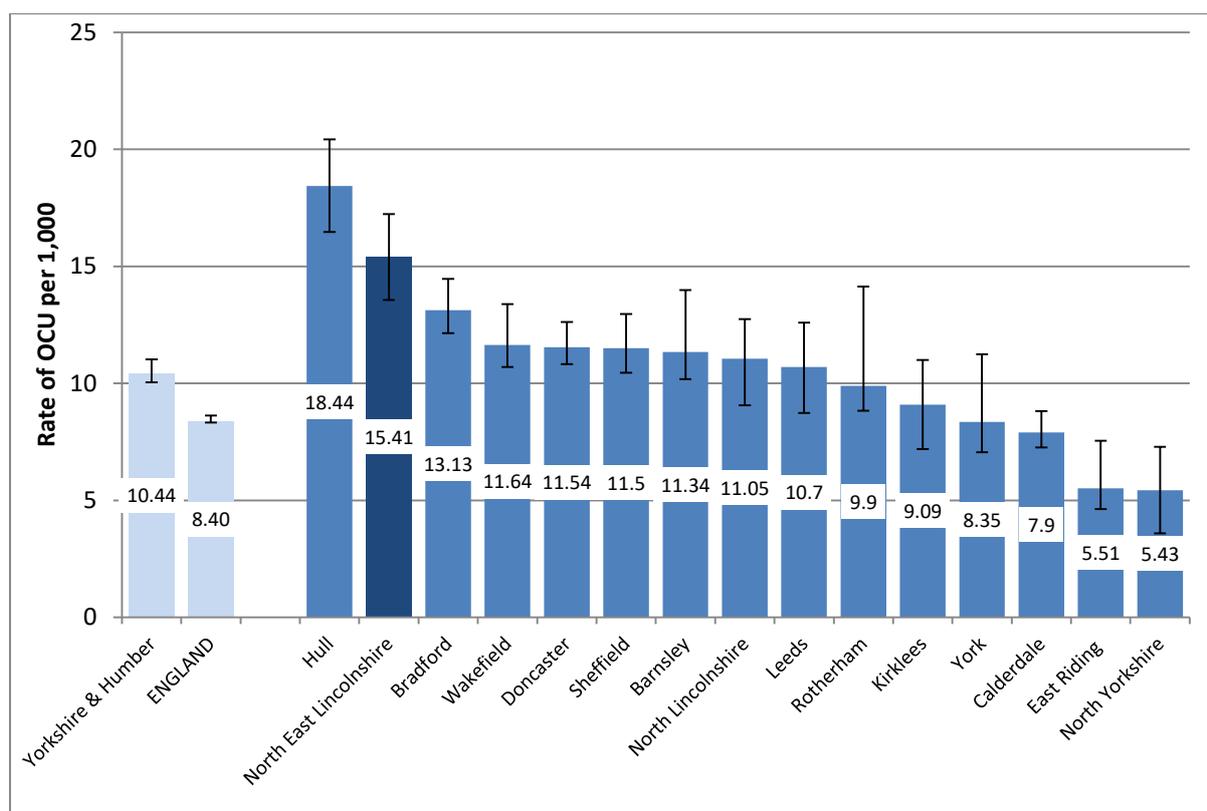
Figure 19 Alcohol related Crime and licenced premises, North East Lincolnshire, 2012-2016



## Prevalence of drug use

The most recently available prevalence estimates for drug use are based on data from 2011/12 and therefore may not reflect the current numbers of drug misusers in North East Lincolnshire. The 2011/12 prevalence estimates 1,587 opiate and/or crack users in North East Lincolnshire (1,442 opiate, 560 crack users, total exceeds 1,587 since some use both). This equates to a rate of 15.41/1,000 adult population, a significantly higher rate than the regional average of 10.44/1,000 and the national rate of 8.40/1,000. North East Lincolnshire ranks second highest (worst) behind Hull, see Figure 20.

Figure 20 Prevalence of opiate and/ or crack users, Yorkshire and Humber region, 2011/12



Source: Public Health England

Prevalence estimates by age-group may be misleading when comparing the numbers by age-group in treatment (See **Substance Misusers in Treatment** section). Estimates show that those age 25-34 are most likely to be users of opiates and/ or crack accounting for over half of all OCU. With a rate of 45.38 it is significantly higher than any other age group. However figures of opiate users in treatment don't reflect this as it is those in their 30's and 40's that make up the majority of the opiate users in treatment, 77% of all opiate users in treatment are aged between 30 and 49 years. The age-bands used in the estimates hide the high number of those in their 40's using opiates.

Table 13 Prevalence Estimates of opiate and or crack users by age group, 2011/12

Age-group	Number	Rate per 1,000	Percentage
15-24	121	5.84	7.6%
25-34	853	45.38	53.7%
35-64	613	9.65	38.6%

Source: Public Health England

Since national prevalence estimates are out of date and don't measure use of drugs such as NPS, prescribed drug addiction and club drug use it may be necessary to carry out local research to help calculate more up-to-date estimates.

## North East Lincolnshire population estimates of alcohol drinkers

The ONS Adult Drinking Habits data series describes alcohol consumption data for adults aged 16 years and above in Great Britain from the Opinions and Lifestyle Survey (OPN). Using these data it is possible to estimate the total number of alcohol drinkers in North East Lincolnshire and number of people who are potentially drinking over safe alcohol consumption levels.

It is likely that the data reported in the OPN survey underestimates drinking levels to some extent due to the people consciously or unconsciously underestimating their alcohol consumption. Similarly it is likely that the figures presented below are not entirely representative for North East Lincolnshire given the varying demographic which are more distinct locally than nationally.

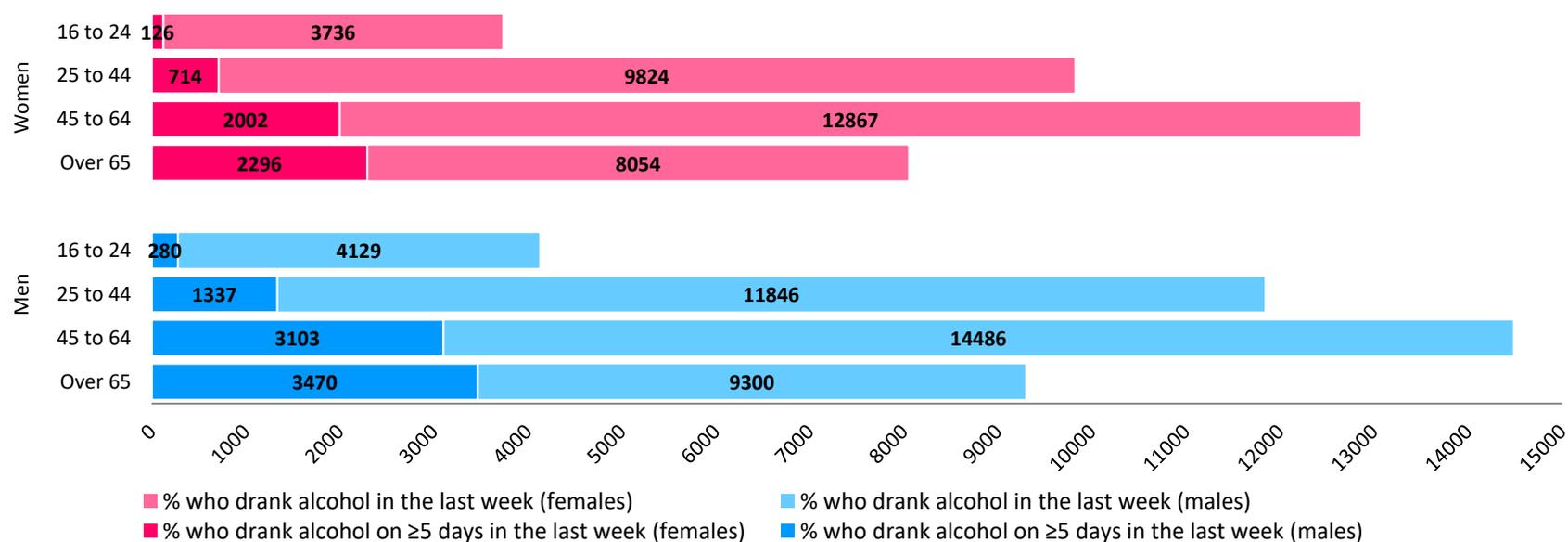
Young people are less likely to have consumed alcohol; less than half (46.0%) of those aged 16 to 24 years reported drinking alcohol in the previous week, compared with 64.2% of those aged 45 to 64 years; although young people are more likely to binge drink on their heaviest day of drinking. Men were more likely to be drinkers than women. Specifically, 62.8% of men drank in the previous week compared with 51.3% of women.

Using the OPN proportions with the North East Lincolnshire population it can be estimated that over 74,000 people aged 16 and over drank at least once in the week and of those 13,000 of those drank on 5 or more days in the last week. Figure 21 below shows the number of people who drank alcohol in the last week and those who drank alcohol on 5 or more days in the last week by gender and age group.

Table 14 Alcohol consumption estimates for NEL based on ONS OPN survey % by broad age group, 2016

		16 to 24		25 to 44		45 to 64		65 and over		Total 16+
		ONS est.	NEL	ONS est.	NEL	ONS est.	NEL	ONS est.	NEL	NEL
<b>Females</b>	% who drank alcohol in the last week	45.53%	3736	50.26%	9824	59.91%	12867	47.25%	8054	34490
	% who drank alcohol on ≥5 days in the last week	1.54%	126	3.65%	714	9.32%	2002	13.47%	2296	5138
<b>Males</b>	% who drank alcohol in the last week	48.02%	4129	61.63%	11846	69.21%	14486	65.93%	9300	39761
	% who drank alcohol on ≥5 days in the last week	3.26%	280	6.96%	1337	14.83%	3103	24.60%	3470	8190

Figure 21 Estimated number of persons aged over 16 within North East Lincolnshire who have drunk alcohol in the last week and of those who have drunk on at least 5 of the last week by gender and age group, 2016



## Prevalence of Alcohol dependency

### *Summary of alcohol dependency estimates for North East Lincolnshire and statistical neighbours*

Alcohol dependency, for the purposes of these estimates, is defined as an alcohol-use disorder identification test (AUDIT) score of 16 or more<sup>8</sup>, with 16-19 suggesting a high risk of alcohol dependence and 20 or more with possible dependence<sup>9</sup>. This test has been termed 'gold standard' by Public Health England<sup>10</sup> and is considered to be highly accurate<sup>11</sup>, with 92% sensitivity<sup>12</sup> and 94% specificity<sup>13</sup> meaning there are few false results and suggesting that estimates of dependence based on AUDIT scores are not affected by a lack of accuracy of the test itself.

### *Estimates of the dependent population*

As of 2014, there are an estimated 1,957 (95% CI 1,575-2,523) adults dependent on alcohol in North East Lincolnshire, equivalent to 1.56% (95% CI 1.25-2.01%) of the adult population. Figure 22 below shows the alcohol dependency rate for North East Lincolnshire, statistical neighbours, geographical neighbours as well as regional and national benchmarks.

Large confidence intervals for the estimates make statistically significant conclusions difficult. Going by the mean value alone, North East Lincolnshire appears to have higher rates of alcohol dependence than regionally or nationally, and in line with many statistical neighbours. North Lincolnshire's estimated mean rate is one of England's lowest, whilst Hull's is one of England's highest.

Overall, North East Lincolnshire ranks 54<sup>th</sup> out of 151 upper-tier local authorities, giving it a higher estimated mean rate of alcohol dependency amongst the adult population than 64.2% of England's upper-tier local authorities.

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<sup>8</sup> Pryce et al (2017) *Estimates of alcohol dependence in England based on APMS 2014, including estimates of children living in a household with an adult with alcohol dependence: prevalence, trends and amenability to treatment.*

<sup>9</sup> NHS (Greater Manchester Mental Health NHS Foundation Trust) *Alcohol Screening Tool*

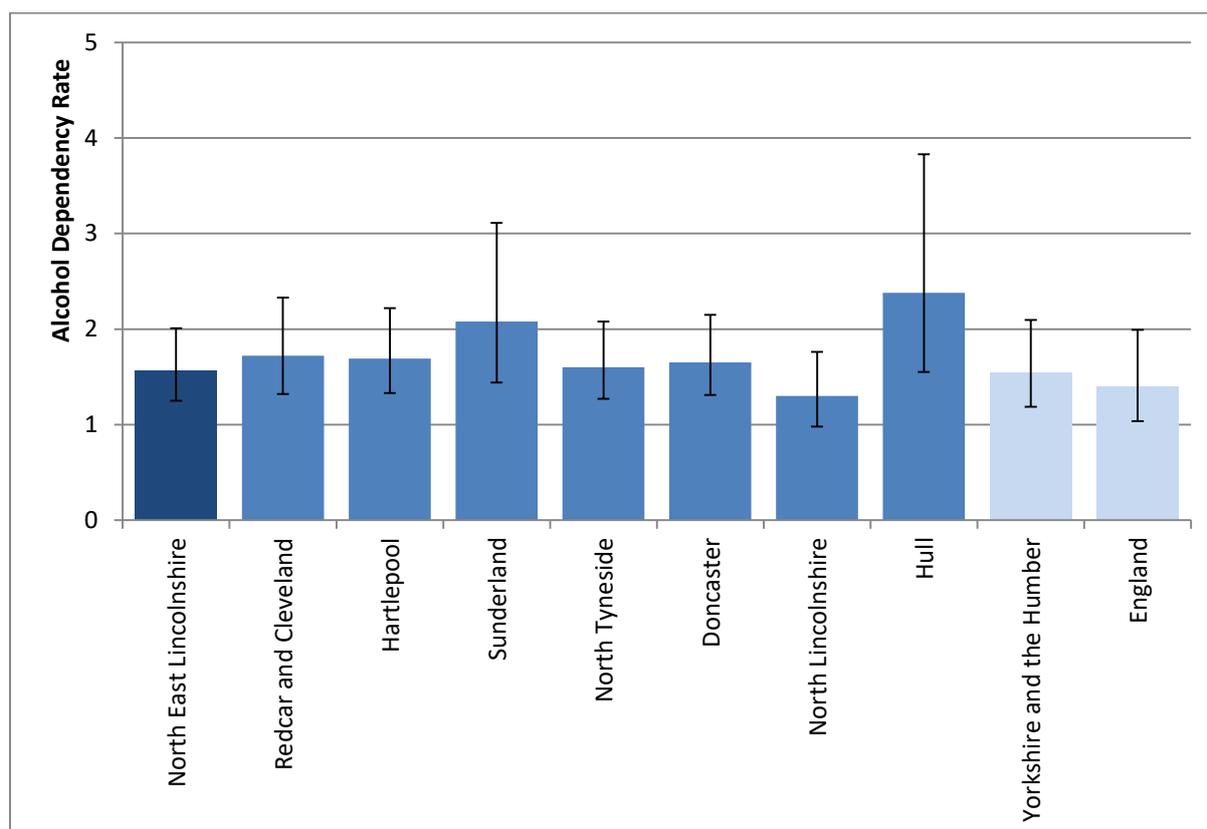
<sup>10</sup> Public Health England (YEAR) *Alcohol Risk Assessment/NHS Health Check/Challenges*

<sup>11</sup> Saunders et al (1993) *Development of the alcohol use disorders identification test (AUDIT)*

<sup>12</sup> The ability of a screening test to correctly identify the presence of the condition, i.e. the true positive rate

<sup>13</sup> The ability of a screening test to correctly identify the absence of the condition, i.e. the true negative rate

Figure 22 – Estimated alcohol dependency rate within the adult population, 2014



Source: Pryce (2017)

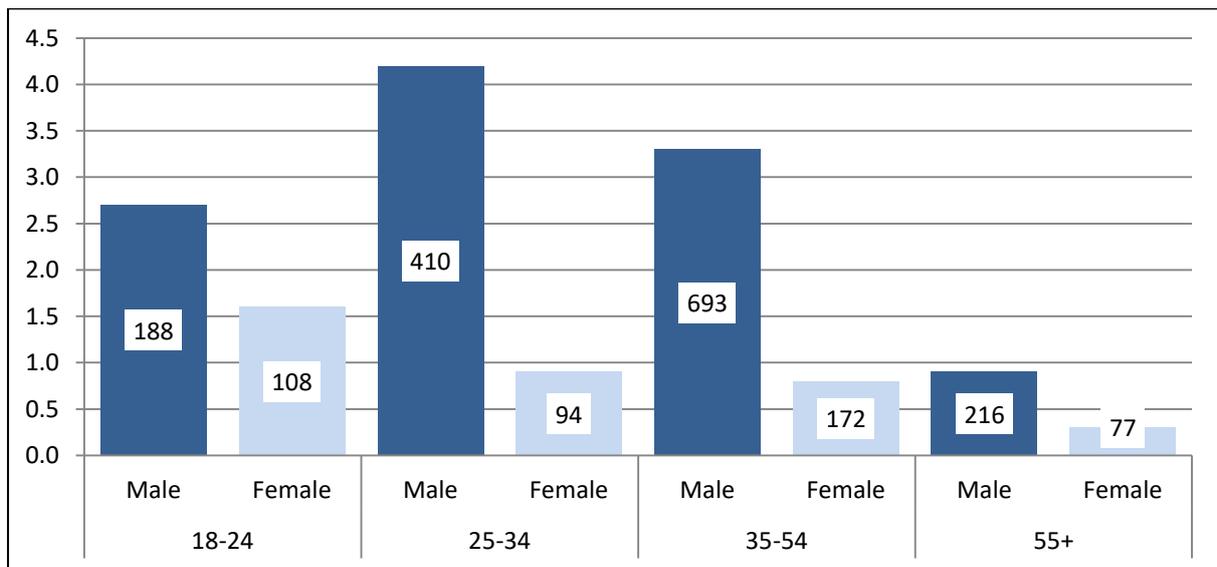
*Dependency by age and sex*

Within North East Lincolnshire, there is considerable variation between the sexes and across age groups. This is shown below in Figure 23. The actual estimated *number* of individuals is displayed within the bar representing the rate.

As can be seen, alcohol dependency is consistently more prevalent amongst the male population than the female population. Whilst there is a trend of alcohol dependency becoming less prevalent amongst women as they move through the life course, alcohol dependency is more prevalent in men aged 25-54 than it is men aged 18-24.

The rate of alcohol dependency amongst young women is particularly high, at an estimated 1.6% of the 18-24 year-old female population. This is higher than most other local authorities, though the aforementioned wide confidence intervals suggest this may not be a statistically significant difference. Such a high rate may be suggestive of a high prevalence of underage drinking leading to dependency or perhaps a historically unprecedented high level of drinking amongst young women, suggesting changing attitudes towards alcohol use amongst young women, with alcohol dependency a historically male problem.

Figure 23 – Estimated alcohol dependency rates and the number of dependent people within the adult population by age and sex, North East Lincolnshire, 2014



Source: Pryce (2017)

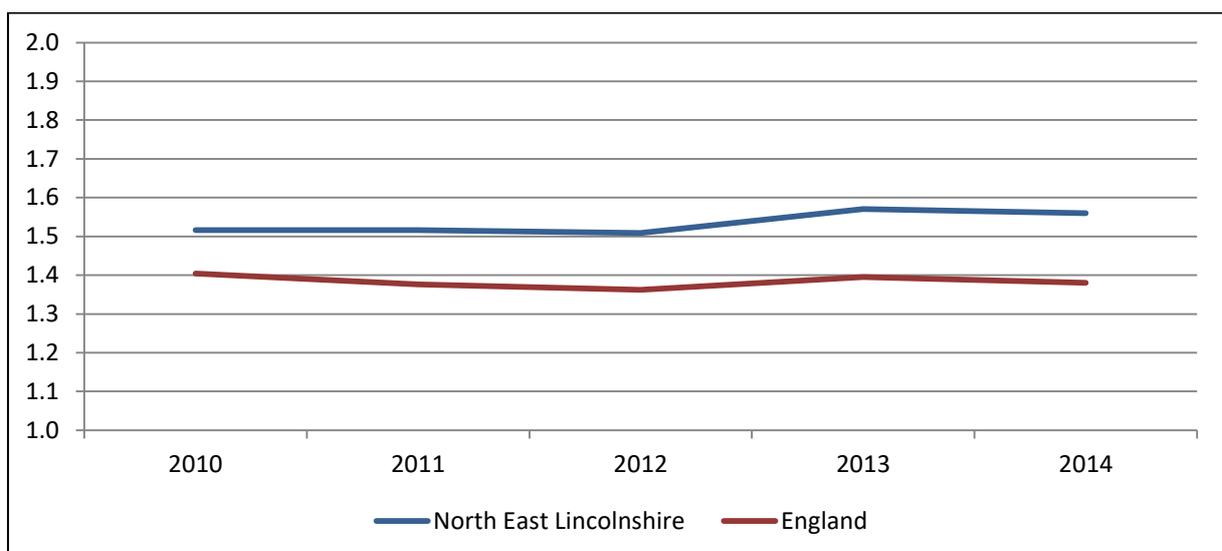
#### Trends in alcohol dependency

The number of people estimated to be alcohol-dependent in North East Lincolnshire rose steadily from 1,890 in 2010 to 1,957 in 2014, representing growth of 3.54%.

Figure 24 shows the dependency rate between 2010 and 2014 for North East Lincolnshire and England.

Growth in alcohol dependency locally has outstripped growth nationally, with alcohol dependency declining in prevalence nationally during 2010-2014.

Figure 24 – Estimated alcohol dependency rates by year, North East Lincolnshire and England, 2010-2014



Source: Pryce (2017)

## Burden of Disease In Northern Lincolnshire

The recent Burden of disease in North East Lincolnshire<sup>14</sup> study examined the likely impact of disease (particularly long term conditions (LTCs)) on the local health and social care system and identified interventions and prevention strategies required to ‘turn the curve’<sup>15</sup>. The aims of the study were to:

- identify the current burden of disease in Northern Lincolnshire in a number of major long term conditions;
- model the future burden of disease relating to LTCs, taking a life course and predictive approach to examine the likely impact on the health and social care system in years to come;
- undertake an evidence review of the most effective low cost, high impact public health interventions that have the potential to ‘turn the curve’;
- make recommendations to Healthy Lives Healthy Futures, CCG, Local Authority and GPs on where investments should be made now in order to reduce future/ delay costs associated with health and social care in the future.

Key points concerning to drug related harm from the study:

- One of the leading causes of years of life lost amongst those aged 35 to 44 years was liver disease associated with alcohol and injecting drug use. Between the ages of 25 and 65 there were substantial excess years of life lost due to drug related deaths.
- For Years of Life with Disability (YLD), most conditions increase proportionately with age with one of the exceptions being mental and behavioural disorders due to drug use which peak in young middle age. The pattern of drug use disorders is distinctive and varies substantially by age and gender
- Alcohol and drug use was identified as one of the top 10 causes of behaviour related causes of disease.

Further analysis using the local Burden of Disease methodology was undertaken to develop a greater understanding of drug related years of life with disability. To develop an understanding of the extent of which life years are affected by particular drugs data from the UK Global Burden of Disease Study<sup>16</sup> was utilised at Yorkshire and Humber Quintile 2 level.

Figure 25 shows the difference between the rate of YLD’s for North East Lincolnshire compared to England. Overall males have significantly greater rates of drug related YLD rates than females. Teenage females in North East Lincolnshire have a greater proportion of drug related YLD than average but following that women between the ages of 20 to 29 have a lower rate of YLD than the national average. North East Lincolnshire females largely follow the national average of YLD for the rest of the life cycle with the exception of females aged 40 to 44 years (lower rate) and females aged 45 to 49 (higher rate). For North East Lincolnshire males however, there is a much greater disparity between national drug related YLD rates and local rates; most notable amongst males where the greater local rates of YLD in those aged 25 to 29 years and 40 to 44 years.

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<sup>14</sup> <http://www.nelincsdata.net/resource/view?resourceId=403>

<sup>15</sup> ‘Turn the curve’: a process of using informed strategic decision making to influence outcomes and changing negative performance trends to positives

<sup>16</sup> Newton et al. (2015) *Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013*. 386 (10010) p2257-2274.

Figure 25 Total drug related YLD per 100,000 for North East Lincolnshire compared to England, GBD 2013

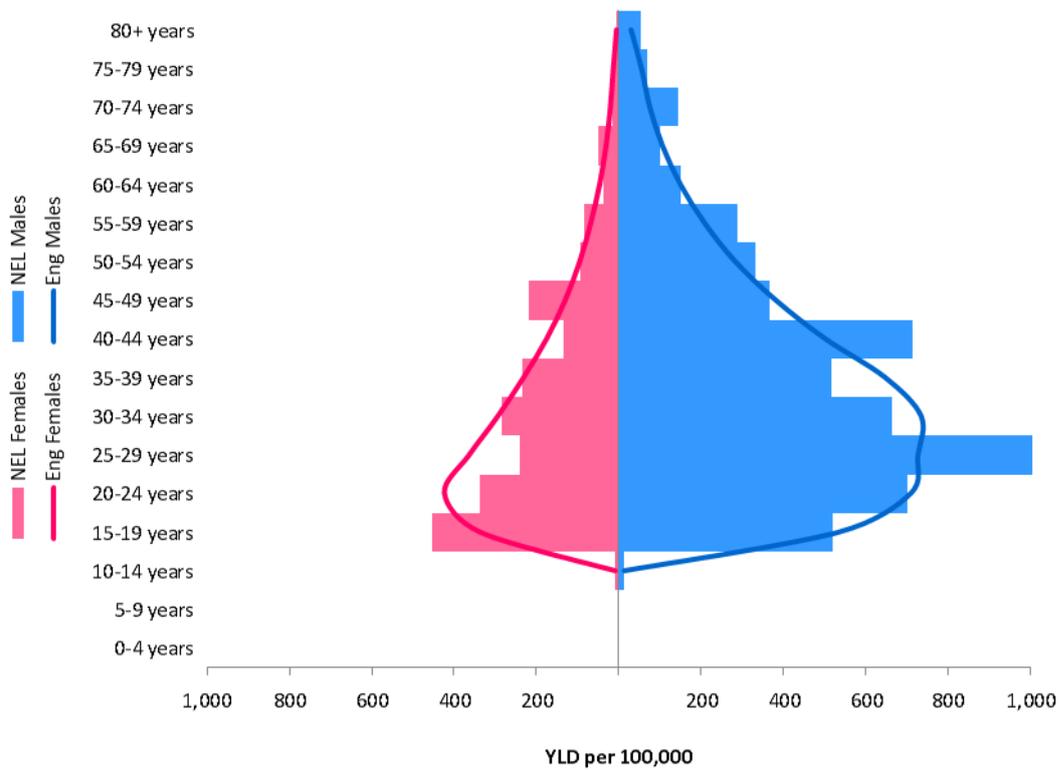
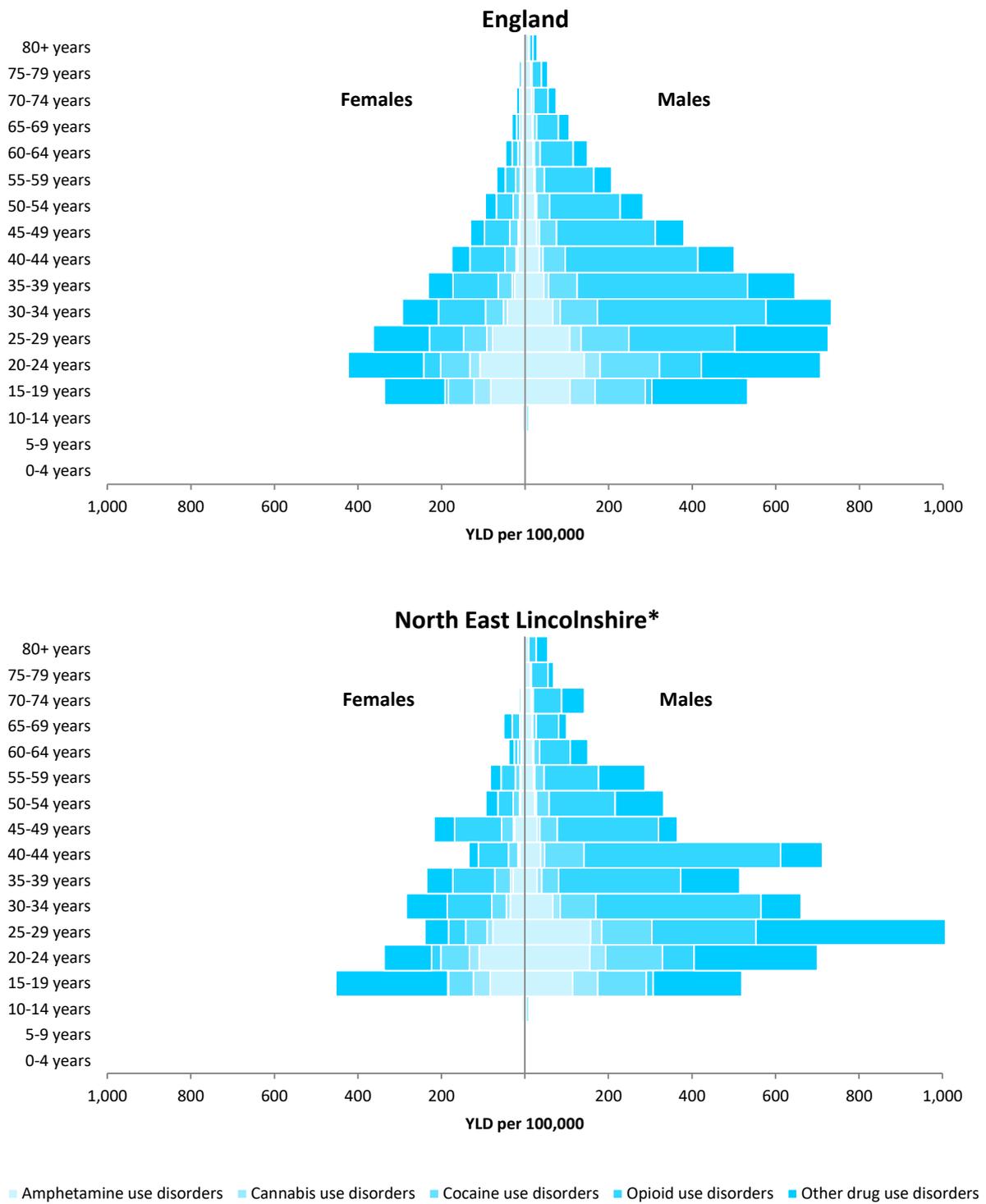


Figure 26 shows the detailed comparison of drug related YLD for North East Lincolnshire compared to England. This enables the identification the specific drugs that are shown to have greater rates of YLD amongst particular age groups and gender. For teenage females it appears there is a greater YLD as result of “other drug use disorders” and for females aged 45 to 49 there is a considerably greater rate of opiate related YLD. Amongst males the increased rate of YLD in younger males is due to “other drug use disorders” whereas in the 40 to 45 age group it is the result of opiate use.

Figure 26 Detailed comparison of drug related YLD per 100,000 for England and North East Lincolnshire\*, GBD 2013



\*Global Burden of Disease Study – Yorkshire and Humber Quintile 2

## Current service provision

### Who commissions what?

Commissioner	Services Commissioned / Current Provider	Budget 2017/18
North East Lincolnshire Council and Police and Crime Commissioner (c£291k per annum funding)	<u>Secondary Care</u> North East Lincolnshire Drug and Alcohol Treatment Service delivered by Foundations	NELC budget £1,081,800*
		PCC funding £291,000**
North East Lincolnshire Council	Prescribing costs	£417,010*
Clinical Commissioning Group on behalf of North East Lincolnshire Council	<u>Primary Care</u> North East Lincolnshire Drug and Alcohol Treatment Service delivered by Grimsby Practices in Partnership (GPIP)	£125,000
North East Lincolnshire Council	Needle Exchange Freelance Needle Exchange Ltd	£150,000*
North East Lincolnshire Council	Supervised Consumption Freelance Needle Exchange Ltd	£200,000*
North East Lincolnshire Council	Carers Centre funded post	£21,500
<b>TOTAL PER ANNUM</b>		<b>£2,286,310</b>

\* Funding for the above budgets will continue to be reduced by 2.6% per annum to take into account Governments reduction in public health funding to North East Lincolnshire Council.

\*\* Funding from the PCC has been confirmed for 2017/18, however future funding for following years will be determined at a later date, depending on a number of strategic decisions to be made by the PCC's office in respect of the Humber area.

The table below identifies the total budget per annum from North East Lincolnshire Council for substance misuse services within North East Lincolnshire over the next five years:

Financial Year	North East Lincolnshire Council Budget Availability
2018/2019	£1,801,715
2019/2020	£1,745,870
2020/2021	£1,709,244
2021/2022	£1,664,803
2022/2023	£1,621,518
<b>TOTAL</b>	<b>8,552,151</b>

In 2019-20 it is anticipated that the Public Health grant will no longer be ring-fenced and the funding arrangements for Local Authority's will change considerably. At this point the funding of the contract will become part of ordinary Council funding.

## **Drug and Alcohol Treatment Services within North East Lincolnshire (Secondary Care)**

In 2013, most Public Health commissioning in North East Lincolnshire was transferred from the Care Trust Plus to the Council and the drug and alcohol treatment services became the responsibility of North East Lincolnshire Council (the Council) as part of the changes outlined in the Health and Social Care Act 2012.

In order to tackle long standing health inequalities within North East Lincolnshire, the Council adopted a new approach and redirected resources from intervention towards prevention, to enable the design of a fully integrated systems approach to drug and alcohol services. Following this in 2013, the drug and alcohol treatment service was remodelled/re-commissioned.

The integrated systems approach service commenced delivery on 1<sup>st</sup> July 2014 for an initial 3 year period, this saw 3 service providers (Care Plus Group, The Alcohol and Drug Service and Rotherham Doncaster & South Humber NHS Trust) join together as a partnership named 'Foundations' to deliver the North East Lincolnshire Drug and Alcohol Treatment service (NELDAT). This service is a unique integrated multi-disciplinary approach that brings together social care, nursing, medical and criminal justice professionals (Care Plus Group, 2017).

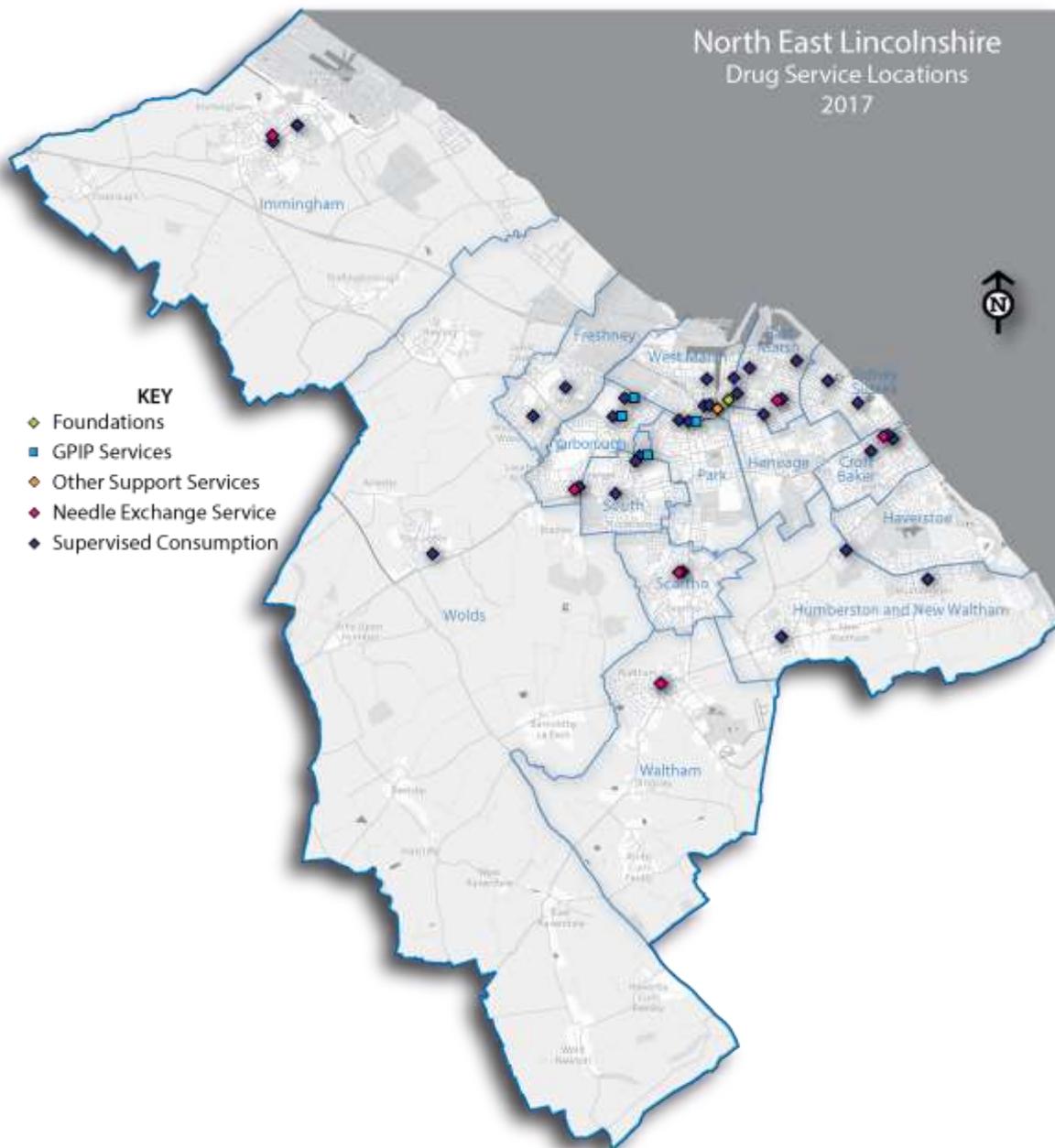
Within the current service specification the aim of NELDAT is to deliver high quality recovery based drug and alcohol treatment services working as an integrated system for the population of North East Lincolnshire.

The services are outcome focussed towards supporting people to achieve and maintain a long term recovery from their drug and/or alcohol misuse by:

- Improving the health and wellbeing and quality of life for all people affected by drug and alcohol misuse;
- Reducing health inequalities and improve public health;
- Reducing drug and alcohol related crime, disorder and re-offending; and
- Supporting pathways to facilitate social inclusion.

The overall purpose of drug and alcohol treatment services are to support the Council priorities of a stronger community and stronger economy, they do this by supporting the strategies and plans of the two local statutory partnerships – the Health and Wellbeing Board and Safer and Stronger Communities Partnership. The service is available for all ages of people living in North East Lincolnshire as temporary or permanent residents, regardless of ethnicity, culture, disability or sexual orientation.

## Location of drug services



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Foundations is located in central Grimsby and GPIP has 3 locations, all in Grimsby. Currently there are no drug treatment services based in Immingham or Cleethorpes. The pharmacies offering a needle exchange and/ or supervised consumption are located across North East Lincolnshire.

## Foundations overview

NELDAT is provided by Foundations at Queen Street, Grimsby, DN31 1JA. This is situated within walking distance of Grimsby town centre, the police station and situated next to the probation service.

The direct access opening hours for the service at Foundations are Monday-Friday 09:00 – 16:30, with core service hours being 09:00-17:00. The service delivers a support session for service users that are employed on Thursday evenings 18:30-19:30 at Open Door, Albion Street, Grimsby.

Foundations also provides a service within the Police Custody Suite for those that are arrested for alcohol and/or drug related offending (trigger offences such as acquisition crimes), covering the following peak times:

- Monday to Friday 08:30 – 21:00
- Saturday 08:30 – 19:00
- Sunday 10:00 – 16:00

There are currently 48 staff employed as part of the Foundations service.

Foundations was recently inspected by CQC as part of the Rotherham Doncaster and South Humber NHS Foundation Trust – Substance Misuse Service review (inspection date 26-28<sup>th</sup> September 2016/report published January 2017), and scored an overall rating for the service as ‘Good’.<sup>17</sup>

Foundation believes the aspiration for all service users should be recovery and defines this as:

*“a process that involves not only achieving control over substance use, but also involves improved health and wellbeing and building a new life, including family and social relationships, education, voluntary activities and employment. While the individual is at the heart of the recovery, their relationship with the wider world – family, peers, communities and society – is an intrinsic part of the recovery process”.*

Foundations deliver the following contract service specification requirements:

- Direct community access for those requiring advice, harm reduction and treatment for drugs and alcohol for any age group and for any substance. This is well publicised and locally known;
- General advice, guidance and signposting to all other appropriate services such as housing, education, training, employment, benefit services etc;
- Provide training and support to other organisations such as primary care and the hospital if required;
- A range of harm reduction services and/or access to them;
- Blood borne virus control; including responsibility for the budget for purchasing vaccines and testing;
- A needle exchange scheme linked to the wider pharmacy based scheme;

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<sup>17</sup> CQC Rotherham Doncaster and South Humber NHS Foundation Trust, Substance misuse services quality report January 2017

- A range of screening, brief interventions and prevention activities coordinated with those provided by other organisations/agencies locally, regionally and nationally;
- Recovery focused structured drug and alcohol treatment for any substance, with access to pharmacological and psychosocial interventions. Ability to deal with clients with a high degree of risk, vulnerability and complexity such as those with a dual diagnosis, pregnant women, problematic poly drug and alcohol users and those with complex health needs;
- Recovery focused structured drug and alcohol treatment exclusively catering for those under eighteen years of age, for any substance, with access to pharmacological and psychosocial interventions. Interventions are provided in an appropriate setting for young people (i.e. in a non-adult treatment setting);
- Community based alcohol detoxification which includes access to the local facility 'Fieldview' and the control of the budget for that facility
- Assessment and referral to residential and in-patient rehabilitation and detoxification 'out-of-area'.
- Custody suite based arrest referral for drugs and alcohol coordinated with court administration, so as to provide a seamless process for Required Assessment and Restrictions on Bail;
- Provides drug and alcohol treatment for offenders subject to Drug Rehabilitation Requirements, Alcohol Treatment Requirements or entering treatment via the local Drug and Alcohol Interventions Programmes, requiring the additional competency of challenging offending behaviour and maintaining already established links to Integrated Offender Management;
- Effective transitions between prison and community;
- Service user support, mentoring, mutual aid and activities aimed at building social capital in support of maintaining recovery. This include links to Narcotics and Alcoholics Anonymous as well as already established local groups;
- Provider adequate resource to support primary care based drug services.
- Referral pathways, information sharing arrangements and working links with primary care based drug and alcohol services as part of the wider local drug and alcohol treatment system, and;
- Provide outreach when situations demand.

NELDAT is measured against the following Public Health indicators (gov.uk, 2017):

- PHOF 2.15 Successful Outcome of Drug Treatment
- PHOF 2.16 People entering prison with a substance misuse dependence issue who are previously not known to community treatment
- PHOF 2.18 Alcohol related admissions to hospital

## Office of Police and Crime Commissioner (PCC)

NELDAT service currently receives additional annual grant funding from the Office of the PCC (£291k per annum). Funding from the PCC goes towards engagement work carried out by NELDAT with individuals within and alongside criminal justice services (including working with individuals within the custody suite, the courts and probation services).

### Custody Suite

Between September 2016 - December 2016 of those eligible<sup>18</sup> to be tested for class A drugs, 49% tested positive and had an initial required assessment imposed. 95% attended this appointment which is usually carried out whilst the individual is still in the suite. Of those seen, 95% were assessed as needing a further intervention, 20% of this cohort were remanded, 31% either refused or were already with another service provider and 49% attended a further intervention at Foundations.

The approach taken for the Alcohol Intervention Programme work in the custody suite has also had positive outcomes. Between Sept 2016 - Jan 2017, 606 individuals were arrested in connection with alcohol related offending, of this number 563 (93%) were referred to the Alcohol Intervention Programme. 73% of those referred attended their initial intervention. Of those that were charged or bailed, and who were compelled to attend a series of appointments, as part of their bail condition or conditional caution, the data shows that 93% attended all their appointments.

### Courts and Probation service

Foundations also has a presence in the local courts and strong links with the probation service which provides opportunities for early interventions such as Restrictions on Bail (RoB) and offers advice on sentencing options to the courts e.g. Alcohol Treatment Requirement (ATR) and The Drug Rehabilitation Requirement (DRR).

ATR focuses on offenders who are dependent on alcohol or whose alcohol use contributes to their offending. The aim is to reduce or eliminate the offender's dependency on alcohol. DRR's are part of a community sentence. They are a key way for offenders to address problem drug use and how it affects them and others. A DRR can last between six months and three years, and encourages offenders to: Identify what they must do to stop offending and using drugs.

Foundations is also involved in the treatment/recovery aspect of these community based sentences working alongside both the local Community Rehabilitation Company (CRC) and Humberside Probation Service.

Between Sept 2016 – Feb 2017 31% of those eligible were given a RoB by the courts. In the same time period a total of 38 successfully completed their RoB with a further 11 being breached. Between the same time period, out of those who were sentenced by the courts, 30 (15%) received a DRR as part of their community sentence. Foundations also works with the prisons in relation to

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<sup>18</sup> Those eligible include anyone arrested for a trigger offence such as acquisition crime (theft, shop theft, burglary, etc.).

when offenders are released to ensure continuity of treatment/recovery services and to reduce the risk of illicit substance use and possible overdose.

The Office of the PCC have confirmed the additional grant funding for 2017/18 towards the criminal justice work of the NELDAT service will remain. However, future funding for following years will be determined at a later date, depending on a number of strategic decisions to be made by the PCC's office in respect of the Humber area. This poses a risk to the future of the criminal justice aspect of service delivery.

## **National Drug Treatment Monitoring System (NDTMS)**

The National Drug Treatment Monitoring System (NDTMS) collects, collates and analyses information from and for those involved in the drug treatment sector. NELDAT services report all client performance data onto NDTMS. Public Health England has responsibility for monitoring the performance of the drug treatment system in England against local and national targets. To this end various performance management reports and statistical releases are produced using data collected through the NDTMS.

**Table 15 2015-2016 Referral data : source Treatment Map Summary - NDTMS**

The following table is an example of an NDTMS report, and identifies referral routes into North East Lincolnshire services for period 2015-2016, compared against other areas such as Yorkshire & the Humber and Nationally. In all referral cases, self-referral was the highest referral source.

REFERRAL ROUTES 2015-16	GP		Self		Drug services		Probation		CARAT		CJS other		Other		Total	Treatment naïve at presentation	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	n	%
<b>National</b>	<b>28,455</b>	<b>12</b>	<b>116,344</b>	<b>49</b>	<b>19,969</b>	<b>8</b>	<b>8,033</b>	<b>3</b>	<b>12,229</b>	<b>5</b>	<b>8,457</b>	<b>4</b>	<b>36,497</b>	<b>15</b>	<b>235,692</b>	<b>75,378</b>	<b>32</b>
<b>Yorkshire &amp; the Humber</b>	<b>4,261</b>	<b>16</b>	<b>11,909</b>	<b>44</b>	<b>2,930</b>	<b>11</b>	<b>866</b>	<b>3</b>	<b>1,827</b>	<b>7</b>	<b>1,064</b>	<b>4</b>	<b>3,508</b>	<b>13</b>	<b>27,182</b>	<b>8,551</b>	<b>31</b>
<b>North East Lincolnshire</b>	<b>47</b>	<b>6</b>	<b>485</b>	<b>62</b>	<b>58</b>	<b>7</b>	<b>33</b>	<b>4</b>	<b>105</b>	<b>13</b>	<b>41</b>	<b>5</b>	<b>9</b>	<b>1</b>	<b>778</b>	<b>231</b>	<b>30</b>

## **Substance Misuse Carer Support Worker**

The effects of substance misuse in a family are wide ranging and can be overwhelming, they encompass all areas of family member's lives and can have short and long term consequences. The effects can include: finding it hard to live with the substance user, monetary problems, worry about the health of the substance user and their prospects and on-going safety; concern about the detrimental affects on the whole family, living with personal anxiety and high levels of stress, feeling powerless and low or depressed. The result of having to cope with these issues is often detrimental to the physical and psychological health of family members as well as having a significant negative affect on relationships between the family and the substance user and between the family members themselves. The Substance Misuse Carer Worker post is based in the main/generic carer centre. The centre is commissioned by the CCG to provide carer services. The Substance Misuse Carer Support Worker provides support to those who are caring for individuals who have a substance misuse issue, such as parents, kinship carers, siblings, grandparents, partners, friends, etc.

## **North East Lincolnshire Drug and Alcohol Treatment service (Primary Care)**

During 2016 the CCG on behalf of the Council commissioned (primary care) GPIIP (Grimsby Practices in Partnership – Birkwood, Pelham, Chantry, Woodford/Littlefield, Drs Sinha & De) to deliver a NELDAT service via a payments by results contract within primary care settings.

1. Payment 1 is based on throughput determined from the monthly NDTMS provider report, detailing the number of clients in treatment; and
2. Payment 2a and 2b are payments by results on outcomes of clients.
  - 2a is payments by results for clients leaving treatment substance free in a month (completion)
  - 2b is payments by results for clients who left treatment in the year, but who did not return within 6 months of successful completion (representation)

The service specification identifies this service is based on a stepped approach, that utilises the most cost and clinically effective services, and provides an integrated model of health and social care services to meet substitute prescribing and therapeutic one-to-one psychosocial interventions.

### Population covered

Cohort of registered patients within the practices of GPIIP and offer treatment to patients who are currently registered but residing outside of practice boundaries.

### Location of service

The service is hosted by Birkwood Medical Centre, Westward Ho, Grimsby, North East Lincolnshire, DN34 5DX on behalf of GPIIP.

The aims of the service (as identified within the current service specification) are:

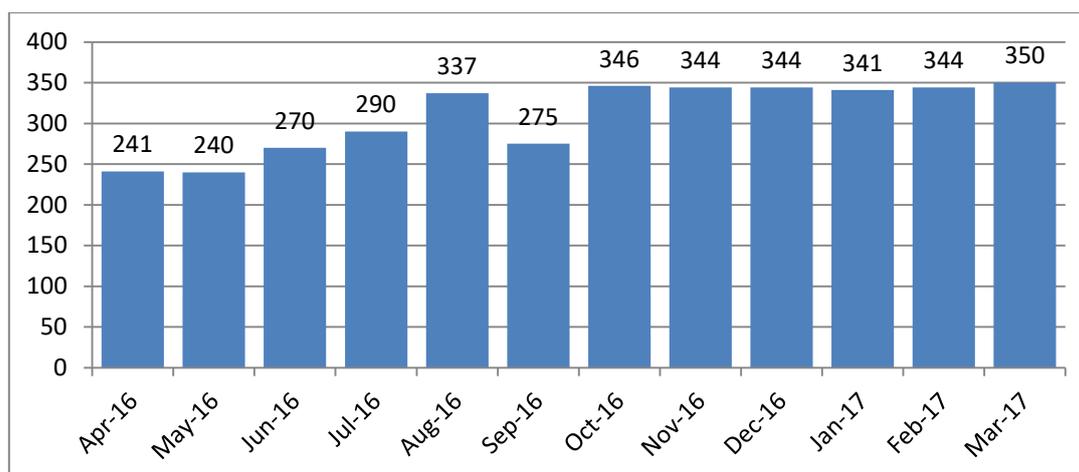
- To provide a primary care GP led, fully integrated health, wellbeing and social care drug and alcohol service to GPIP NDTMS/PHE compliant cohort of patients with a borough-wide recovery orientated integrated system;
- Improve the health and wellbeing of their registered patients by providing drug, alcohol and integrated health and substance misuse services to their NDTMS/PHE compliant cohort of patients;
- To provide swift access to drug and alcohol services for the NDTMS/PHE compliant cohort of patients, based on patient needs and at times of crisis
- To provide substitute opioid medication treatment programmes in line with local and national guidelines;
- To offer and deliver nurse health checks and appropriate healthcare treatments, Hepatitis A/B immunisations and Hepatitis C screening and referral to the specialist Hepatitis C treatment provider as appropriate;
- Provide one to one care planned psychosocial therapeutic interventions in line with national and local guidelines in the Management of Substance Misuse/PHE requirements;
- Provide in surgery family support for vulnerable adults and the safeguarding of children in line with local and national guidelines and with swift access to the GPIP treatment service;
- Provide signposting and/or referral to a full range of services and agencies as appropriate to patients' needs and choices, including options for accommodation, training and employability;
- Provide a full range of preventative and educational, harm reduction advice and information;
- To provide some flexibility for carers of patients to attend appointments as appropriate
- To actively support patient engagement into locality recovery networks, including peer support and mutual aid; and
- To provide flexibility within service to meet change within the substance misuse environment, legislation, or national and local strategies.

**Table 16 GPIP 2016-17 Payment Data**

		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Payment 1	Clients in treatment	241	240	270	290	337	275	346	260	260	260
Payment 2a	clients out of treatment drug free - successful completions	5	2	0	0	3		1	1	3	1
Payment 2b	Clients successfully completed, not returning within 6 months)	1	3	0	0	0		0	1	5	3

N.B. Figure for September based on 275, due to no submission data being available for July, Payment 1 figure capped at 260 patients from November to ensure service remains within budget availability

Figure 27 [GPIP actual numbers of patients in treatment 2016-2017](#)



N.B. Figure for September based on 275, due to no submission data being available for July

## Needle Exchange Overview

Needle exchange programmes supply needles and syringes, and other preparation equipment, to members of public who inject drugs. The aim of needle and syringe programmes is to reduce sharing of needles (and equipment) which can consequently result in blood-borne viruses and other infections (such as HIV, hepatitis B and C) being transmitted. It is hoped that if there is a reduction in these infections being transmitted, via sharing of needles, then the prevalence of blood-borne viruses will reduce, benefiting wider society (NICE, 2014). This service also helps to reduce/eliminate drug litter within North East Lincolnshire.

Within North East Lincolnshire the demand of the needle exchange programme is continually increasing year on year. It is recommended by NICE that needle and syringe programmes should meet the needs of the user, and not be subject to limits. It is important to monitor what equipment is being used to ensure the best use of limited financial resources.

In January 2016, a survey was undertaken by the Public Health team within North East Lincolnshire of the Needle Exchange service. Questions included in the survey aimed to identify what equipment service users were using, and what they were using it for, as well as some broader questions such as the receiving of advice and information.

The survey was conducted at seven different sites (pharmacies and drug services) across North East Lincolnshire who offer the needle exchange service, between November 2015 -January 2016, and a total of 156 responses were received.

The survey identified the following key points:

- Total number of syringes/needles issued have increased since 2005
- The number of visits to the needle exchange have increased, however, the average number of needles issued per visit has decreased
- Majority of respondents were male compared to female
- There was a higher proportion of respondents who were in the 35-64 age category

- Higher proportion of females than males in the 18-24 age category
- Heroin was the most commonly used drug followed by cocaine
- Majority of respondents reported that they do not share needles
- A high proportion of respondents stated that they always return their used needles

### Local Needle Exchange Service

The Council commission Freelance Needle Exchange Ltd to manage, co-ordinate and deliver the needle exchange service in partnership with community pharmacists within North East Lincolnshire. The service is delivered over 6 pharmacy sites (and one further site is located within Foundations), the busiest sites are:

- Cottingham, Wellington Street, Grimsby (approximately 1200 visits per month)
- Foundations, Queen Street, Grimsby (approximately 350 visits per month)
- Lloyds Bradley Crossroads, Grimsby (approximately 200 visits per month)

The service receives 21,360 annual visits at a rate of 1780 per month, with 269,863 annual syringes being exchanged, equating to 22,489 per month.

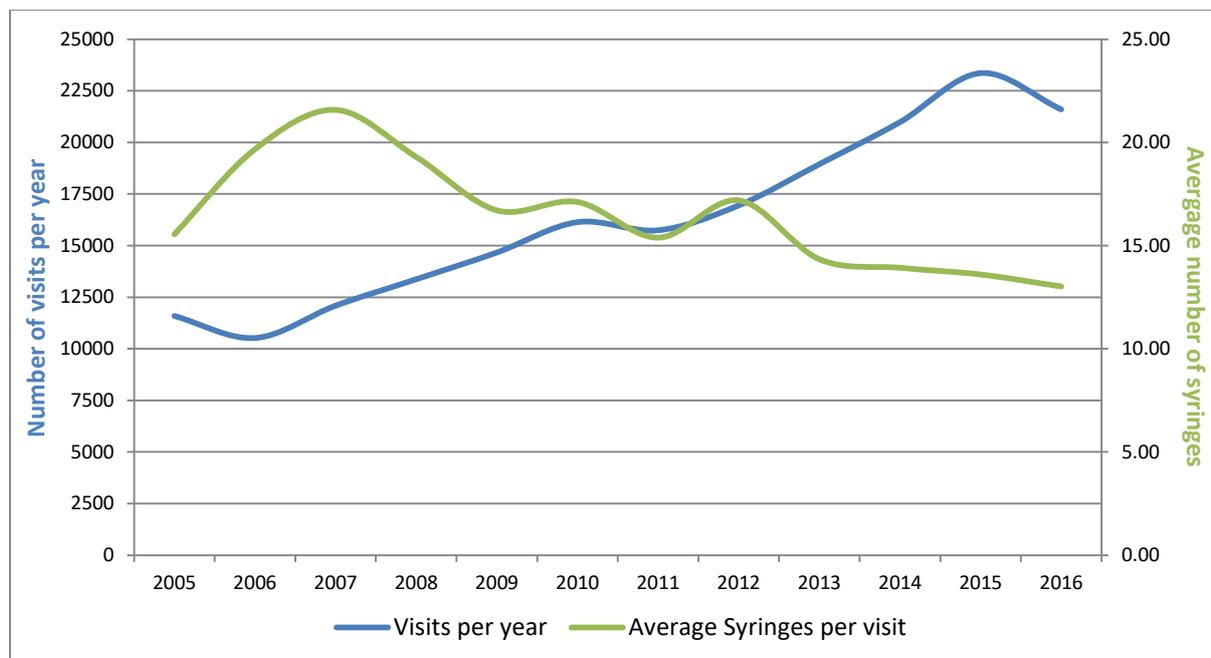
Table 17 Quarter 4 2016-2017 report highlights the service has distributed the following items:

Citric Acid Sachets	Ascorbic Acid Sachets	Stericups	Sterile Water
25,542	140,441	168,435	19,253

Source: Freelance Needle Exchange Q4 report 2016/2017

During 2016/2017, almost 2 out of every 3 individuals visiting the exchange for equipment returned used equipment in the waste disposal containers they are supplied with.

Figure 28 Number of visits to the needle exchange and the average number of syringes issued per year



### Supervised Consumption of Methadone and Buprenorphine

Pharmacists play an important role in the care of substance users within our communities. Pharmacists supervise consumption of methadone or buprenorphine by individuals in treatment, which reduces incidents of accidental deaths through overdose and helps keep to a minimum the misdirection of controlled drugs, which in turn assists in reducing drug related deaths in the community.

Pharmacists also play a unique role in the treatment/recovery journey of substance users as they have daily contact with them, and are able to monitor and offer advice on the service user's general health and wellbeing.

The supervised consumption service also helps to reduce the risk to local communities of overuse or under use of medicines as well as accidental exposure to the dispensed medicines.

Models of Care 2002 (updated 2006) describes community prescribing programmes as Tier 3 services. Community pharmacies are located in a Tier 1 setting so the privacy and dignity of the patient should be taken into account when making arrangements for supervised consumption. Supervised consumption by an appropriate professional provides the best guarantee that a medicine is being taken as directed. Since the advent of supervised consumption the number of drug-related deaths involving methadone has reduced during a period when more methadone is being prescribed, providing indirect evidence that supervising the consumption of medication may reduce diversion (Department of Health (England) and the devolved administrations, 2007).

#### Local Supervised Consumption Service

The Council commissioned Freelance Needle Exchange Ltd to deliver and oversee the supervised consumption service within North East Lincolnshire working with community pharmacies.

The aims of the service are:

- To deliver a high quality supervised methadone and buprenorphine scheme to NEL residents aged 18 years and over (except where indicated otherwise in the service specification) who are misusing substances;
- To assist prescribing clinicians in the provision of community based prescribing;
- To ensure that the patient takes the correct doses of medication as prescribed;
- To prevent prescribed medication being diverted to the illegal market; and
- To reduce the possibility of accidental poisoning, particularly of children.

The service is delivered over 25 community pharmacy sites, the busiest sites (with in excess of 30 service users) are:

- Cottingham, Wellington Street, Grimsby
- Boots, Freeman Street, Grimsby
- Lloyds Bradley Crossroads, Grimsby
- Boots, St Peters Avenue, Cleethorpes
- Asda, Holles Street, Grimsby
- Birkwood Pharmacy, Westward Ho, Grimsby

The average number of individuals who have been supervised per month within North East Lincolnshire over a 3 year period for Methadone and Buprenorphine were 450 and 80 respectively.

Payments to pharmacies that deliver the service are made on a quarterly period basis, and are based on the total number of supervised doses for that period. The service has a budget to deliver 7,725 doses per month (92,700 per annum), if the number of doses increases, the payment per dose reduces. The payment per dose is currently £1.54.

At the end of December (2016), 560 people were on supervised medication, 60 people were receiving unsupervised methadone, with 10 people receiving unsupervised Buprenorphine. In total 650 people are prescribed opiate substitute medication within North East Lincolnshire (Freelance Needle Exchange Report). The majority of service users have daily supervised doses, with less collecting only 2 or 3 times a week.

By the end of December, service user numbers taking supervised Methadone were just over 6% higher than a year ago and actual supervised doses are up by 8%. During 2015/16, service users taking Methadone visited pharmacies on average, 16.7 times a month. For the 12 months of 2016/17, this has increased slightly showing 17.1 times a month.

Service user numbers taking Buprenorphine did stabilise during the start of the year and the number does now appear to be falling. During 2015/16, service users taking Buprenorphine visited pharmacies on average, 15.1 times a month. For the whole of 2016/17, it was noticeably up at 16.0 times a month. Around 1 in 7 people receiving supervised substitute medication is currently being prescribed Buprenorphine.

## Supervised Consumption Data

Figure 29 Number of supervised doses for Methadone and Buprenorphine

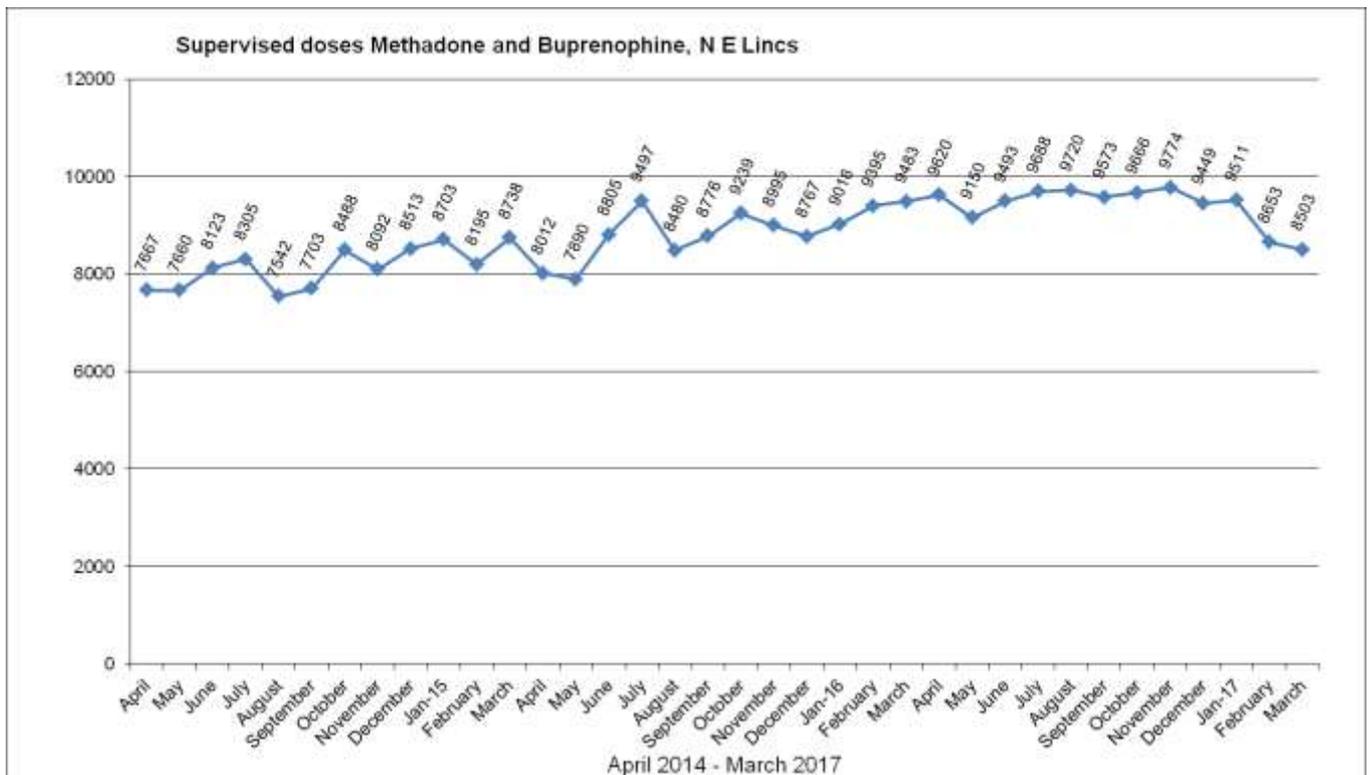
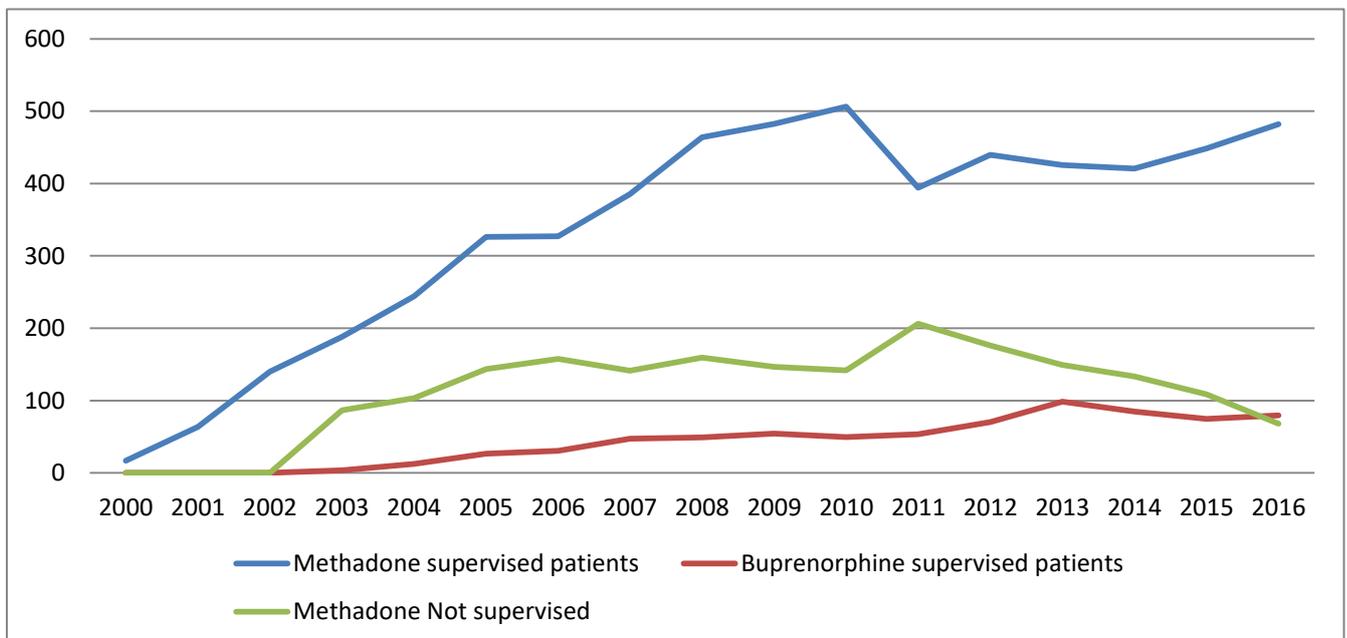


Figure 30 Average number of people in contact with NEL Pharmacies 2000-2016<sup>19</sup>



<sup>19</sup> Freelance Needle Exchange Ltd

## 6. Recommendations

### PROVISION OF SERVICES

As was expected a number of the recommendations related to the provision and therefore the re-procurement of substance misuse services in NE Lincolnshire. The following are the recommendations that have been included in the specification for the procurement of The North East Lincolnshire Integrated Substance Misuse Recovery Service:

- The rise in the use of New Psychoactive Substances and the misuse of over the counter and prescribed substances was highlighted in the report. It is vital that the commissioned service provides effective information, support, harm reduction messages and treatment for those misusing these substances.
- Services for young people need to be appropriate, preventative and accessible. They should also include anonymous routes of access for support to those wanting to avoid the perceived 'stigma' of treatment, etc.
- Given the positive impact of providing targeted interventions to those within the criminal justice services, close working relationships with the Office of the Police and Crime Commissioner (PCC) must be maintained. It is also essential that the PCC on-going funding situation be clarified.
- Unlike the national picture the drug-related mortality rate in North East Lincolnshire has been falling. However it is essential to continue to provide universal and targeted prevention and harm reduction interventions, such as the needle exchange scheme as well as maintaining excellent referral wait times (under 3 weeks) to continue the downward trend in mortality.
- The age of opiate misusers and alcohol misusers accessing treatment is rising therefore it is important that particular attention should be given by providers to the needs of this older cohort especially in respect of on-going/developing health needs.

### 1. DATA

- The Public Health Department needs to work with the following services to close the data gaps identified in the needs assessment. This is essential in order for there to be an ongoing development of the evidence base in respect of substance use/misuse in NEL.

The services are:

- **The Accident & Emergency Department** - in respect of attendance data relating to drug and alcohol use.
  - **Hospital admissions** – in respect of the recording and reporting of substance misuse
  - **The Ambulance Service** - in respect of data relating to alcohol use.
  - **Mental Health Services** – in respect of recording drug use data in a reportable format.
- **New Psychoactive Substances (NPS)** – NPS use is not recorded by services even though anecdotally its use is having an impact on those services. A method of recording use of NPS needs to be developed across the above services as well as the police.

## **2. EARLY INTERVENTION/PREVENTION**

- Three main themes emerged from the needs assessment in respect of early interventions/prevention:
  - Services need to be provided to work alongside children living with an alcohol or drug user especially with the NSPCC FEDUP scheme coming to an end.
  - There needs to be targeted prevention and harm reduction work carried out with vulnerable young people in order to equip them to make informed decisions in respect of substance use particularly cannabis, alcohol and NPS use in adolescence.
  - A universal approach is also required that again equips young people to make informed choices in respect of substance use and ultimately prevent them from developing drug and alcohol misuse problems.

## **3. POPULATION LEVEL**

- It is evident that there continues to be a growing numbers in respect of hospital admissions due to alcohol related conditions and alcohol related mortality in NEL. Therefore it is essential there are both targeted and universal approaches developed by The Substance Misuse Strategic Development Group that will:
  - bring about attitudinal and behaviour change so that people no longer think it is acceptable to drink in ways that could cause harm to themselves or others
  - reduce the number of young people aged 11 to 15 drinking alcohol and the amount they drink;
  - encourage parents to think about the effect of their alcohol consumption on their children even at safe levels
  - reduce the level of alcohol-fuelled violent crime;
  - reduce the number of adults drinking above the lower-risk guidelines;
  - reduce the number of people binge drinking; and
  - reduce the number of alcohol-related health conditions and deaths.

## **4. PARTNERSHIP WORKING**

- In order for there to be progress made in all aspects of tackling substance misuse in NEL there needs to a full partnership approach that includes drug and alcohol services, carer services, hospital services, primary care, criminal justice services, sexual health, health and wellbeing, education, mental health services, housing, employment and the voluntary sector.

## **5. OUTCOME MEASURES**

- To measure success of treatment provision, it is recommended that local outcome measures are developed alongside those suggested by PHE (An evidence review of the outcomes that can be expected of drug misuse treatment in England <http://www.nta.nhs.uk/uploads/phe-evidence-review-of-drug-treatment-outcomes.pdf> )

## 6. FUTURE PROJECTS

- Carry out an investigation of NPS use and the impact this is having on local services who are currently reporting anecdotally there is a growing problem in NEL.
- To run a one-year pilot programme of supplying naloxone kits to accommodation services for homeless people in North East Lincolnshire, with the intention of preventing drug-related deaths from opiate overdose and to improve our own understanding of the incidence of overdose or suspected overdose.
- To run a two year pilot that will establish a NEL Recovery Hub. This will become the centre of a wider 'recovery' community across the Borough providing both in-reach and outreach peer-support and mutual aid within our communities.
- Ensure alcohol is considered as an area to be investigated as part of the NELC mental health needs assessment.
- Encourage treatment/recovery service providers to participate in the new online system that will help tackle harms from new psychoactive substances (Report Illicit Drug Reaction (RIDR) <https://report-illicit-drug-reaction.phe.gov.uk/> ). This new tool will improve knowledge of the harmful effects of new psychoactive substances.
- Regular night club goers have a higher propensity to use drugs; this should be explored further to establish if any future provision can increase the uptake of harm reduction/treatment/recovery services from this group of the night time economy.

## **7. Appendices**

**Appendix 1 North East Lincolnshire Substance Misuse User Survey Results**

**Appendix 2 North East Lincolnshire Substance Misuse Community Survey Results**

**Appendix 3 North East Lincolnshire Substance Misuse Provider Survey Results**

**Appendix 4 Foundations User Satisfaction Survey**

**Appendix 5 NSPCC Interim Report - FEDUP**

**Appendix 6 Needle Exchange Survey**

**Appendix 7 NALOXONE Report**

# NORTH EAST LINCOLNSHIRE SUBSTANCE USE NEEDS ASSESSMENT USER SURVEY

Drug Users



Most started using drugs in adolescence

Two thirds of those who inject drugs use a needle exchange



59% have been ARRESTED as a result of their DRUG use

Of problem drug users CANNABIS was the most common gateway drug



73% said being in treatment helped them STOP

Alcohol Users



46% have been admitted to hospital as a result of their drinking

## KEY FINDINGS

44% said their CHILDHOOD influenced their drinking



65% said someone at home drank a lot

74% said alcohol was in the home growing up

14% are homeless or living in a hostel

All Respondents



85%  
smoke tobacco

71% are UNEMPLOYED



- 54% said they have MENTAL HEALTH problems
- 63% have thought about SUICIDE
- 78% said their drink/ drug use has a NEGATIVE effect on their FAMILY

## Drug Users- Key Points

- Most started using drugs in adolescence.
- Cannabis was the most common gateway drug for problem drug users.
- Two thirds of those who inject use the needle exchange.
- 73% of those who have stopped said being in treatment helped them stop.
- 40% of drug users have overdosed.
- 59% have been arrested as a result of their drug use.

## Alcohol Users- Key Points

- Most were under 18 when they had their first alcoholic drink.
- 74% said alcohol was around in the home growing up.
- 65% said someone at home drank a lot.
- 44% said their childhood influenced their drinking.
- 46% have been admitted to hospital as a result of their drinking.
- 44% of drinkers have been arrested as a result of drinking.

## All respondents – Key Points

- 55% have educational qualifications and 50% have vocational qualifications, however 71% are unemployed.
- 14% are homeless or living in a hostel.
- Most said their substance use has a negative effect on their family.
- 13% had an unplanned pregnancy as a result of substance use.
- 85% smoke tobacco.
- 54% said they have mental health problems.
- 63% have thought about suicide.

## The Participants

201 drug and alcohol misusers living in NEL took part in the survey.

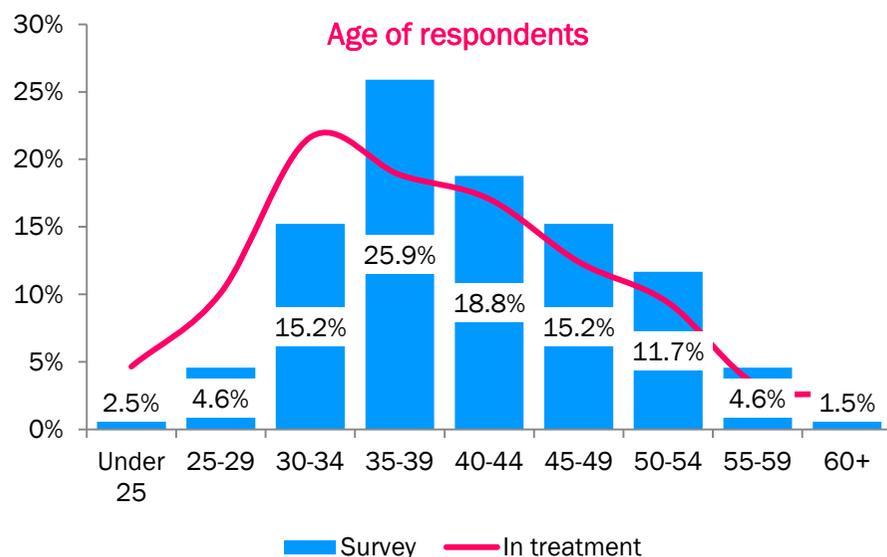
63.2% of respondents were male.

28.5% said they had children living with them.

97.5% described their ethnicity as British.

91.5% said they were heterosexual, 6.5% said they were LGBT, 2% said other.

The majority of user survey respondents were aged between 30 and 49, with the largest proportion in age-group 35 to 39.

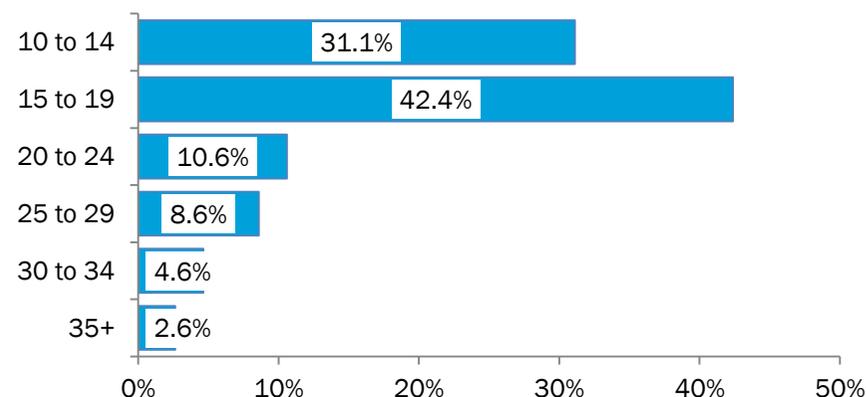


14% of survey respondents, used alcohol as their main substance, 86% used drugs as their main substance, this is fairly representative of those in treatment with 19% using alcohol and 81% using drugs.

## Drug Use

For most, drug use started in adolescence, 70% got their first drugs from friends, 12% from family and 11% from a partner.

### How old were you when you started taking drugs?



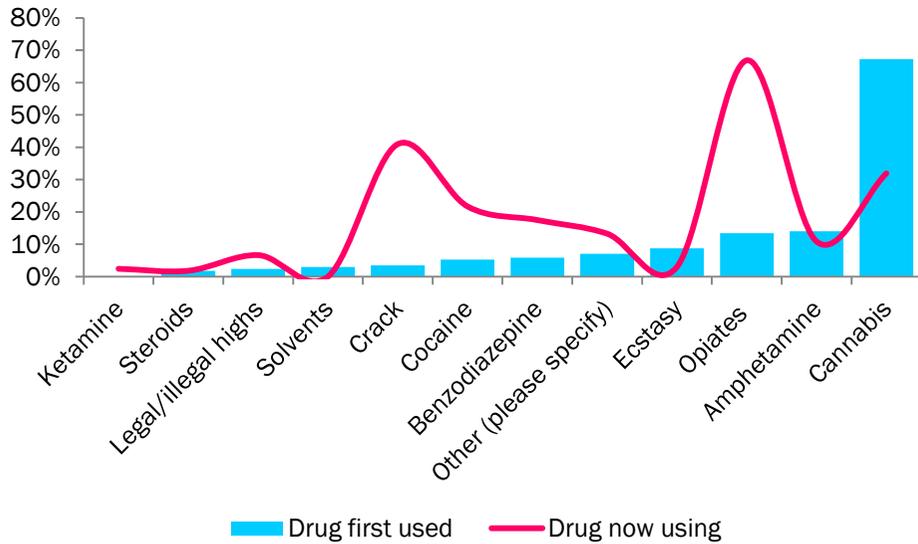
67% said the first drug they used was cannabis, currently only 32% are using cannabis. Opiate drugs are the most common drug used by those who completed the questionnaire, accounting for 67%.

3.5% said crack was the first drug they tried, now 41% are using crack.

5.8% started using benzodiazepine, now 17.5% use benzodiazepine.

5.3% said cocaine was the first drug they used, now 21.7% said they use cocaine.

Respondents were able to give more than one answer and so totals exceed 100%, the most commonly used drugs amongst respondents were opiates, crack, cannabis and cocaine.



48% use drugs daily.

How do you take your drug?	%
Smoke	68.4%
Injection	34.8%
Orally (e.g. tablet, drink, bombing)	18.7%
Other	4.5%
Nasal (sniffing)	3.9%

Respondents could give more than one answer so total exceeds 100%.

20.4% always take more than one drug at a time, 35.2% sometimes take more than one drug at a time and 44.4% never take more than one drug at once.

34.0% always have someone with them when they take drugs, 40.3% sometimes have someone with them and 25.8% never have anyone with them.

55.7% have injected drugs at some point in their lives.

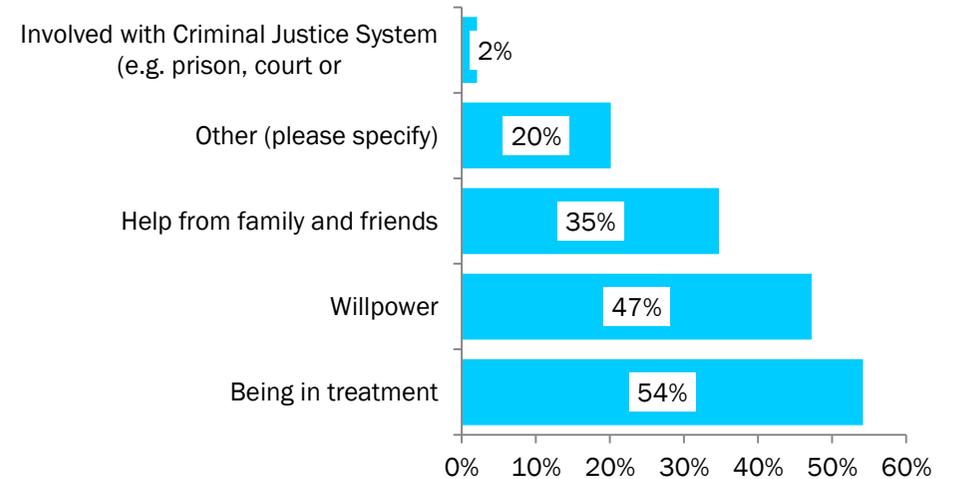
Of those who have injected, 42.5% have had an infection from injecting.

90% of those who inject always use clean needles, a quarter have shared needles in the past. Half have shared other equipment/spoons/ filters at some point.

Two thirds of those who inject use the needle exchange. Most of those who use the needle exchange attend weekly.

Over half of drug users said being in treatment would help them stop.

**If you are currently in treatment, what would help you stop?**



41.3% have been in hospital as a result of their drug use.

39.8% have overdosed at some point in their life.

Most of those who had overdosed had done so once or twice, 14.1% of those who had overdosed had done so 5 or more times.

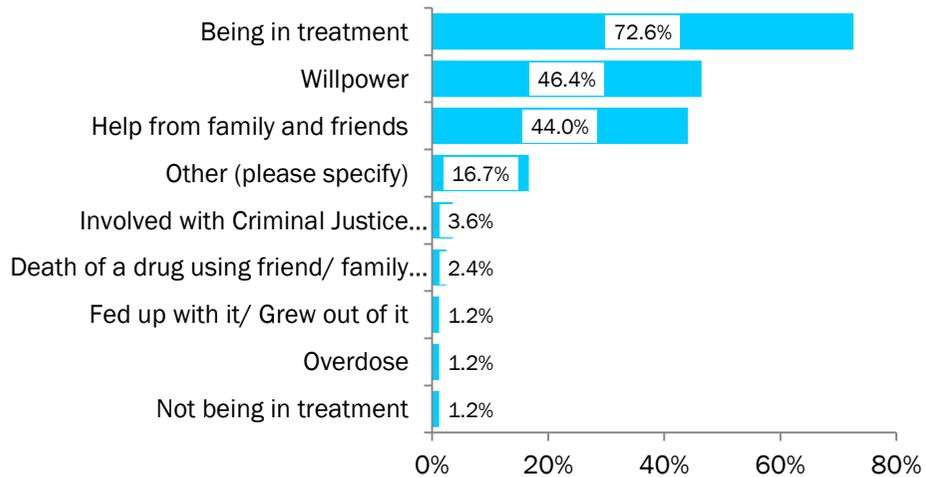
Half of drug users said they also drink alcohol.

Most drink beer or strong beer.

23.2% of drug users who said they drink alcohol said their drinking is a problem.

Of those no longer using drugs, 72.6% said it was being in treatment that helped them stop. Willpower and help from family and friends were also important factors.

### If you are no longer using, what helped you stop?



58.8% said they had been arrested as a result of using drugs.

Of those who had been arrested, 51.1% said it was for a drugs only offence, 69.8% said it was to fund their drug use. Of the whole sample of those who use drugs, 20.8% have been convicted as a result of drug use and 17.9% have served a custodial sentence.

## Alcohol Users

All except 2 were under 18 when they tried their first alcoholic drink, the youngest was 9.

Most said beer was their first alcoholic drink, cider and spirits were the next most common first drink.

68% got their first alcoholic drink from their friends and 32% from their family.

74% said that alcohol was around in their home growing up and 65% said there was someone in their family who used a lot of alcohol.

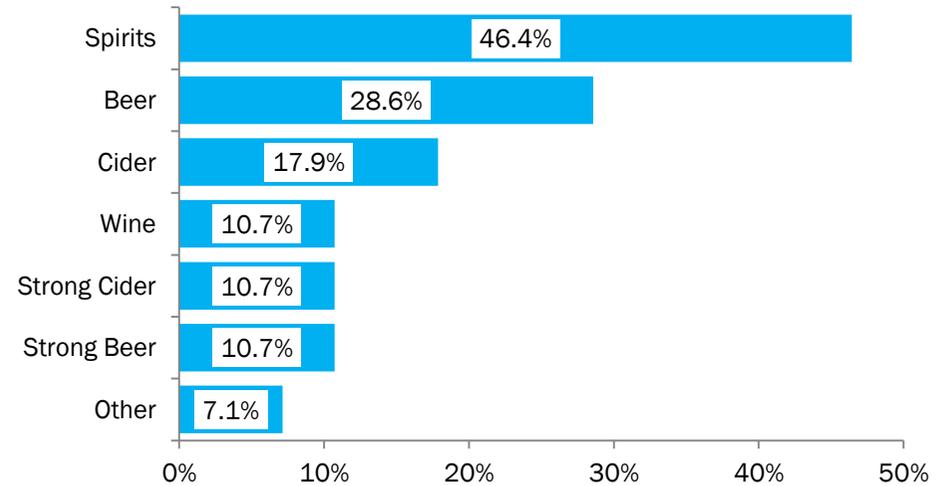
44% said there were problems in their childhood which influenced their drinking.

Spirits are the main choice of drink for those who took part in the survey, followed by beer.

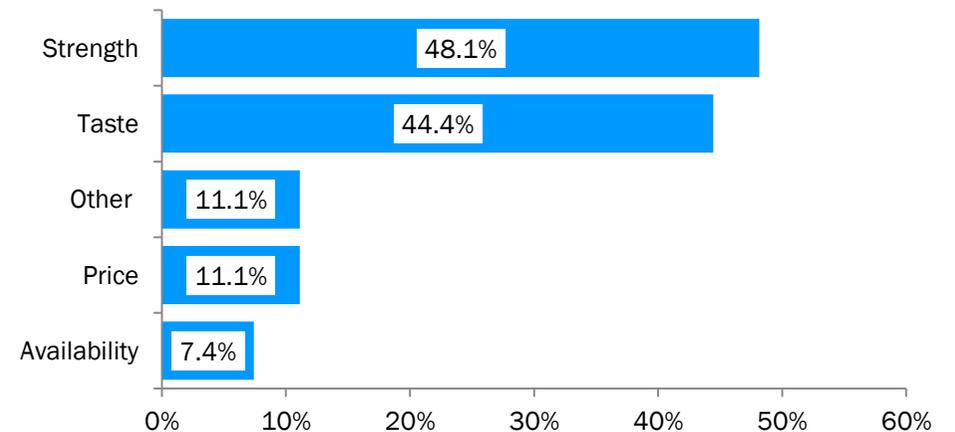
The main reasons for choice of drinks are strength and taste.

58% said they drink daily.

### What is your main choice of alcoholic drink?



### Is there any particular reason for your choice?



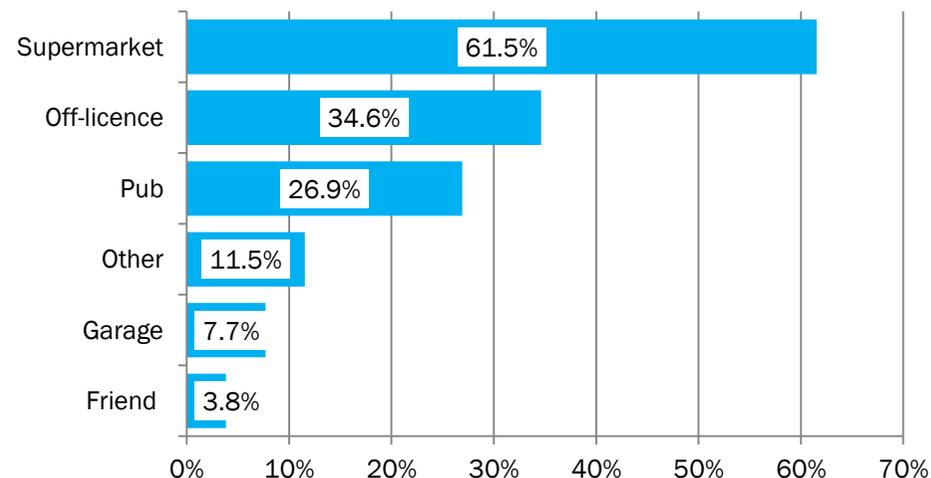
Who do you usually drink with?	%
Alone	61.5%
Friends	42.3%
Partner	15.4%
Other	7.7%
Family	3.8%
Strangers	3.8%

Most people said they drank alone, many also said they drank with friends.

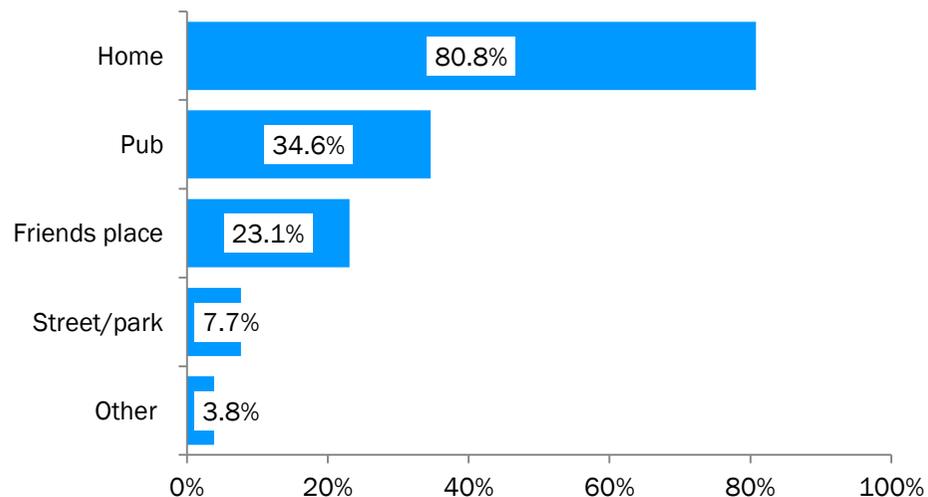
81% usually drink at home, 35% usually drink in the pub.

63% said they are not influenced by happy hours and promotional offers.

### Where do you normally buy your drink?



### Where do you usually drink?



Three quarters said they do not take drugs in addition to alcohol.

Of those who do also use drugs, the most common used drug was cannabis.

77% said that drinking does have a harmful effect on their health.

31% said they have been diagnosed with a medical problem because of their drinking.

46% have been admitted to hospital as a result of drinking.

What has/ would help cut down your drinking	Already cut down	Currently drinking
Help from family and friends	61.9%	41.7%
Being in treatment	47.6%	58.3%
Willpower	42.9%	45.8%
Other	14.3%	0.0%
Fed up with it/ Grew out of it	9.5%	16.7%
Involved with Criminal Justice System	4.8%	0.0%
Death of a friend/ family member due to drinking	4.8%	0.0%
Not applicable	0.0%	8.3%

44% have been arrested as a result of drinking, most of those who were arrested (82%) were convicted.

All survey Respondents

Blocks out the stress and sadness

Affects daily life, children, money, mental health

All aspects, it destroyed my life. Bad choices affected relationships

Horrible, no money, no friends, on the rob

How has/have alcohol/ drugs

Destroyed my life slowly

affected your life?

Depression/ anxiety

Gets me motivated and feeling normal

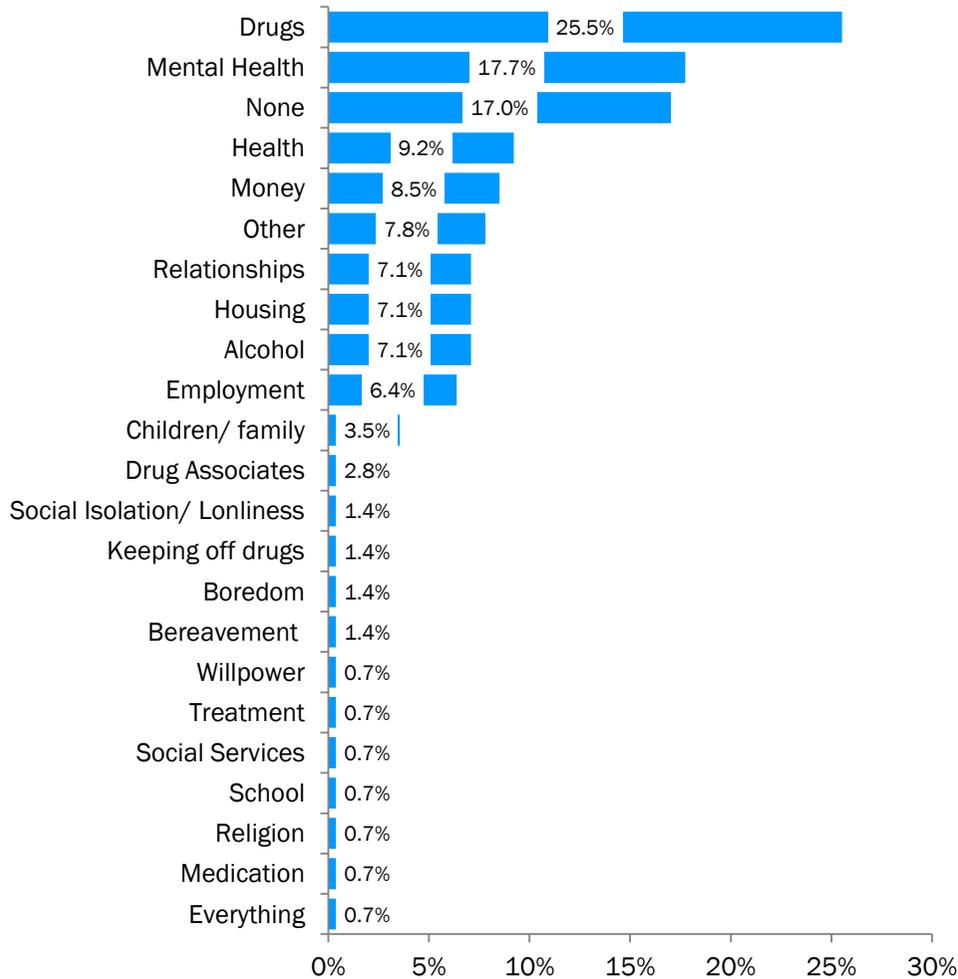
No life at all, you just exist from day to day, all you think about is getting your next bag

It controls me

Messed up my life

No money, no desire to do anything

### What are the main issues affecting your life at the moment?



Drugs are the main issue affecting lives, followed by mental health, additionally 17% said they had no issues in their life at the moment.

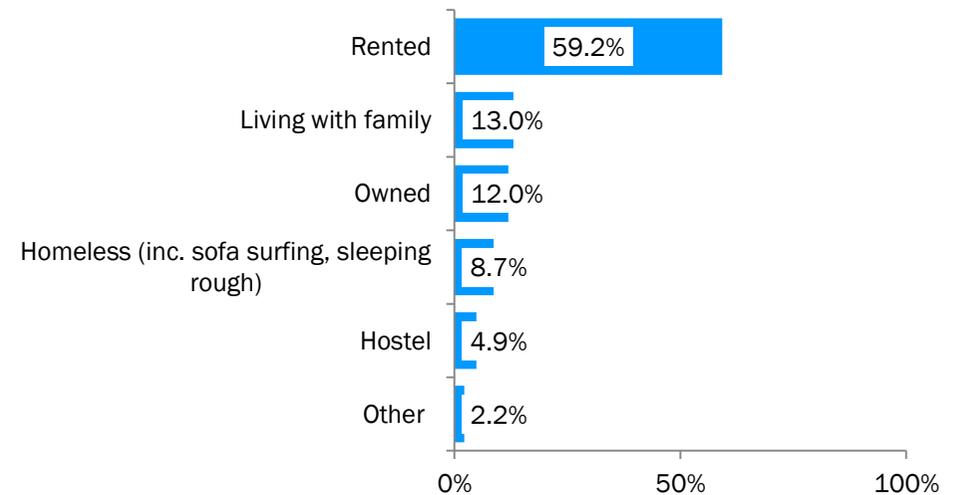
55% said they have educational qualifications.

50% said they have vocational qualifications.

The majority of respondents (71%) are unemployed, 17% are employed, 3% are volunteers, 2% are self-employed and the remainder said other.

Almost half of respondents claim Employment support Allowance.

### What sort of accomodation do you have?



The majority live in rented accommodation.

What effect does/did drinking/drug use have on your...	Family	Friends
Positive	9.4%	9.6%
Negative	77.6%	65.8%
No Effect	12.9%	24.7%

Only 17% thought their health was good, 27% said their health was bad and 57% said their health was fair.

13% said they or their partner had unplanned pregnancies as a result of their drink/ drug use.

When you have sex, would you use a condom with...			
	Long term partner	New partner	Casual partner
Yes	24.3%	75.5%	76.7%
No	75.7%	24.5%	23.3%

*Does not include those who answered not applicable.*

8.5% said they have/ have had Hepatitis B.

Just over a quarter said they have/ have had Hepatitis C.

85% said they smoke (tobacco), this is a far higher proportion than the NEL prevalence of 23%.

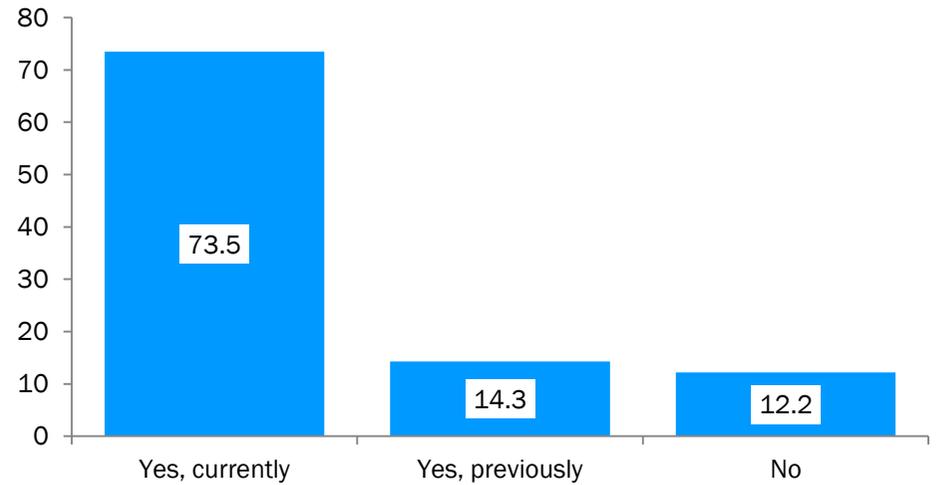
54% said they have mental health problems, 37% said they didn't and 9% didn't know if they had a mental health problem.

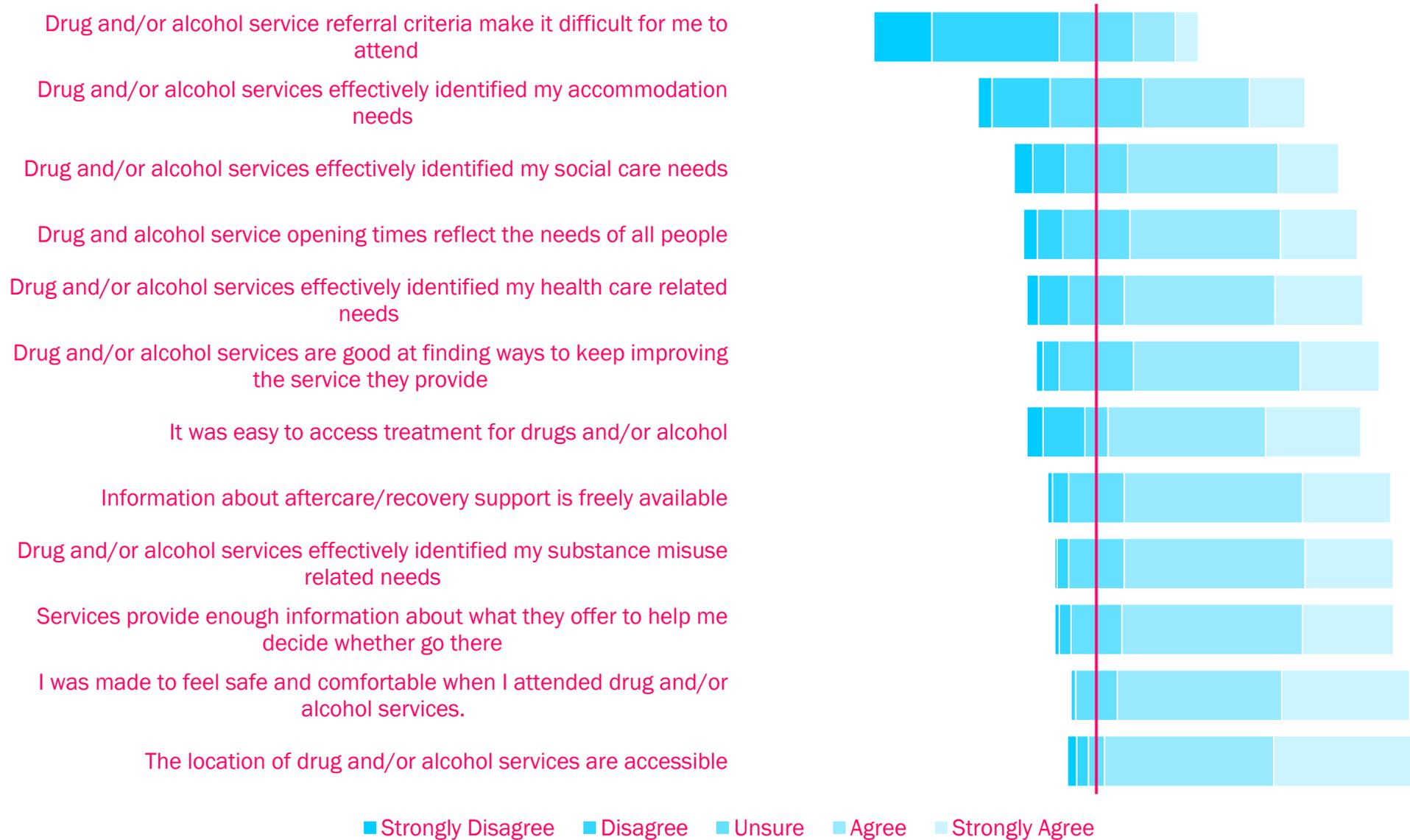
61% said they think their drink/ drug use does have a harmful effect of their mental health.

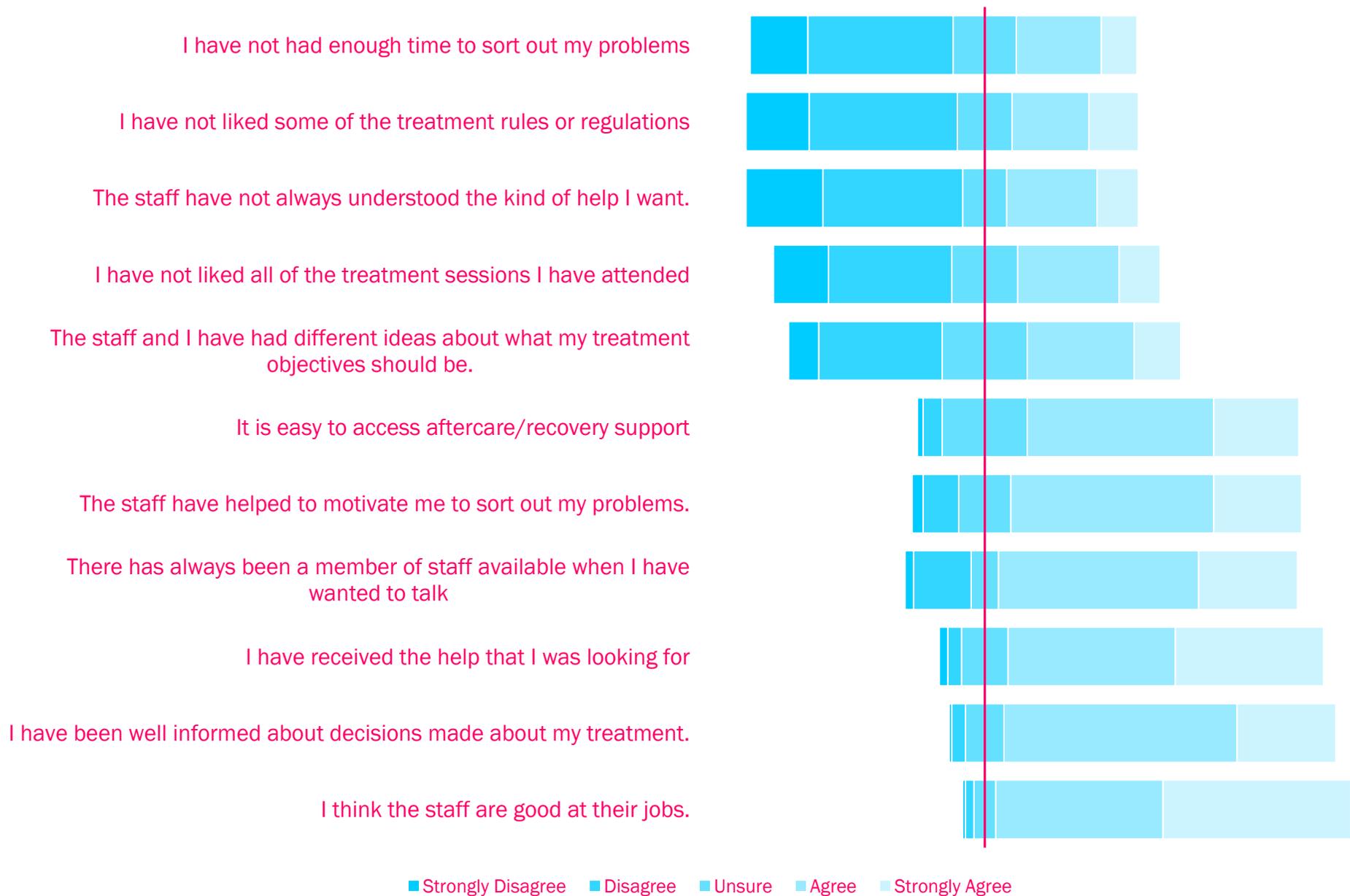
63% said they had thought about suicide at some point in their life.

Of those who had thought about suicide, 61% had attempted suicide, this equates to 38% of all respondents in this section.

### Have you ever been in treatment?







## More about the survey.

This survey was carried out in North East Lincolnshire in February and March 2017. Because of a short time scale the surveys were sent to local drug and alcohol services and the local needle exchange . Responses were collected on paper and completed either by the respondent or with support from the community engagement officer. All surveys are anonymous and confidential. Where responses exceed a total of 100% the respondent was able to give more than one answer to the question.

The general community survey (see **Appendix 2**) asks if the respondent has ever used cannabis. Additionally the local Adolescent Lifestyle Survey includes questions about drugs (**Click here**). Future research should include a wider audience to include users who are not in service, casual drug users, club drug users, those addicted to prescription drugs and painkillers. This would give a more accurate picture of prevalence across North East Lincolnshire and may help address some of the gaps in our current knowledge around issues such as use of NPS.

If you would like any further information please contact

Mike Hardy [mike.hardy@nelincs.gov.uk](mailto:mike.hardy@nelincs.gov.uk)

Hazel Stevens [hazel.stevens@nelincs.gov.uk](mailto:hazel.stevens@nelincs.gov.uk)

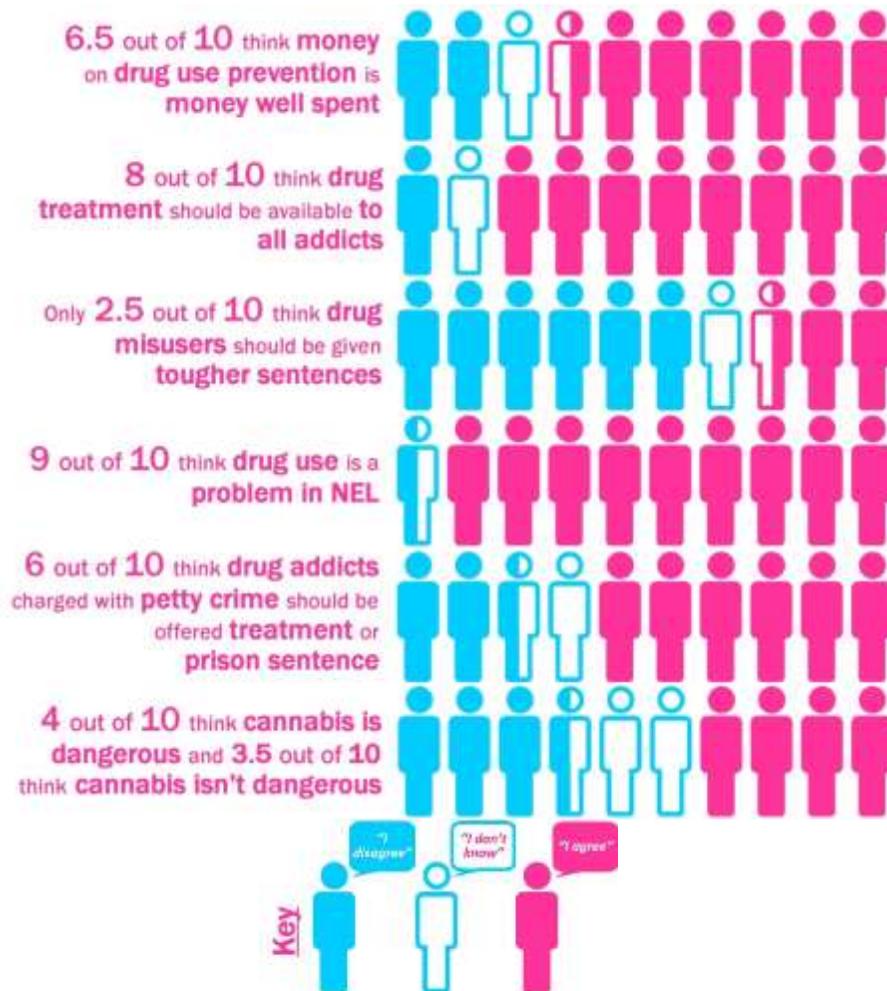
Phil Huntley [philip.huntley@nelincs.gov.uk](mailto:philip.huntley@nelincs.gov.uk)

**We would like to thank everyone who took part in the survey.**

# SUBSTANCE USE NEEDS ASSESSMENT

## COMMUNITY SURVEY

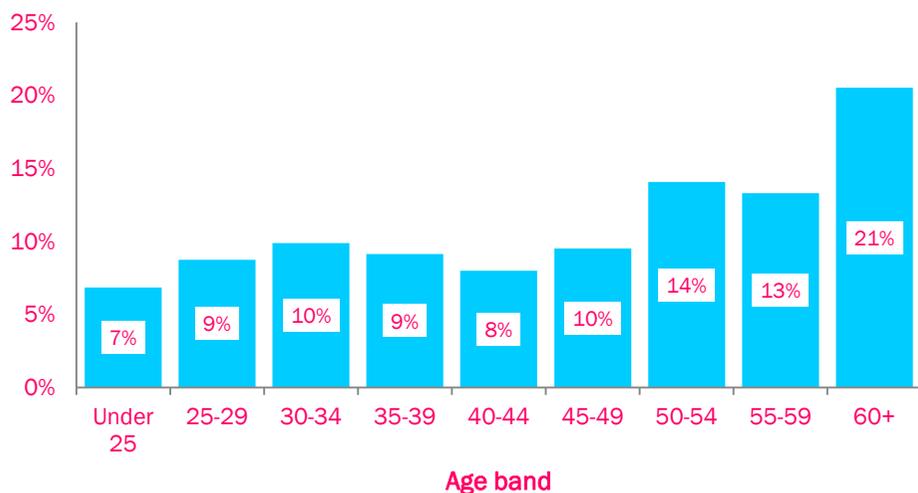
### Appendix 2



# The Participants

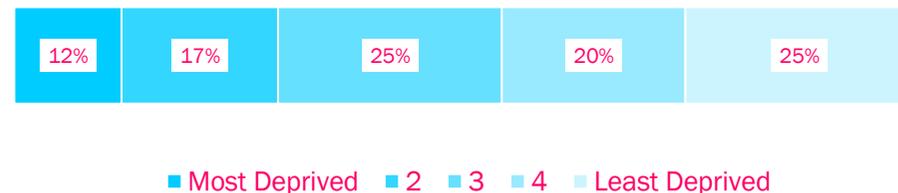
- 291 people took part in the survey.
- 33% of respondents were male. 65% were female and 2% did not answer.
- 36% said they had children living with them.
- 92.1% described their ethnicity as British.
- 49% were married, 24% were single, 15% were cohabiting and 9% were divorced widowed or separated.
- The majority of user survey respondents were over 60.

Age profile of respondents *n=287*



Local deprivation rank of respondents (IMD 2015)

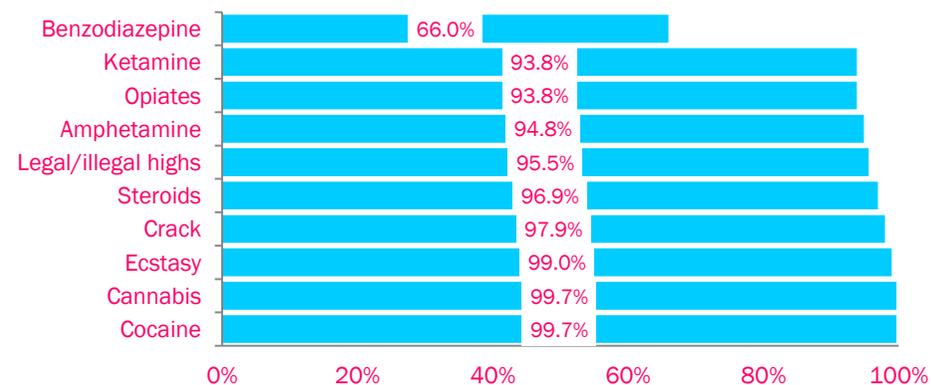
*n=201*



- A lower proportion of respondents lived in the more deprived areas of NEL.
- Responses were received from all wards in NEL.
- Most people had heard of all the drugs, but the least heard of drug was benzodiazepine.

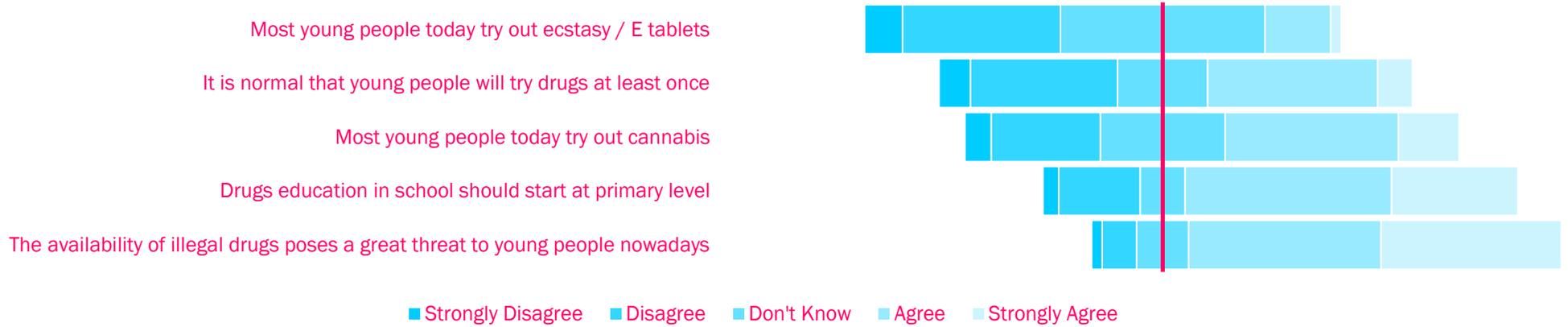
Which of the following drugs have you heard of?

*n=291*

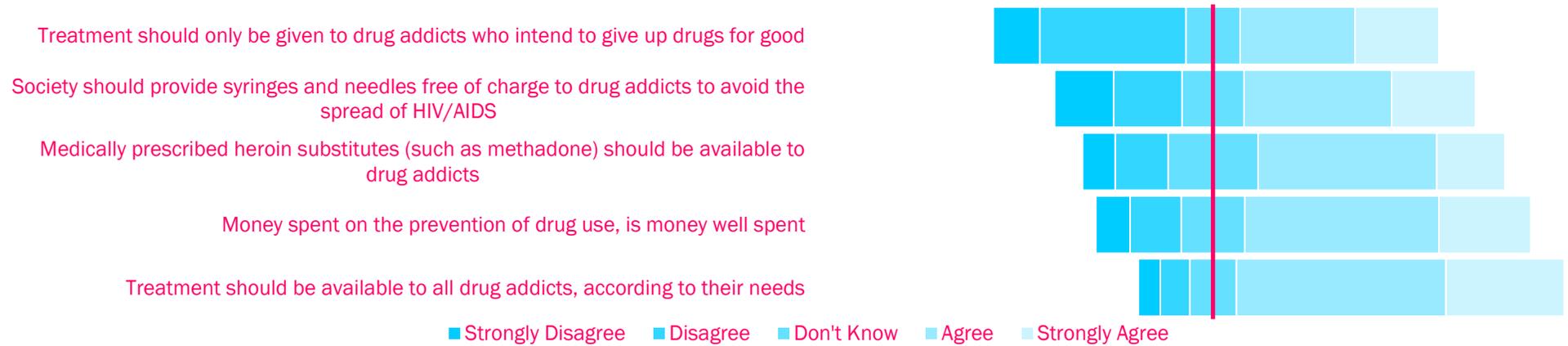


The following sections categorise the community's perception and opinion in relation to substance misuse and its impact on the local area.

## Young people



## Treatment



## Drug related crime



## Drug users in the community



# Drug usage

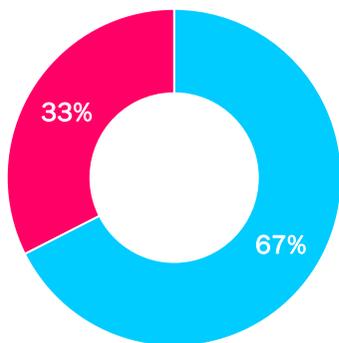


## Drug usage *continued...*

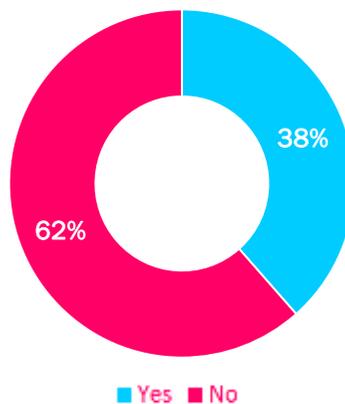


## Community drug use, exposure and experience

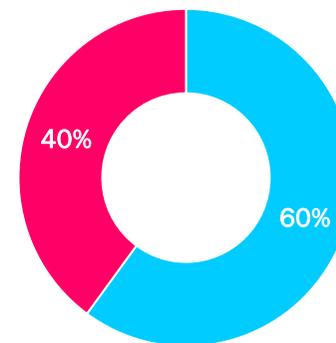
I personally know someone who smokes cannabis/ weed



I have tried cannabis/ weed



I personally know someone who has/had a drug problem



■ Yes ■ No

# Comments from the community

This section summarises the comments received from the community in relation to substance misuse in the local area. Comments were reviewed and categorised as follows.

## Drug policy

"Cannabis needs to be legalised taxed and regulated"

"Legal highs need to be better regulated"

"Decriminalised drug policy should be adopted. All rational research shows this will benefit society"

"[Drugs] should not be a crime but managed as problem like alcohol. More support and advice about the specific effects of drugs and how to use them safely would be more effective..."

"Cannabis should be legal and available... it has many medicinal benefits ... yet it demonised by society"

"Cannabis should be decriminalised as in the US and parts of Europe"

"Softer drugs such as cannabis should be legalised and taxed... making it pointless being a dealer... creating jobs and lower crime."

## Services and Treatment

"There is less help for alcoholics than drug users"

"Services are not accessible... people have to travel from Immingham to Grimsby"

"The current provider does a good job ... it would be nice to see some links with the hospital and community and mental health services"

"...endlessly throwing money at a problem with little or no benefit is a waste of resources"

"...methadone scheme should be scrapped as all it does is gives users free drugs to top up the illegal drugs they are still taking..."

"Don't waste money on it. It will be better spent on other essential services"

"To address the substance misuse issue... start by not continually underfunding and reconfiguring services"

## Drug and alcohol misuse

"They leave their dirty needles in parks ... and gardens..."

"Use of legal highs cause almost as many problems as illegal drugs in this town"

"...obviously a problem with certain drugs in this area, namely legal highs, heroin, crack and meth..."

"There is a really big drug and alcohol problem in Grimsby and Cleethorpes"

"Drug and alcohol misuse is rife in the East Marsh area of Grimsby"

"the most noticeable problem in the area is alcohol abuse and people openly drinking in the streets during the day"

"People injecting drugs in their groin as I leave my home to pick up my children. Now that in my opinion is totally out of control"

"Alcohol is the worst of all the substances... it goes under the radar"

"I know more people with a misuse of alcohol problem than a problem with occasional use of cannabis, ecstasy and amphetamine"

## Drug availability and dealing

"Legal highs... seem to be easily available to all ages"

"Heroin has been readily available for far too long"

"...blatant dealing taking place in the East Marsh"

"Outside my home... has become a production line of drug taking and selling drugs"

"Too many people sell drugs tin Cleethorpes on a night out"

"Massive problem with dealing/taking drugs on nights out in Cleethorpes"

"To address the substance misuse issue... start by not continually underfunding and reconfiguring services"

### Young people

"Young people are starting to drink from a younger age"

"MCat is wrecking kids' lives along with legal highs"

"There's nothing for young people to do and they start taking drugs to kill time and boredom"

"I don't think young people are given enough information on how dangerous alcohol is as a drug..."

### Prescription Drugs

"Prescribed drugs... is a big concern"

"Prescription only drugs are often sold on"

### Criminal justice and policing

"Dealers should be given much tougher sentences"

"I think it's disgusting that the police allow people to sit at the bus stops in town drinking all day... they do nothing about it"

"Crime such as theft is constantly linked to hard drug and alcohol abusers"

"Harsher sentencing for those flooding our streets with these lethal drugs"

"I think the law is not dealing with the issues of drug misuse... punishing them doesn't work... Prison is not the answer, more rehabs forced treatment"

"Strong enforcement against illegal drugs is important... [drugs are] too easily available"

"...dealers and suppliers... should be prosecuted to the full extent of the law... more police on the ground"

"Punish the dealer who profit from it not the users"

"Probation does not work and criminal approach only those with existing social and emotion problems further into a hole."

"... more needs to be done to stop those who are supplying (drugs)..."

### Prevention and education

"...there needs to be education for adults too..."

"I feel it should be more widely talked about and discussed with parents at a school evening.... I don't think youngsters are given enough information on how dangers alcohol is"

"Too much information given to children when they are still innocent..."

### Community issues

"Low paid jobs, no aspirations and unemployment. Poor housing and a lack of reasonably priced leisure facilities. Poor schooling and second and third generation drug users."

"Rather than being tough on users we should be tough on the causes of harmful use – alienation, neglect, lack of opportunity"

# NORTH EAST LINCOLNSHIRE SUBSTANCE USE NEEDS ASSESSMENT PROVIDER SURVEY



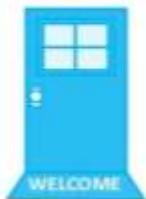
83% know where to find **INFORMATION** about  
**LOCAL DRUG & ALCOHOL TREATMENT**  
services



67% have been affected by others use of drugs and  
alcohol



42% of providers surveyed were unsure if drug  
& alcohol services provide a good service.



Only **28%** of providers thought it was easy to **ACCESS**  
treatment services, however **76%** of users thought it was  
easy to **ACCESS** treatment services.

Immingham has no  
representation from  
drug rehab  
programmes

Opening times need  
to be extended

Group sessions don't work for  
me, it doesn't help that most  
service users are drug users



83% think **ALCOHOL** is a  
**SERIOUS PROBLEM**  
in North East Lincolnshire



91% think **DRUGS** are a  
**SERIOUS PROBLEM**  
in North East Lincolnshire

I know where to find information about local drugs and alcohol treatment services if I need it

I have been affected by others use of drugs and/or alcohol

I am aware that there is support for those coping with someone else's drug and/or alcohol misuse (carers)

The location of drug and alcohol services make it easy to access them

Drug and alcohol services are good at finding ways to keep improving the service they provide

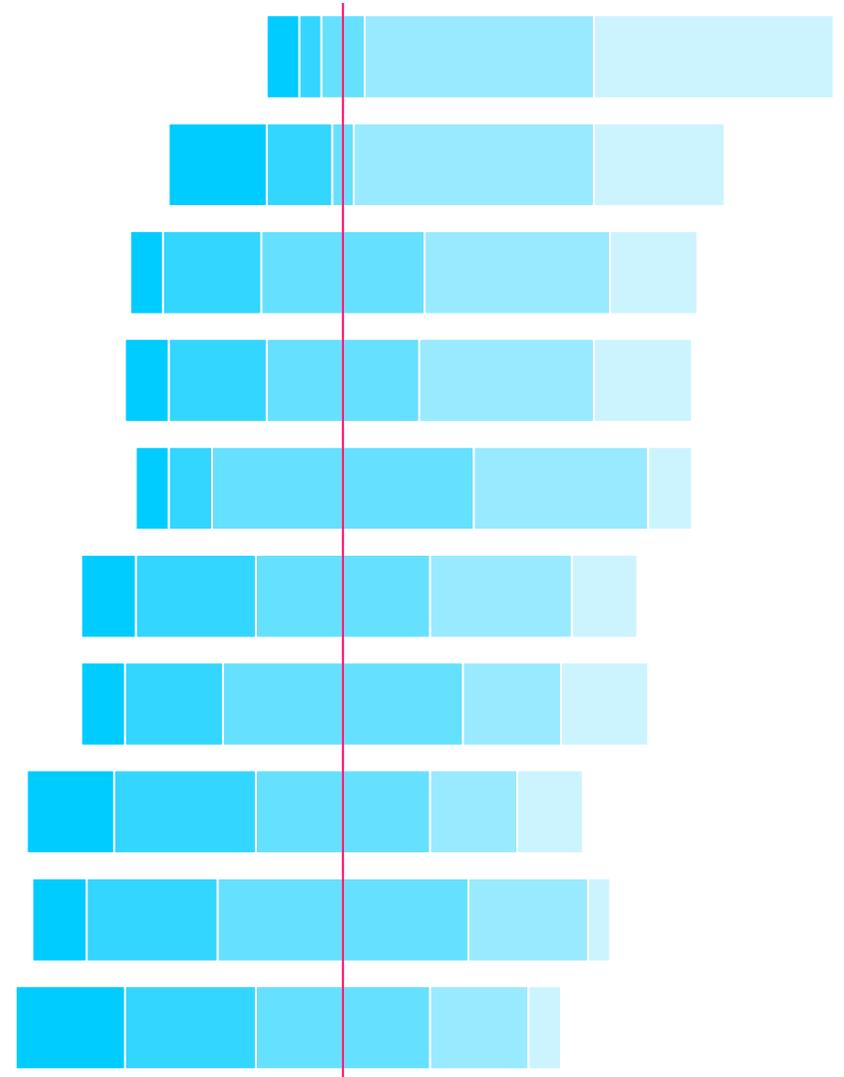
Services provide enough information about what they offer to help individuals decide whether go there

I think the drug and alcohol services in NE Lincolnshire provide a good service

It is easy to access treatment for drugs and/or alcohol

Drug and alcohol service referral processes make it difficult for people to attend

Drug and alcohol service opening times make it easy to access them for all people



■ Strongly Disagree ■ Disagree ■ Unsure ■ Agree ■ Strongly Agree

Many service providers were unsure if the drug and alcohol services in North East Lincolnshire provide a good service, a slightly higher proportion either agreed or strongly agreed than those who disagreed or strongly disagreed. Almost half of respondents agreed or strongly agreed that they were aware of support for carers of people with substance addiction. Just under half of respondents were unsure if drug and alcohol services are good at finding ways to improve. 41.2% were unsure if the referral processes made it difficult for people to attend.

The majority disagreed/ strongly disagreed that opening times make it easy to attend, this was also reflected in the additional comments with many respondents stating that opening times are not adequate. 27.5% agreed/ strongly agreed that it is easy to access treatment. A slightly higher proportion agreed that services do provide enough information than those who disagreed. Almost half agreed/ strongly agreed that the location of treatment services make them easy to access, however many also commented that the location is not currently easy to access. 82.7% of respondents from the provider survey said they know where to get information about local drugs and alcohol treatment services. The majority of respondents had not been affected by others use of drugs/ alcohol.

The majority of respondents from the provider survey think that drugs and alcohol are a serious problem in North East Lincolnshire, see table below.

Misuse of drugs/alcohol is a problem in North East Lincolnshire	Drugs	Alcohol
A serious problem	90.6%	82.7%
A minor problem	5.7%	9.6%
Don't know	3.8%	7.7%

Service providers were asked if they had any additional comments about drug and alcohol treatment services in North East Lincolnshire and about drug use in North East Lincolnshire.

The opening times and location of treatment services were the main additional issues raised in the provider survey.

*"If someone works full time it is impossible to get a service due to the opening hours."*

*"Opening times need to be extended."*

*"The building [Foundations] shuts before ours and there are regularly people hanging around outside, vomiting, urinating and defecating outside of our building. This is not currently well managed."*

Many felt that the location of treatment services excluded people, it was felt that for Immingham in particular there is a lack of treatment service provision.

*"Immingham has no representation from drug rehab programmes and no outreach services."*

*"The services are not accessible to all, in particular Immingham area has no services and service users have to travel to Grimsby which creates barriers for people..."*

*"I feel it would help if there were perhaps mobile units that could get to those who found it more difficult to get to bases where services are provided from."*

Some thought that group work and grouping together all drug users and alcoholics didn't always work.

*"Foundations is very intimidating for people to attend as they have a lot of trouble."*

*"Group sessions do not work for me, it does not help that most service users are drug users, which is slightly different [from alcohol users]."*

*"The system can be set up to favour the using addict and not the person who is in recovery."*

*"Many people who struggle with substance misuse are put together but not in the right way. If this is not done correctly, rather than becoming a place where recovery can happen it becomes a place where you find company to drink and take drugs."*

## Appendix 4

### Foundations Service User Satisfaction Survey

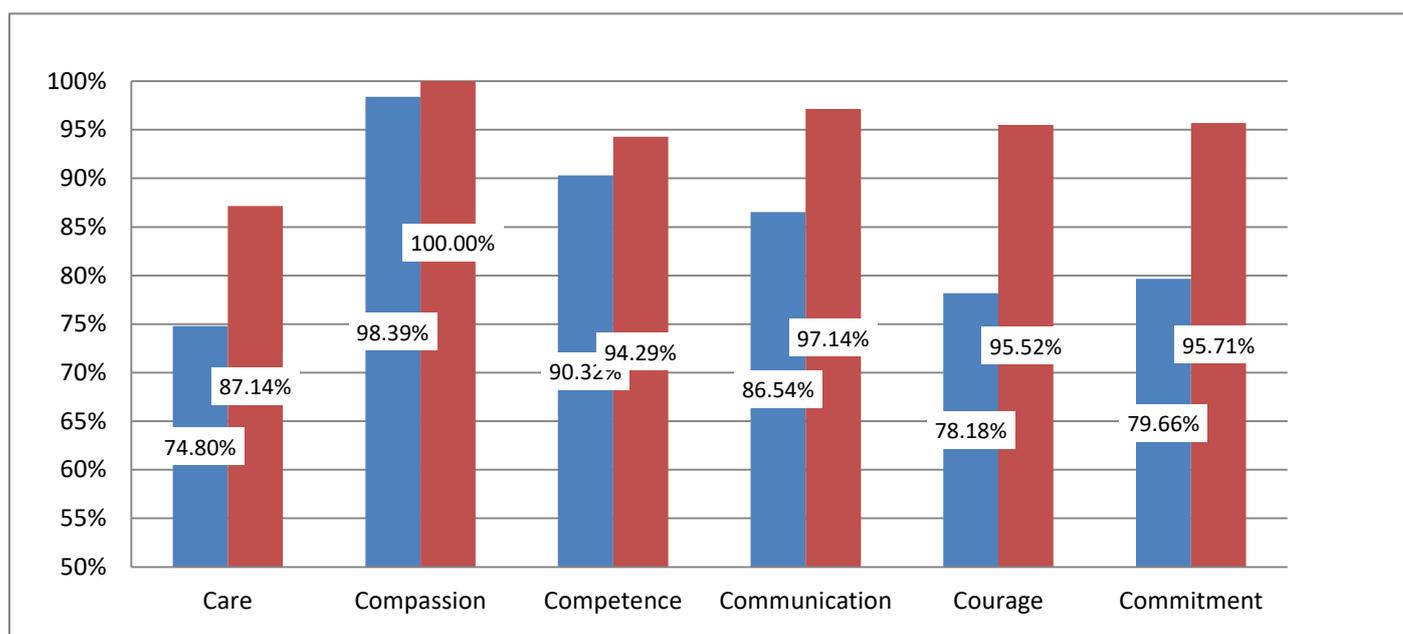
Foundations completed a service user satisfaction survey within Quarter 4 2016/17.

72 service users that attended the service during 6<sup>th</sup> and 7<sup>th</sup> March 2017 were given the opportunity to complete the survey. Their responses were as follows:

Table 18 Foundations Feedback Quarter 4 2016-17

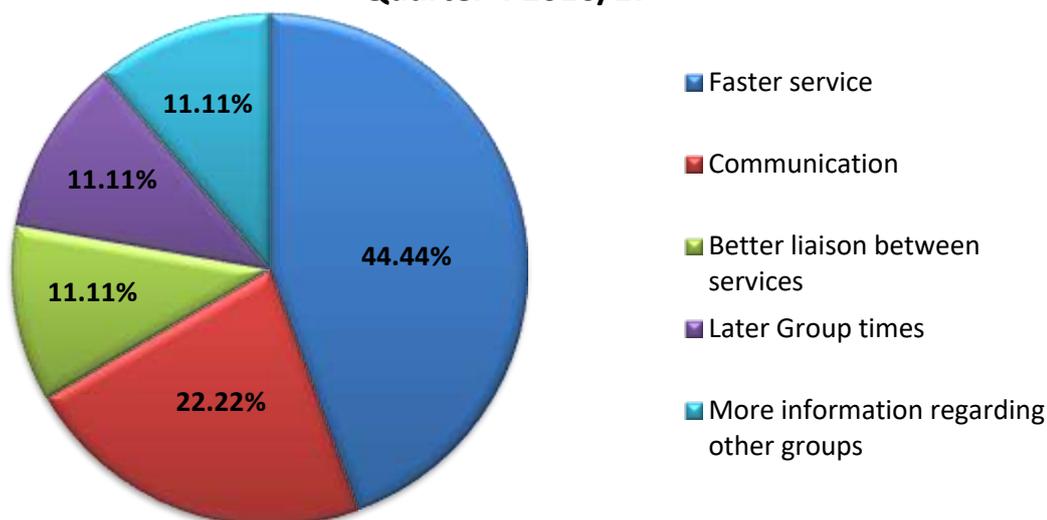
	Foundations Service User Experience 2016/17 – Percentage rated Excellent or Good						
	Care	Compassion	Competence	Communication	Courage	Commitment	Overall Satisfaction
<b>Quarter 3</b>	92/123 <b>74.80%</b>	61/62 <b>98.39%</b>	56/62 <b>90.32%</b>	90/104 <b>86.54%</b>	43/55 <b>78.18%</b>	141/177 <b>79.66%</b>	483/583 <b>82.85%</b>
<b>Quarter 4</b>	122/140 <b>87.14%</b>	69/69 <b>100.00%</b>	66/70 <b>94.29%</b>	136/140 <b>97.14%</b>	64/67 <b>95.52%</b>	67/70 <b>95.71%</b>	524/556 <b>94.24%</b>

Figure 31 Foundations - Service User Experience - Quarter 3 & 4, 2016/17 (Percentage rated the service Excellent or Good)



Q4 16/17 Service User Experience Comments	
Theme	Number of Negative Returns
Faster service	4
Better Communication	2
Better liaison between services	1
Later Group times	1
More information regarding other groups	1
<b>Grand Total</b>	<b>9</b>

### Percentage of Negative Returns - Foundations Quarter 4 2016/17



#### Comments provided when asked 'Is there anything that you feel could have been done to improve your experience?'

Sometimes when certain decisions have been made some clients haven't been informed until after the fact, so I'm saying that a little bit more communication wouldn't go amiss.

I think that you should be a lot faster and quicker eg appointments etc. DIP & Junction was hell of a lot faster and better service.

Yes I think you should marry up with the care we need, we are struggling. We need help fast please. Sort it out

Being faster would help

Waiting for treatment is far too long and frustrating at times. This can result in using drugs when not wanting to.

Agencies could liaise better with one another when trying to put together a care package

Communication, Communication, Communication!!!

Group times later in day

Could be more open views and information regarding other groups (Dyslexic - ect)

#### Q4 16/17 Service User Experience Friends and Family Test (Percentage Either Extremely Likely or Likely to recommend the service to Friends and Family)

**Foundations**

62/68

**91.18%**

The percentage is a result of the number of answers received that were rated Extremely Likely or Likely to recommend the service to friends and family against the number of answers received.

### NSPCC interim report - FEDUP

NSPCC deliver a FEDUP programme within North East Lincolnshire working with parents, children and young people. NSPCC has recently completed an interim report identifying findings that provide promising evidence that FEDUP can help reduce the negative impact of parental drug and alcohol misuse on children.

#### *Children and young people reported a decrease in their emotional and behavioural problems*

Children found the programme helpful because it:

- enabled them to develop their skills to improve their emotional well-being;
- provided a safe space to discuss issues that they previously found difficult to talk about;
- enabled them to meet other children in similar situations, so helping them to realize that they were not alone and to build new friendships; and
- provided supportive practitioners who made them feel valued.

Some children said that they didn't like:

- being in groups with varying levels of knowledge about drugs/alcohol
- being the youngest or oldest child in a group;
- not having access to support after the programme finished; and
- changes in lead workers delivering the group work.

Parents reported:

- being less unhappy;
- being more confident about their parenting; and
- having a greater knowledge about children's needs at the end of the programme.

Parents found the programme helpful because it:

- gave the time to reflect on how their drug/alcohol taking behaviour affected their child;
- helped them to see situations from their child's perspective;
- gave them new skills to address challenging behaviours;
- gave them a greater understanding about their strengths, so increasing their confidence; and
- provided supportive practitioners.

Some parents said they found the programme difficult because:

- they struggled with reflecting on the past;
- some family members, such as teenage children, were excluded from the group work;
- they were experiencing stress about other things at the time of the programme; and
- they had an initial negative view of the NSPCC as an organisation focussed on preventing child abuse.

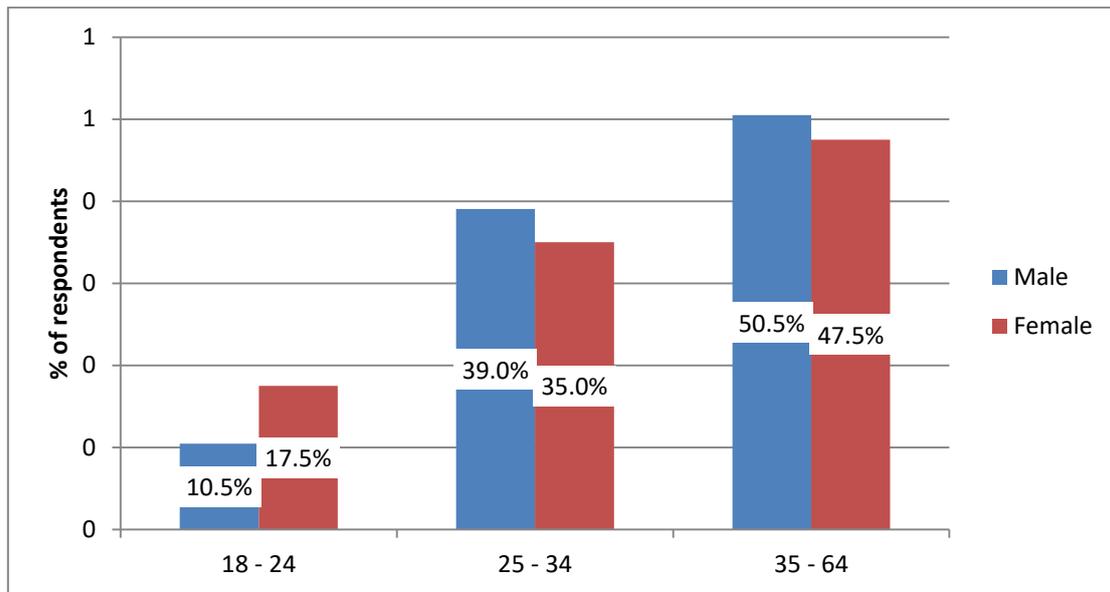
This evaluation highlights the complexity of change for these families. Children and young people's well-being increased and parents' awareness about the impact of their drug/alcohol use on the family also increased. But we do not yet have the evidence to show increases to children's self-esteem or parents' protective behaviours.

A final evaluation report will provide more insight into whether the programme was effective in changing parents' understanding, attitudes, and behaviour in the long-term. It will include findings from a comparison group who were on the waiting list for this service. It will also include interviews with practitioners delivering the programme, and the agencies who referred families to the service.

### Needle Exchange Survey

Despite there being a greater amount of males than females who completed the survey, within the 18-24 year age category, there were slightly more (6%) females than males.

Percentage of male and female respondents within each age category



There were a high proportion of people who obtain needles/syringes from the needle exchange service. The small proportion (4.1%) of respondents who did not obtain needles collected various things such as citric acid, swabs, bins and foils. Sterile water is the least used piece of equipment, with one comment being written on the questionnaire saying “when available” which may indicate that this is often not available, resulting in lack of use.

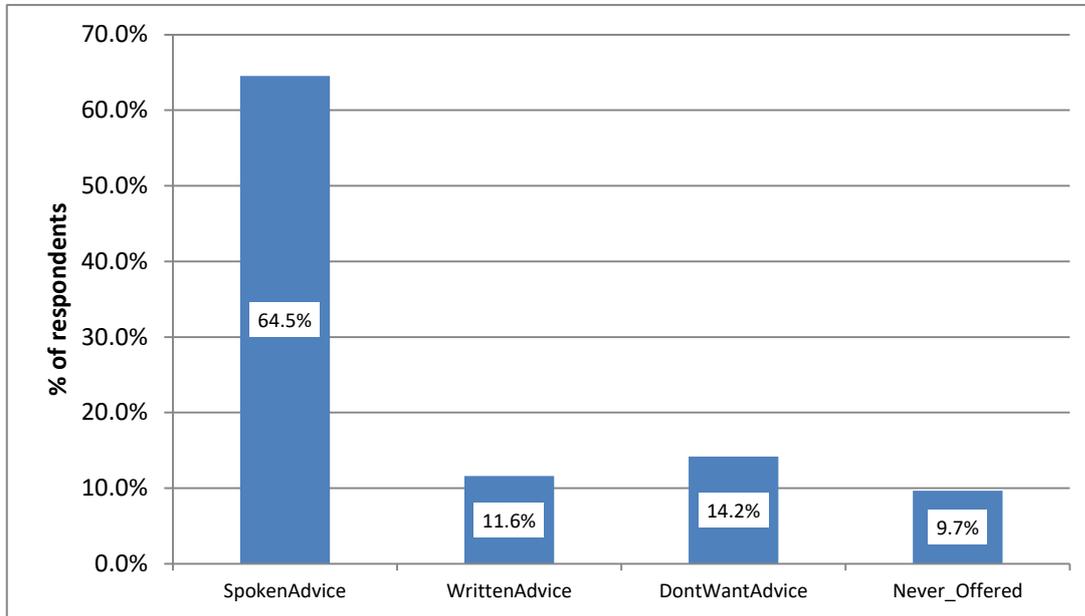
A large proportion (42.8%) of respondents reported taking more than one type of drug. The maximum number of reported drugs injected was 4, with only 2.1% of respondents reporting they use 4 different drugs. The table below identifies the breakdown of the proportion of people who reported injecting one or multiple drugs.

Total number of respondents who are injecting one or more multiple types of drugs

Number of drugs injected	Percentage of respondents
Only one drug	56%
2 types of drugs	31%
3 types of drugs	11%
4 types of drugs	2%

A high number of respondents (64.5%) reported that they had received spoken advice. A small proportion stated that they had received written advice. There were some responses that stated that they had never been offered any advice from the needle exchange service.

**Have you ever received advice from the needle exchange service about injecting drugs?**



A high proportion (61.4%) of respondents reported that they had read leaflets that are available with advice about injecting drugs. A quarter (25%) of respondents knew that they were available however, had not read them. A small proportion (13.6%) stated that they did not know they were available.

**Do you understand the risk of infections? and do you understand the risk of contamination?**

Response	Risk of Infections (%)	Risk of Contamination (%)
Yes	86.4	77.9
No	5.0	10.0
Unsure	8.6	12.1

Majority (86.4%) of respondents answered that they understood the risks of infections from injecting. A small proportion (8.6%) were unsure, and an even smaller amount (5.0%) stated that they did not understand. A similar picture was reflected when respondents were asked about their awareness of possibility of drug contamination, however, slightly less, with just over three quarters (77.9%) reporting being aware of drug contamination, and a higher proportion (12.1%) reported that they were unsure and 10% said no they were not aware of the possibility of drug contamination.

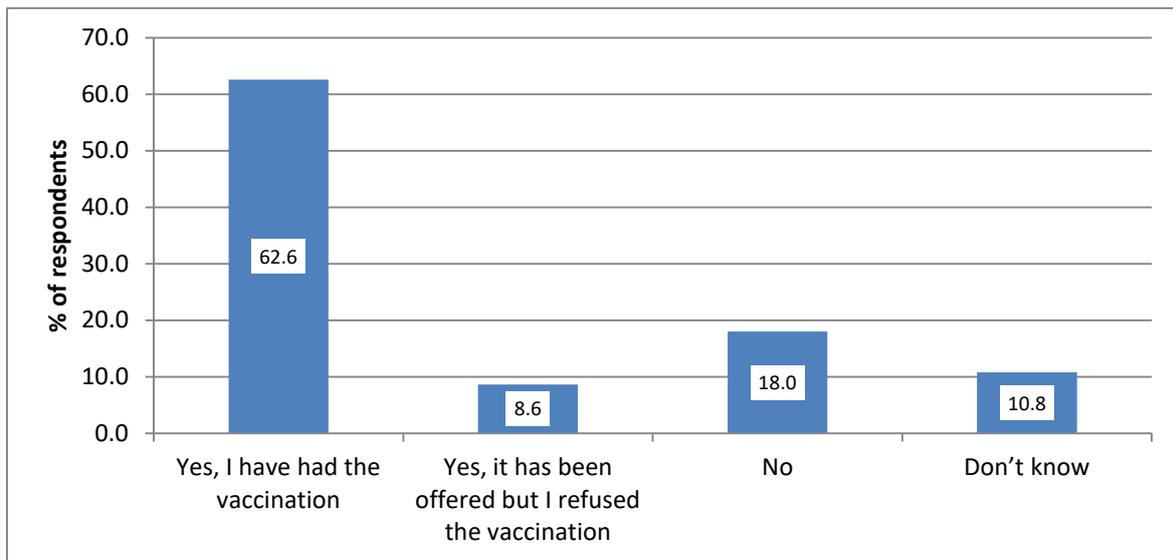
A large proportion (78.6%) of respondents reported that they did not want more information and advice about injecting drugs. However, there was still 21% of respondents that would like to receive more information and advice about injecting drugs.

Leaflets were the most popular way of how respondents would like to receive advice and information about injecting drugs, with 70.5% reporting they would like to receive information this

way. There were 34% that would like to talk to a professional, and a quarter of respondents would like an informal discussion at the needle exchange. There were 5% who reported wanting information in another form, free text responses in the 'other' category included in a DVD and talking to a recovery worker.

A high proportion (62.6%) of respondents reported that they had been offered and received the Hepatitis B vaccination. A very small proportion (8.6%) had refused the vaccination despite it being offered to them. There were 18% of respondents who stated that they had not been offered the vaccination, and 10.8% said that they did not know if they had been offered or received it.

**Have you ever been offered or received Hepatitis B vaccination?**



A large proportion (81.9%) of respondents reported that they always returned their used needles. A much lower proportion (15.9%) reported that they sometimes return needles, and a very small proportion (2.1%) stated that they never return needles.

**Do you return all your used needles?**

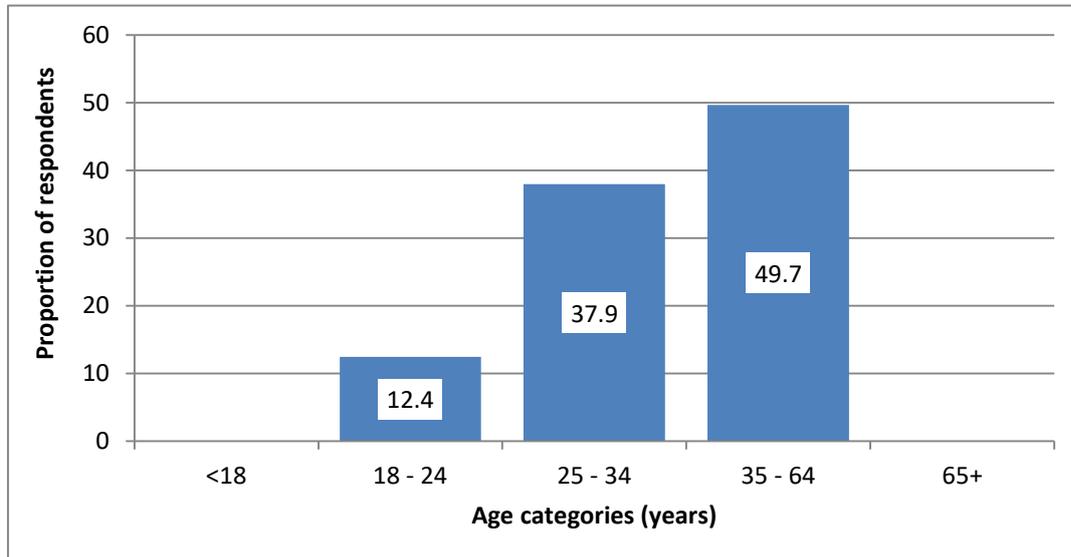
Response	% of respondents
Always	81.9
Sometimes	15.9
Never	2.2

Respondents who sometimes or never return their needles were asked what they do with the needle they do not return. Free text responses included answers such as "put them in the bin" or give them to friends.

A large proportion of respondents were male, with 72.4%, whereas only 27.6% were female. This figure is similar to the ratio of males and females which was reported by the Needle Exchange Surveillance Initiative (NESI) in Scotland.

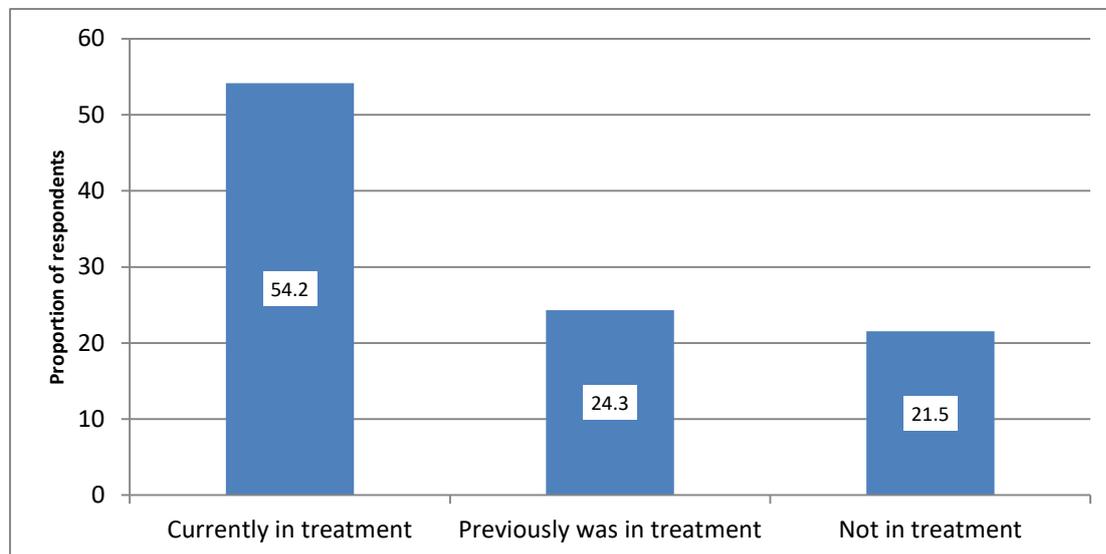
The majority of respondents to the survey were in the age category of 35-64. With each age group the prevalence of drugs increases with age (see figure 5). However, there were no respondents who were in the under 18 or over 65 year age range.

Proportion of respondents within each age category



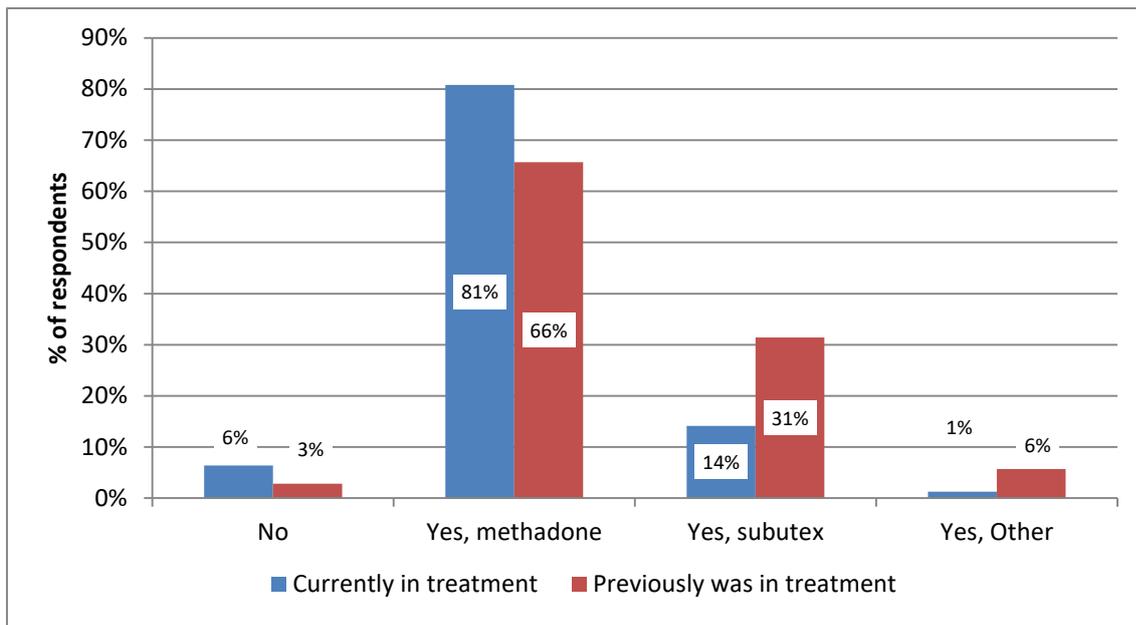
Over half 54.2% of respondents stated that they were currently in treatment. Nearly a quarter were previously in treatment and 21.2% have never been in treatment.

Proportion of respondents in treatment, previously in treatment or not in treatment



Methadone was the most commonly prescribed drug among both respondents currently in treatment and previously in treatment. Subutex appeared to be prescribed more in the respondents who had previously been in treatment rather than currently.

Percentage of people who are currently or were previously in treatment and what they were prescribed



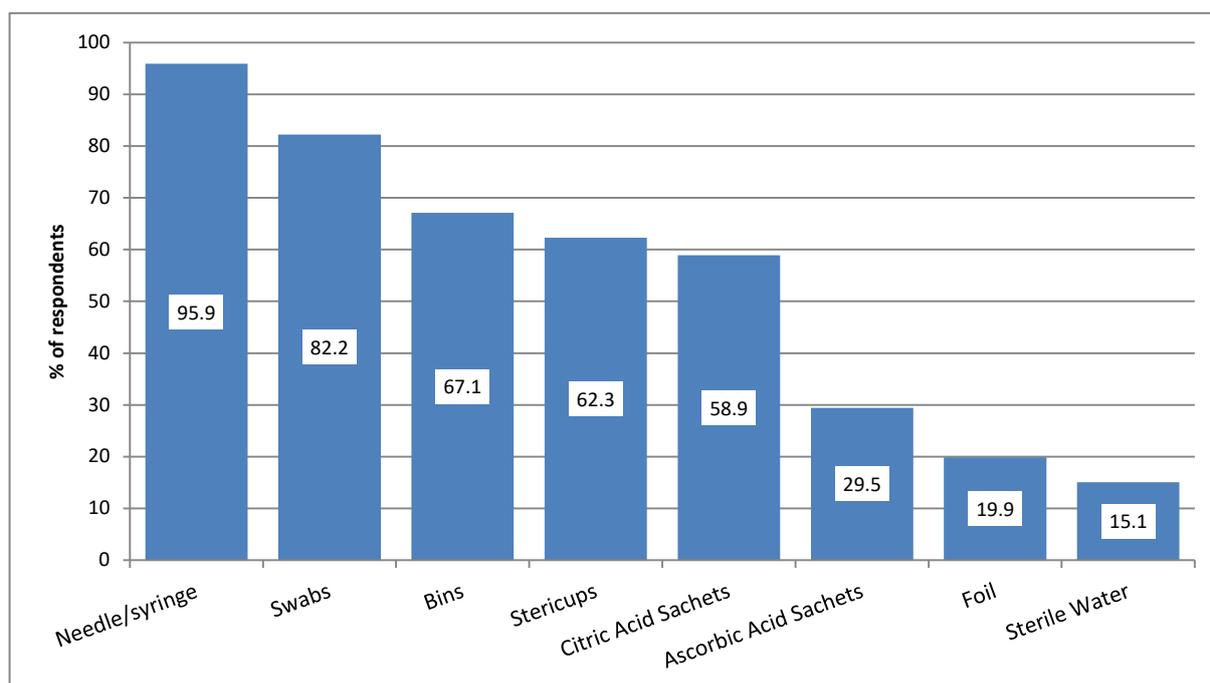
41.4% of respondents reported that they use the need exchange service weekly, with nearly a quarter (24%) of all respondents reporting using the service daily.<sup>20</sup>

The most common combination with 13.8% of respondents stating that they use needle/syringe, swabs, citric acid, stericups and bins. Only 2.1% stated that they use all 8 pieces of equipment on offer.

When asked if they ever share needles, the majority (73.1%) stated that they never share needles. Currently 2.8% of respondents are sharing needles. Despite this figure being relatively small, still highlights that people are sharing needles, and putting themselves at risk of infection and disease.

<sup>20</sup> NB. This question was ambiguous could have been interpreted as how often do you use needles

Percentage of respondents who obtain which pieces of equipment from the needle exchange service



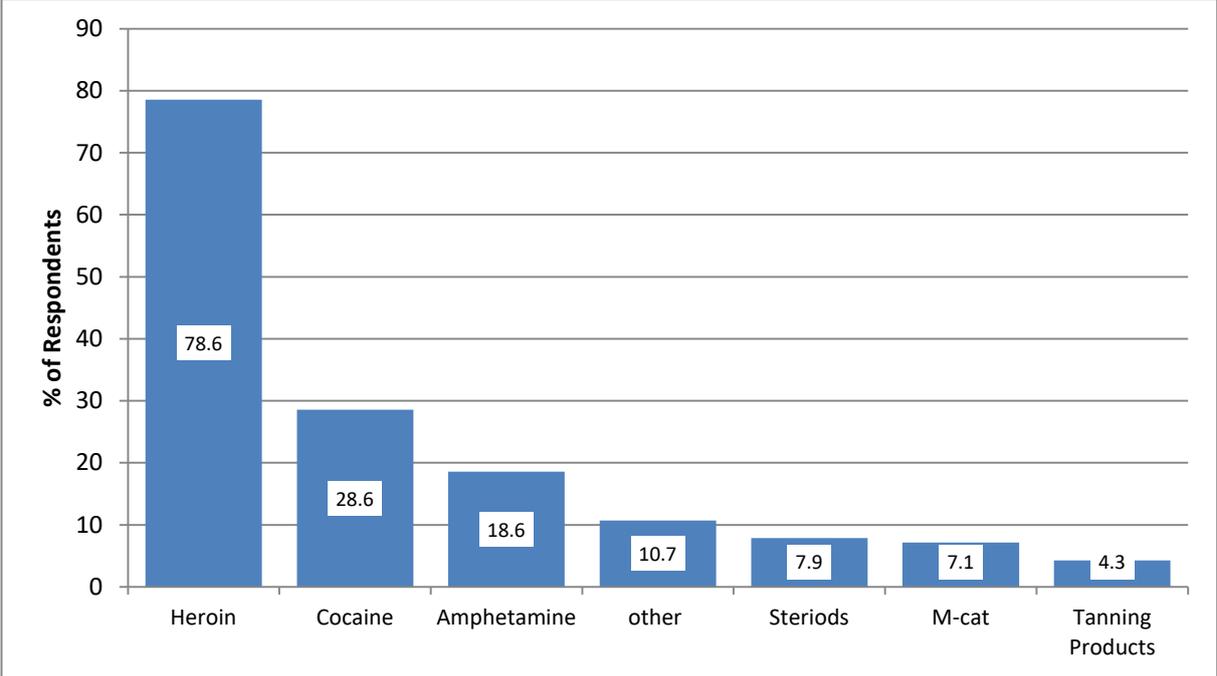
Do you ever share the same needle/syringe

Response	%
Yes, currently	2.8
Yes, sometimes	10.6
Yes, previously	12.0
No, never	74.6

The most common reported drug used was heroin, with over three quarters (78.6%) of respondents reporting using it. Of respondents who took heroin, approximately half (51.8%) only took heroin, whereas the other half took heroin and other type of drugs (48.2%). Surprisingly steroids were the third lowest used drug used with only 7.9% of people who responded taking them. Of these 83% were sole steroid users.

There were 10.7% of respondents taking other drugs not stated in the list provided. The responses included MDMA, snowballing (cocaine and heroin), crack and ketamine, there was also one person using needles due to being a diabetic.

Percentage of respondents who stated what drugs they used their needles for



**NALOXONE Report**

**Is there a case for North East Lincolnshire to pilot the use of naloxone as emergency opioid overdose intervention?**

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## Summary and recommendations

Naloxone is a life-saving drug used to temporarily prevent the effects of heroin or other opioids on the body, which can give extra time for emergency services to attend in the event of a suspected overdose.

The legal status of naloxone and the ease with which commissioned drug services can provide it has recently changed, allowing drug services to provide naloxone to users themselves, as well as their family and responsible staff members in organisations such as hostels with a high prevalence of substance misusers.

Naloxone programmes exist across the world, notably in Scotland and Wales where the programme has morphed from a trial into a national programme providing thousands of naloxone kits each year.

This brief report considers the viability of a naloxone programme for North East Lincolnshire, by discussing the prevalence of opioid misuse in North East Lincolnshire and by presenting statistics on the number of people in recent years who have been admitted to hospital or have died with drug use as a potentially contributory factor.

- North East Lincolnshire is estimated to have high levels of both opioid misuse and drug injecting relative to the population. There are few local authorities in the country with higher rates.
- North East Lincolnshire has a high level of individuals in treatment for opioid misuse.
- Between April 2013 and April 2016, there were at least 144 opiate-related hospital admissions to Diana Princess of Wales Hospital for opioid poisoning. These admissions are socially and geographically patterned, with middle-aged drug users in North East Lincolnshire's poorest areas most affected.
- Between 2010 and 2014 there were 18 opioid-related deaths registered in North East Lincolnshire. These deaths are also patterned socially and geographically, disproportionately affecting middle-aged drug users in North East Lincolnshire's poorest areas.

It is unclear from this evidence alone whether a naloxone programme would be a cost-effective measure for North East Lincolnshire. To determine this, it is recommended that a pilot programme is implemented, administered by commissioned drug services in the area and monitored by both the commissioned drug services and local authority to determine suitability and cost-effectiveness.

This would allow drug services and the local authority to determine whether or not naloxone is a cost-effective measure and if it isn't, what the effects on the drug-using population are, beyond those that can be measured simply in terms of cost.

# 1 Naloxone

## What is naloxone?

Naloxone is a competitive opioid receptor antagonist, meaning that naloxone displaces opioid drugs from their receptor sites and blocks their mechanism of action by preventing further receptor activation<sup>21</sup>. In a pre-hospital setting, such as the immediate aftermath of a heroin overdose in the home, a one-off dose of naloxone administered via intramuscular injection is a temporary solution only, as naloxone's short half-life<sup>21</sup> (approximately one hour) necessitates further treatment. In a hospital setting, naloxone can be administered intravenously<sup>21</sup>.

## What is take home naloxone?

Take home naloxone kits (THNs) are kits of ready-to-inject naloxone containing one or more doses to be used in the event of an opioid overdose with the intention of gaining time until the emergency services can attend.

Previously, these kits could be supplied only to identified users of opioids. However regulatory changes<sup>22</sup> now mean that THN can be supplied to a wider range of individuals including family, friends, carers, service workers and even managers of accommodation services for homeless people via a drug service commissioned to do so.

A number of countries including the United States, Canada, Australia and New Zealand have trialled or implemented THN programmes. Scotland and Wales have ran successful trials over the past decade that have grown into national programmes. [Section 6](#) explores these in greater detail.

## Who do take home naloxone programmes target?

THN programmes are targeted towards patients already in treatment for substance misuse. This is because they are a readily accessible population with a number of risk factors for opioid overdose and because regulations regarding the supply of naloxone allow for commissioned substance misuse services to supply these individuals without the need for an individual prescription<sup>22</sup>.

Indirectly these programmes target the wider circle of friends and acquaintances of drug users. In their evaluation of their THN project, the Welsh government found that a number of individuals supplied with THN kits actually used them on someone else<sup>44</sup>. It is legal to use naloxone on someone else for the purpose of saving a life, and so by providing THN kits to substance misusers who are likely to take drugs with other misusers who may or may not be in contact with services, the availability of naloxone can be indirectly extended.

## Risk factors for drug-related death

There are a number of risk factors for drug-related death. Generally speaking, these include being male, being older than 34, being recently discharged from hospital<sup>23</sup>, being recently released from prison<sup>24</sup>, being a recent heroin injector and being an alcohol or benzodiazepine<sup>25</sup> misuser.

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<sup>21</sup> DrugBank (2017) *Naloxone*

<sup>22</sup> HM Government (2016) *Widening the availability of naloxone*

<sup>23</sup> White et al (2015) *Drugs-related death soon after hospital-discharge among drug treatment clients in Scotland: Record linkage, validation and investigation of risk factors*

Risk factors are also present amongst those in substance misuse treatment programmes in receipt of methadone, particularly amongst those with alcohol use disorders and those who have begun methadone replacement therapy in the last month<sup>26</sup>.

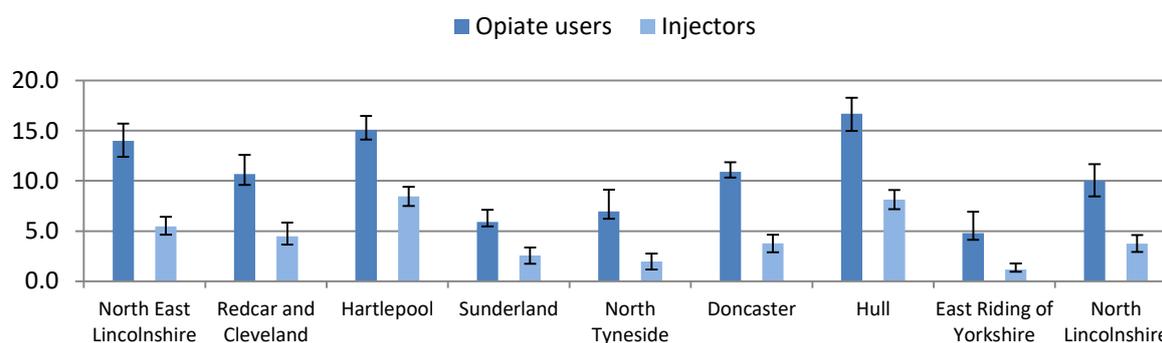
## 2 Opioid Misuse in North East Lincolnshire

### Estimated prevalence of opioid misuse and drug injecting in North East Lincolnshire

It is estimated that in 2011/12<sup>27</sup>, North East Lincolnshire had approximately 1,442 opioid users - a rate of roughly 14/1,000 residents – of which approximately 563 (39%) were injectors. Figure 32 below shows the estimated rates per 1,000 residents aged 15-64 of both opioid use and drug injecting for North East Lincolnshire’s five closest statistical neighbours (Redcar and Cleveland; Hartlepool; Sunderland; North Tyneside; Doncaster), and three other local authorities in the Humber region (East Riding of Yorkshire, North Lincolnshire and Hull).

It shows that North East Lincolnshire has a higher estimated mean rate of opioid use than most other local authorities in this comparison. There is no statistically significant difference between Hull, Hartlepool and North East Lincolnshire as the 95% confidence intervals overlap.

Figure 32 – Estimated rate of opioid users and drug injectors per 1,000 residents aged 15-64 (2011/2012)



Source: Hay, Rael dos Santos and Worsley (2012)

In terms of injecting, only Hull and Hartlepool have a statistically significant higher rate. North East Lincolnshire’s rate is broadly in line with the remaining local authorities, though Sunderland, North Tyneside and East Riding have statistically significant lower rates.

### Recorded number of patients in treatment for opioid misuse

<sup>24</sup> Leach and Oliver (2011) *Drug-related death following release from prison: a brief review of the literature with recommendations for practice*

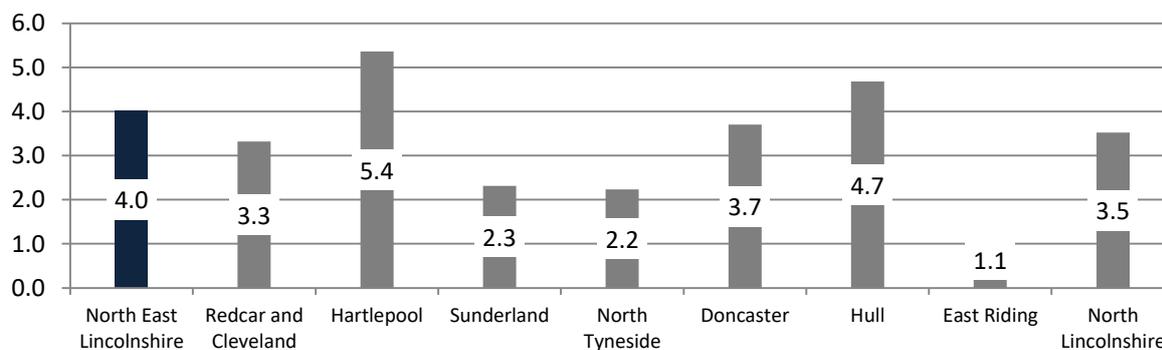
<sup>25</sup> Best et al (2001) *Overdosing on opiates*

<sup>26</sup> Kimber et al (2015) *Mortality risk of opioid substitution therapy with methadone versus buprenorphine: a retrospective cohort study*

<sup>27</sup> Hay, Rael dos Santos and Worsley (2012) *Estimates of the prevalence of opiate use and/or crack cocaine use, 2011/12: Sweep 8 report*

As of 31<sup>st</sup> of March 2015, 642 people were receiving treatment for some form of opioid use in North East Lincolnshire, 458 of whom (71.3%) were receiving treatment for opioid use but not crack use. Figure 33 below shows the rate of people in treatment as of 31<sup>st</sup> of March 2015 for some form of opioid use, either opioid without crack or opioid with crack. A further 165 were recorded as being known to substance misuse services, but had not received treatment within the last year.

Figure 33 – Rate of individuals receiving treatment for some form of opioid use per 1,000 residents of all ages (2015)



Source: PHE (2015)

Of those who were in treatment<sup>28</sup> on 31<sup>st</sup> of March 2015:

- 68.5% were male
- 99.2% identified as white
- 2.8% were aged 15-24, 34.0% were aged 25-34, 63.2% were aged 35-64.
- 39.4% were current injectors

### 3 Prevalence of risk factors for drug-related deaths in North East Lincolnshire

There are a number of risk factors for drug related death. As mentioned above, these include being male, being over the age of 34, being a drug injector, alcohol and/or benzodiazepine use, recent hospital discharge, recent prison release and recently starting methadone treatment.

#### Male population aged 34+

As stated, it is suggested that being male and over the age of 34 are risk factors for drug-related death<sup>29</sup>. Estimates of the prevalence of opioid use<sup>27</sup> for the 35-64 age group suggest that approximately 41% (590) of opioid users in North East Lincolnshire are aged 35-64.

There does not appear to be data that estimates the number of opioid users by both age *and* gender. However, this number can be estimated through the use of current estimates and treatment statistics.

<sup>28</sup> Public Health England (2015) *Bulls Eye Data: 2014/2015*

<sup>29</sup> Bird and Robertson (2011) *Toxicology of Scotland's drugs-related deaths in 2000-2007: presence of heroin, methadone, diazepam and alcohol by sex, age group and era*

Data from Hay, Rael dos Santos and Worsley<sup>27</sup> suggests approximately 590 opioid and crack users in North East Lincolnshire are aged 35-64, representing 41% of the total. Data from Public Health England on the numbers in treatment does show gender distribution, showing that 67.3% (440 of 642) of opioid and crack users in treatment on the 31<sup>st</sup> of March 2015 were male. If this gender distribution is applied to the estimated number of opioid and crack users over the age of 34, it would give an estimate of approximately 397.

### **Drug injecting**

Drug injectors are at a greater risk of drug related death<sup>30</sup>,

Figures from 2011/2012<sup>27</sup> show that in the local area, only Hull has a statistically higher estimated rate of drug injecting. Figures from March 2015 show that of 642 patients in treatment for some form of opioid use, 39.4% (253 of 642) were current drug injectors.

### **Population abusing alcohol and/or benzodiazepines**

Research from the National Treatment Agency for Substance Misuse<sup>31</sup> (NTA) showed that alcohol and benzodiazepines are commonly found when screening blood samples of those who have died from an opioid overdose. Over 2,000 toxicology reports were analysed, showing that in more than 75% of heroin overdoses and more than 80% of methadone overdoses, another drug was present. Typically, these drugs are alcohol or benzodiazepines, predominately diazepam and temazepam. The NTA state that overall however, the general trend appears to be a decrease in people testing positive for benzodiazepines.

### **Recent hospital discharge**

Research on substance misusers in Scotland suggests greater risk of a drug-related death shortly after a hospital discharge. The reasons for this are unclear, but could be related to loss of tolerance or patients being discharged without appropriate prescriptions being issued, resulting in the use of street heroin or other substances.

Whilst the number of drug users discharged from hospital is unknown, findings from the Council's recent substance misuse needs assessment suggests that approximately two-fifths of substance misusers surveyed said they have been hospitalised due to drug use. This could mean that there is a significant number of drug users released from hospital each year, who may be at greater risk from a drug-related death.

### **Recent prison release**

A number of studies have found an increased risk of death following prison release **Error! Bookmark not defined.**, an effect which can last for up to a month after release. This is primarily due to reduced tolerance to opiates. Recently released prisoners who return to substance misuse after a length of time without using, in this instance opiates, whilst imprisoned may go back to the dosage

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<sup>30</sup> Mathers et al (2012) *Mortality among people who inject drugs: a systematic review and meta-analysis*

<sup>31</sup> National Treatment Agency (2007) *Does the Combined Use of Heroin or Methadone and Other Substances Increase the Risk of Overdose?*

they were using before being imprisoned. Due to the reduced tolerance, this can result in a fatal overdose<sup>32</sup>.

Between November 2016 and January 2017, there were 59 appointments booked with Foundations for prisoners due to be released, the majority from HMP Hull. Of the 23 who actually were discharged into the Grimsby area, 19 (82.6%) attended their appointment. Of the 36 who did not attend their appointment, the vast majority were not discharged by their release date. A small number of prisoners who were discharged, did not attend their appointment.

#### **Recently starting methadone treatment**

Several studies have found evidence that recently beginning methadone treatment increases the risk of drug-related death<sup>33,34,35,36</sup>. Data from Care Plus Group shows approximately 155 patients starting a course of methadone treatment via Foundations between April 2016 and April 2017. There is currently no data from GPIP on this.

## **4 Opioid-related hospital admissions in North East Lincolnshire**

An opioid-related hospital admission (ORHA) refers to an admission to hospital with a diagnosis code for the following:

- Poisoning: Heroin
- Poisoning: Methadone
- Poisoning: Other opioids

Between April 2013 and April 2016, there were 144 ORHAs to Diana Princess of Wales Hospital, Grimsby. Analysis of these ORHAs indicates that they are socially and geographically patterned.

#### **Age and Gender**

For both men and women, the peak incidence of an ORHA occurs between 30 and 44 years of age, with men aged 30-34 having the greatest frequency of admission and women aged 40-44 having the greatest frequency of admission.

Just under half of all recorded ORHAs in this time period were attributable to the 30-44 age bracket, despite making up just 22.3% of the adult population, based on 2015 population estimates<sup>37</sup>. Figure 34 below shows the distribution of ORHAs by age and gender.

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<sup>32</sup> Merrall et al (2010) *Meta-analysis of drug-related deaths soon after release from prison*

<sup>33</sup> Leece et al (2015) *Predictors of opioid-related death during methadone therapy*

<sup>34</sup> Hickman et al (2010) *Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database*

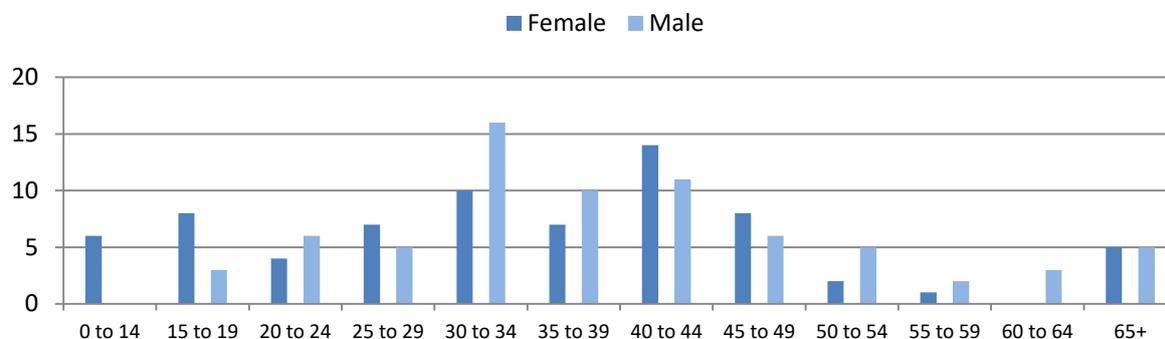
<sup>35</sup> Strang et al (2010) *Impact of supervised methadone consumption on deaths related to methadone overdose*

<sup>36</sup> Buster et al (2002) *An increase in overdose mortality during the first two weeks after entering or re-entering methadone treatment in Amsterdam*

<sup>37</sup> Office for National Statistics (2016). *Population estimates by single year of age and sex for local authorities in the UK, mid-2015*.

In total, there were 72 male admissions and 72 female admissions. As this data may show multiple admissions for one person, the actual number of individual men and women admitted may be different.

Figure 34 – Frequency of ORHA by age and gender (2013-2016)



Source: North East Lincolnshire Clinical Commissioning Group (2016)

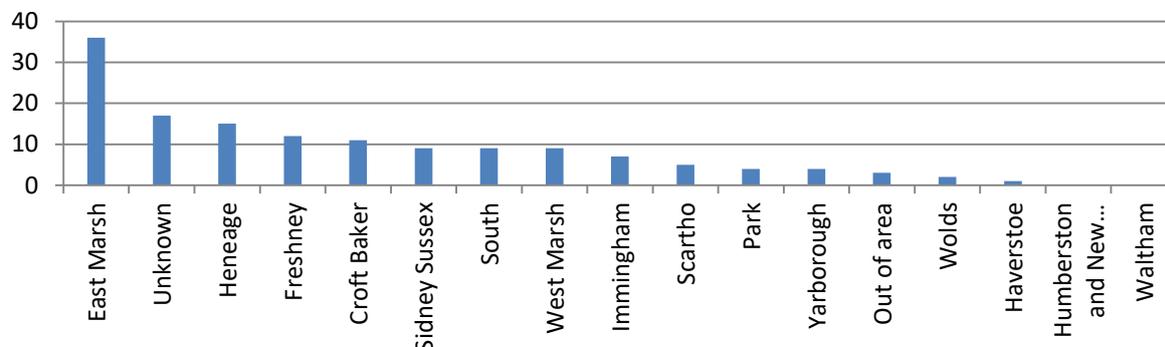
### Ward

There is a relationship between wards and the frequency of ORHAs. In terms of simple frequency of admission, the ward with the greatest number of admissions is East Marsh with 36, which is more than Heneage and Freshney combined, the second and third highest ranking wards by ORHA frequency. Figure 35 overleaf shows the frequency of admission for all wards.

### Deprivation

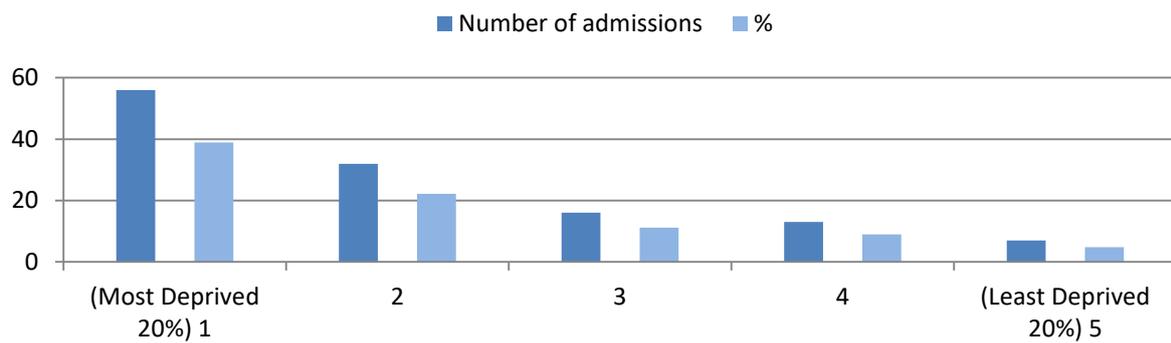
As there is a relationship between electoral ward and ORHA frequency, and there is a relationship between electoral ward and deprivation, ORHAs are also patterned by deprivation. Nearly two-fifths (39%) of admissions were from wards with a deprivation quintile of 1 (most deprived) whilst only 5% of admissions were from wards with a deprivation quintile of 5 (least deprived). There is a clear relationship between frequency of admission, and proportion of admissions by deprivation as shown overleaf in Figure X.

Figure 35 – Frequency of ORHA by North East Lincolnshire electoral ward



Source: North East Lincolnshire Clinical Commissioning Group (2016)

Figure 36 – Frequency and proportion of ORHAs by deprivation quintile



Source: North East Lincolnshire Clinical Commissioning Group (2016)

### Registered GP

Over a quarter of admissions (26.3%) came from patients registered at just three GP surgeries – Open Door, Roxton at Weelsby View and Pelham Medical Group. Open Door had the greatest frequency of ORHAs with 17.

### Substance

Diagnosis codes for each admission indicate the primary substance was heroin in 47 admissions (32.6%), methadone in 9 admissions (6.3%) and ‘other opioids’ in the remaining 88 (61.1%). The listing of ‘other opioid’ could suggest two things and is significant for considering the provision of naloxone. If other opioid mostly refers to opioids taken illicitly, perhaps in combination or perhaps of unidentifiable origin, then the provision of naloxone would be appropriate. If other opioid mostly refers to accidental overdose or misuse of prescribed therapeutic opioids, e.g. misuse of a fentanyl patch or overdose of morphine sulphate solution (Oramorph) then naloxone provision would be less appropriate, within the parameters of this pilot.

### Time of Year

Whilst the number of admission varies month to month, there appears to be no clear pattern in relation to admissions and time of the year, other than December (7) and January (10) having the second and joint-third lowest admissions after June, which has only 6. February and May have the joint highest with 17 each, after July which has 16.

## 5 Opioid-related drug-related deaths in North East Lincolnshire

Data from the Office for National Statistics suggests that between 2010 and 2014 there were 18 opioid-related drug-related deaths in North East Lincolnshire. Data from Her Majesty’s Coroner for North East Lincolnshire and Grimsby District can be used to give further detail on these deaths. 9 of these deaths occurred in 2010, 3 in 2011, 4 in 2012 and 1 in 2013, an average of 4.5 opioid-related drug-related deaths per year.

### Age

The age of those who died of opioid-related drug-related deaths ranges from 16<sup>38</sup> to 54 with 16 of 18 deaths occurring between the ages of 28-42. The average age of death is 35.6 and the median age of death is 36.5. This finding is consistent with the peak incidence of opioid-related hospital admissions (ORHAs) between the ages of 30-44.

### **Gender**

Whilst ORHAs appeared not to be patterned by gender, opioid-related drug-related deaths are, with 13 of 18 decedents being men.

### **Ward**

There is a relationship between ward of residence and opioid-related drug-related death. 17 of 18 deaths were plotted by postcode and ward. The findings broadly follow the findings for ORHAs. East Marsh – the ward with the greatest number of ORHAs – has the greatest number of opioid-related drug-related deaths, with 7 between 2010 and 2013. Whilst only 2 wards had no ORHAs (Waltham and Humberston and New Waltham) 8 wards had no opioid-related drug-related deaths:

- Croft Baker
- Haverstoe
- Immingham
- Scartho
- South
- Waltham
- Wolds
- Yarbrough

### **Deprivation**

There is a relationship between deprivation and opioid-related drug-related deaths. The 7 wards that had at least one death - East Marsh, West Marsh, Freshney, Park, Heneage, Sidney Sussex and Humberston and New Waltham have an average deprivation score of 37.5 compared to an average score of 22.9 for those without any opioid-related drug-related deaths. This is however not as straightforward as it seems, as Humberston and New Waltham, one of North East Lincolnshire's least deprived wards has a death, whereas South, one of the most deprived, does not.

### **Substance**

Of the 18 recorded deaths, the majority involved more than one opioid, including a number of opioids involved in substance misuse therapy such as methadone and buprenorphine.

- Methadone was involved in 11/18 deaths
- Heroin was involved in 9/18 deaths
- Morphine was involved in 4/18 deaths
- Buprenorphine was involved in 1/18 deaths
- Any other opioid was involved in 8/18 deaths
- More than one opioid was involved in 10/18 deaths

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<sup>38</sup> This was an unusual case and the typical age range in North East Lincolnshire is 21 to 54.

As mentioned, there is a tendency for polydrug use amongst opioid users. This was evident amongst these deaths, as both alcohol and benzodiazepines were involved in a majority of deaths.

### **Time of year**

Much like ORHAs, there is little to no relationship between the time of year and the likelihood of opioid-related drug-related deaths. The peak incidence however does occur in August.

### **Number discovered unconscious**

The successful administration of naloxone is dependent on a number of factors, but it is important that there is another person present to witness either the overdose event or the aftermath to then administer it, and that the individual who has overdosed is discovered alive.

Coroner's reports have been used to determine whether the above conditions were met in the above deaths.

Whilst in practice nobody is considered life extinct until they are classed as such by a competent medical professional, this analysis excludes those whose bodies were found cold, stiff or otherwise giving indication that life had been extinct for a length of time.

- One decedent (J1) lived with his girlfriend who was unable to rouse him. He was apparently unconscious at the time but was pronounced life extinct shortly after arriving in hospital.
- One decedent (K1) was alive in cardiac arrest when paramedics arrived. Her friend had called paramedics and told them that prior to their arrival, the decedent had injected with heroin. The decedent was administered naloxone by paramedics but died later that evening in hospital.
- One decedent (F1) lived with his partner. He had spent the entire day (4<sup>th</sup>) asleep following drug use the previous evening (3<sup>rd</sup>) and was last seen awake on the sofa on the morning of the 4<sup>th</sup>. In the early hours of the 5<sup>th</sup>, he was unresponsive and paramedics called. Life extinct pronounced at the scene.
- One decedent (S1) was identified by an anonymous caller to paramedics to be having a suspected heroin overdose. The caller claimed the individual not to be conscious or breathing. Life extinct pronounced at the scene.

It is not possible to know for sure, but it is arguable that had the above drug users, their family, friends or carers been issued with naloxone kits, their deaths could have been prevented. This is however a very small number of preventable deaths. Assuming the coroners reports are accurate descriptions of the true nature of the deaths and that witnesses have not misrepresented or given incorrect information, there is an average of one preventable opioid-related drug-related death per year.

## 6 Naloxone services elsewhere in the UK and internationally

### Scotland

Scotland have had a take-home naloxone programme since 2010<sup>39</sup>, initially starting in prisons and then the community soon after<sup>40</sup>. Scotland issues thousands of these kits per year, including 8,146 in 2015/16<sup>41</sup>.

A study carried out in 2014<sup>42</sup> carried out a service evaluation of Scotland's THN programme, interviewing stakeholders, surveying local naloxone coordinators, finding out the views of service providers and speaking to service users. They found that:

- Between 2011 and 2014, there were 365 recorded successful uses of the THN kits, however this figure is estimated to be over 500 uses taking into account unrecorded uses.
- Of 169 service-users surveyed, a majority agreed that:
  - THN saves lives (73%)
  - THN has made them more aware of life saving techniques (90%)
  - THN has made them more aware of the causes of overdose (92%)
  - THN has empowered drug users to take greater control of their health (86%)
- Carers and families felt reassured by the 'safety net' provided by naloxone.
- Service providers were overwhelmingly positive about the programme.

However, despite the kits being used successfully and their popularity amongst service providers, service users and carers, opioid-related drug-related death statistics for Scotland are mixed. The rate of opioid-related deaths has fallen by only 0.3 deaths per 100,000 since 2008 as displayed below.

The blue half of the graph denotes the full years for which the THN programme was up and running. The rate has fluctuated and appears to have declined little. However, data specific to opioid-related deaths within four weeks of prison or hospital discharge give a contrasting view.

The 2015/16 Naloxone Monitoring Report<sup>41</sup> shows that the number of opioid-related deaths within the first 4 weeks of prison release, expressed as a percentage of the number of opioid-related deaths within the first 12 weeks of prison release, has undergone a statistically significant decline since the introduction of the THN programme. For example, in 2011, 36% of opioid-related deaths within the first 12 weeks of prison release occurred within the first 4 weeks. Figures for 2012 through 2015 are all below the baseline, with statistical significance.

Whilst it is not possible to determine that the provision of a take-home naloxone programme is a causal factor in the reduction of opioid-related deaths in the recently discharged from prison population, there is a strong association between the two, based on the known risk to this population and a statistically significant reduction in deaths over several years is unlikely to be coincidental or due to other factors – though this is certainly possible.

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<sup>39</sup> Scottish Drugs Forum (2013) *Take Home Naloxone*

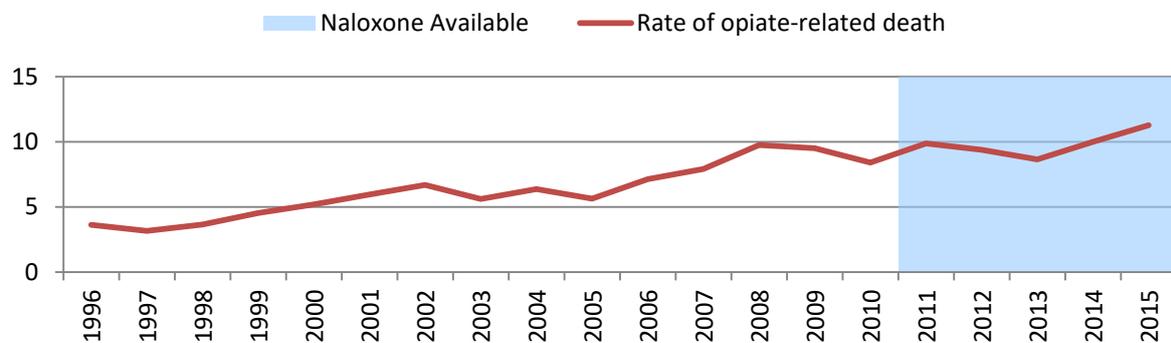
<sup>40</sup> NHS Scotland (Information Services Division) *National Naloxone Programme Scotland Monitoring Report 2011/12*

<sup>41</sup> NHS Scotland (Information Services Division) *National Naloxone Programme Scotland Monitoring Report 2015/16*

<sup>42</sup> Watt et al (2014) *Service evaluation of Scotland's national take-home naloxone programme*

However, whilst a statistically significant reduction in opioid-related drug-related deaths was found amongst the recently-released prison population, it was *not* found for the recently discharged hospital population.

**Figure 37 – Rate of opioid-related drug-related deaths between 2008-2014 in Scotland per 100,000 people resident in Scotland**



Source: National Records of Scotland (2015) *Drug related deaths in Scotland in 2015*

## Wales

Wales trialled a THN programme between 2009 and 2011, which has grown into a national programme. Between 2009 and 2015, Wales issued 7,364 THN kits to 3,793 individual patients.<sup>43</sup>

In 2011, the Welsh government published a document evaluating the trial of the THN programme<sup>44</sup> reaching the following conclusions:

- Drug users had greater knowledge of life-saving techniques and were better equipped to respond to an overdose, with a greater willingness and confidence to carry out life-saving procedures
- Those in the naloxone arm of the trial less frequently used the recovery position or called an ambulance in the event of an overdose
- On average, 10% of the kits handed out between 2009 and 2011 were used.
- There was insufficient data to link naloxone to fewer drug-related deaths.

The trial concluded with the recommendation that the THN programme is rolled out nationally.

## Australia

Australia's first take-home naloxone programme was initiated in 2012<sup>45</sup>. Over 200 individuals, including 18 prison inmates were trained in the use of naloxone and life-saving techniques to manage an overdose. The majority of those trained, including some released inmates, received a naloxone prescription.

The evaluation of this trial<sup>45</sup> found that:

<sup>43</sup> Public Health Wales (2015) *Harm Reduction Database Wales: Take Home Naloxone 2014-15*

<sup>44</sup> Welsh Assembly Government (2011) *Evaluation of the Take Home Naloxone Demonstration Project*

<sup>45</sup> Australian Capital Territory Government (2015) *Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT)' programme 2011-2014*

- Naloxone can be appropriately used by lay users in a non-medical setting
- 57 overdose reversals were documented between April 2012 and December 2014
- Peers and family members also benefitted as trial participants taught their friends and family about naloxone

The programme concluded with the recommendation that is “important” to continue the programme, with some modifications such as shorter training programmes and refresher workshops.

## **Canada**

The province of British Columbia introduced a THN programme in 2012<sup>46</sup>. Between August 2012 and March 2014, the programme had trained 1318 participants at 40 different sites in the prevention of overdose. 836 kits were given out, with 85 reported overdose reversals.

It was found that stakeholders supported the programme and that clients were more confident in responding to overdose events following the training. However, there were reported difficulties in recruiting participants and a reluctance to contact emergency services in the event of an overdose. The evaluation also found that the police themselves had some misconceptions about the take-home naloxone programme suggesting that implementing one requires engagement with a wide range of stakeholders not just those giving or receiving training and treatment.

The evaluation concludes with the suggestion that “...communities across Canada should consider implementing take-home naloxone programmes and evaluate their findings”

## **United States**

Several states such as New York, New Mexico, Connecticut, Maryland and California have established full or pilot take-home naloxone programmes<sup>47</sup>. A study evaluating six U.S. based naloxone programmes found that:

- Those who have been trained to use naloxone can have ability in identifying situations when administration of naloxone is appropriate, comparable to that of medical professionals
- Training successfully improved recognition of and response to opioid overdoses

The evaluation concluded that “Expansion of overdose training and naloxone distribution programmes for drug-using populations is warranted”.

## **Conclusion**

There is a wealth of international evidence that the provision of naloxone is associated with benefits such as greater confidence and greater ability to manage in an overdose situation. However, the evidence is mixed in regards to the efficacy of *naloxone* in preventing drug-related deaths.

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<sup>46</sup> Banjo et al (2014) *A quantitative and qualitative evaluation of the British Columbia Take Home Naloxone programme*

<sup>47</sup> Green, Heimer and Grau (2008) *Distinguishing signs of opioid overdose and indication for naloxone: an evaluation of six overdose training and naloxone distribution programmes in the United States*

Clearly, the kits are being used, and evidence from Scotland, Wales, Australia, Canada and the United States demonstrates this. However, linking naloxone to fewer drug-related deaths shows unclear findings, as evidence from both Scotland and Wales shows

Despite this, there is consensus amongst the aforementioned studies in recommending naloxone programmes, suggesting a belief at least that they are successful and efficacious interventions.

## **7 Could a naloxone programme be implemented in North East Lincolnshire?**

### **Do we have the right number of target groups, in the right quantities and the right areas?**

North East Lincolnshire not only has a high number and rate of opioid users and injectors but also high numbers in risk groups, such as alcohol users, polydrug users and men over the age of 34, as indicated by estimates of the prevalence of opioid use and statistics on those in treatment from Public Health England.

Do we have support from commissioned drug services in the local area?

Discussions have been held with one of the area's commissioned drug services who have expressed support for the concept of a naloxone programme.

### **It is logistically possible?**

Yes, with support from local drug services, target users could be identified, training given and naloxone dispensed. Take-home naloxone programmes are delivered elsewhere in the country and there are unlikely to be any major issues in relation to distribution and evaluation of the proposed THN service.

### **Is naloxone considered cost-effective?**

In their evaluation of Scotland's THN programme, Bird et al<sup>48</sup> calculate that Scotland's THN programme 'may have' prevented up to 65 (95% CI 19-65) opioid-related deaths upon prison release. This is from giving out approximately 12,000 kits at a total cost of £225,000, which works out at £18.75 per naloxone kit. They calculate if 10 life-years are gained through the use of naloxone, then this provides 6.1 QALYs (Quality Adjusted Life-Years)<sup>49</sup> at a cost of £560-£1940, with 3% discounting per annum.

Coffin and Sullivan<sup>50</sup> calculated the cost-effectiveness of a take home naloxone programme in Russia, finding that distributing naloxone is "robustly cost effective" despite using conservative estimates for their economic model.

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<sup>48</sup> Bird et al (2016) *Effectiveness of Scotland's National Naloxone Programme for reducing opioid-related deaths: a before (2006-2010) versus after (2011-2013) comparison*

<sup>49</sup> QALYs are a measure of quality of life, and are often used to determine the cost-effectiveness of an intervention. A QALY of 1 is equivalent to one year of full-quality life. In the above example, 10 years of life is equivalent to 6.1 QALYs, suggesting that the study population were living longer, but not full-quality life.

<sup>50</sup> Coffin and Sullivan (2013) *Cost-effectiveness of distributing naloxone to heroin users for lay overdose reversal*

Leece et al<sup>51</sup> calculated the cost-effectiveness of a take home naloxone programme in Toronto, Canada concluding that if the same results in Toronto were achieved in the UK, then “it [the THN programme] would meet the National Institute for Health and Clinical Excellence cost-effectiveness threshold ... per QALY”

Holdford<sup>52</sup> in a US based study, calculated the cost-effectiveness of an alternative take-home naloxone option, Evzio, the brand name of a naloxone device that automatically injects when placed against the thigh. Taking into account the probability of a range of variables, such as likelihood of survival and likelihood of emergency services attending, as well as the cost of Evzio, Holdford concludes that the cost per QALY “is within acceptable cost-effectiveness values for new therapies” – however this is referring to the US and not the UK.

### **Do substance users support the use of naloxone?**

Evidence from evaluations of both the Welsh and Scottish national naloxone programmes indicate that service users have an overwhelmingly positive attitude towards naloxone, with interviewees recognising that naloxone is a life-saving tool.

Concerns expressed about naloxone are more around the delivery of training rather than the use of the drug itself. However some interviewees did comment on the fact that whilst they would administer naloxone regardless, that someone overdosing would be extremely unhappy with having their “high” temporarily blocked by naloxone to the extent that some had asked *not* to be brought back if they overdose. This creates an ethical dilemma in that the law states naloxone can be used in a life-saving situation, but would be against the explicit wishes of the person it is being used on.

### **Are there sufficient drug-related deaths in which naloxone could have been used?**

Evidence from reports filed by Her Majesty’s Coroner for North East Lincolnshire and Grimsby suggest a small number of deaths in which the administration of naloxone could have saved a life, with a large number of decedents being discovered long after naloxone would have had any effect. However, evidence from the Scottish and Welsh naloxone programmes suggests that the kits are being used due to the number of kits reissued. There is anecdotal evidence from these two programmes that naloxone has been used successfully.

### **Conclusion**

In 2016, Professor Sir John Strang and Rebecca McDonald of King’s College London published a systematic review of research into take-home naloxone programmes to determine their effectiveness<sup>53</sup>. They stated that “take-home naloxone programmes are found to reduce overdose mortality among programme participants and in the community”, have a “low rate of adverse events” and conclude that “THN distribution to at-risk users should be introduced as standard ... [for] prevention of heroin overdose deaths”.

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<sup>51</sup> Leece et al (2013) *Development and implementation of opioid overdose prevention and response program in Toronto, Ontario*

<sup>52</sup> Holdford, D. (2015) *Cost effectiveness of prescribing Evzio (naloxone autoinjector) for lay heroin overdose reversal*

<sup>53</sup> McDonald, R. and Strang, J (2016) *Are take-home naloxone programmes effective? Systematic review utilising application of the Bradford Hill criteria*

Given the estimated number of opioid users in North East Lincolnshire and the number of those in risk groups (e.g. recently released prisoners, men over the age of 34) the basic conditions that would make a naloxone programme effective are in place. However, witness statements from the coroner's reports suggest that decedents are dying alone, rendering naloxone of little use in those deaths.

Whilst naloxone has support from commissioned drug services in the area, further exploration of the attitudes of North East Lincolnshire's substance users towards a naloxone programme is needed. A pilot amongst a particularly vulnerable group of substance misusers, e.g. recently released prisoners, misusers with a history of overdose or those recently starting methadone, would be the most effective way to determine the long-term viability of a naloxone programme in the local area.

## **8 A Naloxone Pilot**

The evidence regarding the viability of a naloxone programme within North East Lincolnshire is mixed. Whilst in the three year period from 2013-2016 there were 144 opioid poisoning hospital admissions (ORHAs) to Diana Princess of Wales Hospital, reports from Her Majesty's Coroner for Grimsby and North East Lincolnshire appear to indicate that there are few opioid-related deaths in which the administration of naloxone could have been a lifesaving factor.

A pilot programme would be best placed to determine whether a naloxone programme is suitable for North East Lincolnshire's cohort of opioid users.

### **Who to target**

Those who should be targeted by the pilot are those to be deemed most at risk of an opioid-related death. This includes recently released prisoners, substance misusers recently discharged from hospital, those with polydrug use, those recently starting methadone and men over the age of 35. For simplicity, it may be best to target a single group of service users, such as recently released prisoners with opioid substance issues.

A conservative estimate of the number of prisoners over a year could be as high as 50. To take into account those kits that are lost, misused, stolen or otherwise rendered unusable, purchasing 65 kits and providing training could cost between £1,500 and £2,000.

### **Potential costs**

Naloxone kits cost approximately £15-£25 inclusive of VAT<sup>54,55</sup>. In addition to this, there is the cost of training substance misusers to recognise the symptoms of an overdose, how to administer life support and how to administer the naloxone kit correctly.

### **How to administer**

Due to naloxone needing to be given to substance misusers, their families or carers via a drug service (e.g. Foundations or GPIP) the pilot would be best administered by the drug misuse service. This could be carried out in conjunction with the local authority.

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<sup>54</sup> Exchange Supplies (2017) *Prenoxad: naloxone injection kit*

<sup>55</sup> British National Formulary (BNF) (2017, March) *Naloxone Hydrochloride*

## Collection of results

Collection of results from participants could be carried out during their regular meeting with support workers, through interviews or questionnaires. It would be important to learn their feelings about using the naloxone kit, how often they carry it, and if they ever had or would use it.

## Assessment

The assessment of the programme would take place from a number of perspectives, such as assessing how cost-effective the programme is from a commissioning perspective, the effect it has had on substance misusers themselves from their point of view, and the effect on their families and carers. It may be the case that naloxone is *not* cost effective (in terms of it isn't being used) but could bring immeasurable benefit to families and carers by reassuring them that in the event of an overdose, they have a life-saving tool.

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## Glossary

<b>Drug</b>	In common usage the terms refers to psychoactive drugs, and often more specifically to illicit drugs, of which there is non-medical use in addition to any medical use
<b>Illicit drug</b>	A psychoactive substance, of which the production, sale or use is prohibited
<b>Poisoning (drug or alcohol)</b>	Defines a state of major disturbance of consciousness level, vital functions and behaviour following the administration of excessive doses (deliberately or accidentally) of one or more psychoactive substances
<b>Misuse (drug or alcohol)</b>	Indicates the use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medication
<b>Prescribed drugs</b>	Require a prescription from a GP or other suitably qualified healthcare professional. Prescribed drugs are limited in that they can only be collected from a pharmacy or dispensing GP practice under the supervision of a pharmacist.
<b>Proprietary drugs</b>	Commonly known as over-the-counter (OTC) drugs. These are sold without the need for a prescription but certain pharmacy-only medicines will only be sold under the supervision of a pharmacist.
<b>Controlled drugs</b>	Psychoactive substances and their precursors whose distribution is forbidden by law or limited to medical and pharmaceutical channels. Under the Misuse of Drugs Act 1971, the list of controlled drugs includes all class A, B and C drugs
<b>Dual Diagnosis (DD)</b>	Refers to the complex needs with coexisting mental health and substance misuse problems
<b>Polydrug use</b>	Considered to be the use of more than one type of drug being taken either at the same time (simultaneous use) or more than one type of drug being taken within the same period of time, for example in the last year (concurrent use). The corresponding measure of poly substance use includes the use of alcohol alongside drugs is classified in the same way
<b>Treatment Naïve</b>	Is a term used by Public Health England to describe those who enter treatment services for the very first time
<b>HLHF</b>	Northern Lincolnshire Healthy Lives Healthy Futures
<b>CCG</b>	North East Lincolnshire Clinical Commissioning Group
<b>New Psychoactive Substance (NPS)</b>	A new psychoactive substance is defined as 'a new narcotic or psychotropic drug, in pure form or in preparation, that is not controlled by the United Nations drug conventions, but which may pose a public health threat comparable to that posed by substances listed in these conventions'. More simply, NPS are drugs which were designed to replicate the effects of illegal substances like cannabis, cocaine and ecstasy whilst remaining legal – hence their previous name 'legal highs'.