WARWICKSHIRE SUBSTANCE MISUSE NEEDS ASSESSMENT

EXECUTIVE SUMMARY

1. INTRODUCTION AND BACKGROUND

1.1. General introduction to the problem of substance misuse

Addiction to drugs and alcohol is destroying lives and has negative impact on health and communities as a whole. A recent national review has shown that young people are being let down by a lack of effective prevention programmes (ref ambitious for recovery) while we know that every £1 invested in prevention can save £ £2.50 in NHS and social care and crime costs (annual report).

Alcohol consumption is related to a range of adverse health effects. Regular consumption of even low levels of alcohol increases the risk of cancer of the lip, oral cavity, pharynx, oesophagus and breast. At higher levels of regular consumption, there is increasing risk of liver and colorectal cancer. Alcohol contributes to the risk of epilepsy, hypertension, cardiac arrhythmias, non –ischaemic stroke, chest infections, cirrhosis of the liver and pancreatitis. Those who drink regularly are also at risk of becoming dependent on alcohol. This is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (NICE Guideline Review Panel, 2011). An analysis of 67 risk factors and risk factor clusters for death and disability found that globally in those aged 15 to 49 years old, alcohol is a leading risk factor followed by smoking and hypertension (Lim SS et al, 2012).

1.2. Purpose of the substance misuse needs assessment

This needs assessment contributes to the Joint Strategic Needs Assessment (JSNA) for Warwickshire (JSNA Commissioning Group , 2015) and is produced to inform commissioning for the retendering of the Substance misuse services in 2017. It gives the epidemiological picture of need for these services, latest evidence base of effective interventions and gives recommendations for future models of care.

In addition to an epidemiological approach it has elements of comparative analyses as we compared service use in Warwickshire with England & Wales, West Midlands and Worcestershire , our statistical comparator, as well as a corporate approach, involving a survey of wide range of stakeholders including practitioner, partners and providers. Taking all this information, which is detailed in the main Technical document into account, we give recommendations for commissioning services as well as ways of progressing partnership working.

The needs assessment was produced by a group consisting of County Council public health specialists and commissioners as well as partners who have important roles to play in the identification and treatment of those in need.

2. KEY FINDINGS

Needs assessment findings presented below aim to give the picture of need for services in Warwickshire by analysing data and interpreting information on:

- Description of the current and estimated future population size and characteristics
- Current epidemiology and estimates of substance misuse in the future for adults and young people
- Analysis of use of services including hospital admissions and local treatment services
- Findings of the Drugs and Alcohol Service review that was undertaken for the purpose of this needs assessment
- Analysis of impact of interventions and services to reduce substance misuse on communities, society and crime with some options regarding how partnership working can address it
- Evidence reviews conducted for the purpose of this needs assessment
- Summary of the findings of consultation with the main stakeholders

2.1. POPULATION OF WARWICKSHIRE AND RISK FACTORS FOR SUBSTANCE MISUSE

The 2015 mid-year population estimates show that Warwickshire is home to over 554,000 people. The population is projected to reach a total of 584,800 by 2026 (5.1% increase) with the greatest increase in the over seventy-fives.

Rugby Borough has the largest increase in population, with growth of 3.3% since the 2011 Census and 18.2% since the 2001 Census compared to the mid-2015 population estimate (103.400) and this trend is expected to continue with estimated 8% increase by 2026. Warwick District population growth follows with 10.9 % and 2.9% change (2015 estimate of 136 000), while the population in North Warwickshire has been increasing at a lower rate of 1.6% (% change from 2001) and 1.3% change from 2011 (2015 estimate of 62.800). Nuneaton and Bedworth Borough and Stratford-on-Avon District's rates of growth between 2011 and the mid-2015 population estimates have slowed to the lowest in the County (0.8%) with mid 2015 population estimate of 126.300 and 121.500 people respectively.

Ninety-two per cent of Warwickshire's population is white. Around the county, Warwick District and Rugby Borough have more diverse ethnic communities while North Warwickshire Borough and Stratford-upon-Avon District are less diverse.

Socioeconomic deprivation is an important factor to consider in public health alcohol policy development (Fone D et al, 2016). Studies have found that people in deprived neighbourhoods may be more likely to both abstain from alcohol than those in more affluent neighbourhoods (Kuipers et al., 2013, Galea et al., 2007, Chuang et al., 2007) and more commonly adopt heavier patterns of consumption, such as binge drinking, particularly young and middle aged men. (Matheson et al., 2011, Cerdá et al., 2010, Stimpson et al., 2007, Fauth et al., 2004, Mulia and Karriker-Jaffe, 2012). A higher risk of excess consumption, but less than binge drinking, seems to be associated with living in less deprived neighbourhoods. Nationally, young white people are more likely to have an alcoholic

drink than those from Black and Minority Ethnic group background (72% compared to 27%). Social deprivation is also associated with higher levels of drug misuse.

The Health Survey for England, 2014 (The Health and Social Care Information Centre , 2015) findings show that drinking habits increase with age, household income and are more present in the White ethnic group.

2.2. CURRENT EPIDEMIOLOGY AND ESTIMATES OF FUTURE SUBSTANCE ABUSE IN WARWICKSHIRE

2.2.1. Alcohol misuse in adult population

Two different models were used to estimate the prevalence of alcohol misuse in the County. Both models have their limitations but this is the only way we can estimate the levels of alcohol misuse. Applying the Rush prevalence rates (model originates from Canada and is very generic), suggests that Warwick District has the highest number of adults (29,555) drinking at above low risk levels, drinking at harmful levels (5,979) and those that are dependent on alcohol (4,061) across the County. These estimates are directly proportionate to the size of population, so North Warwickshire has the lowest estimated number of people drinking in the given categories.

The local alcohol profiles for England (LAPE) model estimates, based on self-reported drinking behaviour, suggest that Warwick District and Stratford-on-Avon District have the highest estimated proportions of increasing risk drinkers (Definitions in appendix) . This is higher than the regional and national estimates. Nuneaton and Bedworth Borough has the highest estimated level of abstainers of alcohol, the highest estimated level of lower risk drinkers and the lowest proportion of those binge drinking (20.4%). This contradicts the literature findings related to association of binge drinking and social deprivation, but as this model is based on self-reporting, this may be an underestimate. The rates are lower than the regional and national figures for abstainers. (put table in graphics)

Area	Adult Population (18+)	Adults drinking above low risk levels (24.2%)	Adults drinking at harmful levels (3.8%)	Alcohol dependence (5.9%)
North Warwickshire	50,555	12,234	1,921	2,983
Nuneaton & Bedworth	99,116	23,986	3,766	5,848
Rugby	80,356	19,446	3,054	4,741
Stratford-on-Avon	98,506	23,838	3,743	5,812
Warwick	112,807	27,299	4,287	6,656
Warwickshire	441,340	106,804	16,771	26,039
England	43,108,471	10,432,250	1,638,122	2,543,400

Source: (McManus S et al, 2009)

As we can see from the tables above, in 2015 there were over 26,000 adults in Warwickshire who were alcohol dependent, over 16,500 people drinking at harmful levels and over 106,000 people drinking above low risk levels. Males were affected roughly twice as much as females.

Applying The Adult Psychiatric Morbidity survey, we estimated that in Warwickshire there are about 107,000 adults drinking above low risk levels around, nearly 17,000 drinking at harmful levels and 26,000 who are alcohol dependent.

Armed forces personnel have a higher incidence of problematic alcohol use. Applying the estimates the number of ex-Service personnel in the Coventry, Solihull and Warwickshire area suggests there could be 9,000 people with moderate alcohol problems and 900 with more significant alcohol problems.

2.2.2. Alcohol misuse in young people in Warwickshire

A large national survey (HSCIC, NatCen Social Research and National Foundation for Educational Research, 2015) findings show that around two-fifths (38%) of English 11–15-year-olds have tried alcohol. This rate has been falling since 2002-3 and the decline is accelerating.
However, The What about YOUth survey 2014, which gives local as well as national data, is showing that compared to the national average, more young people in Warwickshire have had an alcoholic drink, are regular drinkers and significantly more have been drunk. In fact, the proportion who report being drunk in the last 4 weeks is the highest in the West Midlands.

2.2.3. Alcohol misuse related mortality

The most common cause of alcohol related death is alcoholic liver disease. In England, in the period 2013-15, there were 12,255 alcoholic liver disease deaths, aged under 75, which is 111 (0.9%) more than in 2010-12. This, albeit small, increase is due to an extra 91 female deaths and is reflected in slightly increased proportion of female alcoholic liver disease deaths (34.2%) across the country.

In Warwickshire, the rate of alcoholic liver disease deaths is lower than but not significantly different to the national rate of 8.7 per 100,000 population aged under 75. In contrast, the rate across the West Midlands is significantly higher at around 10.9 per 100,000. Mortality from liver disease is increasing in England. Both locally and nationally alcoholic liver disease accounts for approximately 63% of alcohol related deaths.

2.2.4. Drug misuse

Statistics on drug misuse England 2016 reported in 2015/16 that around 1 in 12 (8.4%) of adults aged 16-59 had taken an illicit drug in the previous year, equating to around 26,000 people in Warwickshire. This level of drug use was similar to 2014/15 (8.6%), but significantly lower than a decade ago (10.5% in the 2005/06). Drug misuse in young people increases significantly with age, from 6% of pupils aged 11 to 24% of 15 year olds, equating to around 1,500 of all 15 year olds in Warwickshire (HSCIC, Statistics on Drug Misuse, 2016).

National Treatment Agency reported prevalence rates for drug misuse have been reducing both nationally and locally in the period 2009-2012. The number of opiate and or crack users in

Warwickshire has reduced by 42% from an estimated 3,100 in 2009-2010 to an estimated 1,800 in 2011-2012. This is significantly lower than the national figure.

2.2.5. Drug misuse related mortality

Drug use and drug dependence are known causes of premature mortality, with drug poisoning accounting for 1 in 7 deaths among people in their 20s and 30s in 2015 (Office for National Statistics, Deaths related to drug poisoning, 2015)

At a national level, drug related deaths have been increasing, with a peak in 2015 of 39.7 deaths per million populations or 3,416 deaths, the highest absolute number and rate since records began in 1993. Of these, 2,300 (67%) were drug misuse deaths involving illegal drugs, an 8% increase since 2014.

The mortality rate for all drug related deaths in 2014 increased for both males and females to 91.0 and 39.6 deaths per million population respectively (Office for National Statistics, Deaths related to drug poisoning, 2015). In part, this was due to an ageing cohort of drug users and in part due to an increase in the availability of heroin following a global shortage. (Public Health England 2016-280, 2016). The proportion of these deaths that are suicides are higher in females (27%) than in males (15%).

In Warwickshire, local analysis by underlying cause, shows that there were 117 drug related deaths registered from 2010-14 of which 76 (65%) were males and 41 (35%) females. Age breakdowns suggest that over half of the deaths occurred in people aged in their 30's (28%) and 40's (26%). An analysis of crude death rates per 100,000 population reveals that the highest rate was in Warwick District (4.88 per 100,000 population) and the lowest rate was in North Warwickshire and Rugby Boroughs (both 3.52 per 100,000 population). Analysis at County level should be treated with a degree of caution bearing in mind that overall numbers, for the five year period, average at little more than 20 deaths per year across the County.

2.3. USE OF SERVICES

Compared to England, the population of Warwickshire is using drug and alcohol services at significantly lower rates for the age groups 25-64 and under 18. It is interesting to note that service use rate is not significantly different for age group 19-24 and over 65s. Service users are often treated for misuse of more than one substance. Alcohol misuse was the most commonly treated condition in Warwickshire, accounting for 6,067 people (54%) receiving treatment ,while in England, most of those receiving treatment, 798,000 (53%), were using opiates. Most people in treatment nationally and locally were treated for more than one substance (63% and 45% respectively). Similarly to England, crack (16%) and cannabis (16%) were the third and fourth most commonly misused substances among those receiving treatment. Cocaine (7%) and amphetamines (3%) were the only other substances of misuse accounting for more than 1% of all clients in treatment in Warwickshire.

In our analysis presented below, we compared Warwickshire with England, West Midlands and Worcestershire as this county is our statistical comparator having similar population size and mix of rural and urban areas.

2.3.1. Use of Alcohol treatment services:

The total number of people being treated for alcohol misuse in Warwickshire has increased in the period 2010-2015 from 1,219 in 2010/11 to 1,297 in 2014/15, equating to around 3 per 1000 population aged 18 and over while in the same period the rate for England remained stable at 3.5 per 1000. The greatest proportion of clients in treatment is in the 40-44 year old age group (17%) and clients aged 30-59 comprise 66% of total in treatment. Comparing the Rush model estimates of service use data would suggest that there is a small gap between the expected and observed numbers of clients in treatment, meaning that less people than expected are using services. Some of this is due to the assumptions of the model, however further outreach work may help to close this gap.

Younger Warwickshire residents aged 18-20 have been using services significantly less compared to England with continuous reductions over the given 5yr period. This is not in line with the findings above showing that young people drink more compared to national and regional levels and points again to need to do more preventative work with young people. However, consultation with users showed that there are issues that need to be addressed regarding transition from young people to adult services and this decline in service use in this age group may be the result of these difficulties.

2.3.2. Successful alcohol treatment completion

Alcohol users who successfully leave structured treatment and do not re-present within 6 months , have significant improvement in terms of increased longevity, reduced alcohol related illnesses and hospital admissions. Performance of the service in Warwickshire has been inconsistent from 2010 to 2014, whereas it has been improving in the West Midlands and England. In contrast, in Worcestershire, the rate of successful completion has declined year on year in the same period. This inconsistent performance points to the need to look into the effectiveness of current services in more detail so as to understand the pathways and identify areas of improvement to be able to inform the future service specification.

2.3.3. Alcohol related hospital admissions:

In this analysis we compared Warwickshire findings with the national and regional findings as well with Worcestershire which is our statistical comparison. Alcohol related hospital stays (**narrow measure**) were increasing nationally, regionally and locally over the 5 year period we analysed. Warwickshire has significantly lower rates for alcohol related hospital stays compared to England, West Midlands and Worcestershire. However, the rates of alcohol related admissions are increasing at a faster rate in Warwickshire than regionally or nationally.

The alcohol related hospital admission rate in Coventry and Rugby CCG is significantly higher compared to other local CCGs, England, West Midlands and Worcestershire.

Alcohol related harm hospital stays **(broad measure**) are increasing as well. Over a 7 year period, England has seen an increase of 29% (from 1,654 per 100,000 to 2,139 per 100,000). The rate across Warwickshire has increased by over 32 % whereas Worcestershire has seen an increase of only 10%. Within Warwickshire, trends show increasing age standardised rates for alcohol related hospital

admissions for all districts and boroughs from 2008/09 to 2014/15. There are variations across the county with the lowest rates in Stratford District and the highest in Nuneaton and Bedworth.

This increase in hospital admissions may be related to the lower than expected use of Alcohol treatment services, some issues regarding access to services and inconsistent performance of the treatmnt services, as discussed previously.

2.3.4. Drug treatment service use

The number of people in treatment for opiate misuse over the period 2010-2014 has been decreasing both nationally (by 9%) and locally (by 8%). In Warwickshire, most people in treatment are in the 30-34 yr old age group (25%), and 80% of people in treatment are between ages 25-44. At the age of 18, only 0.1% of the total in treatment is in this age group while by the age of 25-29, we had 16.1% of total service users from this group. This highlights the need for preventative work with young people. This mirrors the use of treatment services for crack misuse and overall; clients aged 20-44 comprise 83% of those being treated for crack misuse.

As with the treatment of alcohol misuse, there have been inconsistencies in service performance measured in the numbers successfully completing treatment. However, Warwickshire compares more favourably compared to the England average, West Midlands and Worcestershire in the in 2013 , whereas in 2014, 7.4% completed treatment, the same percentage as in England and better than West Midlands.

The age profile of those in treatment for cannabis in Warwickshire is slightly younger than those in treatment for opiate and crack misuse with prevalence rates being fairly similar for all client age groups in the range 20 to 44 years. Data for the New Psychoactive Substances (NPS) have been reported only since 2013/14 and small numbers make analysis difficult.

2.3.5. Drug related hospital admissions

In 2014/15 there were 14,279 hospital admissions with a primary diagnosis of poisoning by illicit drugs across England. This is 2% more than 2013/14 and 57% more than 2005/06. In Warwickshire, there were 135 such hospital admissions in 2014/15, four less than in 2013/14. (HSCIC, Statistics on Drug Misuse, 2016). Inconsistency of the data and relatively small numbers makes analysis of local trends difficult.

The admission rates per 100,000 are similar for both Warwickshire and England with the slight increase over the 10 yr perod.

2.3.6. Use of services for young people

Five hundred and twenty-four young people between 14 and 17 years old were receiving treatment in Warwickshire between 2012 and 2014. Mirroring national figures, cannabis was the most common substance of misuse (88%), followed by alcohol (36%). Fewer young people were being treated for misuse of more than one substance locally (24%) compared to nationally (42%). Analysis of trends is hampered by having only three years of data locally. Nationally, numbers of young people in treatment has decreased by 8%, whereas locally, there has been a 28% increase. This is

consistent with findings presented above pointing to the estimates that young people in Warwickshire drink more compared to the national and regional levels.

2.4. DESCRIPTION AND REVIEW OF TREATMENT SERVICES

2.4.1. Core services for adults

Current drug and alcohol services for adults were reviewed and found to meet the service specification, contractual arrangements and targets. Furthermore, the overarching philosophy around treatment is in line with national guidelines. However, the review and surveys of service users, providers and stakeholders identified some gaps and areas for improvement, relating mainly to the need for increased community based support and increased outreach provision.

There are currently no inpatient or residential detoxification facilities in the county. Brief audit of the current referral process for residential rehabilitation identified the need to improve processes and implementation of the evidence based referral criteria for this part of the service.

2.4.2. Core services for young people

are meeting service specification and 'Payment by Results' targets set in 2012. The review identified following areas of care that need to be addressed:

- further improvement in transition from young people service to adult service ,
- better working with mental health services and
- further development of the hidden harm programme

This would ensure clear pathways from young people services to adult services which would address complex needs these clients often have, including mental health needs.

2.4.3. Interface of core drugs and alcohol services with other services including community support for sustainable recovery:

Some of the findings regarding service user experience conducted as a part of wider consultation are listed below:

'I don't think mental health services work with drug and alcohol services. There seems to be a lot of talk/discussions around dual diagnosis and partnership working. But nothing ever really seems to happen or any actions implemented following discussions. I've never yet met anyone who has drug or alcohol problems that doesn't also have mental health issues. I think it's extremely important to have more joined up working.'

'Agencies don't work together.'

'It is known by Recovery Partnership that I have mental health issues, and my GP knows I suffer from depression/anxiety but I have never spoken to any mental health professional.'

'ESH and Recovery Partnership (RP) try to help but my sibling needs major mental health help and his RP counsellor has no mental health training or personal experience.'

Consultation with key stakeholders also identified need for community peer led support in the post-recovery period working in partnership with primary care, school and community nursing, social care and other key partners and organisation to provide integrated pathways and sustainable recovery.

2.4.3.1. Interface with mental health services:

Although service users were happy with mental health services when these were accessed, there was concern that patients with dual diagnoses were not adequately identified or supported. Taking this and the fact that, for drug and alcohol use, the proportions receiving treatment from both disciplines seems to be lower in Warwickshire than West Midlands or England, into consideration, we can conclude that there is a considerable amount of unmet need for services in Warwickshire.

2.4.3.2. Interface with primary care:

Evidence is showing that Identification and brief advice (IBA) programmes for alcohol misuse are very cost effective. IBA are part of the Making Every Contact count remit. The principles also form part of the NHS health checks. However, it is unclear how often and how well these interventions are being delivered in primary care and the wider health and social care environment.

2.4.3.3. Interface with Criminal Justice Service

Consultation with stakeholders identified the need to review Criminal Justice Service provision and explore co-commissioning opportunities with the Police and Crime commissioner. Although we have no prisons in Warwickshire, we have residents who are released into our community after having served a prison sentence.

Criminal Justice System (CJS) referrals are an important route into treatment both locally and nationally. In Warwickshire 10% of alcohol misuse clients and 19% of drug misuse clients were referred in this way. Alcohol Diversion Scheme and Alcohol Treatment Requirement are cost effective interventions aiming to combat substance misuse and the data available shows high success for completion rates and the number of clients appears to be increasing.

It is estimated that up to a quarter of prisoners misuse heroin and there are significantly more individuals leaving prisons with drug problems than alcohol problems. Proportionally more of those leaving prison engage with drug treatment compared to alcohol treatment services in Warwickshire (84.9% and 46% respectively). These numbers suggest that some sensitisation around drug treatment options is happening in prisons and that more work around alcohol education may be needed.

Drug Rehabilitation Requirement (DRR) referrals appear to be increasing in Warwickshire, while the Test on Arrest scheme recorded a small decrease in numbers in the last two years. We should await the evaluation results regarding the effectiveness of Test on Arrest scheme and inform commissioning accordingly. Further details are needed regarding local DRR referral successful completion rates over time.

2.4.3.4. Housing and employment

Some support is offered around securing housing and employment. Lack of funding, perceived difficulty in accessing social services and a lack of job opportunities were identified as important barriers by both service providers and service users.

2.4.3.5. Blood borne viruses and TB services

In terms of hidden harm prevention, the current service includes needle exchange, screening, vaccination and treatment support for blood borne viruses. Consultation with key stakeholders shows that these services were valued both by service users and hospital partners. There are no clear pathways for tuberculosis screening, and the population presenting to drug and alcohol services could reasonably be judged to be at increased risk.

2.4.3.6. Service for Families and Careers

Consultation with key partners concluded that Experience, Strength and Hope Works (ESH) provides a very good service for families and carers by providing mutual support for those addicted to or affected by alcohol, drugs and other dependencies.

2.5. IMPACT OF INTERVENTIONS AND SERVICES TO REDUCE SUBSTANCE MISUSE ON COMMUNITIES, SOCIETY AND CRIME AND WHAT CAN WE DO ABOUT IT

2.5.1. Impact on crime

Our analysis of the impact of drug and alcohol misuse on crime showed that over 10% of total crimes and 30% of violent crime recorded in Warwickshire in 2014/15 were alcohol related. Drugs were implicated in over 6% of total and 21% of violent crime. A significant number of Violence Against Person (VAP) & Sexual Offences recorded in Warwickshire in 2014-2015 can be attributed to alcohol use (30% of the total) and drug misuse (21% of the total).

Alcohol is major concern in North Warwickshire and Nuneaton and Bedworth while drugs are more of a problem in Stratford on Avon and Nuneaton and Bedworth. There is anecdotal evidence that anti-social behaviour (ASB) is frequently linked to the night-time economy and street drinking. The highest absolute number of ASB incidents, highest percentage of and highest rate per 1000 population is in Nuneaton and Bedworth. Partnership working with police and licensing authorities to limit alcohol misuse would clearly impact on crime reduction in these areas.

2.5.2. Licensing

Prevention of crime is key licensing objective and licensing authorities have a range of regulatory powers and voluntary schemes at their disposal to tackle this. Public health is now one of the responsible authorities invited to contribute to the licensing process. In Warwickshire, there are 2,878 licenced premises, which equates to one premise for every 153 adults. Across the County, there is an encouragement for licensees to become members of voluntary, self-regulated best-practice schemes, such as Best Bar One. The use of Cumulative Impact Policies and Designated Public Place Orders is, at present, restricted to Warwick District.

Although shops account for only 6.6 % establishments selling alcohol locally, national level data are showing change in drinking behaviour, with most alcohol now being bought in shops and drunk at home. So far, there have been no schemes established to address this behaviour.

We should work on improving access to and use intelligence from the" InKeeper "database to improve targeted preventative work, working closely with business and other partners. By analysing

this information we could target interventions like a voluntary ban on high strength drinks and introduce a late night levy in appropriate areas.

2.5.3. Investment in effective substance misuse services

There is a clear positive association between investment in effective drug treatment and related cost savings to health services, crime prevention services and society as a whole. It is estimated that the effective drug treatment benefits resulted in crime reduction cost savings to society of over £4000,000 per year since 2007/8 and over £1,000,000 in non-cashable benefits relating to quality and length of life. Cashable cost savings to the health economy were estimated at over £1,400,000 in 2012/13.

Using the value for money tool developed by Public Health England, it was estimated that the accrued benefit for every £1 spent in 2005-06 was £2.77. By 2012-13, this had risen to £5.22.

As analysis of data above is showing, alcohol and drug misuse are affected by and impact on a wide range of health, societal and social care factors. As a result, partnership working across a broad range of agencies at every stage of the process is likely to provide the most effective and cost efficient way to tackle the problems faced.

2.6. EVIDENCE REVIEWS AND WORKING TOWARDS NEW MODELS OF CARE

In addition to the information above, we looked at the evidence of effectiveness of inpatient detoxification and rehabilitation and evidence of effectiveness of interventions in preventative work with young people in particular. We also looked at evidence of effectiveness of interventions in identifying people at risk of substance misuse to be able to intervene early and have a higher chance of sustainable recovery.

Evidence reviews show that both the 'Alcohol-use disorders identification test' (AUDIT) and 'Alcohol identification and brief advice' (IBA) provide valuable tools for partnership working and highly effective in identifying those at risk from alcohol abuse.

Literature reviews conducted for this needs assessment have shown that the prevention of underage drinking should be addressed through strengthening school based interventions as well as interventions involving family. The effectiveness of inpatient detoxification and rehabilitation literature review findings were that residential rehabilitation and inpatient detoxification may be more suitable than community rehabilitation for some patients with chaotic lifestyles only and this should be supported by an post-treatment outreach intervention, if possible, for best results.

Drugs and alcohol service users are a higher risk population in respect of Blood Borne Viruses (Hepatitis B and C, HIV) and Tuberculosis. In terms of public health harm prevention, Drug and Alcohol services are places where screening, testing and access to treatment should be provided.

2.7. CONSULTATION WITH KEY STAKEHOLDERS

A consultation process took place to further inform this needs assessment with a wide range of stakeholders including providers, partners, service users and their families, as well as children and young people. Analysis of the data gathered through the consultation process resulted in five common overarching themes being identified:

- barriers to service users accessing mental health services and support;

- cycles of dependency through generations of the same family;
- need for flexible and responsive wraparound services available to meet individuals' needs across the County;
- need for more outreach services and support for young adults to access treatment and recovery services which are age appropriate.

3. RECOMMENDATIONS

3.1. Commissioning recommendations

3.1.1. Build on ESH service and explore the development of a peer-led recovery community model which promotes and supports sustained recovery through local volunteering and employment opportunities, social enterprise initiatives and life skills development so as to support community cohesion, personal resilience and social integration which benefits service users, their families and the wider community.

3.1.2. There is scope for increasing level and type of user involvement in all aspects of service by forming an independent service user forum which would influence and shape the drugs and alcohol services. Embedding co-production principles within the commissioning cycle, ensuring the service user is at the forefront of the commissioning process and over the course of the contract service users are actively involved in service design, delivery and review.

3.1.3. The model should focus on prevention and early intervention, early identification, harm reduction services and support in order to reduce or delay the need for longer term involvement and reliance on services. Evidence based preventative work with young people should be a priority.

3.1.4. The service model should be based on community based outreach treatment and recovery provision, working with mental health and primary care hubs and use of community facilities: GP practices, pharmacies, community buildings, acute and primary care settings.

There is a need for services in all areas of Warwickshire but the need seems to be highest in Warwick District.

3.1.5. PHE recommends, following national guidelines, that a reduction in drug related deaths may be affected through effective and holistic care addressing drug use and the wider determinants of health and wellbeing. (Public Health England 2016-280, 2016) Commissioning of services should encourage good clinical practice and effective partnership working and community support.

3.1.6. Inpatient detoxification and rehabilitation may be more suitable than community rehabilitation for some alcohol misuse patients who have chaotic lifestyles. Residential rehabilitation and psychosocial interventions are currently the most cost effective treatment for opiate misusers only. Therefore, commissioners need to have effective systems in place to continue improving cost effective utilisation of the residential rehabilitation component of the service as well as review and improve the inpatient detoxification provision. It is necessary to have a comprehensive care package after discharge as there is evidence that patients who are provided with an o post-treatment outreach intervention have improved compliance with aftercare and improved outcome.

3.1.7. We should work with ESH to enable them to measure cost effectiveness of Tier-4 services (residential rehabilitation and Inpatient detoxification) by tracking patient recovery in the community over set periods of time.

3.1.8. Core services should work with CAMHS and other mental health services to define and implement robust and effective pathways to support those children, young people and adults with dual diagnoses. In the management of cases of dual diagnosis in which clients require mental health services and drug and alcohol treatment services, improved clear care pathways with "open doors" policy need to be implemented.

3.1.9. The hidden harm programme should be further developed as part of the early intervention and preventative service offer. Strengthening and formalising partnership relationships with other key agencies and organisations would ensure holistic approach to supporting families to try and prevent potential intergenerational substance misuse.

3.1.10. Transition from young people's to adult services have to be addressed to ensure clear overlap into the adult service to support young adults with substance misuse problems.

3.1.11. The issues identified above can be secured by outcome based commissioning, delivering outcomes that positively impact on people's health and well-being, measured through ongoing engagement with service users & families and other stakeholders.

3.1.12. Provider performance monitoring reviews should include process and outcome measures.

3.1.13. It is recommended that referrals related to safeguarding are regularly audited to ensure that the Substance misuse services are fully embedded into the safeguardingagenda including prevention of domestic violence, adult and child abuse.

3.2. Recommendations relating to partnership working

3.2.1. Commissioners and partners need to explore the feasibility and affordability of more community based support, building communities for recovery and increased outreach provision. This can be done in partnership with Primary care, community nursing, social care and others by strengthening links with key partners and organisation in order to provide integrated pathways. This includes partnership multi agency working in securing education, training, employment and housing of those in recovery. It is recommended that the Drugs and Alcohol Management Group be reformed and work on developing a strategy to achieve this.

3.2.2. Criminal Justice Service Provision should be reviewed and opportunities for co-commissioning opportunities with the Police and Crime commissioner explored. Alcohol Diversion Scheme and Alcohol Treatment Requirement are cost effective interventions and it is recommended that we continue improving and increasing the number of people accessing services via these schemes, as the data available shows high success for completion rates and the number of clients appears to be increasing.

3.2.3. We should work on improving access to and use of intelligence from the "InnKeeper "database to improve targeted preventative work, working closely with business and other partners. By analysing this information we could target interventions like avoluntary ban on high strength drinks and introduce a late night levy in appropriate areas.

3.2.4. Partnership working with police and licensing authorities to limit alcohol misuse would clearly impact on crime reduction in all boroughs and districts in Warwickshire but especially in Warwick District, Nuneaton and Bedworth and North Warwickshire. Considering crime data, we should explore the establishment of the Cumulative Impact Zone in Nuneaton and Bedworth. Schemes like "Breathalyser on the Door" and minimum unit price have shown positive impact on crime reduction. It is recommended that the Warwickshire Licensing Technical group consider and facilitate the implementation of these and other initiatives aimed at reducing impact on crime and disorder.

3.2.5. Primary care: In collaboration with CCGs, commissioners should develop appropriate data sharing agreements with primary care to assess the use of AUDIT-C during health checks and other patient contact and review how often this translates to IBA or referral. Financial incentives and training were found to be effective strategies to increase delivery of AUDIT-C in primary care (Anderson P et al, 2016) and we should explore with partners ways of implementing this.

3.2.6 Secondary care: Implementation of the new CQUIN indicator aiming to prevent ill health by risky behaviours (alcohol and tobacco). The goal is to support people to change their behaviour to reduce the risk to their health from alcohol and tobacco. There are three actions to deliver this CQUIN: screen and record; deliver brief advice; and refer (where relevant). The inclusion criteria are unique adult patients who are admitted to an inpatient ward for at least one night (excluding admissions to maternity wards). The minimum proposed value of the CQUIN is 0.25% of providers' Actual Contract Value. It covers Community and Mental Health Trusts across both years (2017-18 and 2018-19), and Acute Trusts in 2018-19.

At its most simple this means:

1. Giving patients an AUDIT-C scratch card to complete or asking the AUDIT C three questions orally and scoring their answers.
2. Feeding back to the patient what their score indicates about their health risk.
3. Providing a patient information leaflet with information about harm, benefit and cutting down.
4. For patients who are identified as dependent drinkers, healthcare professionals will refer them to local specialist services.
5. Recording the outcomes.