

Reading drug and alcohol misuse needs assessment

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Suzie Watt

Public Health Programme Officer

Kim McCall

Drugs and Alcohol Contract Performance Analyst

Sally Anderson

Drugs and Alcohol Contract Manager

Dr Andrew Burnett

Interim Consultant in Public Health Medicine

CONTENTS

	Summary	1
1	Introduction	3
2	Context	3
	2.1 Population – age, ethnicity and socioeconomic deprivation	3
	2.2 Drugs & Alcohol	6
	2.3 Commonly-used illicit drugs	6
	2.4 Alcohol	8
3	The impact of drugs	10
	3.1 Hospital admissions	10
	3.2 Overdose	12
	3.3 Drug Misuse Deaths	12
	3.4 Injecting Drugs and Blood Borne Virus	14
	3.5 Other harms	14
4	The health impact of alcohol	15
	4.1 Hospital admission	15
	4.2 Mortality and alcohol	20
	4.3 Other harms	22
	4.4 Economics, accidents and injuries	23
5	The impact of drug and alcohol misuse on other aspects of community life	25
	5.1 Police and judicial systems	25
	5.2 Domestic violence and parental substance misuse	30
	5.3 Local authority housing	33
6	How big is the problem of drug and alcohol misuse in Reading?	34
	6.1 Drugs	34
	6.2 Alcohol	39
	6.3 Dual diagnosis – mental illness combined with drug or alcohol use	41

7	What works and what is available in Reading for people who misuse drugs and/or alcohol?	42
	7.1 Prevention and early interventions to reduce long term dependence on drugs and/or alcohol	42
	7.2 Drug and alcohol treatment services in Reading	46
	7.3 Needle Exchange	48
8	How are services currently being used in Reading?	49
	8.1 All in treatment population	50
	8.2 Opiate and crack users in treatment	52
	8.3 Users of other drugs in treatment	55
	8.4 Residential rehabilitation	55
	8.5 Alcohol users in treatment	56
	8.6 Drug treatment completion rates	57
	8.7 Alcohol completion treatment rate	60
	8.8 Complexity	61
	8.9 Young people and treatment	63
9	Discussion	65
10	Conclusion	68
11	Recommendations	69
12	References	

I

SUMMARY

The misuse of both drugs and alcohol is a problem in Reading, as elsewhere, and is growing for alcohol; locally, we are not doing all that we can to prevent misuse and the provision of interventions are not to be addressing the need of local Reading residents.

Alcohol misuse, mainly in the adult population, is a far greater problem than drug use in Reading, as elsewhere. Principally this is because of the sheer number of people who drink alcohol in our society (a very large majority) and the increasing proportion who do so in ways that risk injuring their health: based on current guidelines, we estimate that at least some 30,000 Reading residents are drinking to hazardous levels and 4,500 are drinking to harmful levels. As these figures are based on national self-reported drinking levels, and research shows that people significantly under-report their drinking, we can infer that people's true drinking levels are even higher than this. It is noteworthy that Reading has high rates of alcohol-specific mortality and mortality from chronic liver disease in both men and women. These rates indicate a significant population who have been drinking heavily and persistently over the past 10-30 years. Liver disease is one of the major causes of mortality and morbidity which increasing in England with deaths reaching record levels having risen by 20% in the last decade.

Whilst locally the numbers of drug-related admissions and drug-related deaths are proportionally smaller, what is clear is that drug misuse, particularly of opiates and crack cocaine, places an enormous strain on the families of drug users, including their children; can have a serious negative impact on the long-term health and well-being of family members; and that many drug misusers have a myriad of health and social problems which require interventions from a range of providers.

The most commonly used drugs, such as cannabis, opiates and crack cocaine, are illegal, uncontrolled novel psychoactive substances (also known as 'legal highs' and 'club drugs') are relatively easily available.

Drug and, especially, alcohol misuse is a significant cause of both violent crime and acquisitive crime. Whilst we know that acquisitive crime, mainly associated with drug use, is declining, violent crimes and assaults (including domestic abuse) are increasing and are a significant factor in personal and family problems, often placing children at especial risk.

Many young people receiving interventions for substance misuse have a range of vulnerabilities that require specialist support and intervention. Those in treatment often report being victims of domestic violence; having contracted a sexually transmitted infection; experiencing sexual exploitation; being more likely not to be in education, employment or training; and being increasingly likely to be in contact with the youth justice systems.

More needs to be done to encourage and enable front-line personnel in education, health and social care, and across other relevant sectors, to sustainably raise awareness of the risks of drug and alcohol misuse and how to avoid it.

Education, health and social care front-line personnel also need to be enabled and encouraged to do more to identify people at risk of misusing drugs and/or alcohol, to provide brief interventions, and to refer to appropriate services. It would be appropriate to extend this to other services too, which may come into contact with vulnerable adults and young people, such as housing and the police.

A review of current specialist service provision for drug and alcohol misuse against current resource allocation in Reading is required. It may be appropriate to change the way current services are delivered, with the current resources allocated, in order to meet the needs of an ageing, dependent, opiate using population and increase the access to specialist alcohol misuse services and youth services. Specifically, Reading needs a revised approach to its drug and alcohol services that:

- puts a much greater emphasis on the problems of alcohol misuse at all ages (that is, younger people and older ones), and for people with different problems causing them to use drugs and/or to misuse alcohol;
- puts a much greater emphasis on prevention, particularly targeting 0-18 year-olds, with specialist family support for children at risk, but also helping to address the issue that both young and older adults face;
- ensures that all health and social care services, and those of the police and judicial system, work together more effectively so that people do not fall into gaps between services and so that it is simple to provide care between different agencies without the service user having to try to negotiate their way from one to another;
- provides services of all types in different locations to improve engagement and thus outcomes;
- enables and encourages front-line staff in all sectors, to do much more to identify people at risk of misusing drugs and/or alcohol and to provide brief interventions, and refer to appropriate services; and
- enables different policies and services and the enforcement of regulations, to take account of the cumulative impact of drug and alcohol misuse to enable greater benefit to people's health and to the community more widely.

IMPORTANT NOTE

At the time of writing this report it was announced that the Department of Health was expected to publish new guidelines on alcohol consumption including that the recommended weekly upper limits for drinking were to be reduced and made the same for men and women. In addition, it was expected that the Department of Health would add that there was actually no real safe lower limit for alcohol consumption.

This report was completed before the publication of these revised guidelines and the calculations in it in relation to the number of people in Reading drinking alcohol at hazardous and at harmful levels are likely to be underestimates in the light of this expected revised guidance.

Reading drug and alcohol misuse needs assessment 2015/16

1 Introduction

The Reading Borough Council (RBC) drug and alcohol misuse needs assessment quantifies the extent of misuse of alcohol and drugs in Reading; the effect this is likely to have on people and thus on health and social care and other services, and on prevention and early interventions and, the nature of current services and treatment demand for substance misuse; and what might be done to better meet identified needs.

This needs assessment will enable the development of a Reading drug and alcohol strategy and action plan. We have sought contributions from key stakeholders and partners, particularly those who have direct involvement in drug and alcohol treatment services.

The most significant drug of addiction in England,ⁱ nicotine – most commonly inhaled in tobacco smoke – is not considered in this report; this is a sufficiently large topic to merit dealing with separately, and references here to the use of ‘substances’ should be read as being ‘the most likely after tobacco in terms of having a deleterious effect on health.

2 Context

2.1 Population – age, ethnicity and socioeconomic deprivation

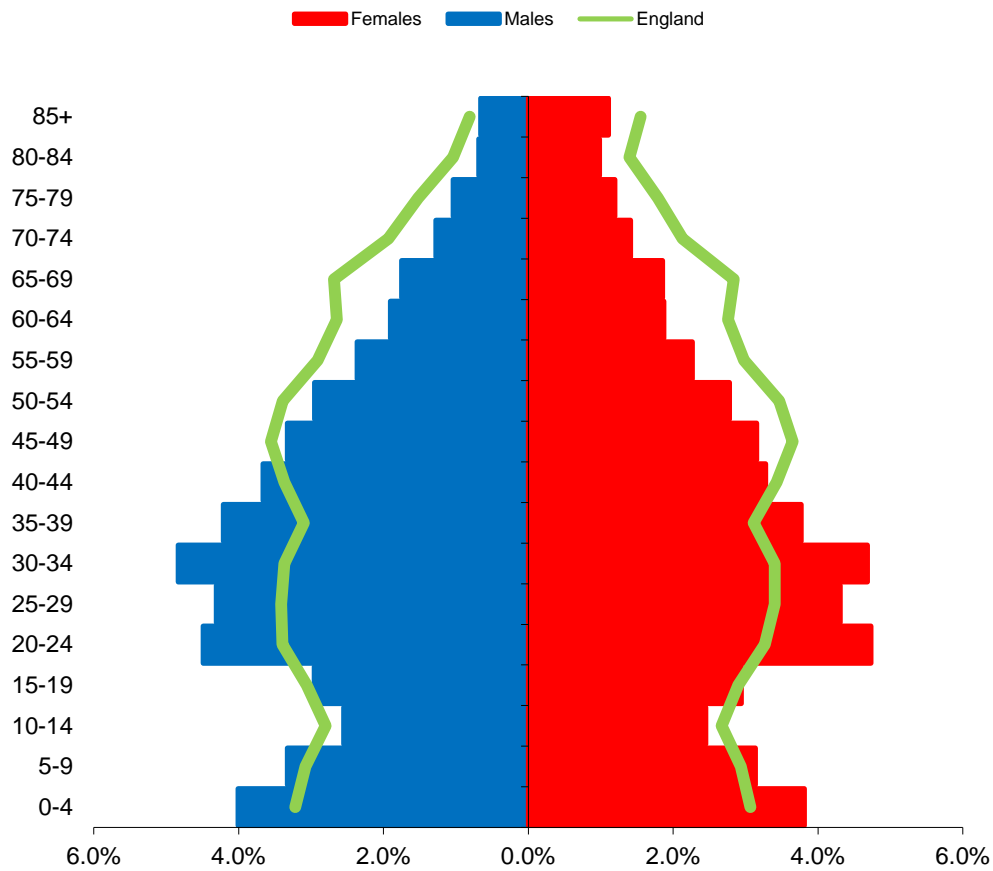
The structure of a population can have an impact on how we apply and model evidence about local drugs and alcohol misuse and more importantly, how we plan prevention, intervention and treatment services. There is good evidence that different populations have different relationships with drugs and alcohol, this includes age, sex and ethnicity. Socioeconomic deprivation is linked with health inequalities and with a higher incidence of substance misuse.¹

The Office for National Statistics (ONS) mid-year 2014 population estimates 124,171 people aged 18+ as living in Reading² and, as seen in Figure 1, Reading has a greater proportion of younger residents aged 18-27 years in comparison to the England average and other local authorities in Berkshire. The difference between the Berkshire local authorities could be partially explained by the number of students attending Reading University and Reading College and the number of large business that provide employment opportunities.

The majority of people from Black and ethnic minorities (BME) in Berkshire come from the Asian/Asian British community (Figure 2), making up approximately 12.6% of the population in Reading. In total, people from BME backgrounds make up approximately 20% of the total Berkshire population and 22.2% of the Reading population (Figure 3).

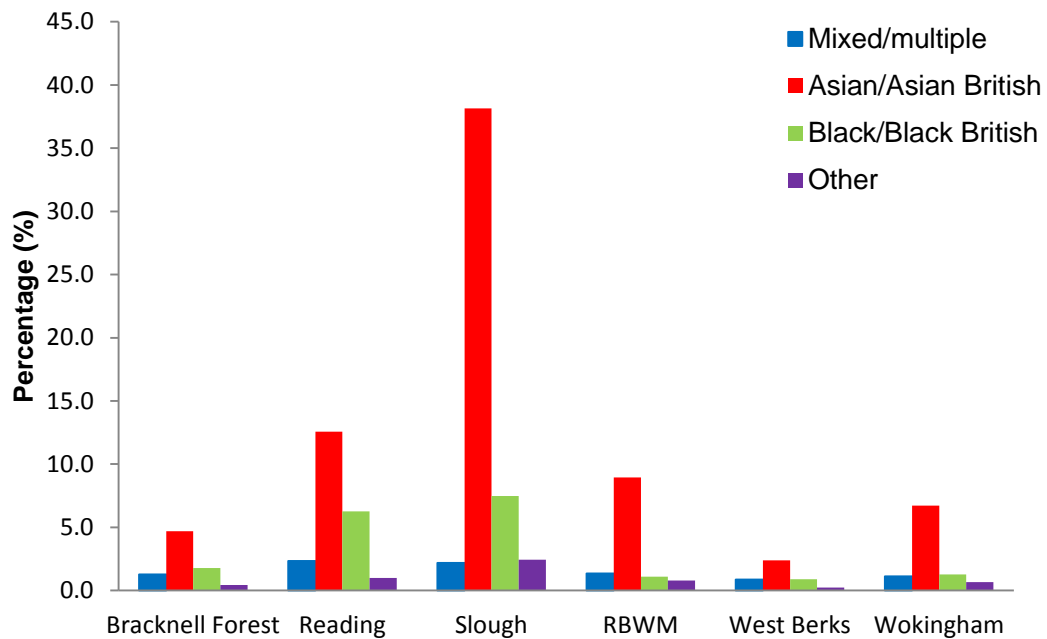
ⁱ Addiction, increasingly referred to as ‘dependence’, is characterised by various features, including a compulsion to take a substance; tolerance (a need to take increasingly larger amounts to get the same effect); and physical and psychological withdrawal symptoms when unable to do so. (World Health Organisation. *Management of substance abuse. Dependence Syndrome*. See http://www.who.int/substance_abuse/terminology/definition1/en/ (accessed 26 October 2015))

Figure 1. Reading population structure 2014 compare to England



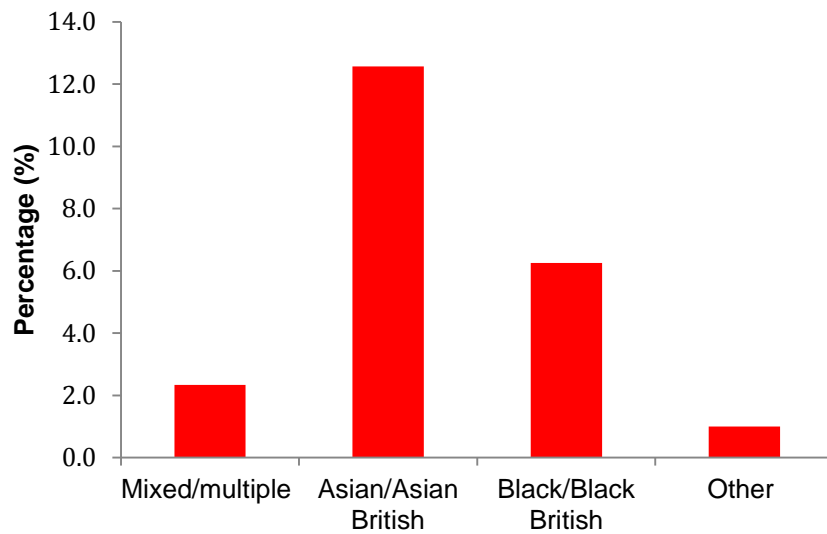
Source: ONS Mid-year population Estimates, 2014.

Figure 2. BME ethnicity in Berkshire as % of population, by Berkshire local authority, 2013



Source: ONS Mid-year population Estimates, 2013.

Figure 3. Proportion of people in the population from BME groups in Reading



Source: Cx

Social and economic inequalities in society are reflected in, and can help to determine, our health outcomes.³ In 2011, Lower Super Output Areas (LSOA)ⁱⁱ boundaries were revised, taking changes into account, Public Health England (PHE) have used a formulation, applying a score and ranking system. LSOAs are ranked using adjusted scores and are aggregated into ten groups, or 'deprivation deciles' based on their ranking. The most deprived tenth were allocated to decile one and the least deprived to decile ten.⁴ Depending on the year of the data source, Reading falls predominantly within the fifth decile.

Reading has over half of the LSOAs in Berkshire that fall within the 20% most deprived areas, a significant higher proportion than most other Berkshire local authorities (as shown in Table 1). Current evidence shows, for example, that a boy born to parents living in Minster ward, is expected to live 11 years longer than one born at the same time to parents in Whitley ward. Some sources of evidence usefully allow us to compare Reading outcomes against areas that are estimated to have similar levels of deprivation. Where comparators are available, we have used these throughout the report.

Table 1. Number of LSOAs by Berkshire Local Authority that fall in the 20% most deprived nationally:

Local Authority	Number
Reading	12
Slough	10
West Berkshire	1
Wokingham	0
Bracknell	0
Royal Borough of Windsor & Maidenhead	0

Source: Department for Communities and Local Government 2011

ⁱⁱ Lower super output areas (LSOAs) are subdivisions of electoral wards for data analysis purposes that are defined by aggregating individual household data collected at the decennial census into larger groups. The importance of analysing data at LSOA level is that electoral wards are not homogenous: most wards are patchworks of, for example, small areas of different levels of deprivation and different proportions of people from Black and minority ethnic groups. These differences affect local need and how services can be targeted effectively

Whilst health outcomes are determined by a number of different factors, understanding local inequalities is useful in us being able to determine what the local needs are in relation to drugs and alcohol misuse, particularly where vulnerabilities are socioeconomically factors. Identifying what the alcohol and drug misuse issues are in Reading is also reliant on data such as hospital admissions, treatment services and crime statistics, being recorded in such way that we can confidently draw conclusions from them. Where local data and intelligence is available and relevant, it is presented and discussed, and, where appropriate, we have extrapolated national and international evidence and applied this to our local population in order to estimate the impacts of drug and alcohol misuse in our community.

2.2 Drugs & Alcohol

Alcohol, within certain limits, is legal to purchase and use in this country, however the situation with drugs is different. Drugs can be obtained on prescription, some of them can be sold and bought legally, and some are illegal.

Unlike alcohol, it is also less clear whether the use of some drugs can be associated with reasonably safe relaxation and pleasure. Legal and illegal drug use is less obvious to the public. This may be that many people use certain drugs without significant harm being apparent (as is the case with moderate use of alcohol) and thus do not come to the attention of the health, social care or police or judicial systems.⁵

It is also noteworthy that there anecdotal reports from children and young people in Reading that it is far easier to obtain drugs than it is alcohol. This phenomenon is likely to be found elsewhere too with the increasingly effective enforcement of age restrictions on the selling of alcohol to minors. Whilst there are number of factors that influence a person's alcohol and drug use behaviour, we know that young people's attitude and behaviours are heavily influenced by people they live with.^{1,6}

What is clear is that drug misuse, particularly of opiates and crack cocaine, can place an enormous strain on the families of drug users, including their children; can have a serious negative impact on the long-term health and well-being of family members; and that many drug misusers have a myriad of health and social problems which require interventions from a range of providers.¹

The use of alcohol, to an extent, is largely socially acceptable, not only because of its legal status but also because drinking is a well-established part of our culture. We know that chronic heaving drinking, hazardous and harmful drinking (to a lesser degree) also pose threats to the health and wellbeing of the drinker, their family, and friends as well as to the community and has wide health and social care costs.⁷

2.3 Commonly-used illicit drugs

The illicit drug most likely to be used in the United Kingdom (UK) is cannabis, followed by cocaine, and then other stimulants such as amphetamine and similar drugs such as the extremely addictive crystal methamphetamine. Opioids (such as heroin), lead to the most significant health problems, are used less commonly,⁸ and, as will be seen later, are more commonly used by an ageing cohort who took up the habit in the 1980s and 1990s. Opioids are now much less commonly being taken up by younger people. Novel psychoactive substances (NPSs) are an emerging issue and are commonly advertised and sold as 'legal highs' and 'club drugs' and are often cheaper than illicit drugs.⁹ The impact of illicit drug use is discussed in further detail in section 3.0 of this report.

Cannabis is mainly consumed as marijuana (which essentially is the dried flowering tops of plant *Cannabis sativa*), as hashish (resin, commonly referred to as 'hash'), or as an oil extracted from the resin. Cannabis is commonly mixed with tobacco and smoked in a cigarette or 'joint', but can also be swallowed. It contains a psychoactive ingredient, delta-9-tetrahydrocannabinol (also known as THC) and levels of this vary in different strains of plant. Cannabis remains in the body for up to a month; when smoked it is rapidly absorbed by the bloodstream and reaches the brain within seconds. Health impacts are dependent on quantity consumed and frequency of consumption: cannabis impairs both short and long-term cognitive functioning, including being able to organise and integrate complex information, and impairs recall of previously-learned tasks for up to 24 hours after consumption.^{10,11}

Opiates is the generic term used to describe the group of drugs which are derived from the opium poppy (*Papaver somniferum*). Naturally-occurring drugs in this group include opium, morphine and codeine, whilst substances such as heroin are classified as semi-synthetic. Opioids, or 'opiate-like' substances such as methadone, pethidine and fentanyl, are wholly synthetic products. Opiates depress the central nervous system and are used therapeutically in many commonly-used and prescribed medications.^{10, iii}

Because of its ability to penetrate the blood-brain barrier, heroin produces a quicker 'high' in comparison to other opiates, making it the drug of choice for many opiate users. The euphoriant effects of heroin, often results in the reduction of anxiety, boredom, physical and emotional pain. Heroin can be snorted, smoked or inhaled (a method known as 'chasing the dragon' whereby it is heated on foil and the fumes inhaled). In addition to the features of dependence, its use, especially if injected intravenously, is associated with a number of harms.^{10,12}

Cocaine acts a stimulant to the central nervous system. Some naturally occurring plants which act in a similar way include khat and betel nuts (not currently under international control). Crack-cocaine and cocaine hydrochloride are products which are extracted from the leaf of the coca bush. Similar to opiates, there are therapeutic uses for cocaine, for example being used a local anesthetic and, synthetic stimulants, which are similar in chemical structure and effects, are used in treatment for narcolepsy and of children suffering from attention deficit disorder.^{10, 13}

Drugs which act as a central nervous system stimulant are often used to elevate mood, to overcome fatigue and to improve performance. The effects vary depending on the drug of choice. Effects from cocaine can last from a few minutes to less than an hour, whereas the effects of amphetamine-type stimulants (ATS) may last several hours. Cocaine hydrochloride is most commonly snorted, but can also be injected. Crack cocaine is usually smoked and ATS can be taken orally, injected, smoked or snorted.^{5, 10,13}

NPSs are drugs that affect brain function (hence the term 'psychoactive'). They are 'novel' because many are relatively new and/or variants of other drugs and chemicals which are not currently prohibited substances under the United Nations (UN) Single Convention on Narcotic Drugs or by the Misuse of Drugs Act 1971. They are predominately used for their intoxicating and stimulating properties. NPSs began to appear in the UK drug scene around 2008/09.^{9,14}

The fact that most NPSs are not currently prohibited does not mean that they are

iii Opiates are powerful pain killers, the best known being morphine. Heroin is manufactured from morphine and has been used with great benefit in medical practice, albeit much less commonly since Harold Shipman was convicted of multiple murders using excessive doses of this drug.

harmless. Heavily marketed as ‘legal highs’ (and tagged with various trade names), in most cases they only remain lawful because there has been no scientific testing and advice leading to a ban. They are usually sold with no indication of active ingredients or dosage, while others are sold as ‘research chemicals’ with chemical names, but both are often of unreliable quality and analysis shows that the contents can change substantially between batches.^{9,10}

NPSs fall into four main categories:⁹

- Synthetic cannabinoids – these mimic cannabis and bear no relation to the plant other than to act on the brain in a similar way. Current trade names include Clockwork Orange and Black Mamba.
- Stimulant-type drugs – these drugs are structured to mimic amphetamines, cocaine and ecstasy and include mephedrone, ethylphenidate, benzylpiperazine (BZP), methylenedioxypropylvalerone (MPDV), Naphyrone (NRG -1), Benzo Fury, 5,6-Methylenedioxy-2-aminoindane (MDAI).
- ‘Downer’/tranquiliser-type drugs – structured to mimic anti-anxiety or tranquiliser drugs, particularly from the benzodiazepines family, and include Etizolam, Pyrazolam and Flubromazepam.
- Hallucinogenic drugs – these drugs mimic substances like LSD and include 25i-NBOMe, Bromo-Dragonfly and the more ketamine-like methoxetamine.

In recent years, the UK has seen an increase in the number and range of new NPSs. Health care professionals have reported dealing with patients under the influence of substances that they have not heard of. In part, this is because chemists involved are dynamic, responding quickly to changes in the law, easily creating new substances to replace newly-banned ones repackaging substances as a different (and allegedly legal) product.^{9,10}

2.4 Alcohol

Alcohol is a psychoactive substance made from a chemical called ethanol, produced by putting either grains, fruits or vegetables through a fermentation process. The length of fermentation determines the drink’s alcohol content. Whilst our bodies, mainly the liver, can generally process one unit of alcohol per hour (although this is dependent on a number of factors), the fact is that ethanol is a poison which sometimes has lethal consequences.^{15,16}

Most people who drink alcohol reportedly do so in moderation, its use is widely associated with relaxation and pleasure, and is a well-established part of culture in the UK. It is the *misuse* of alcohol that leads to problems, with ‘binge drinking’ accounting for half of all alcohol consumed in the UK.¹⁷

Whilst excessive alcohol intake does not always lead to harm, alcohol consumption is the primary causal factors in more than 200 different diseases and injury conditions.¹⁵ It also increases the risk of social, physical and mental harm to the drinker and to others. For example, it is well known that driving under the influence of alcohol substantially increases the risk of having a serious accident, with fatal injuries occurring especially in relatively younger age groups.¹⁵ Excessive alcohol intake is also associated with antisocial behaviour, street violence, domestic violence and suicide; it also affects people’s ability to work and, when it becomes a significant problem, this can often lead to job loss.^{15,18} An estimated 7.5m people in England are unaware of the damage their drinking could be causing.¹⁹

A variety of factors have been identified at individual and societal levels, which

affects the levels and patterns of alcohol consumption. For example, culture, availability of alcohol, enforcement of alcohol policies, family history; psychological factors such as anxiety or depression; the addictive nature of alcohol itself, and the environment in which people live.²⁰

Whilst alcohol consumption in the UK has nearly doubled since the 1950s,²¹ official data available shows that in the UK, between 2005 and 2012 the proportion of adult men who self-reported drinking in the week preceding the surveys fell from 72% to 67% and the proportion of adult women fell from 57% to 53%.⁶ As 40-60% of alcoholic drinks sold in this country are unaccounted for based on self-reported consumption, it is reasonable to assume that these statistics are not a wholly reflective of alcohol consumption in the population, and it is likely to be significantly higher.²²

Statistics also show that between 2009 and 2012, household spending on alcoholic drinks increased by 1.3%, whilst alcohol brought outside the home decreased 9.8%, but more importantly, alcohol was 53.8% more affordable in 2014 than it was in 1980. This is based on a 'basket of alcohol' rather than cheapest, or that with the highest purity.²²

Over one third of adults are apparently drinking above weekly guidelines and more than three-quarters are drinking above daily limits on their heaviest drinking day each week, with women as likely as men to be binge drinking and more likely to exceed daily limits.²³ It is important to note that binge drinking is not limited to the media image of young people consuming excessive amounts of alcoholic drinks in public places but includes people of all ages often binge drinking in the privacy of their own homes. Adults living in household in the highest income quintile are twice as likely to drink heavily than adults in the lowest income quintiles – 22% compared to 10% and whilst older people tend to drink more frequently, younger people tend to drink more heavily on a single occasion.²⁴

The current recommended limits to alcohol drinking are that:

- men should not regularly drink more than 3-4 units^{iv} of alcohol each day;
- women should not regularly drink more than 2-3 units of alcohol each day; and
- anyone who has had a heavy drinking session should refrain from drinking alcohol for the next 48 hours.^{25, v}

iv In the UK, consumption of an alcohol drink is measure in units. Units are a simple way of expressing the quantity of pure alcohol in a drink by offering a standardised comparison of the volume of pure alcohol between alcohol beverages, that is 1 unit is equal to 8 grams of pure alcohol, which is equivalent to 10 millilitres of pure ethanol (alcohol).

v There are two important aspects to these recommended limits: (1) the recommended maximum intake for women is lower because the relative amount of fat and muscle is different in women's and men's bodies. This leads to alcohol being distributed in the body differently and metabolised at different rates, and (2) many alcoholic drinks are now stronger than when these recommended drinking limits were defined. For example, the average strength of wine is now 12.5% whilst alcohol units are based on wine of 9% strength, and a unit of beer was based on an alcoholic strength of 3.5%, whilst the strength of most modern lagers is 4%. In addition, wine is normally now sold in pubs and bars in 175ml or 250ml glasses whilst a unit of wine is based on a 125ml measure. Most alcoholic drinks are now labeled with definitions of their alcohol contents and show, for example, that whilst a 70cl bottle of wine used to contain six units of alcohol most now contain 9-10 units

It is also noteworthy that some authorities now recommend that people who drink on most days of the week should refrain from drinking on two days of every week.^{vi}

The *Smoking, Drinking and Drugs Use Amongst Young People in England* survey contains information on drinking in children aged 11 to 15 years in secondary schools. In 2013, there was a decrease in the national trend of pupils reporting drinking alcohol as well as the proportion of pupils who drank alcohol in the week preceding the survey. Pupils were more likely to drink if they lived with someone who did and/or if they felt their families would not mind them drinking, as long as it was to excess.²⁶ Despite this, alcohol misuse remains a problem in children and young people, with over 24,000 treated in the NHS for alcohol-related problems in 2008 and 2009 and, the secondary school survey would not account for our most vulnerable children who may not be in long term education or training.²⁷

3 The impact of drugs

Individuals who take illicit drugs face risk of being poisoned, overdosing and other potential health risks.¹ This section presents a range of national and local information about the impact of drugs, including hospital admissions and health and social care impacts.

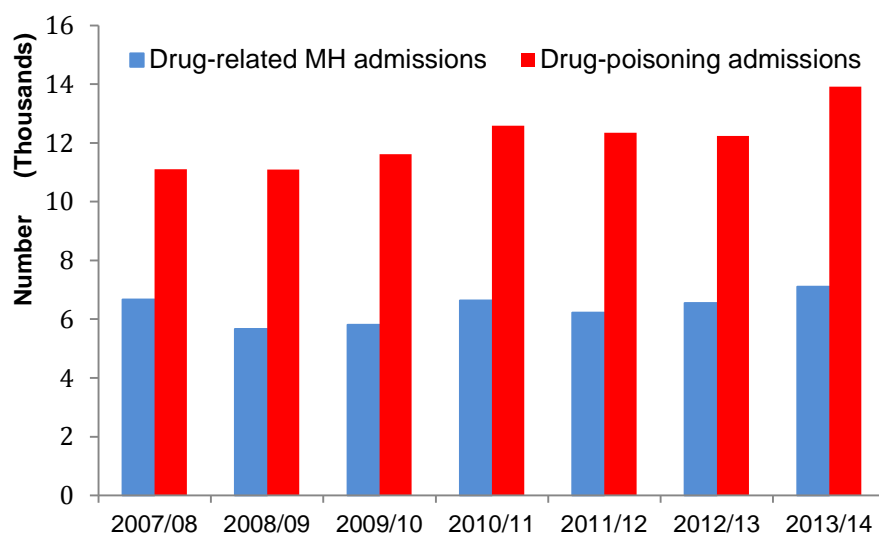
3.1 Hospital admissions

Nationally there has been a marginal increase since 2011/12 in the number of people being admitted to hospital because of an illicit drug-related mental health and behavioural disorder, with the greatest increase being in people aged 16 to 24 years. Despite this, the overall numbers have still not returned to the higher levels seen in the early 2000s. The same cannot be said for the number of NHS hospital admission in England with a primary diagnosis of poisoning by illicit drugs; this has been on the increase since 2003/04 (see Figure 4). This is true of all age groups, with the exception of those under the aged of 16 where nationally there has been a marginal decrease. The largest increase in admissions was seen in those aged between 45 and 54 years.^{28,29}

The numbers for such admissions for 2013/14 were relatively small for Reading, there being fewer than five admissions recorded for drug-related mental health or behavioural disorders and 32 for poisoning by illicit drugs. Both have declined since 2010/11, down from 21 and 45 respectively. We unable to confidently compare figures to previous years as 2013/14 was the first year admissions were reported by local authorities, prior to which admissions were reported by primary care trusts (PCTs).²⁸

vi Some academics consider that there is no safe lower limit for alcohol consumption and that there is no 'moderate' intake of alcohol that actually improves health. See http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/ft_intimate.pdf (accessed 1 November 2015). Certainly, there have been no good-quality randomised controlled trials comparing the long-term effects of alcohol against a placebo. And observational studies that were thought to show a so-called J-shaped mortality curve (implying that people who totally abstained from alcohol had higher death rates than those imbibing 'moderate' amounts, whilst those consuming much larger quantities had much higher death rates) are now thought to have suffered from confounding with a high proportion of subjects refraining from taking alcohol because they were already in poor health and thus at a higher risk of dying

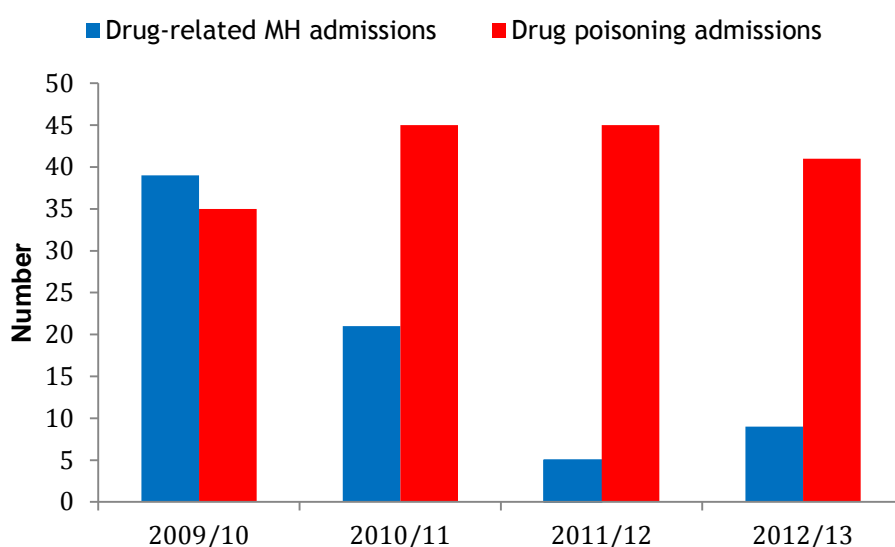
Figure 4. The number of NHS hospital admissions in England by primary diagnosis of drug-related mental health or behavioural disorder, or primary diagnosis of poisoning by illicit drugs, 2007/08 – 2013/14.



Source: Hospital Episode Statistics (HES). The Health and Social Care Information Centre 2014.

Figure 5 below shows the number of NHS hospital admissions for Berkshire West PCT^{vii} for both drug related mental health conditions and drug poisonings, 2009/10 to 2012/13. It is difficult to confidently draw conclusions on what the true numbers are for Reading, but what we can say is that drug-related mental health admissions showed a decreasing trend until 2012/13, whilst drug poisoning admissions remain fairly consistent.²⁵

Figure 5. The number of NHS hospital admissions in Berkshire West PCT where there was a primary diagnosis of drug-related mental health (or behavioural disorder) and of poisoning by illicit drugs 2009/10 to 2012/13



Source: Hospital Episode Statistics (HES). The Health and Social Care Information Centre 2014.

vii Under the historical structure of PCTs, the patient population for Berkshire West PCT was made up of residents from Reading, West Berkshire and Wokingham.

3.2 Overdose

A drug 'overdose' is the usually inadvertent consumption of an excessive and amount of a substance leading to harm. The main causes of overdose include:³⁰

- low tolerance/using too much – users' bodies develop tolerance to repeated presence of drugs. Tolerance is reduced if there is a break or reduction in drug use for a period. Higher doses are often needed to achieve the same effect, increasing the risk of overdose;
- mixing drugs (including alcohol) – combining drugs often results in unintentional physical effects, especially when depressants are used as they slow down a user's breathing and heart rate. The top four drugs involved in overdoses are depressants such as heroin, diazepam, alcohol and methadone; and
- variable purity levels – illicit drugs vary in strength and unknown purity levels have implications for users when deciding how much to take.

Additional substances may be added to bulk, dilute, complement and enhance the effects of drugs, however stories of illicit drugs being frequently cut with household cleaning products are often inaccurate. Poisonings commonly occur through the use of adulterants^{viii} such as lead, quinine and clenbuterol, to name but a few. Toxicity is also a risk when adulterants such as paracetamol and procaine are used.³¹

The rate of drug misuse death is relatively high in Reading, but the numbers are low (see section 3.3).³² Drug misuse deaths in Reading are mostly associated with overdoses from heroin. In terms of harm, long-term follow-up of heroin addicts show they have a mortality risk nearly 12 times greater than the general population.³³

It is difficult to report the true number of drug-related overdoses, however local usage of naloxone is one source of information we can consider. Naloxone provision is a safe, efficacious drug administered to reverse the effects of opioid overdoses and it is used both nationally and in Reading as an intervention to reduce the risk of a drug-related death.³⁴ Of course, it has to be given in sufficient time following an overdose.

Between April 2014 and June 2015 naloxone was administered by South Centre Ambulance Service (SCAS) paramedics 149 times in Berkshire clinical commissioning group (CCG) areas. Of these, the drug was administered 48 times to residents in South Reading CCG and five times to residents in North and West Reading CCG.³⁵ This represents over a third of all naloxone used by SCAS in Berkshire, suggesting a higher need for use in Reading in comparison to other areas in Berkshire. It was mostly administered to those aged 26-34 (16 individuals) and 35-49 (13 individuals) and to men (37). This correlates to the higher prevalence of drug use, drug-related deaths and injecting-use in Reading in comparison the other Berkshire local authorities.

3.3 Drug Misuse Deaths^{ix}

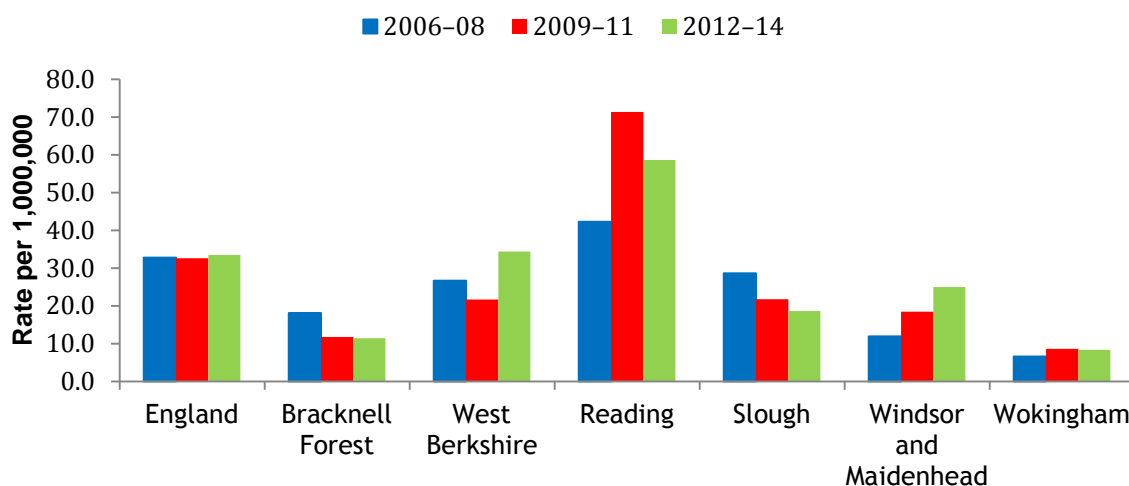
In 2012-2014, Reading had a drug-misuse death (also referred to as drug-related death (DRD)) rate of 58.7 per 1,000,000 population, much higher than the England

viii Adulterants refer to pharmacologically active ingredients added to give either a synergistic or antagonistic effects.

ix Drug Misuse deaths are defined by ONS as deaths where a) *the underlying cause is drug abuse or drug dependence* or b) *where the underlying cause is drug poisoning AND where any of the substances controlled under the Misuse of Drugs Act 1971 are involved*. This definition has been adopted across the UK.

average of 33.5 per 1,000,000, and the highest rate in Berkshire (see Figure 6). Although the rate is high, the number of deaths that occurred is relatively small. Local information suggests that deaths correspond to patterns seen nationally.^{36,37}

Figure 6. DRD rate per million by Berkshire local authority, 2006-2014



Source: Office for National Statistics 2014

In 2014/15, ten people in Reading died as a direct result of their drug use (two are still awaiting inquest, however a verdict^x of DRD is anticipated in both). Heroin was implicated in eight of the deaths (alone or in combination), one involved amphetamines and MDMA, and there is one case where information about the substances involved is unavailable.

So far in 2015/16, nine people in Reading have apparently died of drug-related causes. A verdict of DRD has been recorded in four of the Reading cases, and five are awaiting inquest. Two out of the four cases deaths where verdicts have been made involved heroin, the other two involved a combination of (primarily) prescribed drugs and, in one of the cases, alcohol.

Of the 19 deaths recorded in Reading (in 2014/15 and in 2015/16 to date) seven of those who died were in their 40s, six in their 30s, three in their 20s, two in their 50s and one in their 60s. Eighteen were male and one female. Five of those who died were engaged with local treatment services and one was in residential rehabilitation; the others were not known to the drug and alcohol services. It seems that in most years, only about half of those suffering a drug-related death are known to the local drug and alcohol services.

There is an apparently greater risk of death from overdose in Reading compared to other areas in Berkshire, and in comparison to the England average, but care must be taken in interpreting these statistics as the numbers are very small. The risk is apparently greater for heroin users, which is unsurprising given the evidence of risks associated with heroin use, particularly when injecting. The risk of drug-related deaths is greater in men who are in their late 30s and 40s living alone and this is also seen locally.^{36, 37}

^x Verdicts are determined by the local Coroner and it is important to note that whilst drug use may be factor in a person's death, a DRD verdict may not necessarily be returned in all cases.

3.4 Injecting Drugs and Blood Borne Virus

Whilst non-injecting and injecting drug users face similar harms from the drugs themselves, injecting drug users are also vulnerable to contracting and to spreading blood-borne viruses such as hepatitis B, hepatitis C and Human Immunodeficiency Virus (HIV). They are also at an increased risk of endocarditis (inflammation/infection of the heart); liver disease; kidney disease; thrombosis, abscesses; pneumonia; and death.^{38, 39} A study of injecting drug users also showed that they were 22 times more likely to die prematurely than their non-injecting peers.⁴⁰

Injecting drug users also have a:

- 10-fold greater risk of community-acquired pneumonia;
- increased risk of general infection due to poor nutrition;
- increased risk of contracting tuberculosis; and
- increased risk of experience psychiatric and other psychological problems, that is major depression, anxiety and withdrawal syndromes.²⁷

RBC commissions a needle and syringe exchange service in order to reduce the blood-borne virus risks associated with injecting drug use. Whilst there is good evidence of this as a harm-reduction strategy, we are unable to determine the true impact of this service on the health outcomes of injecting drug users, but based on national evidence, where it is utilised, it is likely to be positive.

3.5 Other harms

Drug users tend to have worse physical and mental health than the general population, and as well as symptoms of physical dependence and withdrawal; there are often factors involved which lead to other adverse outcomes such as offending or risky sexual behaviour.⁴¹

Long-term effects of cocaine use include internal damage to the nasal passages if it is inhaled (because of its strong blood vessel constrictor action), upper respiratory tract infections, heart attack, stroke and sudden death.⁴² Injecting cocaine and crack cocaine^{xi} is associated with the highest health risks.⁴³

Drug users who also inhale (for example, cannabis, cocaine, ATS) have a high frequency of upper respiratory tract infections.¹⁰ Probably the greatest health risk associated with cannabis use is from the tobacco which it is commonly mixed with, and whilst this needs assessment is not focused on tobacco, it is important to note indisputable evidence of the burden tobacco in terms of lives prematurely lost, reduced quality of life (principally through smoking-related illness) and the high health and social care costs.⁴⁴

There is growing evidence that regular use of cannabis, particularly from adolescence, doubles the risk of developing an acute psychotic episode or developing chronic schizophrenia in the longer term.⁴⁵ As well as impairing new learning, cannabis use impairs motor co-ordination and increases the risk of motor vehicle accidents; and its use in pregnancy can impair fetal development and lead to low birth-weight.⁴⁶

People using NPSs are exposed to a number of similar risks to those using illicit

^{xi} Crack cocaine is a form of the drug that can be smoked rather than snorted as a powder. It is considered to be much more addictive.

drugs, but the variable potency and variation in effect mean that it is difficult to determine or compare the level of risk. A 2013 survey carried out by *The Scottish Drug Forum* summarized the short and long term harms of NPSs as:⁴⁷

- overdose and temporary psychotic states and unpredictable behaviours;
- attendance at A&E, some resulting some hospital admission;
- sudden increase in body temperature, heart rate, coma and risk to internal organs;
- hallucination and vomiting;
- confusion leading to aggression and violence;
- intense 'comedown' that cause users to feel suicidal;
- increase mental health issues e.g. psychosis, paranoia, anxiety, depression; and
- physical and psychological dependency.

'Chemsex' is also an emerging issue. Surveys indicate that a higher than average proportion of men who have sex with men (MSM)^{xii} drink alcohol and use drugs to enhance the effect⁴⁸ making them an especially high-risk population. To a lesser extent the risk also applies to the wider community including the lesbian, gay, bisexual and transgender (LGBT) population.⁴⁹

Illicit drugs such as crystal methamphetamine, GHB/GBL and mephedrone are commonly used for chemsex, and there is evidence that these drugs are sometime injected (also known as 'slamming'). National data from the National Drug Treatment Monitoring System (NDTMS) shows that self-reported gay or bisexual men who started drug treatment in 2013/14 accounted for three percent of all men starting treatment in that year. In comparison to heterosexual men, this group presented with problematic amphetamine use (32% compared to 7%), and GBL use (16% compared to 0.1%), whereas problematic heroin and crack cocaine use is more prevalent amongst heterosexual men. Gay or bisexual men in treatment for non-opiate drugs were more likely to inject (16% compared to heterosexual (3%), however injecting rates for opiates were practically the same.⁴⁵ Further assessment of the of the Reading MSM population and associated patterns of drug use is required in order to understand the local impact of this emerging issues.

4 The health impact of alcohol

The national situation with alcohol has shown a similar trend except that the problem is much bigger, in that the numbers are greater. Alcohol misuse is estimated to cost the NHS about £3.5bn per year and society a whole £21bn annually (see section 4.4 for more information on economic cost). This does not include any estimate for the economic costs of alcohol misuse to families and the community.^{17, 50}

4.1 Hospital admission

Hospital admission episodes are coded as being 'alcohol-related' that is, partially attributable to alcohol or alcohol-specific, where they are wholly attributable to alcohol.⁶

xii MSM: 'men who have sexual contact with other men' is the term use most often to describe a population by sexual behaviour rather than sexual identity. Public Health England acknowledges that 'it is not a term appropriate to use more broadly when discussing issues of diversity relating to male gay community or to the lesbian, bisexual and trans communities. PHE feel it helpful in the context of discussing specific topics such as chemsex.

There are two different measures for alcohol-related hospital admissions:

- *broad* – which is an indication of the totality of alcohol-related health harm (primary or secondary diagnosis); and
- *narrow* – which is an indication of admission where alcohol was the primary reason for admission, or was identified as an external cause.

The broad measure is a comprehensive indicator of the total burden that alcohol has on health services because it includes all alcohol-related harms. The narrow measure more precise focus makes it easier to see changes over time.⁶

As shown in Figure 7, there seems to be little difference between alcohol-specific hospital admissions for Reading in comparison to England, but there are more admissions in comparison to the South East England average. The total burden on health services is greater in Reading than the average burden to others in the South East England region. More analysis would be required in order to understand what makes Reading different to others in the South East England, which might include, for example, there being higher levels of deprivation, a generally younger population and the proximity to London.⁵¹

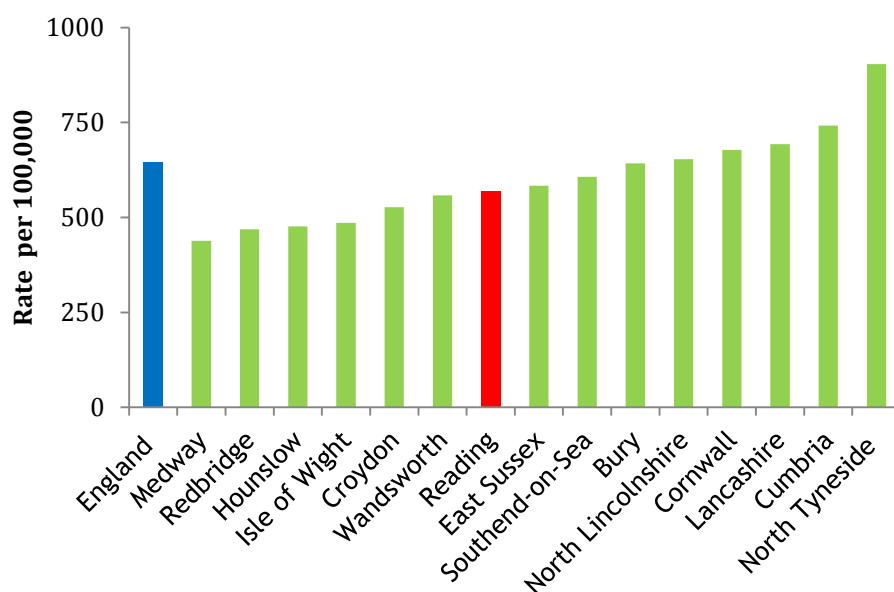
Figure 7. Reading Alcohol-specific hospital admissions (Persons) (Broad) 2008/9 to 2013/14



Source: Public Health England, [Local Alcohol Profile England 2015](#)

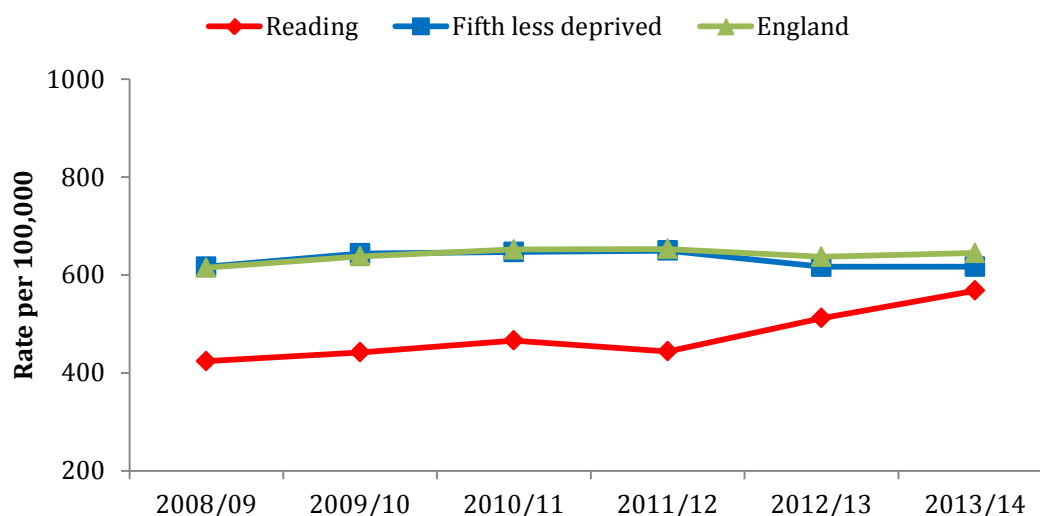
As shown in Figure 8 and Figure 9, hospital admissions for alcohol-related conditions puts Reading as seventh out of the 15 comparator sites (all in the fifth less-deprivation decile) and lower than the England average. Whilst this suggests a comparatively modest rate of alcohol-related admissions, it is worth noting that since 2011/12 there has been a greater increase in comparison to previous years and has significantly narrowed the gap making Reading similar to the England and the average of those in the fifth less deprivation decile.^{51, 52}

Figure 8: Admission episodes for alcohol-related conditions, for Reading, England and comparator local authorities (all in fifth less deprivation decile),^{xiii} 2013/14



Source: Public Health Outcomes Framework, 2015

Figure 9: Admission episodes for alcohol-related conditions (narrow), for Reading, England and all in fifth less deprivation decile, 2008/09 – 2013/14



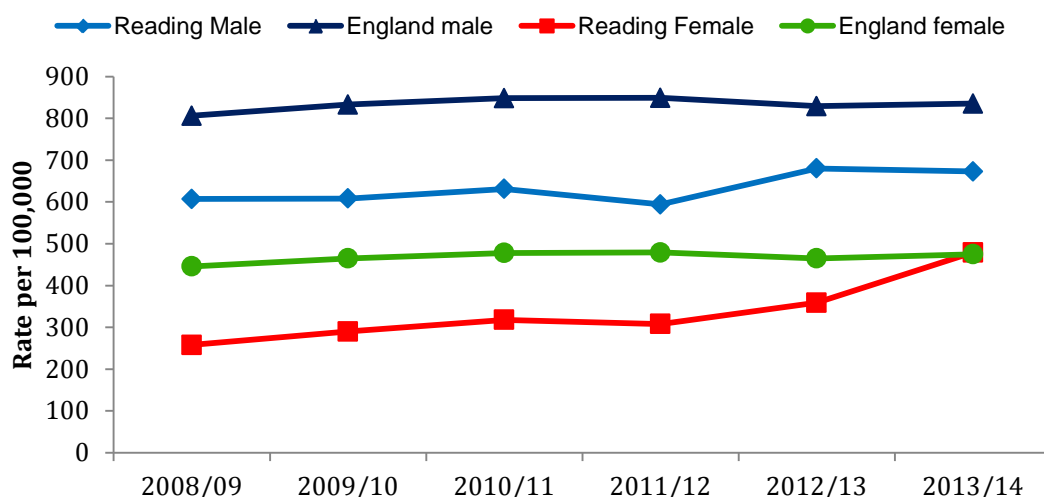
Source: Public Health Outcomes Framework, 2015

^{xiii} As referred to in section 2.1, local authority areas can be compared by looking at levels of deprivation in 'lower layer output areas' (LSOAs), which are subdivisions of electoral wards based on decennial census data. LSOAs are ranked using adjusted scores and aggregated into ten groups (deprivation deciles). The most deprived tenth are allocated to decile one and the least deprived to decile ten. ^{xiii} Depending on the year of the data source, Reading falls predominantly within the fifth decile. Comparator local authorities used in this needs assessment, unless otherwise stated, are those in the same decile as the borough of Reading in the relevant year

The total number of admission per 100,000 were greatest in 2013/14 in all persons and in males aged 65 to 74 years, however for females it was greatest in those aged 55 to 64. There could be number of reasons for this, for example, females being more likely to access health services. In England there has been a steady decline in admissions for all persons aged under 16, whilst all other ages groups show an increasing trend since 2003/04. Females aged under 16 are still more likely to be admitted than males.⁵²

Whilst males in Reading had a far greater number of admission episodes for alcohol-related conditions than females, 673 versus 479 respectively, (see Figure 10), and are lower than the England average, the number of Reading female admission episodes showed a sharp increase between 2011/12 and 2013/14, narrowing that gap with Reading males. This does not necessarily mean that more local women started drinking alcohol at harmful levels during this year, rather, it could be similar number to previous years, but the number of women diagnosed and/or being admitted to hospital with alcohol-related conditions during this year increased.⁵²

Figure 10. Admissions episodes for alcohol-related conditions (narrow), Reading and England, 2008/09 – 2013/14

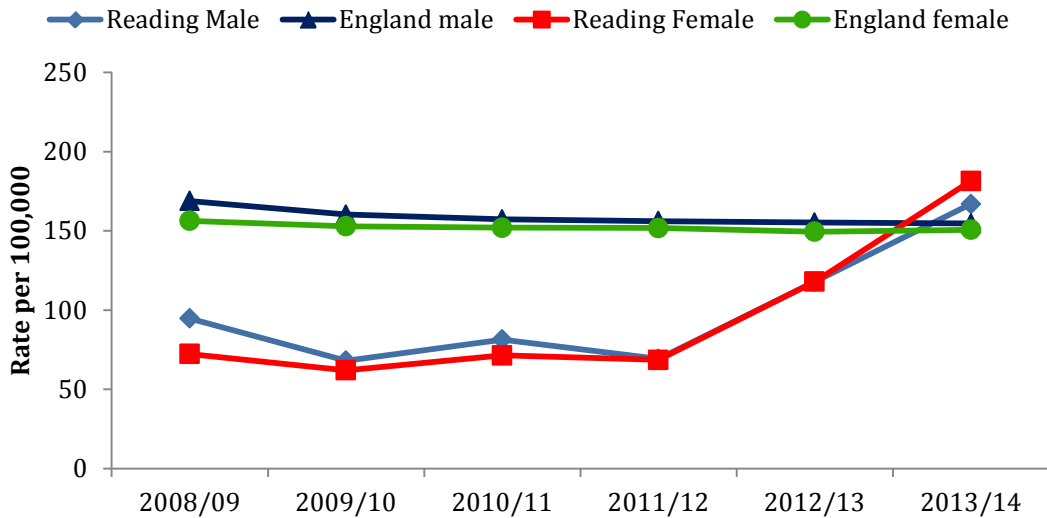


Source: Public Health Outcomes Framework, 2015

Further analysis of the data for alcohol-related conditions (as shown in Figures 11 - 13), reveals that hospital admissions for alcohol-related cancers in Reading residents increased substantially from 2011/12. By 2013/14, females in Reading were more likely to be admitted for this than Reading males. This would go some way to explaining the increase in the overall alcohol-related admissions figures in Reading as shown in Figure 10. At this stage, we cannot be sure what this increase might be attributed to.⁵²

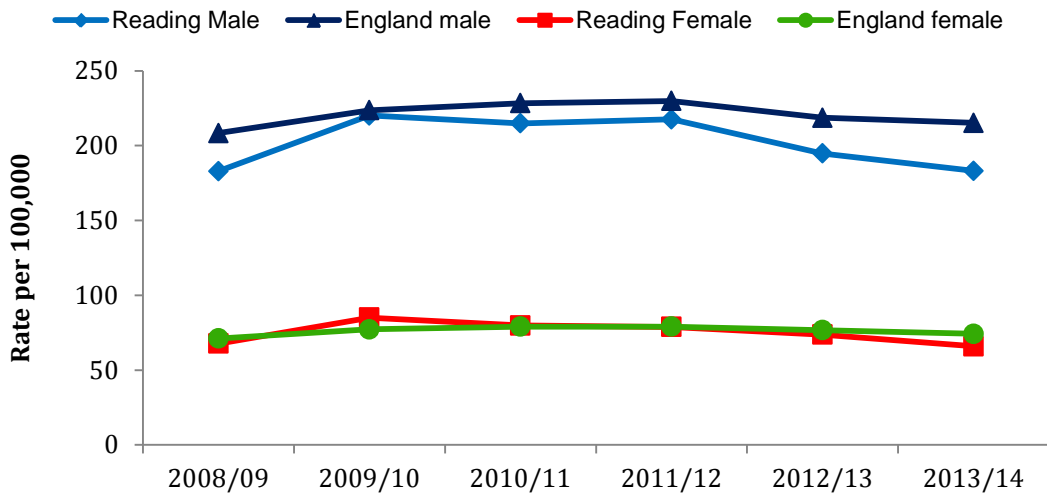
Males in both Reading and England are almost three times more likely to be admitted to hospital for alcohol-related unintentional injuries in comparison to females. This is unsurprising considering the evidence clearly showing that, nationally, males drink more frequently, particularly at harmful levels, and we also know that there is an increased risk of injury when excessive alcohol is consumed.^{6.52}

Figure 11. Admission for alcohol-related malignant neoplasm conditions (narrow), all ages, directly age standardised (males and females), Reading and England, 2008-09 – 2013/14.



Source: Public Health England, Local Alcohol Profile England, 2015

Figure 12. Admission episodes for alcohol-related unintentional injuries (Narrow) all ages, directly age standardised (Males and Females), 2008/09 – 2013/14.

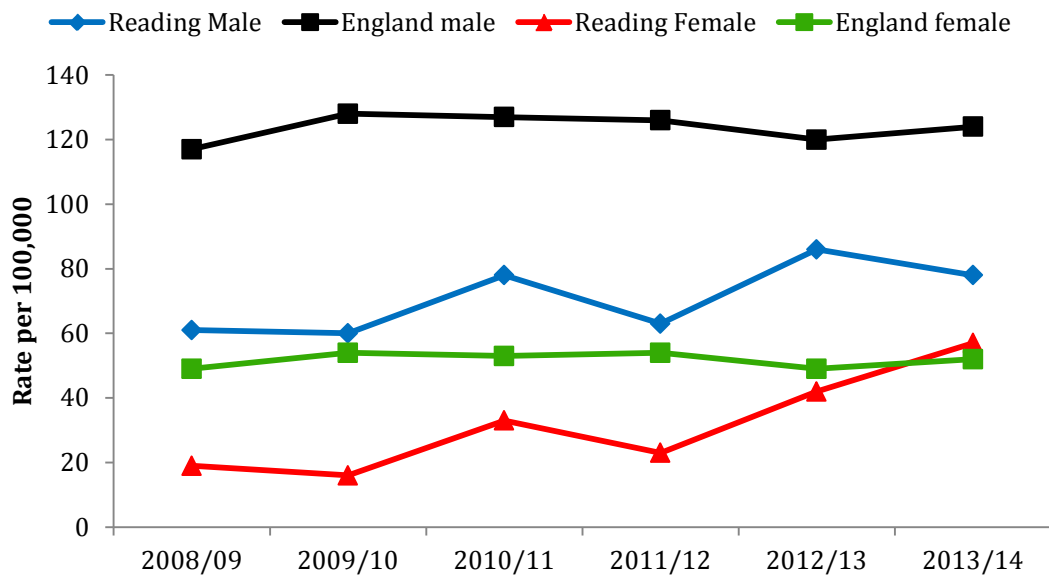


Source: Public Health England, Local Alcohol Profile England, 2015

Nationally, males are one-and-a-half times more likely to be admitted with alcohol-related mental and behavioural problems than females, however for Reading males this does not appear to be the case as rates are significantly lower than the England average (as shown in Figure 13). Since 2011/12, there has been a significant increase in Reading female admissions for alcohol-related mental and behavioural problems due to use of alcohol.⁵² There could several reasons for this, including improved diagnosis of conditions that require hospital treatment, rather than it being a real increase in number of women affected. Regardless of what this can be attributed too, we can be confident that in Reading we are seeing a change in alcohol-related admission trends, particularly in the female population and the risks to males remains higher. In the short term, this has an immediate impact on health

costs and in the long term there is an increased likelihood of increasing costs for social care as well.

Figure 13. Admission episodes for alcohol-related mental and behavioural due to use of alcohol condition (Narrow) all ages, directly age standardised (Males and Females), Reading and England, 2008/09 – 2013/14.

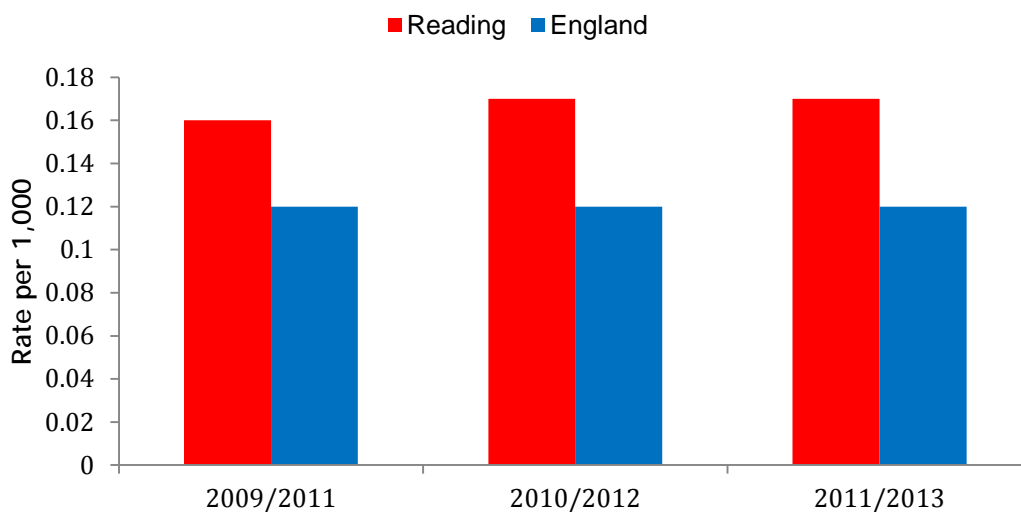


Source: Public Health England, Local Alcohol Profile England, 2015

4.2 Mortality and alcohol

Mortality resulting from alcohol misuse is consistently higher in Reading in comparison to the national average, with around 3% of all deaths in Reading being linked to alcohol use. Of these, about a third are alcohol-specific, as shown in Figure 14, that is conditions that are directly caused by alcohol use such as poisoning, alcoholic liver disease, and alcoholic pancreatitis.^{52,53}

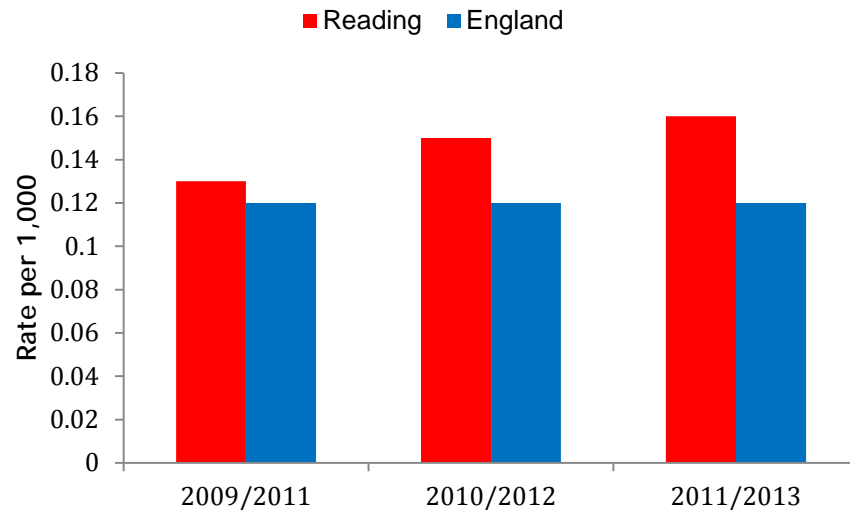
Figure 14. Alcohol-specific mortality 2011-2013 (All persons)



Source: Alcohol Data: JSNA support Pack, Public Health England 2015

High rates of alcohol-specific mortality, as shown above, and mortality from chronic liver disease (shown in Figure 15) are likely to indicate a significant population who have been drinking heavily and persistently over the past 10-30 years.⁵³

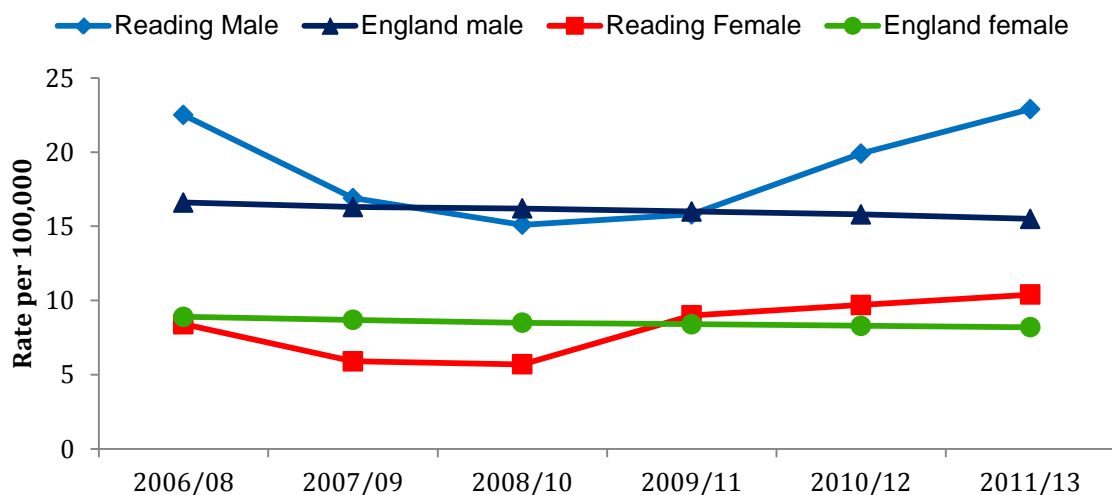
Figure 15. Mortality from chronic liver disease 2011-2013 (All persons)



Source: Alcohol Data: JSNA support Pack, Public Health England 2015

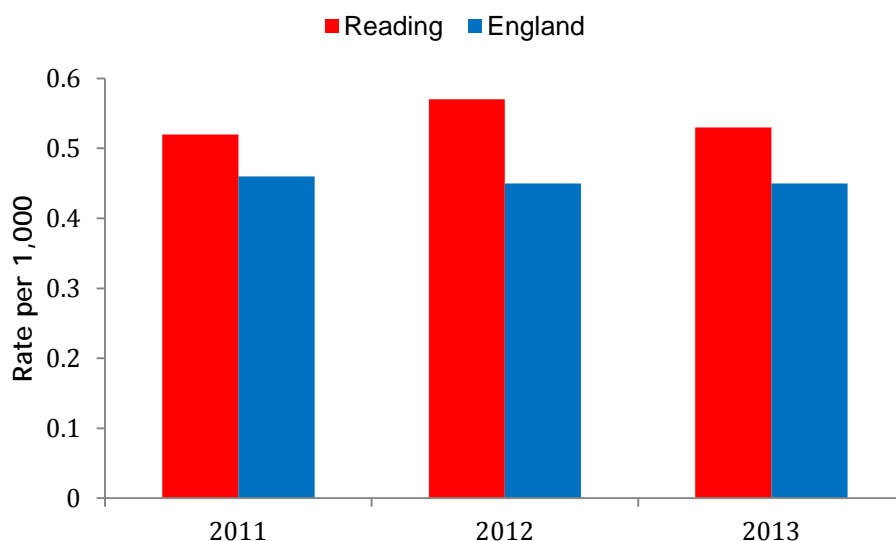
Figure 16 shows that mortality from chronic liver disease in Reading is greater than England averages for both males and females, and, significantly greater in Reading males. This indicates that chronic drinking is significantly prevalent in Reading male population. Liver disease is one of the major causes of mortality and morbidity which is increasing in England, whilst decreasing in other European countries, with deaths reaching record levels, having risen by 20% in a decade.^{54, 55}

Figure 16. Mortality from chronic liver disease, Reading and England, 2006/08 – 2011/13 (male and females)



The remaining two thirds are alcohol-related deaths that is, conditions that are frequently, but not always, related to alcohol, such as haemorrhagic stroke, cardiac arrhythmias, cancer of the oesophagus, road traffic collisions or intentional self-harm (see Figure 17). Males in Reading are also more likely die due to alcohol-related conditions in comparison to the England average and, females in Reading (see Figure 18).

Figure 17. Alcohol-related mortality, Reading and England, 2011 - 2013 (All persons)



Source: Alcohol Data: JSNA support Pack, Public Health England 2015

Figure 18. Alcohol-related mortality, Reading and England (males and females)

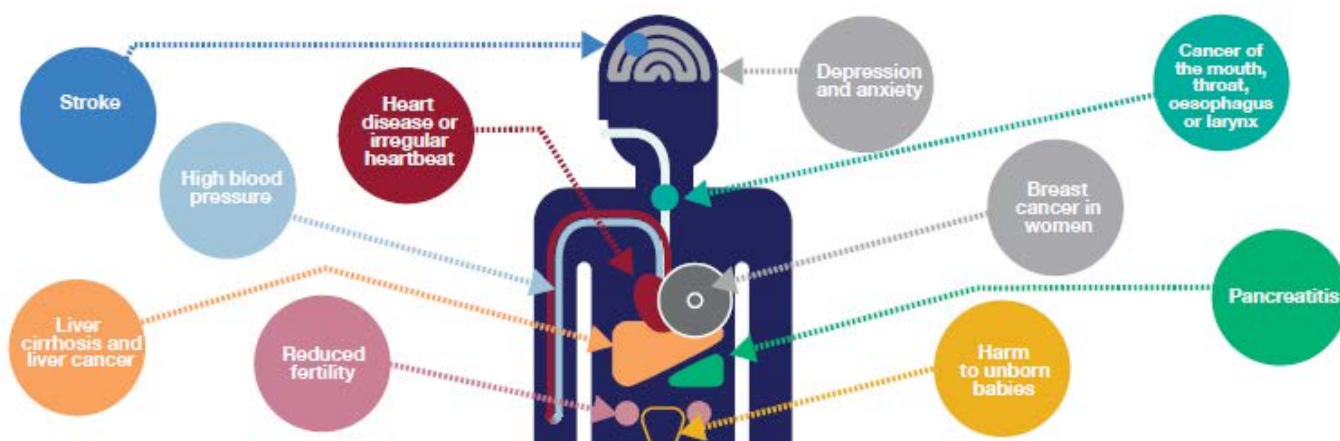


Source: Alcohol Data: JSNA support Pack, Public Health England 2015

4.3 Other harms

Despite the fact that alcohol is legal to buy (for some), and to drink, in the UK, we cannot avoid the fact that alcohol is an addictive drug as well as a toxic substance. As depicted in Figure 19, excessive use is causally related to more than 60 different medical conditions, including cancer of the mouth, pharynx, oesophagus, liver and breast; depression; epilepsy; diabetes; heart attack and stroke; cirrhosis of the liver; and foetal alcohol spectrum disorder (including mental and physical birth defects) in the babies of mothers who drink heavily when pregnant.⁵⁶

Figure 19. Infographic depicting alcohol misuse damages to health



Source: Based on Lisa Jones & Mark A Bellis (2013), Updating England-Specific Alcohol-Attributable Fractions. Alcohol-Attributable Fractions Report, Liverpool John Moores University.

Hazardous drinking is a pattern of alcohol consumption which carries risks of physical and psychological harm. Harmful drinking denotes the most hazardous use of alcohol; this is the level at which damage to health is likely, and carries a risk of alcohol dependence. Alcohol dependence is often a combination of behavioural, cognitive and physiological factors that typically manifests in a person have an overwhelming desire to consume alcohol and difficulties in controlling their drinking.⁵⁷ Dependent drinking is a complex issue and can have many causes, including family history; psychological factors such as anxiety or depression; the addictive nature of alcohol itself; and the environment in which people live and socialise.⁵⁸

Alcohol is an addictive substance in the same way as tobacco and opiates; people can both physically and emotionally depend upon it and become habituated. Dependent drinkers are much more likely to be consuming physically-damaging quantities of alcohol and are thus at greater risk of developing significant ill health as a consequence.⁵⁹ Furthermore, if we consider hospital admissions and death attributable to alcohol, the burden associated with drinking alcohol at harmful levels is generally increasing in Reading. This is likely to increase the burden on the health and social care services as well as having wider impacts. Crucially, these problems are avoidable.

4.3.1 Economics, accidents and injuries

As well as the health impacts, there are also economic implications, for example, revenues generated from local sales, which is taxed by the government, and jobs which are created through alcohol production and distribution.²² It is estimated that the UK alcohol industry directly employs more than 650,000 people and supports a further 1.1 million jobs in the wider economy.⁶⁰ Duty on spirit, wine, beer and cider in 2012/13 raised £10.1b for the Exchequer. It is difficult to be precise about the local economic benefits of alcohol but it is reasonable to assume that it contributes significantly to local economy.

In contrast, the government's alcohol strategy estimated that alcohol-related harm costs England society £21b annually (this excludes estimates for economic cost of alcohol misuse to families and social networks).¹⁷ This is broken down as:

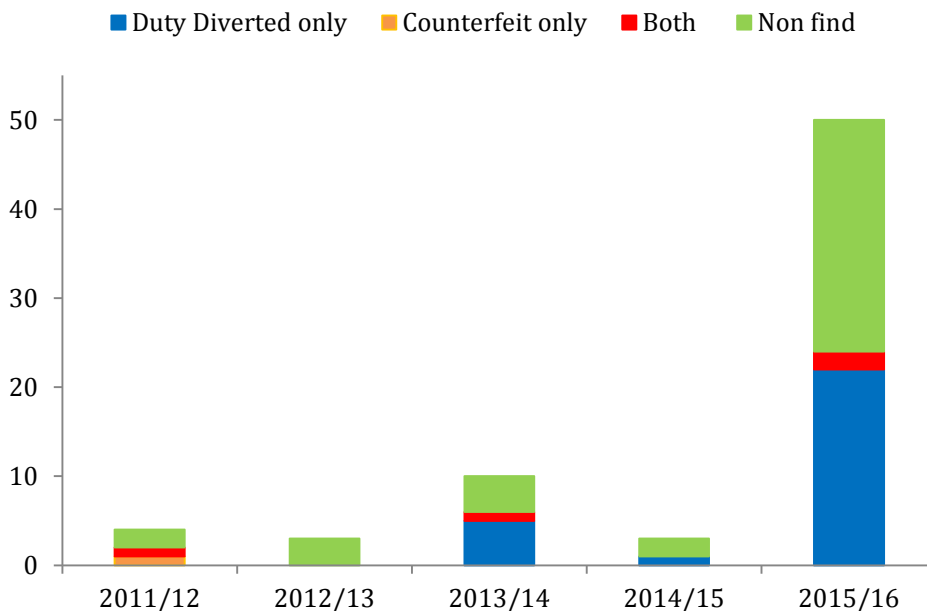
- £3.5b per year NHS costs (at 2009-10 costs);
- £11b per year alcohol-related crime (at 2010-11 costs); and

■ £7.3b per year lost productivity due to alcohol (at 2009-2010 costs, UK estimate).

HM Customs and Revenue estimates that fraudulent alcohol supply costs the UK around £1.3bn a year in lost venue, also having an adverse effect on the drinks industry.⁶¹ Results from the work carried out by the local RBC trading standards and licensing teams shows that this year, nearly half the inspections has resulted in seizures for alcohol where duty was diverted (see Figure 20). During one inspection, where both counterfeit and duty diverted alcohol was found, a total of 103 bottles were seized. Year to date, five licenses have been revoked as a result of the work.

Inspections in 2011-13 were primarily reactive to consumer complaints, with some support from the International Federation of Spirit Producers and HM Revenue and Customs. In 2015, the RBC Trading Standards team had a small increase in capacity which has allowed them to carry out proactive visits.

Figure 20. Trading Standards inspection results, Reading, 2011/12 – 2015/16 (YTD)



Source: RBC Trading Standard Performance Monitoring Report, 2015.

Drink driving is also a significant source of pressure for police, fire, paramedical and hospital emergency services as well as its impact on the victims and their families. Since 1979 there has been an almost six-fold reduction in the number of people killed in the UK in drink-drive accidents and a similar drop in seriously injured casualties. Despite this, in 2013 there were 5,690 road traffic collisions caused by alcohol resulting in an estimated 8,270 casualties. In the same year, 240 people were killed in the UK in accidents attributed to drink-driving, which is more than four deaths per week.

Binge drinking has been calculated to increase road traffic collisions by 17%, costing an estimated £2bn (2014 prices), this cost being spread across emergency services and the wider public sector. Local data on road traffic collisions directly attributed to alcohol is unavailable, but we know that between 2012-14 the rate of people killed and seriously injured on roads in Reading was lower than the England average being 28.3 compared to 39.3 per 100,000.⁶²

In addition to road traffic collisions, we can also measure the burden using local data and intelligence such as that gathered through Reading's First Stop Bus (FSB) project. The service is delivered on an appropriately resourced bus, including medical staff and first-aiders trained to treat minor injuries, and the aim is to ease the burden on the A&E department at the Royal Berkshire Hospital.

Information collected by FSB staff indicates that between December 2013 and October 2015 some 800 people have been seen. South Central Ambulance Service estimates that during this period, 662 people would have either had an ambulance called and/or been taken to A&E. Conservative estimates on the total amount money that was saved through avoidance of ambulance calls for the full period is £46,340 and the total save preventing treatment at A&E was £51,636.^{xiv}

Of those people presenting, mostly as a result of an accident or alcohol intoxication, 685 (87%), had consumed alcohol and 73 (9%) had used other substances. Almost two-thirds were males (62%) and over half (55.4%) were aged between 18-24 years, 18.7% were aged 25-30 years and 14.5% were aged 31-40 years.

5 The impact of drug and alcohol misuse on other aspects of community life

5.1 Police and judicial systems

Drug and alcohol use are both associated with crime. Alcohol is estimated to be implicated in 40% of violent crime and 78% of assaults, including domestic violence, and 88% of criminal damage cases are committed while the offender is under the influence of alcohol.⁶³ Some research studies have found that a lot of acquisitive crime is committed by dependent users of heroin and crack cocaine trying to pay for their drugs. Some show a high proportion of people arrested for a range of offenses testing positive for drug use. It has been suggested that one third to over a half of all acquisitive crime is related to illegal drug use⁶⁴ although acquisitive crime rates have dropped substantially since the mid-1990s⁶⁵ and it is noteworthy, as referred to elsewhere in this paper, that overall opiate and crack cocaine use is less common now.

Categorising crimes as drug-related and alcohol-related is methodologically complex. For example, categorisation would require that relationships between the behaviours of drug-using and offending be established as causal, rather than coincidental, and that records of when offenders have used drugs or are dependent are kept. This is rarely done. As a result, it is not possible to ascertain the true extent to which crime in Reading is related to drug or to alcohol use.⁶⁶

Drugs and alcohol use appear to impact on crime rates in different ways. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) identifies four categories of drug-related crime:

- psychopharmacological - while under the influence of a substance;
- economic compulsive - to obtain money to purchase drugs;
- systemic - drug market activities; and

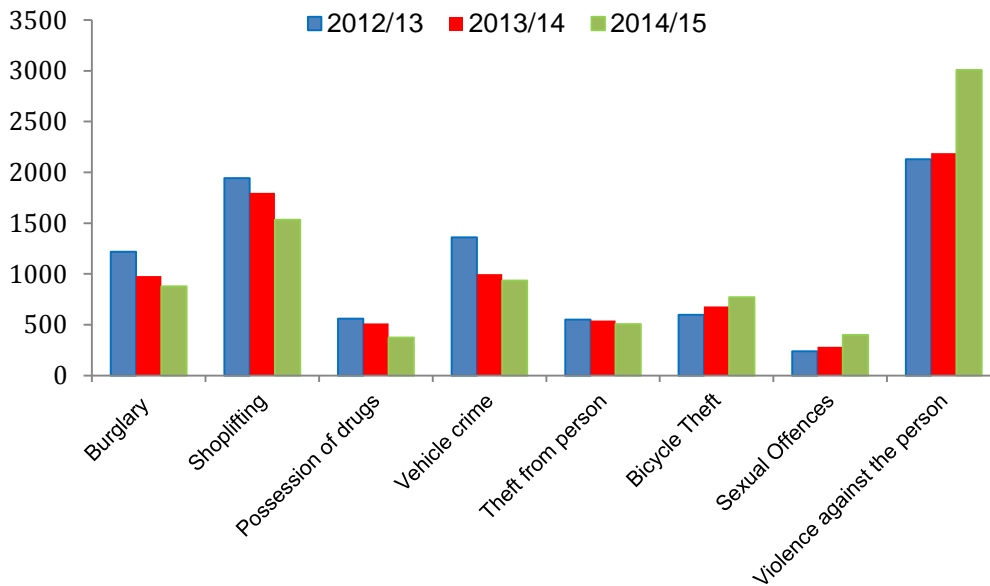
^{xiv} Ambulance call savings are based upon the cost of mobilising an emergency vehicle (£70 per call). This does not take account of the time and treatment that would follow. Total savings for preventing treatment at A&E has been calculated by taking Tier 1 and Tier 2 2014 cost of treatment at an A&E for treatment, which equates to £78 per patient. Higher tiers are not included as most patients treated by FSB would generally not trigger in higher tier costs.

- drug law - in violation of legislation e.g. possession.

The EMCDDA report goes on to associate psychopharmacological crime mainly with alcohol use but also with some illicit stimulant use. Economically-motivated crimes (principally acquisitive crime, sex working and drug selling) are associated with drug dependence.⁴³ Other surveys and reports also link drug use, particularly opiate use and injecting, with shoplifting and other acquisitive crime.⁶⁷

Despite the absence of specific information on drug-related crimes in Reading, reviewing all notifiable offences in Reading, as shown in Figure 21, may help in understanding trends. From October 2014 to September 2015, there was a 2.5% increase in recorded crime^{xv} overall, with a total of 12,853 crimes committed in the period in Reading. While most of these were acquisitive the numbers of most acquisitive crimes have decreased year on year since 2012/13 (with the exception of theft of vehicles and bicycle theft, which are, perhaps, less likely to be related to trying to raise money to buy drugs). The crime types with the largest increases in the same period were violent offences and sexual offences, which are more likely to be related to alcohol use.⁶⁸ Whilst acquisitive crime remains dominant, the figures suggest a growing volume of alcohol-related crime, and a diminishing amount of drug-related acquisitive crime.

Figure 21. Summary of notifiable offenses for Reading, October 2012/13 – September 2014/15



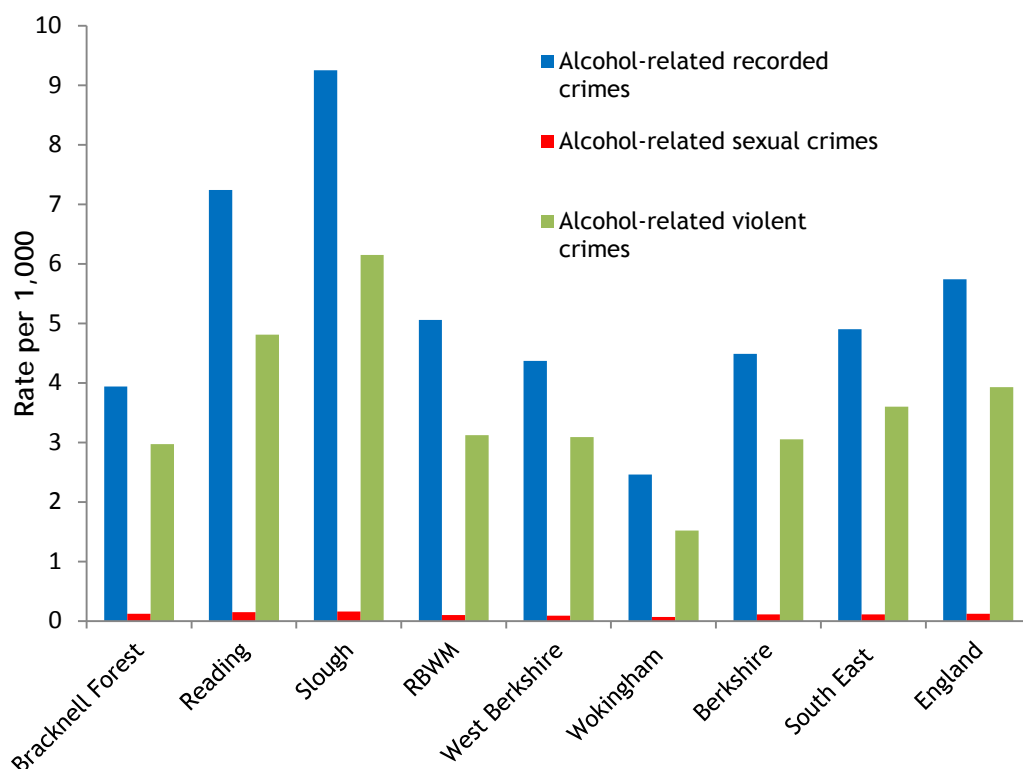
Source: Thames Valley Police, Summary of notifiable offence report, 2015

Three indicators of alcohol-related crimes (all alcohol-related recorded crimes, sexual crimes and violent crimes) have been used to measure alcohol-related crime. These measures are estimates based on the Home Office's former key offence categories

^{xv} Crime is recorded for the year in which it was reported, not necessarily allegedly committed. For example, the increase in reported sexual offences in recent years is, in part, attributable to people reporting alleged historical assaults. The rise in violence against the person has been driven by increases in 'violence without injury' and may, in part, reflect changes in recording practice (see <http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/year-ending-june-2015/stb-crime--ye-june-2015.html> (accessed 6 January 2016))

and include a proportion of all violent offences, domestic violence and visible anti-social behaviour and damage related to the night time economy.⁶⁹ Reading was similar to the national average except for alcohol-related recorded crimes where it has a higher rate of alcohol-related crime than average. Reading also recorded the second highest crime rates relating to alcohol in Berkshire, with Slough recording the highest (see Figure 22). Local crime rates suggest an increasing level of violent crime, but more work is needed to determine the precise nature of this.

Figure 22. Alcohol-related crime^{xvi} rate per 1,000 population by Berkshire local authority and England, 2012/13



Source: Public Health England, Local Alcohol Profiles England, 2015

5.1.1 Treatment for the prevention of offending

There is evidence to suggest that pharmacological treatment interventions for the management of opiate dependence can help to reduce re-offending, especially where dose is high enough, the time in treatment is sufficient, and where psychological support is also provided. Treatment often takes the form of long-term prescribing of an opioid substitute such as methadone or buprenorphine. The aim is for people who are dependent to progress from maintenance to detoxification and then abstinence. However, depending on the individual, it can be associated with longer periods in treatment, sometimes for many years with some clients seeming to have little or no motivation to stop using substances.^{xvii} It is therefore reasonable to

xvi Six offences: violence against a person, sexual offenses, robbery, burglary dwelling, theft of a motor vehicle and theft from a motor vehicle. Alcohol related sexual crimes are therefore included in the alcohol-related recorded crime rates

xvii There are anecdotal reports of some such people being referred to as 'Giro Junkies', that is, when they receive a state benefit payment they buy illicit opioids or other substances and when their money runs out they use methadone or buprenorphine prescribed by drug and alcohol services or by their GP

conclude that this kind of treatment will have little effect on the numbers of people leaving treatment in the short-term or on the average length of time in treatment.^{70, 71, 72, 73, 74}

Reading's Integrated Offender Management (IOM) programme targets the most prolific acquisitive offenders in the area. A recent analysis showed that 58% of those on the scheme were also in drug treatment at the time (which has to raise questions about the effectiveness of treatment and crime reduction, especially as perhaps only half of the opiate and crack cocaine users in Reading are known to the drug and alcohol service) and a further 17% had been referred for treatment or been in treatment at another time. Some 95% of those who had been in treatment while on the programme identified heroin as their main substance of use. No information is available to show what effect opioid substitute prescribing had on their offending. In light of this, while we can say that a high proportion of prolific offenders in Reading engage with substitute prescribing treatment, and that drug-related offending appears to have declined in recent years, it is not possible to conclude that this treatment had a mitigating effect on the offending rates of these local prolific offenders.

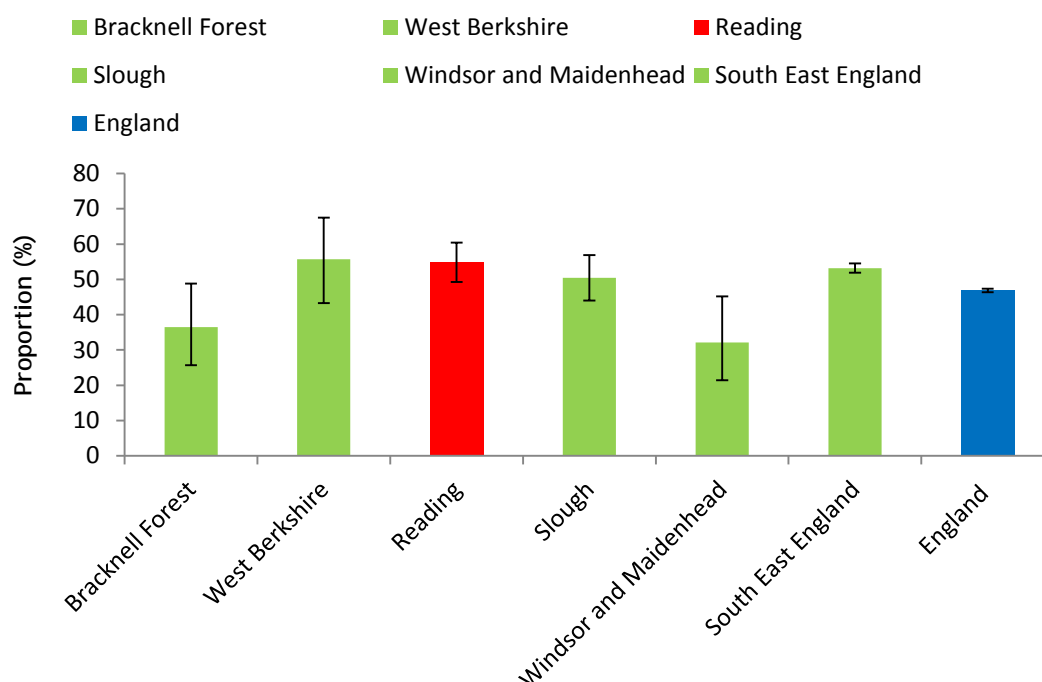
The Public Health Outcomes Framework measures the proportion of those who are assessed for drug and alcohol treatment in prison, who have been engaged with treatment in the community. In the context of the outcomes framework, this is because treatment is considered to be one way of helping to reduce offending and this serves as a measure of prevention work on substance dependence among vulnerable groups.⁷⁵

In 2012/13 Reading had a statistically significantly higher proportion of drug or alcohol users who had not engaged with treatment in the community before entering treatment in prison than the England average. Figure 23 shows the percentage of people entering prison with substance misuse issues who were not previously known to community treatment services in comparison with England and the other areas of Berkshire.

The data indicate that a lower proportion of offenders in Reading have used community treatment services than offenders elsewhere, suggesting that less preventative work is done locally to reduce drug and alcohol-related offending than in the rest of England. Confidence intervals for local authority level data are wide, so it is not possible to conclude that this is significantly worse in Reading than in the rest of Berkshire. We can say, however, that Reading is the only local authority in Berkshire that is significantly worse than the England average.

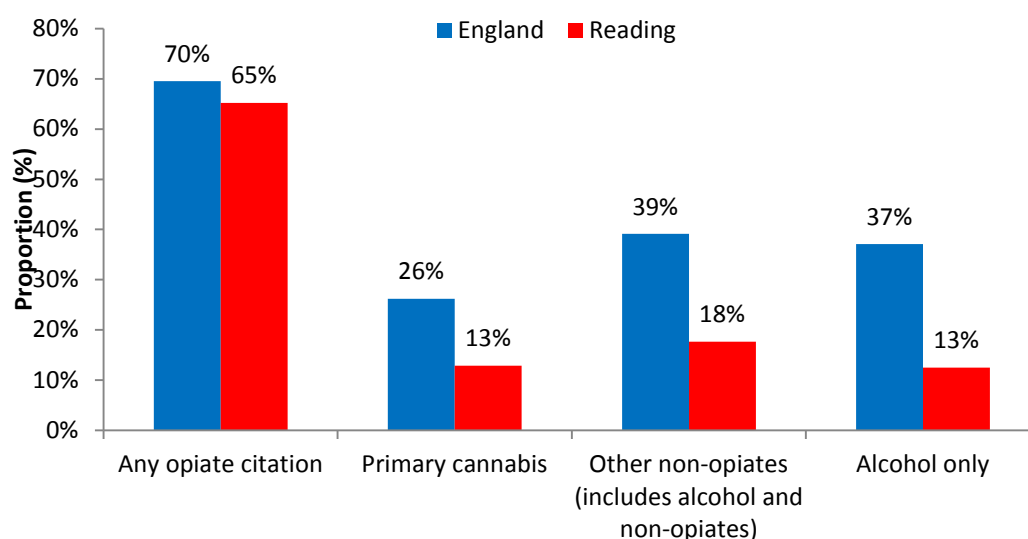
Further analysis shows that 65% of opiate users from Reading who started treatment in prison had been in treatment in the community. This is close to the England average of 70%. The proportions of alcohol, cannabis and other non-opiate are much lower in Reading and the rest of England, but the differences between Reading and the England averages are much greater for alcohol and non-opiate substances (see Figure 24). This suggests a low proportion of offenders and those at risk of offending who use alcohol and non-opiate drugs receive treatment in Reading. Confidence intervals are not provided for this further breakdown, and the numbers at local authority level are small, so these analyses need to be considered with caution.

Figure 23. Proportion of people assessed for substance dependence issues when entering prison who then required structured treatment and have not already received it in the community, 2012/13.



Source: Public Health Outcomes Framework, 2015

Figure 24. Proportion of users in treatment in the community in Reading, 2013/14, by substance



Source: Public Health Outcomes Framework (PHOF) Indicator 2.16 Supporting Data 2013/14

So, while opiate users in Reading are almost as likely as opiate users elsewhere to have received treatment in the community prior to entering treatment in prison, users of other substances appear to be less likely to have received treatment. This may indicate that more preventative work could be done, particularly with alcohol users, to reduce local levels of crime.

5.1.2 **Obtaining novel psychoactive substances**

Because of the legal status of NPSs, they are currently easily obtainable with open sales occurring in offline retail outlets, including being available on most high streets, sometimes being sold in 'headshops' (shops which sell drug paraphernalia), market stalls, takeaways, convenience stores, newsagents or petrol stations. The three main sources which users obtain NPSs from are online retailers, high-street retailers and non-retail vendors (family, friends, and street level dealers).^{9, 76}

Anecdotally it is suggested that transactions with high-street and non-retail vendors could be seen as an easier source for young people to acquire NPSs as they will invariably involve untraceable, cash transactions. Whilst the virtual marketplace is popular and provides anonymity to website owners and buyers because of the sophisticated technical concealment of web market places, for younger people, it requires them to have access to a bankcard, which could make it harder for them to purchase via this source. The clever concealment of these virtual markets makes it increasingly difficult for law enforcement authorities to understand the true scale of the drug trade and therefore drug-related crimes, but it is fair to say that there will be a local impact.^{9,10}

The UK Government proposes to introduce legislation that will seek to eradicate the NPSs market, but there is debate that *The Psychoactive Substance Bill (HL) 2015-16*⁷⁷ does not address the key problems of NPSs and there are concerns it will merely serve to move NPSs into the illicit market, possible at street level and online.⁷⁸ If this happens there is a possibility that it will impact on drug-related crimes but how is unknown. There are no precise numbers of offline or online retail outlets in the UK selling illicit drugs or NPS, however there are reports of there being more than 250 headshops selling non-controlled NPSs and, the National Crime Agency (NCA) estimates there to be between 100 and 150 UK-based 'clearnet' sites, who primarily sell non-controlled NPSs.^{9,10}

5.2 **Domestic violence and parental substance misuse**

Domestic violence and abuse is frequently associated with alcohol use.⁷⁹ In 2013/14, 36% of victims of domestic abuse reported in face-to-face interviews that the offender was under the influence of alcohol⁸⁰ and around 20% of high-risk victims of abuse report using drugs and/or alcohol.⁸¹ Unfortunately, there are no local data for the numbers of women or men accessing domestic abuse services, or coming into contact with police for domestic abuse issues, where alcohol or drug misuse is a contributory factor.

In addition to the harm the adult victim of domestic abuse faces, children in families where there is parental alcohol or drug misuse, including babies in the womb, face an increased risk of significant harm. Parental substance misuse is a major risk factor for harm to children and may expose them to physical abuse or neglect, dangerously inadequate supervision, intermittent or permanent separation or changes in residence, toxic substances in the home, interrupted education, criminal or other inappropriate adult behaviour and social isolation.^{82,83}

An analysis of child deaths and serious injuries in England (2003-2005) found that in well over half of cases (57%), there was evidence of substance misuse, furthermore, over half of children were living with domestic violence, or parental mental ill health, or parental substance misuse (with these three problems often co-existing). There are serious concerns that this is likely to be underestimated as there is no routine screening by children and family services for parental alcohol misuse.⁸⁴

An inquiry by the Advisory Council on the Misuse of Drugs in 2003 estimated that 2-3% of children aged under 16 were likely to be affected by parental substance misuse. Recent estimates of the number of children affected based on UK household surveys suggest that the number of children in the UK living with a parent misusing drugs or alcohol is likely to be higher than previously thought, with an estimated 22% (over 2.6 million children) living with a parent with a drinking pattern that is hazardous and 705,000 living with dependent drinkers.^{74,85,86,87,88}

In Reading, this equates to some around 600 children aged under 16 likely to be affected by parental substance misuse and 6,000 children likely to be living with a parent misusing drugs or alcohol.

An evaluation of Family Drug and Alcohol Courts highlighted both supportive work to enable children to return to their families where possible and swift action to find an alternative home where it was not. The evaluation also reports more positive attitudes amongst parents and savings to local authorities.⁷⁴

RBC has a Parental Substance Misuse Service (PSMS) which was developed to help to address concerns about the needs of parents in drug and alcohol treatment. The team work with any family where a child's needs are affected by their parents' misuse of drugs or alcohol. Children are usually identified by family workers, through children's centres or drug and alcohol treatment services, or, sometimes when child is put on a child protection plan. The service offers a holistic response to each family's needs, helping them to access both drug and alcohol treatment and provides parenting support. The service continues to work with the family until parents are established in recovery or the children have been permanently removed. While families may be required to work with a social worker, engagement with the PSMS is voluntary. Social workers can choose to make a referral but are not required to do so in all cases where substance misuse is identified.

Reading's PSMS currently provides one-to-one support to 22 parents/pregnant women who are experiencing problems with drug and alcohol use; group work programmes called *Just What You Need* and *Family Time* programmes, which are used by a further 17 parents; and they also support three people who are caring for children of drug or alcohol using parents (within their extended family).

Most of those receiving one-to-one support are users of alcohol (15), four primarily use heroin and two cannabis. As shown in Table 2 below, eight have children on child protection plans,^{xviii} nine have children monitored under *Child In Need*^{xix} (three have been de-escalated from child protection plans), two are being assessed after contact with police or identification by the Early Help hub, one parent has a child who is classified as a *looked after child*^{xx} as they are in residential rehabilitation with their child, one is abstinent and receiving support to maintain recovery, and one is currently pregnant. Most of those using the group work programme are currently abstinent from substances and working with the service to maintain their recovery.

xviii A CPP is a plan drawn up by the local authority. It sets out how a child can be kept safe, how things can be made better for the family and what support they will need. Parents should be told the reason for the plan.

xix Section 17 of the Children Act 1989 has defined criteria for when a child is considered as being in need, for more information, please see <http://protectingchildren.org.uk/cp-system/child-in-need/>

xx A *looked after child* may either be accommodated (which means the local council is looking after them with the agreement, at the request or in the absence of their parents) or subject to Care Order by the Family Courts.

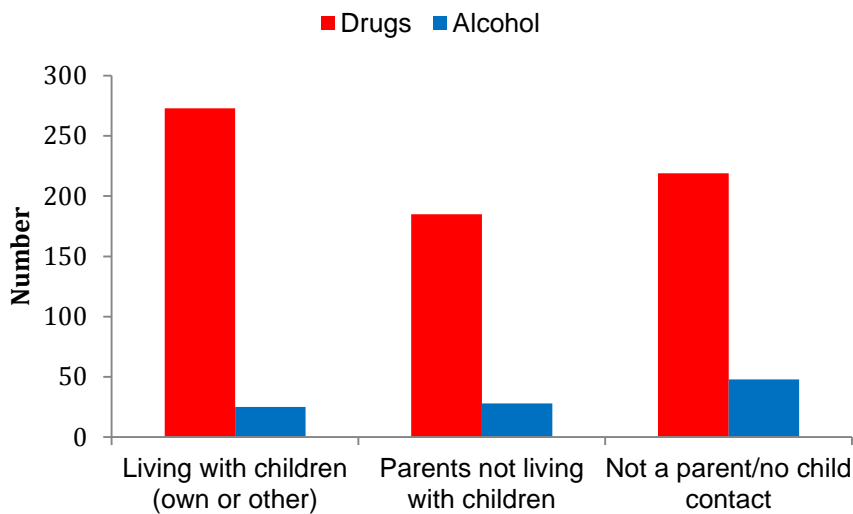
Table 2. Current case analysis (snapshot) of parents supported by RBC PSMS, as of November 2015

Status	Number
Child Protection	8
Child in Need	9
Assessment	2
Looked after child (residential rehabilitation)	1
Abstinent - recovery support only	1
Pregnant	1

Source: RBC Parental Substance Misuse Service, 2015

Data from local treatment services can also be used to illustrate the number of drug and alcohol users in Reading in treatment who: live with children; are parents but do not live with children; and do not have children. This is shown in Figure 25 (incomplete data have been removed). However, it is important to recognise that this is a reflection of the balance of drug and alcohol users in treatment in Reading and not of the actual number of misusers of drugs and, especially, alcohol in the borough.

Figure 25. The parental status number of drug and alcohol treatment-users in Reading



Source: Drug Data: JSNA support Pack, Public Health England 2015

Based on estimates of local alcohol misuse, there is likely to be a significant number of children in Reading whose parents require interventions or treatment for alcohol misuse who are not engaged with treatment services. Furthermore, the number of parents' engagement with the PSMS is relatively low in comparison to the number of children we know to be living with drug users in Reading. It is important to note that these users are engaged with treatment services and referrals to the PSMS may not be necessary if it has been determined that their drug and/or alcohol misuse does not affect their ability to meet their child's needs.

Despite this, the Office of the Children's Commissioner has highlighted the large and increasing prevalence of parental alcohol use and recommends a greater policy focus within the wider scope of all parental substance use.⁵⁵ Several sources

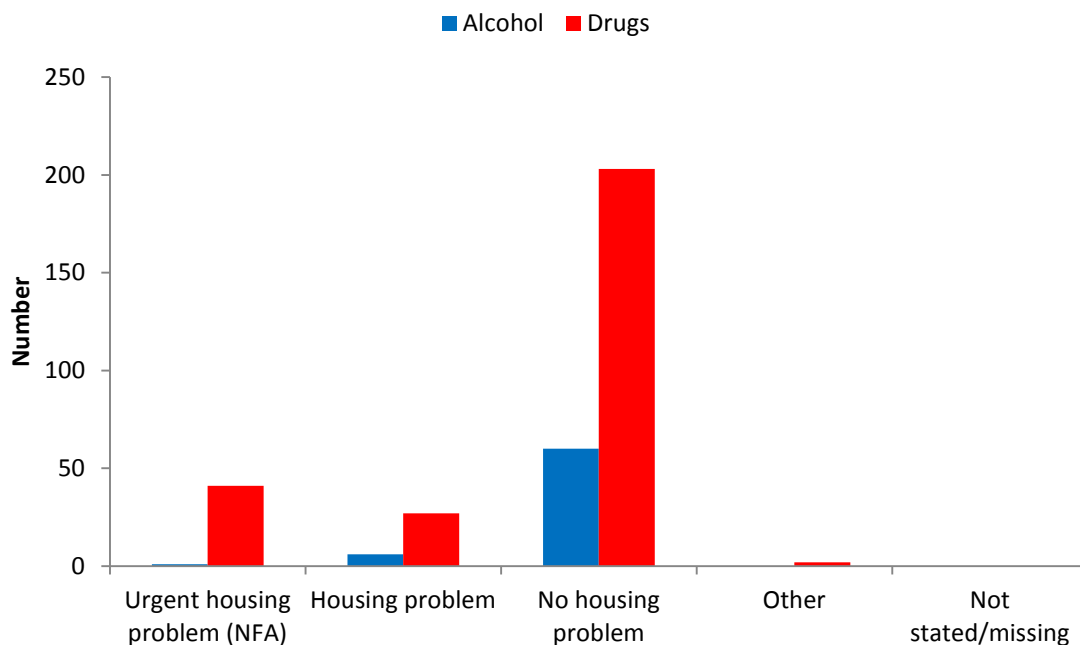
highlight connections between parental drug and alcohol use, inadequate parenting, domestic violence, poor mental health and housing and social problems and recommend ‘whole family’ approaches focussed on creating a stable environment for the child or children. This in turn, is likely to have a positive impact on the future behaviours of children, particularly in relation to drug and alcohol use, which could reduce the burden of health and social care costs.^{52, 53, 89}

5.3 Local authority housing

Local authorities are obliged to give re-housing priority to people who are vulnerable and homeless. For drug and/or alcohol misusers, a safe, stable home environment better enables them to sustain their recovery whilst insecure housing or homelessness threatens it. RBC does not give re-housing priority to people simply because they misuse drugs and/or alcohol.

The overall number of decisions on homelessness applications taken by RBC in 2014/15 was 737. Figure 26 shows the self-reported housing status of adults when they started treatment for drugs and/or alcohol misuse in the same period. Based on self-reported housing status, we can see that urgent housing problems are more prevalent in drug users at the start of treatment, in comparison to alcohol users in treatment, which is unsurprising considering we know locally more people access treatment services for drug misuse rather than alcohol misuse, but that the prevalence of misuse is higher for alcohol than drugs. These data could also mean that people who misuse alcohol in Reading do so without causing significant risk to their housing status and thus do not come to the attention of the council. Based on data in Figure 26, 10% of the applications considered involved someone who commenced treatment for drug or alcohol misuse.

Figure 26. Self-reported housing status of adults at start of treatment (by drugs and alcohol) Reading, 2014/15



Source: Drug & Alcohol Data: JSNA support Pack, Public Health England 2015

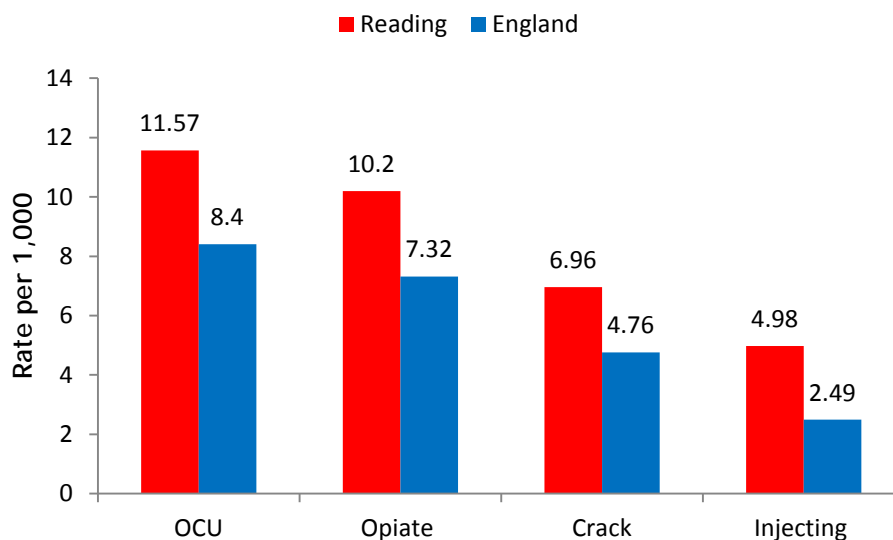
6 How big is the problem of drug and alcohol misuse in Reading?

6.1 Drugs

The estimated prevalence of opiate and crack cocaine use was carried out in eight 'sweeps' by independent researchers commissioned by the Home Office.^{90, 91, 92, 93, 94} The estimates use numbers of known opiate and/or crack users recorded by different sources and other indicators, such as levels of drug-related crime.

The most recent estimate indicates a higher rate of opiate and/or crack cocaine users (OCU) per 1,000 population in Reading than the England average: 11.7 and 8.4, respectively. The rate of injecting drugs in Reading is twice as high as the England average: 4.98 in Reading compared to 2.49 England average (see Figure 27).

Figure 27. Prevalence estimates of drug users, Reading and England

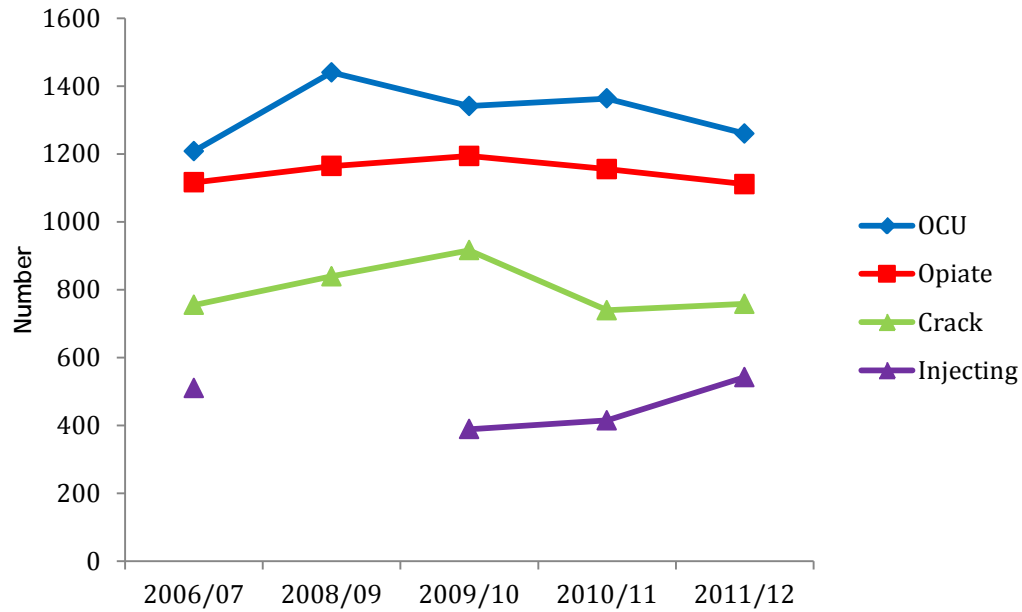


Source: Drug Data: JSNA support Pack, Public Health England 2015

Opiate and crack cocaine use prevalence trends, by drug-use category, are shown in Figure 28. The numbers suggest little change since 2006/07. This is consistent with the overall national picture, which saw a slight decrease in OCU prevalence, but not a significantly significant one. Prevalence estimates also report a national decrease in drug injecting between 2010/11 and 2011/12, but point to an increasing trend in Reading. Although prevalence estimates were carried out prior to 2006/07, these data are no longer publicly available. No local authority-level data for prevalence of injecting is available for 2008/09.

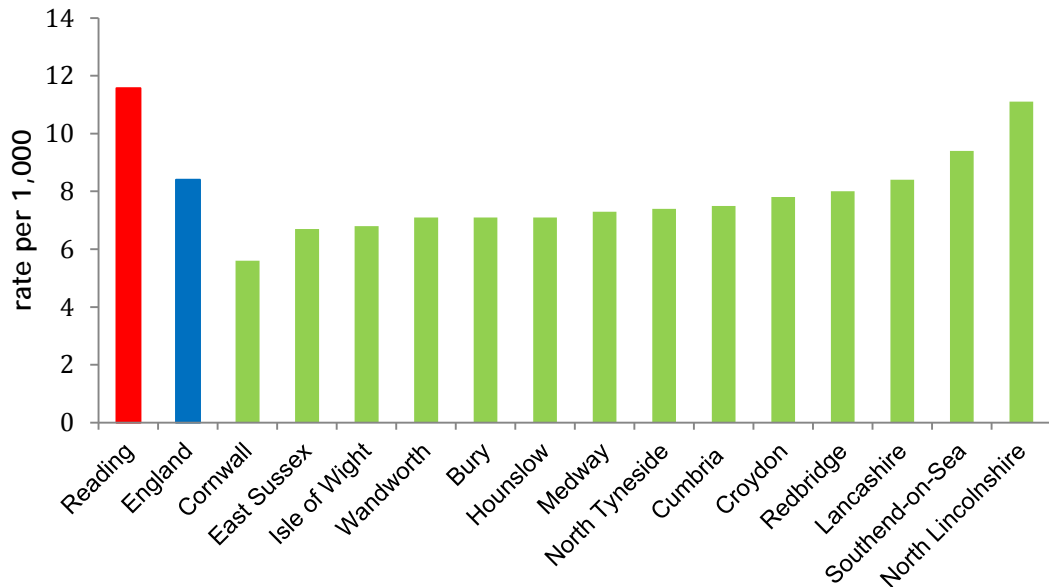
When compared to areas with similar levels of socioeconomic deprivation, Reading's estimated rates of OCU and injecting drug users per 1,000 population are higher than similar local authorities, suggesting that local high rates of opiate and crack cocaine use and drug injecting may not be linked simply to relative deprivation (Figures 29 and 30).

Figure 28. *Estimated number of drug users, by drug use, Reading, 2006/07 to 2011/12*



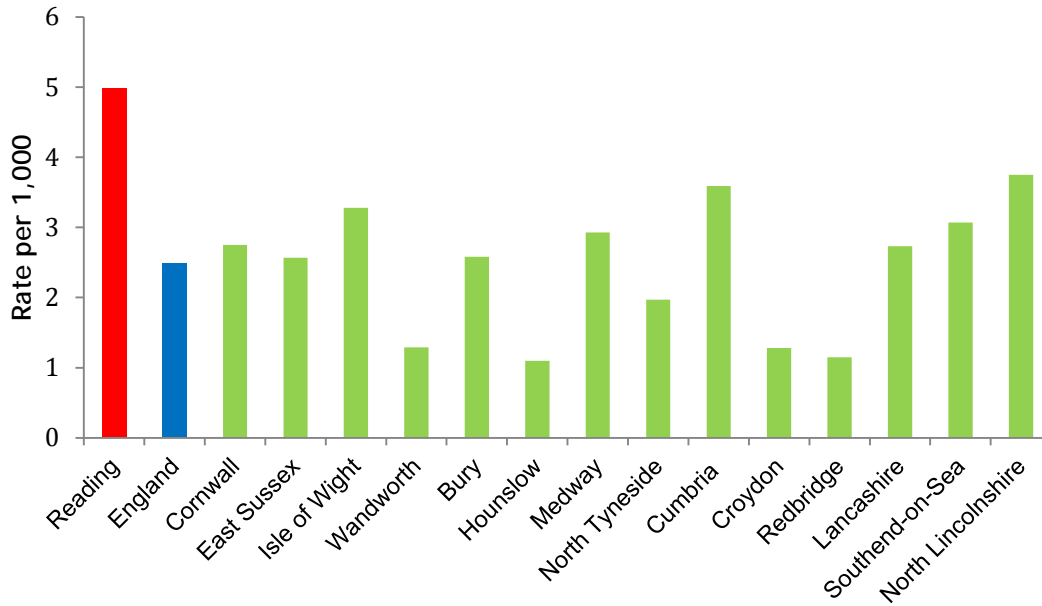
Source: Healthier Lives, Public Health England 2015

Figure 29. *Prevalence estimates of OCU per 1,000 population by comparator local authorities (Socioeconomic decile 6)*



Source: Healthier Lives, Public Health England 2015

Figure 30. Rate of injecting OCU users per 1,000 population by comparator local authorities (Socioeconomic decile 6)



Source: Healthier Lives, Public Health England 2015

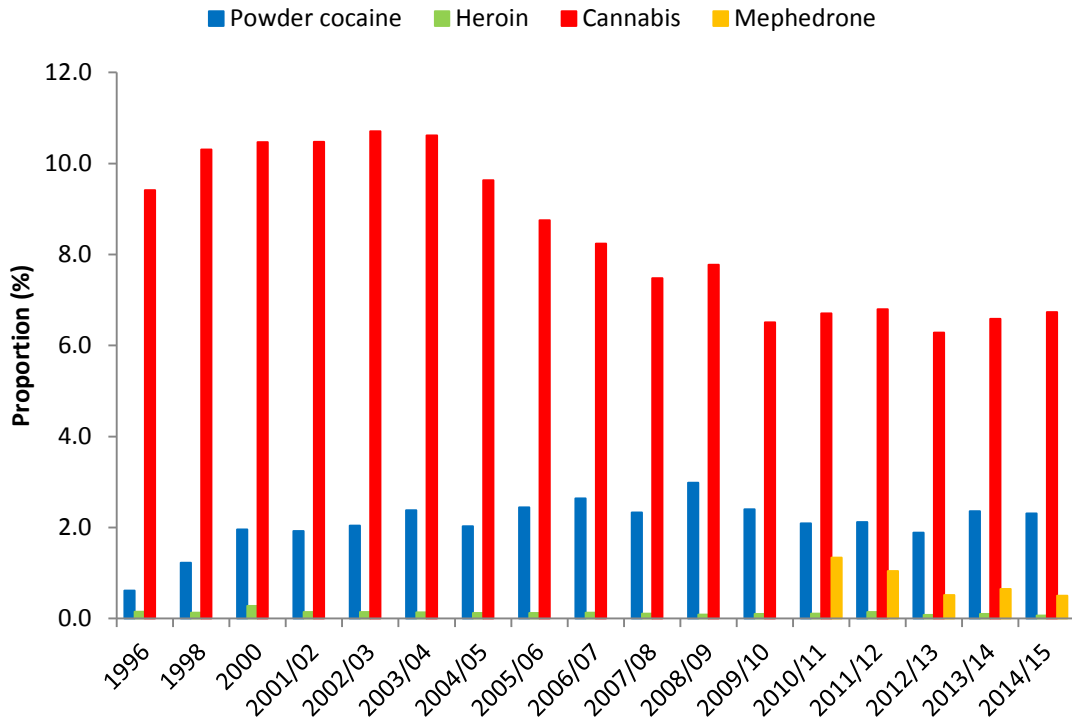
While there are no estimates on the prevalence of cannabis and other drug use by local authority area, the Crime Survey for England and Wales produces statistics on self-reported drug use amongst respondents, most recently, as shown in Figure 31, the evidence suggests that 6.7% of 16-59 year olds used cannabis in the last year and 2.3% used powder cocaine and 0.5% mephedrone (included in the survey since 2011).

Applied crudely to the 2014 mid-year population estimate for 16-59 year olds for Reading,^{xxi} this equates to nearly 6,000 people having used cannabis, some 2,000 having used cocaine, 445 having used mephedrone and about 90 having used heroin in the year 2014/15. We should note that there is likely to be a discrepancy between self-reported drug use and actual drug use, and that this may be greater where there is greater stigma, (for example, more than 500 people from Reading presented to drug treatment services with problematic heroin use in the same period) so we need to consider the implications of using the survey method for collecting information about drug use prevalence. Nevertheless, the survey data suggests much wider use of cannabis, powder cocaine and NPS than class A drugs such as heroin and crack cocaine.

Reliable data on the number of people using NPS are impossible to obtain. The data in Figure 32 cover the main NPS reported by new entrants into specialist drug and alcohol treatment England. While the majority of opiate and crack users can be expected to develop significant health and/or social care service needs in time, the long-term health impact of NPS use is not yet known. Non-opiate using adult NPS users typically have good personal resources – such as jobs, relationships, accommodation – and this may mean that they are less likely to need treatment or, if they do, that they will be more likely to make the most of it.⁹⁵

xxi The borough's estimated adult population in mid-2014, produced by ONS, is 124,975 people aged 18+ years.

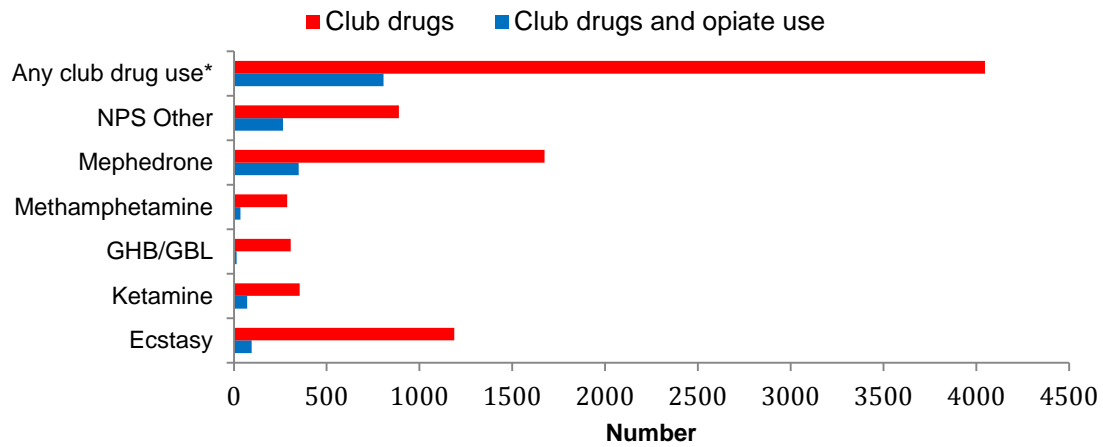
Figure 31. Self-reported drug use in the last year, 16-59 year olds, England, 1996 – 2014/15



Source: Home Office (2015). Drug Misuse: Findings from the 2014-2015 CSEW.

The majority of opiate and crack users can be expected to develop significant health and/or social care service needs in time, whereas possibly a majority of NPS users will not, unless they go on to use opiates and/or crack (although there is no inevitable pathway from one to the other). A very high proportion of opiate and crack users will also use tobacco and alcohol.

Figure 32. The number of new treatment entrants in England citing club drug use or club drug use and opiate



Source: Drug Data: JSNA support Pack, Public Health England 2015

Surveys of young people suggest that 20-40% will have tried an NPS at some time and that, before it was banned, some 34% had tried mephedrone, but these data may be derived from heavily biased samples and give an inaccurate picture.⁹⁶ Despite these limitations, it is probably reasonable to assume that a sizeable minority of young people in Reading have used an NPS at least once.

NPSs are relatively new in the UK and it is difficult to meaningfully determine the profile of people using them; patterns of use vary enormously across the UK. Much of the data are collected from self-reporting or from surveys of self-selecting participants, often carried out amongst those with a higher level of drug use than the general population. So far, relatively few people accessing treatment service cite NPS as their primary drug problem. There could a number of reasons for this, for example, it could reflect that people are able to use NPSs without harm being apparent or without dependency forming, or it this could reflect treatment set-up, including access to specialist club drug services;⁹⁷ there would appear to be only two specialist NPS clinic in England at present, one in London and the other in Brighton. In 2014/15, barely a handful of people accessing drug treatment services cited NPSs as problematic substance during an assessment with the Reading drug treatment service.

Source (Young People's Drug & Alcohol Service in Reading) reports that the majority of young people that they come into contact with are aware of NPSs and some have experimented/used them for a period of time. Based on ONS mid-year data, Reading had over 33,000 young people (aged 15 to 27 years). Using the lower end of the survey's results referred to earlier, this means we can estimate that over 6,500 people aged 15-27 years in Reading will have used NPSs at some time.

With regard to young people and drugs, the key findings from the *Smoking, drinking and drug use amongst young people in England 2014* report, which surveys pupils in secondary school aged between 11 to 15 years in England, included that:⁹⁸

- there is a continuing decline in the prevalence of drug use amongst pupils aged 11 to 15 years in England, however the decline has slowed since 2010;
- almost 15% of pupils have ever taken drugs and 10% have taken drugs in the last year and 6% in the last month;
- drug use prevalence increased with age, 6% of 11 year olds compared to 24% of 15 year olds reported trying drugs at least once;
- 2% of pupils said that they usually took drugs once a month or more often;
- cannabis was the drug most likely to have been taken in the last year by pupils (6.7%), with 2.7% reporting inhaling glue, gas, aerosols or solvents. Very few reported use of other types of drugs;
- 2.5% reported having taken NPSs, including 2% having taken them in the last year and less than one percent taken them in the last month; and
- pupils who smoked, drank alcohol, truanted from school or had been excluded from school were more likely to have taken drugs in the last year. Ethnicity and region were also associated with reported drug use.

The relationship between drug use and mental health problems amongst young people is of particular concern and over time, regular users run the risk of developing dependence. Drug use is more prevalent in young people with multiple vulnerabilities including truanting, exclusion from school, homelessness, time in care or serious/frequent offending. Addressing the issues of drug use amongst young people should aim to change their attitudes and behaviours, as well as providing

information and advice to parents and communities in order to prevent uptake.^{99, 100}

6.2 Alcohol

Obtaining reliable information about drinking behaviour is difficult, however results from the 2013 Health Survey for England¹⁰¹ show that most adults in England who drink alcohol do so in moderation, with 63% of men and 64% of women reporting drinking at levels indicating lower risk of harm, that is, their average weekly consumption is at or under the currently recommended weekly limits. Applying this to the Reading mid-year population data for 2014² we can infer that some 40,000 adult male and 32,400 adult female residents drink alcohol at levels which are considered a low harm risk.¹⁰² Surveys consistently record lower levels of consumption that would be expected from data on alcohol sales with some 40-60% of alcohol sales are unaccounted for¹⁰³ so actual consumption – and thus the number of people at risk – is likely to be much higher.

Whilst there is no reliable national model that estimates prevalence of alcohol dependence at a local level, the latest the *Statistics on Alcohol* produced by HSCIC cites national estimates for hazardous and harmful drinking and alcohol dependence in the general adult population in England.^{6,7,74} In 2007, HSCIC estimated that some 24% of adults in England (33.2% of men and 15.7% of women), were drinking at hazardous levels. Of these, 3.8% (5.8% of men and 1.9% of women) were drinking at levels which were classified as harmful. In men, both hazardous and harmful drinking was most prevalent in 25-34 year-olds, for women it was in those aged 16-24 years, and, as mentioned earlier, females under 16 years are more likely to be admitted to hospital for alcohol-related conditions (broad) than males.⁵² Based on these overall estimates, we can surmise that nearly 30,000 Reading residents could be drinking at hazardous levels and over 4,500 residents drinking at harmful levels. It is also reasonable to assume that the prevalence of alcohol misuse in Reading may be greater than the national estimates because Reading has a younger population in comparison to England.

Alcohol dependence is also more common in white males and females than in those from BME groups. Males are also at risk of cumulative health harms in that they are more likely to drive under the influence of alcohol, commit domestic violence and experience marital breakdown; there is also evidence that heavy drinkers have poorer mental health.⁷⁴

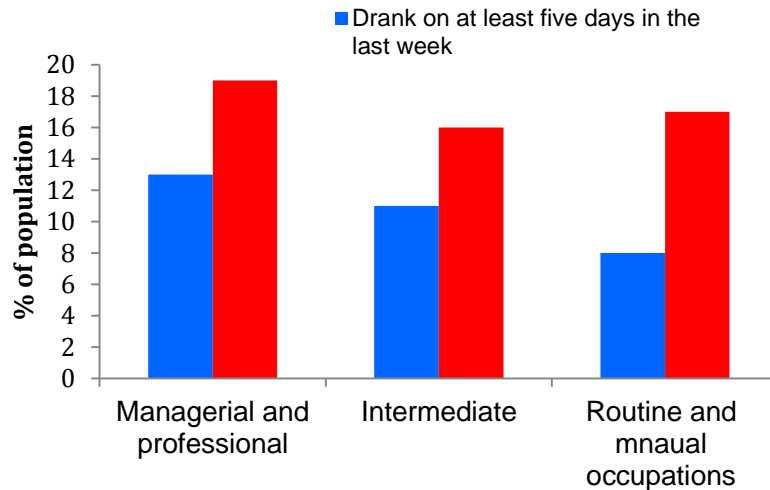
Alcohol consumption is also influenced by availability and affordability, and evidence shows variations in consumption by economic status and other socio-economic variables. Between 1980 and 2014, the price of alcohol increased by 23.2%, however, relatively speaking, it was 53.8% more affordable than in 1980. This is relevant in that affordability is an influencing factor in an individual's choice of whether to purchase alcohol.⁷⁴

It is also fair to surmise the pattern of drinking amongst drinkers in Reading is likely to be widening health inequalities. Whilst data from the General Household Survey¹⁰⁴ (shown in Figure 33) shows that nationally, men and women who are more affluent tend to drink more alcohol than those who are more deprived, people in more deprived areas are:^{105,106}

- 2-3 times as likely to die of causes influenced by, in part, alcohol;
- 3-5 times more likely to die of an alcohol-specific cause; and
- 2-5 times more likely to be admitted to hospital because of an alcohol-related condition.

This differential effect is likely to be related to the generally poorer health experienced by people living in more deprived areas, thus have a negative effect on health inequalities. This is significant for Reading as it has over half the LSOAs in Berkshire that fall within the 20% most deprived areas nationally.

Figure 33: The proportion of adults, by economic class, reporting drinking alcohol in the preceding week

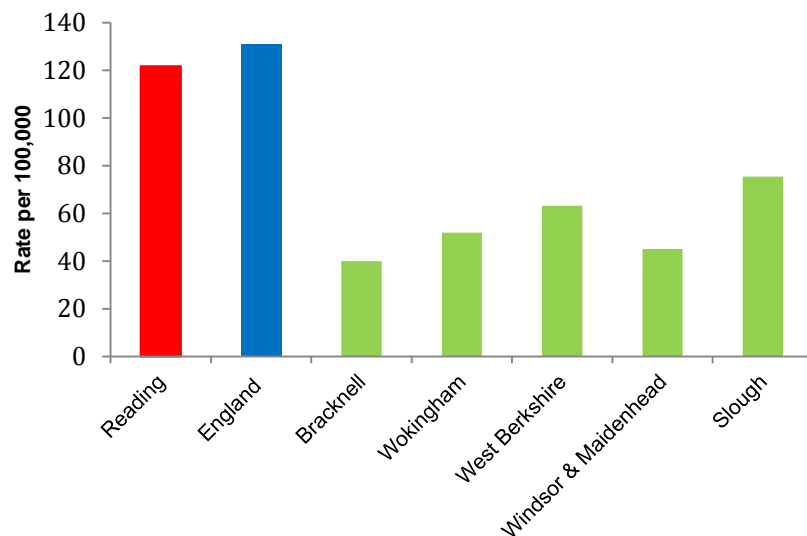


*6 units for women and 8 units for men

Source: ONS 2015, General Household Survey 2013

In 2014, Public Health England calculated a crude rate per 100,000 of claimants of Incapacity Benefit/Severe Disablement Allowance or Employment Support Allowance who cited alcohol misuse as their main disabling condition. As shown in Figure 34, whilst the number of claimants in Reading is similar to the England average, it is double that in comparison to most other Berkshire local authorities (with the exception of Slough).

Figure 34. Claimants of Incapacity Benefit/Severe Disablement Allowance or Employment Support Allowance who cite alcohol misuses as the main disabling condition, 2014.



Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using bespoke request data from Department for Work and Pensions and ONS mid-year population estimates 2014.

The drinking prevalence amongst young people in England has continued on a downward trend since 1998¹⁰⁷ (when measurement first began), when 61% of pupils aged 11-15 years in secondary school reporting having drunk alcohol at least once, in comparison to 38% in 2014. Other key findings of the *Smoking, drinking and drug use amongst young people in England 2014* report in relation to alcohol were that:

- the proportion of pupils having drunk in the week preceding the survey was 8% in 2014, this has continued on a downward trend since 2003 when it was 25%;
- about half (48%) of pupils thought it was acceptable for someone of their age to try drinking alcohol, and 24% thought it was ok to drink once a week. Some 18% thought it was acceptable for someone their aged to try getting drunk to see what it was like and 7% thought it was acceptable to get drunk once a week;
- the proportion of pupils who have ever drunk alcohol increased with aged, from 8% of 11 year olds to 69% of 15 year olds, as well as those who drank alcohol in the last week, increasing from 1% of 11 year olds to 18% of 15 year olds;
- most pupils who drank alcohol in the last week had consumed more than one type of alcoholic drink;
- males and females were equally likely to have reported drinking alcohol and to drink similar amounts. Most were likely to have drunk beer, lager or cider (72%), followed by spirits (59%), alcopops (40%) or wine, martini and sherry (38%). Preferences differ between the sexes, with females more likely to consume spirits, alcopops or wine;
- pupils were more likely to drink alcohol if they lived with someone who did, and 86% of pupils whose households did not include anyone who drank had not themselves drunk alcohol, but 40% of pupils who lived with three or more drinkers had; and
- pupils who thought their families did not like them drinking were less likely to have drunk alcohol in the last with only 2% reported drinking, compared to 16 percent of pupils who said their parents would not mind as long as they did not 'drink too much'.

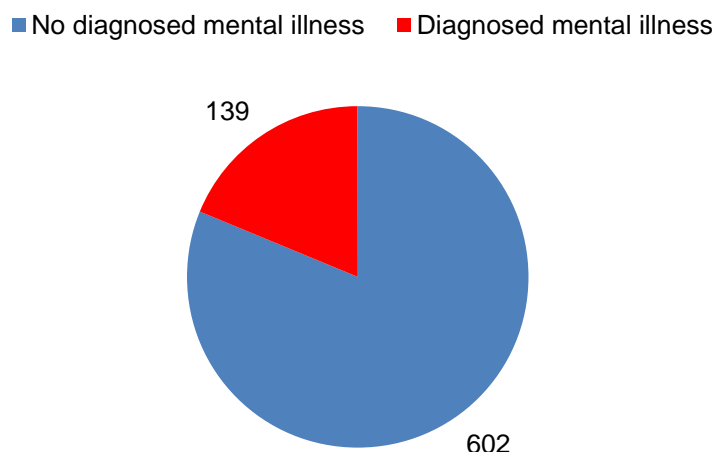
The burden of alcohol on Reading's health care system, and by implication also its social care system (and, probably also its policing and other judicial systems), is likely to be worsening and yet to be under-reported. Whilst the national trend of both young people and adults drinking alcohol has shown a decline, under-reporting means we have more people drinking at harmful and possibly hazardous levels, and they will remain undetected until health and social issues arise.¹⁷ Whilst alcohol-specific and alcohol-related hospital admission in Reading indicate that Reading has similar numbers to the England average, some alcohol-related conditions, alcohol-specific mortality and months of life lost reflects a level of chronic heavy drinking in a proportion of the Reading population, which is not reflected in number of clients in treatment services.¹⁰⁸

6.3 Dual diagnosis – mental illness combined with drug or alcohol use

In the context of this needs assessment, the term *dual diagnosis* refers to a diagnosis of a mental illness alongside a drug and/or alcohol problem. (Some sources use the term to refer to any mental illness, while others restrict the definition to severe illness.) Prevalence estimates range from 20% to 37% of mental health patients and 6-15% of those in addiction treatment having a dual diagnosis.¹⁰⁹

Local treatment data (as shown in Figure 35) shows that 19% of those in drug and alcohol treatment (139 people) in 2014-15 in Reading reported a dual diagnosis at the time of starting their treatment.

Figure 35. Number of people in drug and/or alcohol treatment with dual diagnosis, Reading, 2014-15.



Source: Local drug and alcohol treatment data

Just over 1,000 people registered with GPs in the South Reading CCG and some 770 registered with GPs in North and West Reading CCG have been diagnosed with a serious mental health problem (including schizophrenia, bipolar affective disorder and other psychoses).¹¹⁰ Applying the prevalence estimates above suggests that between 360 and 670 of these people may have a dual diagnosis across North and West Reading CCG and South Reading CCG areas, respectively. These estimates do not include personality disorder, which is likely to be more prevalent amongst those misusing drugs and alcohol.¹¹¹ It should be noted that a small number of the people registered with GPs in these two CCGs may be resident in neighbouring boroughs.

7 What works and what is available in Reading for people who misuse drugs and/or alcohol?

There is significant evidence of the benefit of primary prevention and early intervention of drug and alcohol misuse and of the types of activities that can have a positive impact on behaviour. There are a number of commissioned services in Reading whose primary focus is drug and alcohol misuse, but we know there are whole range of other services, that are not necessarily commissioned or funded directly by RBC, which have either a direct or indirect impact on people misusing drugs and alcohol. These include, but are not limited to, services provided by voluntary and community sector, planning and licensing, housing and domestic abuse services. This section is not intended to be a comprehensive list of all prevention and intervention services.

7.1 Prevention and early interventions to reduce long term dependence on drugs and/or alcohol

Primary prevention is designed to prevent misuse of drugs and alcohol occurring in the first place; this is a particularly important activity to be targeted at children and young people before they start using substances. Young people are particularly

vulnerable because they are at an age when behavioural patterns are being formed and they are particularly influenced by peers and role models.¹¹² At a time when budgets are being significantly reduced, investing in prevention can only benefit Reading residents in both the short and long term; a cost-benefit analysis found that every £1 invested in specialist interventions for young people's substance misuse saved £1.93 within two years and, up to £8.38 in the long term.⁵⁵

Evidence shows that a normative pattern for drug use initiation, beginning with tobacco and alcohol use, moving into cannabis use and then harder illicit drugs, can occur.^{113,114} There is evidence to suggest that progression to illicit drugs is dependent on prior use of alcohol in males, but in females, the use of *either* cigarettes or alcohol is sufficient to lead to the use of cannabis.¹¹⁵ There is continuing debate about whether there is a predictive association between these factors or whether they reflect confounding environmental factors such as socioeconomic deprivation or availability of substances.^{116, 117} Put another way, not all young people who drink alcohol or who smoke will go on to use cannabis or other drugs or to misuse alcohol but all those who misuse substances started with smoking and/or using alcohol. Importantly, the use of cannabis is associated with a doubling of the risk of developing schizophrenia and this risk could be reduced by discouraging its use amongst vulnerable young people;¹¹⁸ and, significantly, American studies have shown that the median age at onset of drug abuse or dependence is 19 years.¹¹⁹ Doing something early in someone's life to prevent progression to substance misuse is therefore important.

School-based approaches that help pupils to develop coping skills and examine motivation for risky behaviour^{120, 121} family-based programmes addressing parenting,^{87,122,123} group-based therapy for children entering secondary school who are persistently aggressive,⁸⁹ and motivational interviewing for under 25s who are already using drugs^{88,89} are recommended evidence-based interventions to prevent the onset of problematic drug and alcohol use.

There is also strong, high quality evidence that community-based multi-component models (that is, mass media as well as local community and school-based approaches) that enable the creation of partnerships are effective in preventing drug and alcohol misuse, bringing together different groups in a community. Whilst there is marginally less strong evidence on multi-component workplace prevention programmes, these too can enable employers to maintain safe and healthy workplaces.¹²⁴

Whilst prevention is often focused primarily on the younger population, it is important to note the steady increase in the amount of alcohol consumed by older people in recent years¹²⁵ and a sizable cohort of people now aged 46-65 years consume more alcohol every day than any previous generation.¹²⁶ It is also likely that there are differences in the reasons that younger and older people drink more heavily, for example because of bereavement, job loss, reduced self-esteem because of major life changes (such as job loss, reduced independence, long-term medical conditions). Perhaps a third of older drinkers are 'late onset' drinkers^{127,128,129} and the remainder, 'early onset' drinkers started before the age of 40 years.¹²⁷ Specialist services for older drinkers are scarce in the UK but there is evidence that not only are specialist services for older people linked to better results but that they offer additional treatment benefits to current mainstream services.¹³⁰

It is also important to recognise that a quarter to a third of drug misusers also misuse alcohol and these people need to be offered treatment for both drug and alcohol

misuse.¹³¹ (It is noteworthy that informal reports from Reading's drug and alcohol services suggest that at least 50% of drug users also misuse alcohol.)

There is also evidence that interventions for people with moderate or harmful dependence on alcohol are cost effective. For example, in the context of the provision of psychotherapy and other interventions for such people it has been found that:¹³²

- social behaviour and network therapy is equally cost effective as motivational enhancement therapy, each saving about five times as much in costs on health, social care and criminal justice services;
- stepped-care interventions (single session of behavioural change counselling by a GP practice nurse, four 50-minute sessions of motivational enhancement therapy delivered by a trained alcohol counselor, and referral to a community alcohol treatment agency) can lead to greater cost savings and more motivation to change compared with minimal interventions (such as 5-minute directive advice);
- extended case monitoring (low intensity, long-term interaction with an alcohol case worker) was both clinically and cost-effective in preventing lapses in those who had previously misused alcohol;
- coping and social skills, behavioural self-control, motivational enhancement therapy, and family therapy were all cost-effective and reduced relapse rates;
- psychosocial/family therapies produced cost savings to the NHS; and
- two-week in and day-patient regimes were as clinically effective as five-week in-patient regimes but had significantly lower costs.

Local primary prevention activity targeting young people in Reading is mainly delivered through Personal Social Health & Economic (PSHE) Education in local schools, RBC's local young person's substance misuse service, *Source*, and initiatives such as the Community Alcohol Partnership (CAP). The collective aim is develop a culture where both young people and adults, are aware of the risks related to alcohol and, are able to drink responsibly; young people under the age of 18 are only able to access alcohol under responsible and informed supervision, and, safe consumption limits are understood.

Source is a small team of drug and alcohol workers who support young people up to the age of 18 years (or 25 years if a young person has a learning disability). Their service is also extended to parents and carers who are affected by a young person's drug use. *Source* can also refer the families and carers of young people with drug and alcohol issues to an independently-funded provider that works across different Berkshire locations, *DrugFAM*, which provide free support and delivers weekly support groups, one-to-one sessions with families, and telephone support.

The Reading CAP initiative aims to raise awareness of substance misuse through the provision of free resources which are made available to schools across the Reading borough; Resources from the Alcohol Education Trust have been independently evaluated and are aimed at those aged between 11–18 years. Using these resources alcohol awareness lessons are delivered by the Reading CAP, teachers and professionals working within the schools. Professionals are trained to deliver these lessons and support is ongoing to ensure this resource will be used consistently for years to come.

The Reading CAP will also be piloting the *Royal Society of Public Health Youth Health Champions Qualification* in some schools in Reading during 2016. The scheme aims to provide knowledge and vital practical skill sets, and harness young people's natural energy and enthusiasm to facilitate peer to peer education and mentoring about lifestyle related risks to health, to effect real and lasting change in the wider community. These Youth Health Champions will be a valuable resource to the community and the school in which they are situated.

Another essential part of the Reading CAP involves enforcement of the laws relating to young people and alcohol including purchase of alcohol by under-18s, sale to under-18s, drinking by under-18s in public places, and proxy or agent purchase. Compliance testing is an integral part of any CAP and usually takes place several times in the life of a CAP to provide benchmarking activity and monitor the success, or otherwise, of retailer training.

Alcohol retailers in Reading are encouraged to use Challenge 25^{xxii} as an age verification policy. RBC funds training for all retailers on this, as well as on how to identify fake identification, to ensure that this policy is applied in practice locally by all authorised staff. All of this training and intervention contributes towards reducing the risk of young people purchasing alcohol in Reading. (It is interesting to note that anecdotal reports from young people in Reading indicate that it is easier to obtain drugs than it is alcohol for this reason.)

The Reading CAP also supports and aims to ensure that local youth diversionary activities are in place and highlights any community where there may be gaps. Diversionary activities have included provision of sports (using local Reading leisure and sports facilities, youth clubs or 'youth buses' and local cafes) and it provides opportunities for young people to drop in and meet in a supervised, safe environment. Youth workers also have access to the alcohol education resources and offer alcohol awareness activities at youth clubs across Reading.

Parental education is also a key part of the CAP. National studies have shown consistently that only a small proportion of under-18s buy alcohol themselves and that it is mainly adults – usually parents, but also older friends or strangers – who purchase alcohol on behalf of young people. The Reading CAP encourages communications targeted at parents and other adults about the importance of not giving children and younger teenagers alcohol and highlighting the offence of proxy purchase (buying alcohol for or on behalf of an under 18 year-old).

There is also a Cumulative Impact Policy (CIP) that applies to all premises in a designated zone in the centre of Reading. To date, the policy has been effective in restricting new premise license application for late night venues that wish to sell alcohol past midnight and takeaways, which are both becoming a focus for disorder at night in Reading town centre. A combination of CIP and partnership working between RBCs licensing team and Thames Valley Police has been key in providing a local focus on restricting extended licenses to applicants that can robustly demonstrate they can meet the conditions of the license, and, to raise standards with existing licensees. This work could be enhanced with the further evidence and support from other key partners, as improved evidence and intelligence creates better opportunities to reduce the burden of anti-social behaviour fuelled by alcohol

xxii Challenge 25 is a scheme that encourages anyone who is over 18 but looks under 25 to carry acceptable ID when they want to buy alcohol. Challenge 25 builds on the Challenge 21 campaign introduced by the British Beer and Pub Association, who represent the beer and pub sector, in 2005. It's now run by the Retail of Alcohol Standards Group, which represents alcohol retailers.

misuse. One way of achieving this may be taking a coordinated response from all responsible authorities in relation to new license applications, or applications to extend alcohol hours, which could make the CIP more robust. Also, there is currently no body within Reading that can bring together the licensees. Previously there were schemes such as *Pubwatch* and *Best Bar None* which helped to give RBC and traders a forum to meet and to raise standards but these no longer exist.

7.2 Drug and alcohol treatment services in Reading

In 2013, RBC adult services responded to a national drug strategy¹³³ and alcohol strategy¹³⁴ by restructuring existing drug and alcohol misuse service provision being delivered through five separate service providers into a single contract, with a greater focus on recovery from addiction. Previously, in line with national policy, investment was concentrated on a service providing pharmacological harm reduction treatment. Local and national strategy aimed to attract those likely to be engaged in risky behaviour and drug-related crime into a substitute prescribing programme intended to minimise risks. Changes in national policy to focus on supporting drug and alcohol users to achieve recovery made this harm reduction model outdated. Amalgamating these contracts appeared to offer an opportunity for investment to be shifted.

The resulting contract was awarded to Integrated Recovery in Services (*IRiS Partnership*),¹³⁵ a consortium led by *Cranstoun* and including *Inclusion*, both well-established third sector providers of drug and alcohol treatment services. The service is structured into three tranches offering:

- **Health and Engagement**: needle exchange, harm minimisation advice, drop-in services;
- **Change and Recovery**: structured pharmacological and psychosocial interventions, e.g. alcohol detoxification, opiate substitute prescribing, key work and group work utilising motivational interventions and cognitive behavioural approaches to relapse prevention; and
- **Recovery and Reintegration**: offering peer support, access to community activities and mutual aid.

In 2014/15, 85% of all people in treatment with IRiS in Reading received motivational interventions and 37% received cognitive behavioural therapy.¹³⁶ Residential rehabilitation is also funded by RBC in exceptional cases. Applicants must demonstrate commitment to their own recovery and that they have made use of community treatment to progress as far as they are able. Typically, a keyworker may suggest residential rehabilitation as a treatment option and help their client to prepare an application, including looking at which establishment is likely to offer the most appropriate treatment.

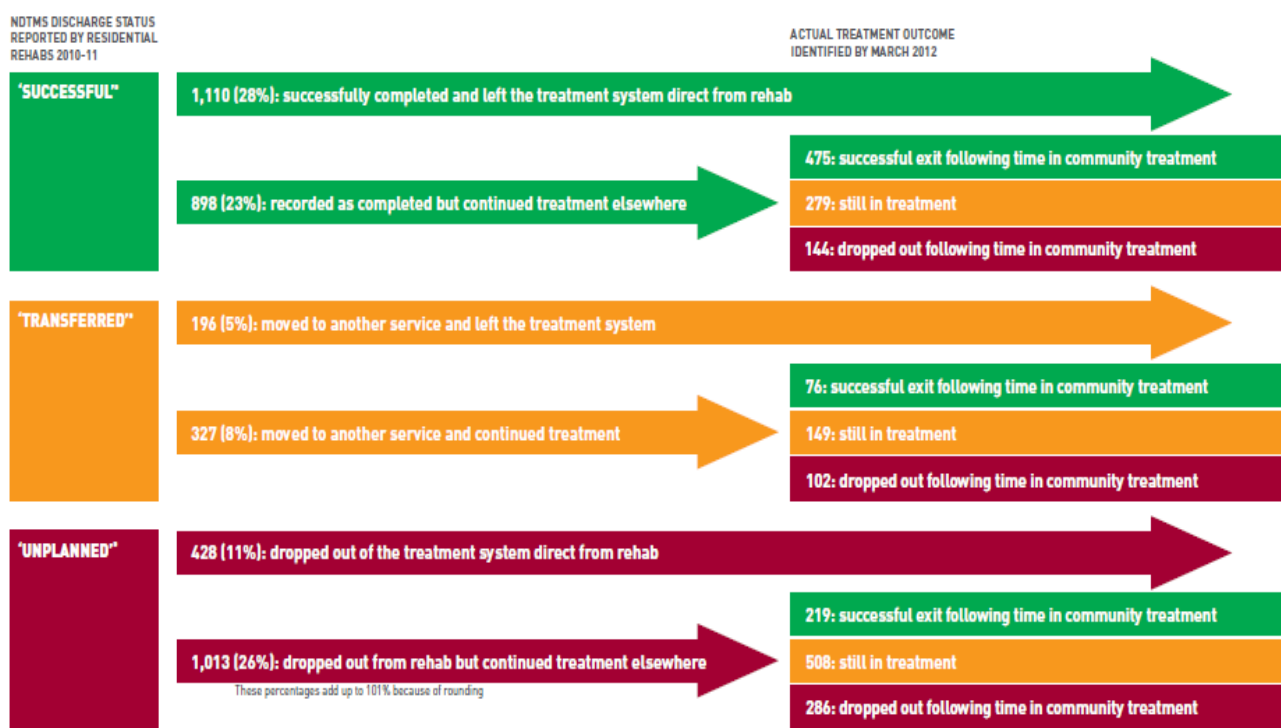
Residential drug or alcohol treatment is perceived as a very powerful treatment option in comparison with equivalent, community-based treatment programmes. There is good evidence to support the effectiveness of residential rehabilitation in helping some people to overcome drug or alcohol addiction.^{137, 138, 139, 140} Residential rehabilitation is particularly recommended for those with complex social and health factors for example, homelessness, significant physical health conditions or severe mental health problems.^{65, 66, 141}

Residential rehabilitation is an expensive provision; each client would be expected to stay for a minimum of 12 weeks at a cost of around £600 per week.¹⁰⁸ Many would be expected to continue to a second stage of a further 12 weeks, sometimes at a slightly reduced weekly cost. Treatment of one client at a residential rehabilitation establishment can therefore be expected to cost between £7,000 and £12,000. Research by the Department of Work and Pensions concludes that, despite good

outcomes, these costs of residential rehabilitation for opiate users are not fully offset by savings from housing benefit, offending, health, and employment.

Evidence published in 2012 by the National Treatment Agency for Substance Misuse (NTA) demonstrates some of the methodological difficulties in understanding effectiveness of residential rehabilitation treatment. The NTA report tracked the treatment journeys of nearly 4,000 residential treatment residents during 2010-12 (see Figure 33) and showed that although half left residential rehabilitation before completion, only 22% of these left treatment altogether. The remainder returned to community treatment and 15% of them ultimately left community treatment free of addiction. Of those who completed their residential rehabilitation treatment, 23% also returned to community treatment (see Figure 36).

Figure 36. The treatment journey of 3,972 residential rehabs residents, 2010 -12



*'Successful' means completed a rehab programme; 'transferred' means moved to another service; and 'unplanned' means dropped-out.

Source: Public Health England (PHE) 2014. *Residential Rehabilitation*, pg. 7.

Through primary care contracts, RBC currently commissions alcohol screening and brief motivation interventions from 27 GP practices across South Reading CCG and North & West Reading CCG. Practices are required to screen both newly-registered and existing patients aged 16 years and older using the AUDIT C tool. AUDIT C is a shortened version of the Alcohol Use Disorders Identification Test, a validated tool developed by the World Health Organisation and used for identifying problematic alcohol use.¹⁴² Where problematic alcohol use is identified, GP practices should offer a brief intervention in line with the 'FRAMES' model described by the National Institute for Care and Excellence,¹⁴³ which includes:

- **Feedback:** identify personal risk or impairment, such as alcohol as a cause of gastritis;
- **Responsibility:** emphasis on personal responsibility to change;

- **Advice:** discuss ways to cut down or abstain in the context of lifestyle choices;
- **Menu:** provide a range of alternative options for changing drinking patterns and setting targets;
- **Empathic interviewing:** listening reflectively without cajoling or confronting; and
- **Self-efficacy:** an interviewing style which enhances people's belief in their ability to change.

Opportunistic brief interventions (also called 'Identification and Brief Advice' (IBA)) are recommended for people drinking above sensible limits who may or may not be experiencing problems which may be related to their alcohol use and, these can be delivered through primary care and other health and social care settings.^{76, 144, 145, 146}

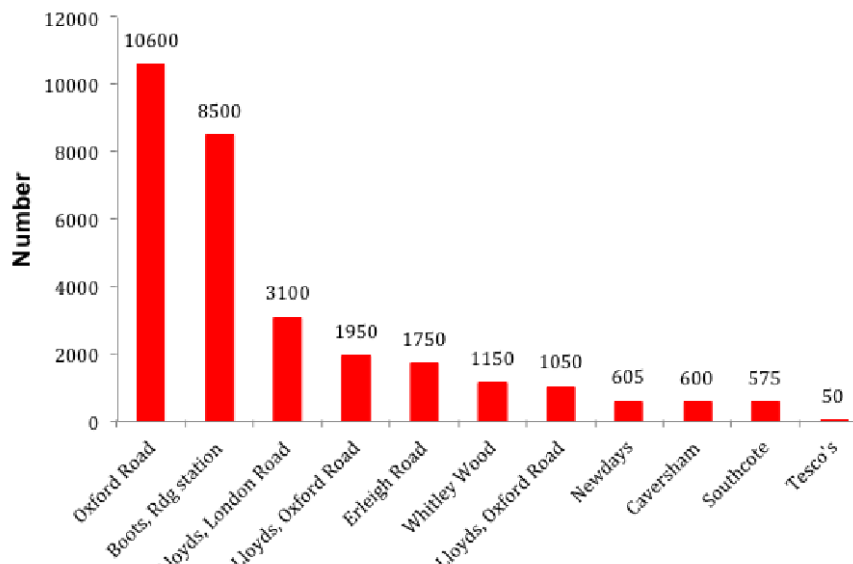
Software used by GP practices uses an automated version of AUDIT C and prompts users to complete assessments. In the first quarter of 2015-16, 812 AUDIT C results were recorded but this does not coincide with modelled estimates of need, or with the number of brief interventions delivered or referrals to structured alcohol treatment. More work is needed to understand how consistently brief interventions are being offered in primary care.

7.3 Needle Exchange

There is good evidence that needle and syringe programmes (NSPs) are an effective way to reduce risks of blood-borne virus transmission associated with injecting drug use, especially where coverage (the proportion of injections for which sterile equipment was used) is high.¹⁴⁷ In Reading, NSPs are provided through nine community pharmacies and at one site provided by IRiS, the specialist drug and alcohol treatment service.

Activity as shown in Figure 37, suggest that the most frequently used pharmacy-based needle exchanges are in Reading station (town centre) and the Oxford Road area (west of town centre).

Figure



Source: Frontier Medical Group, Payments report, 2017-18

xxiii Pharmacists are required to record transactions using the Pharmoutcomes system, but many Pharmacies do not do so and reports are therefore unreliable. The system has capacity to prompt users to ask questions and to link to printable information sheets).

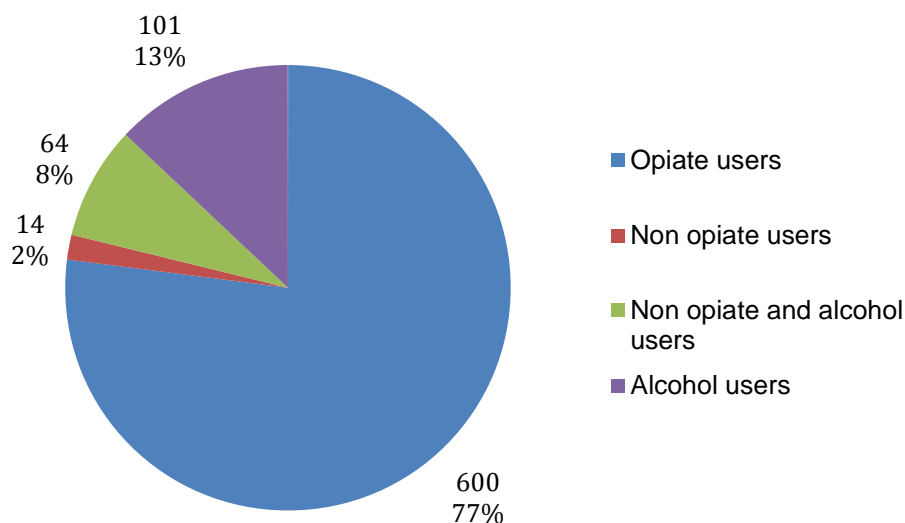
In April 2015, IRiS conducted a survey with pharmacies providing NSPs. The results indicated that pharmacists and pharmacy workers felt that they had gaps in their knowledge about drug use and that they did not always feel confident to provide verbal harm reduction advice to those using needle exchange services, respondents also felt they did not know how to access written information to be taken away.¹⁴⁸ Further analysis of this would be required in order to fully understand the implications of this, for both pharmacy staff and patients.

8 How are services currently being used in Reading?

The following section looks at how local adults and young people’s drug and alcohol treatment services are being used and, at a high level, the outcomes of treatment. The information reported on nationally for adults and young people differs, for example, treatment completion rates for young people are generally measure on planned and unplanned exits rather than successful completions (see section 8.9 for more information).

As shown in Figure 38, three quarters of receiving adults-only care are primarily in treatment for opiate use, followed by alcohol use. These proportions are very similar to those seen in treatment prior to the start of the IRiS contract but does not reflect the need for alcohol misuse identified in this needs assessment. It is important to note that these data do not necessarily include all opiate users in treatment in Reading as some may be prescribed an opiate substitute by their GP without involvement of specialist services.

Figure 38. Substance use profiles of adults in Reading receiving treatment from IRiS, 2014/15

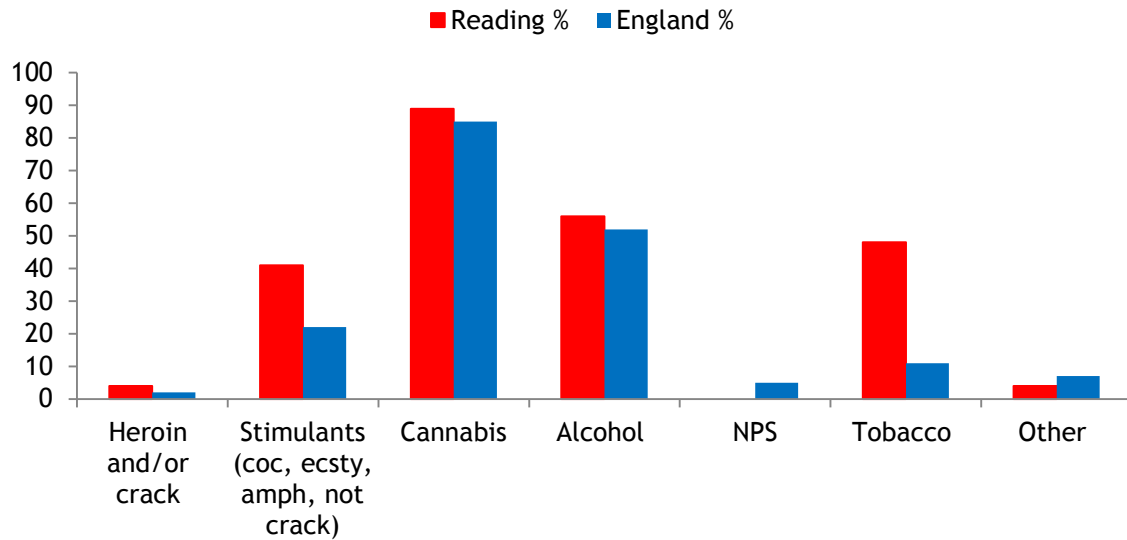


Source: Drug and Alcohol JSNA Support Packs, Public Health England 2015

Cannabis was the main substance used by young people accessing specialist misuses services in Reading during 2014-15 (as shown in Figure 39 below). This includes those aged 18 years and over accessing ‘young people only’ services. Whilst the numbers in Reading are small, 27 in total across all in the service, the percentage comparison against England (substance of use) is similar for all substances except tobacco and stimulants, which were higher in Reading. This

suggests multiple drug use amongst the young people in Reading who are accessing the service.

Figure 39. Substance use in young people* in specialist substance misuse services, Reading and England, 2014-15.

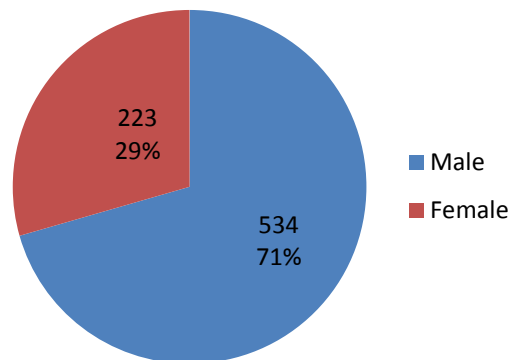


Source: Young People’s substance misuse data: JSNA Support Packs, Public Health England 2015.

8.1 All in treatment population

Over two-thirds of those in drug and alcohol treatment (adults only) in Reading during 2014/15 were male (Figure 40), a similar proportion to that seen nationally (69.9%). While almost half of all referrals into drug and alcohol treatment are self-referrals, fewer women self-refer. Most women are referred to drug and alcohol services through the criminal justice system (35%) or ‘other’ (31%).¹⁴⁹

Figure 40. Reading adult client treatment profile by gender, 2014/15.



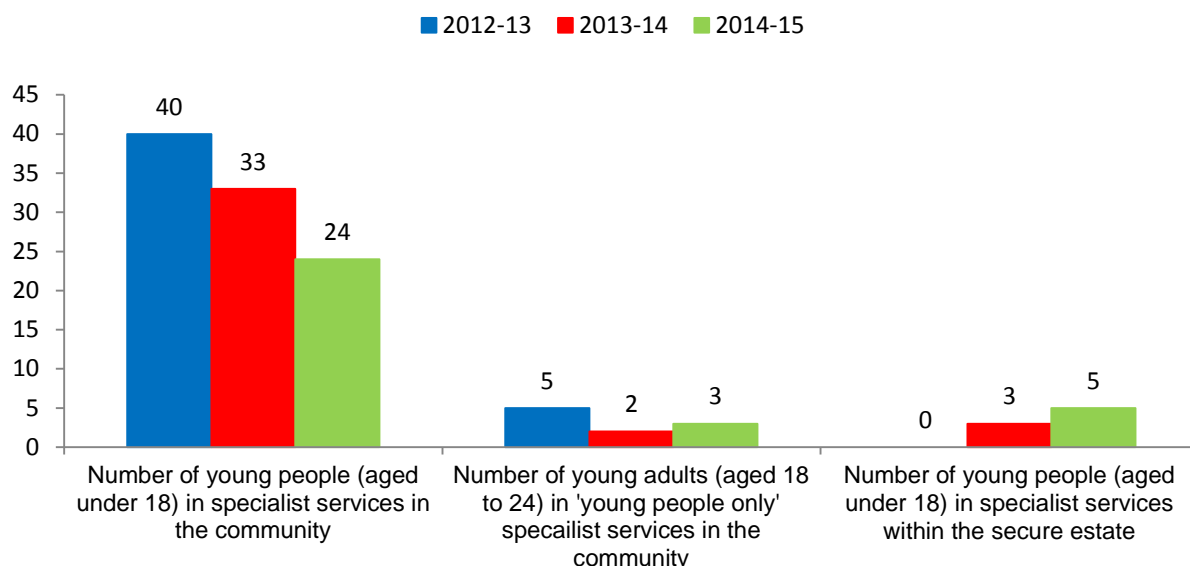
Source: National Drug Treatment Monitoring System, 2015

This was similar for young people in specialist substance misuse services in Reading during 2014/15, where over two thirds (71%) were male. Nationally, the proportion of

females citing alcohol a problematic substance is higher than males, the opposite being the case for cannabis. In Reading, the proportions and numbers are similar.

In Reading, we have also seen a decline in the numbers of young people (aged under 18) in specialist services in the community since 2012-13 (as shown in Figure 41), however we have seen a marginal increase in the number of those in specialist services within the secure estate^{xxiv}.

Figure 41. Numbers in service, Reading, 2012-13 to 2014-15.



Source: Young people's substance misuse data: JSNA support pack. Public Health England 2015.

The number of adults in Reading treatment services from Black and minority ethnic groups is small, as shown in Table 3, and, with the exception of African and Asian populations, roughly corresponding to their proportion in Reading's population. Relationships between drug use and ethnicity are various and complex.

A series of reviews of Department of Health data on drug misuse and different Black and minority ethnic groups discusses the impact of cultural identities on stigma attached to drug use. For example, Black Caribbean participants reported concern about the negative effects of drug use and dealing on their localities and the reputation of their community, leading to increased stigma for users.

The National Treatment Agency for Substance Misuse has concluded that various ethnic groups require more and better-targeted information which not only enables community members to understand the impact of drugs, but also helps them to access and to trust drug services when needed.¹⁵⁰

xxiv Reporting into NDTMS is now done by secure estates such as young offender institutions (YOIs), secure training centres and secure children's homes.

Table 3: Reading users in treatment by ethnic group, 2014/15

Ethnic group		Number in treatment	Proportion in treatment (%)	Proportion in local population (%)
White	White British	586	77.4	65.3
	White Irish	7	0.7	1.5
	Other White	38	5.0	7.9
Mixed	White & Black	22	2.9	1.7
	White & Black African	0	0	0.5
	White & Asian	2	0.3	0.9
	Other Mixed	6	0.8	0.8
Asian or Asian British	Indian	4	0.5	4.2
	Pakistani	27	3.6	4.5
	Bangladeshi	1	0.1	0.4
	Other Asian	20	2.6	3.5
Black or Black British	Caribbean	15	2	2.1
	African	5	0.7	3.9
	Other Black	4	0.5	0.7
Chinese/ Other	Chinese	0	0.0	1.0
	Other	3	0.4	0.5
	Not stated/missing code	19	2.5	0
	Total	757	100	99.4

Source: National Drug Treatment Monitoring System (NMDTS) & Census 2011

Table 4: Patterns of drug use in various Black and minority ethnic groups

Ethnicity	Patterns of Use
Chinese and Vietnamese	Smaller population available for study, difficult to make comments on prevalence. Cannabis and ecstasy most commonly used, especially among young people. Heroin and cocaine powder are also used, but by far fewer than cannabis and ecstasy. Other use of illicit drug is low.
South Asian	Patterns are little different to general population. May be less amongst women, but this may be greater under-reporting.
Black African	Lower prevalence than amongst general population. Cannabis is most used. Khat amongst Somalis and Ethiopians.
Black Caribbean	Large majority exposed to illicit drug use. Cannabis is most used. Crack cocaine more widely used than heroin. Early onset drug use.

Source: Fountain, J (2009).¹⁵¹

8.2 Opiate and crack users in treatment

Reading has an estimated 1,260 opiate and crack users (OCUs).⁷⁸ During 2014/15, 561 opiate or opiate and crack adult users were 'effectively' engaged^{xxv} with treatment services in Reading, equivalent to 44.5% of the estimated number of users

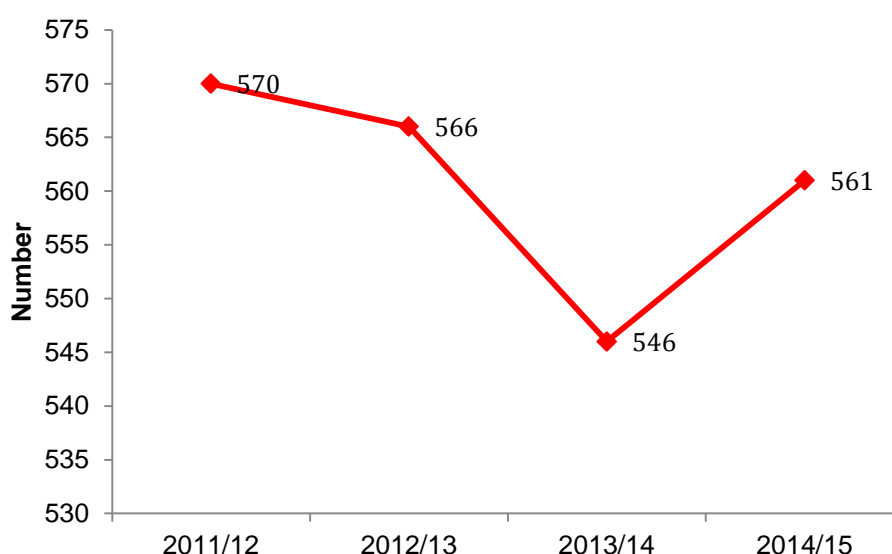
xxv When engaged with treatment, people use fewer illegal drugs. A measure for effective treatment is when people have been in treatment for three months or more and are using fewer or no illegal drugs

in the borough. This is slightly lower than the national rate of 49.6% drug users in treatment of (estimated 293,879 OCU in England, 145,875 in treatment during 2014/15).

Nearly 80% (589) of those individuals using drug and alcohol treatment services in 2014/15 reported problematic heroin or other opiate use at the point when they entered treatment in Reading. Of these, most (59% or 347 individuals) reported using both opiates and crack cocaine. The remainder used opiates only (23% or 139 individuals) or opiates and other drugs (17% or 103 individuals).

The total number of opiate users 'effectively' engaged in treatment declined from 2011/12 to 2013/14, where we can see the number has increase in 2014/15 (Figure 42).

Figure 42. Number of opiate users effectively engaged in treatment, Reading 2011/12 – 2014/15



Source: Public Health England, JSNA Support Pack, Drug Data 2011/12 – 2015/16.

The total number of opiate users 'effectively' engaged in treatment declined from 2011/12 to 2013/14, where we can see the number has increase in 2014/15 (Figure 43).

It is also noteworthy is that a recent statistical analysis by Public Health England and partners of NDTMS data^{152, 153} has drawn attention to the decline in the number of heroin users in treatment in England and highlighted that many now in treatment are older and likely to have additional health needs. The number of opiate users in treatment has fallen from over 170,000 in 2009-10 to less than 155,000 in 2014-15. In 2014-15 nearly half (48%) were aged over 40, compared to just over a third (34%) in 2012-13.

The national report also highlighted a decline in the number of young people accessing drug and alcohol services, which supports the earlier local evidence shown in Figure 44. A large majority of young people in treatment both nationally and in Reading are users of cannabis and alcohol. The total number of young people in treatment peaked in 2009-10 at 23,356, and has since declined, reaching 18,334 in 2014-15. The decline has mostly been seen amongst young alcohol users engaging in treatment, with numbers of cannabis users remaining more consistent. The

number of young people using opiates is consistently low, accounting for not more than 2% of those in treatment in any year since 2005-06.¹³⁸

Figure 43. Trends in opiate users in treatment in England, 2009/10 – 2014/15

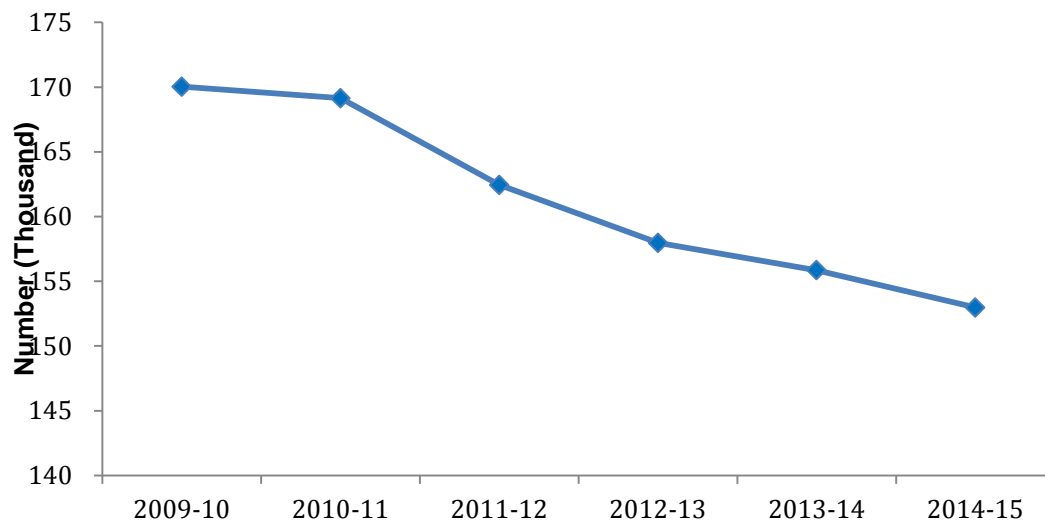
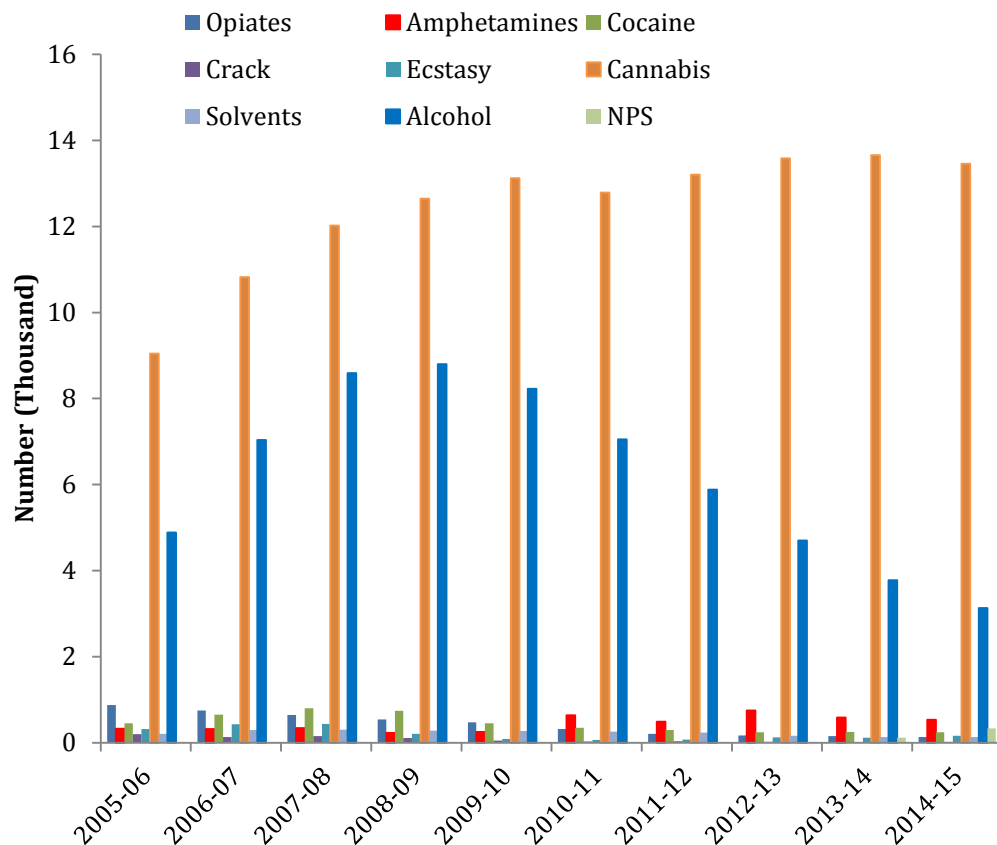


Figure 44. Number of young people in treatment by substance

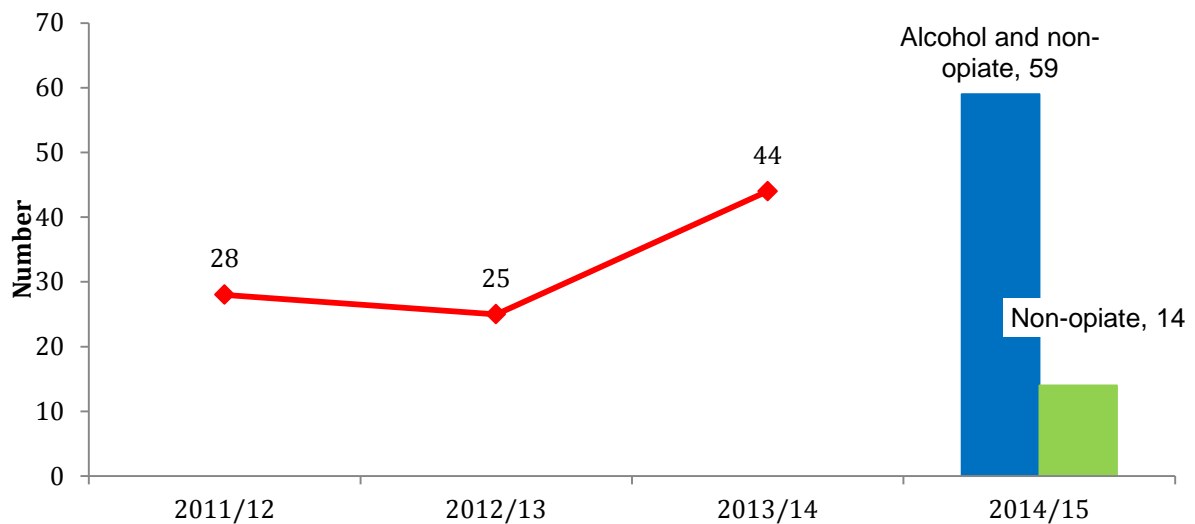


While local data in Reading seem suggest an increasing number of opiate users in treatment, they nevertheless support the finding that opiate users tend to be older, to have been accessing treatment services for their dependence for many years and to have complex needs that are difficult to meet (see section 8.2 for information on complexity)

8.3 Users of other drugs in treatment

Figure 45 shows for the general non-opiate using population, there appears to have been a peak in engagement in 2013/14, which may be related to increased focus on increasing number of successful completions, which tends to be easier to achieve for this cohort. In 2014/15, there was a change in the way substance user profiles were categorised, therefore these numbers have been include in the new categories of 'alcohol and non-opiate' and, 'non-opiate only'.

Figure 45. Non-opiate users in effective treatment, Reading, 2012/13 – 2014/15



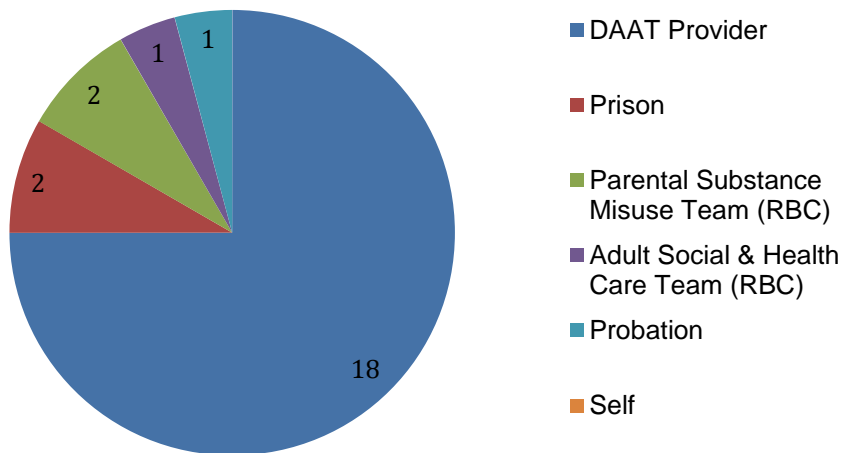
Source: Public Health England, JSNA Support Pack, Drug Data 2011/12 – 2015/16

8.4 Residential rehabilitation

Residential rehabilitation can be very effective but is an expensive treatment option. A local report into outcomes from locally funded residential rehabilitation treatment was made at the end of 2013-14. Applications for funding are made to a panel and reviewed against criteria requiring the applicant to demonstrate their commitment and preparation for residential treatment. During the year, 26 applications for funding were received, with over two thirds being put forward by the drug and alcohol treatment providers (figure 46). Funding was agreed for 17 applicants, the remainder either withdrew applications or were not considered to have met the criteria.

At the end of 2013-14, six of the 17 applicants had completed successfully. Only two successfully completed before the standard 12 weeks of treatment; two completed at 24 weeks of treatment and two after completing more than 24 weeks of treatment. Nearly half have gone beyond the standard 12 weeks of rehabilitation. Using the average weekly costings outlined in section 6 of this report, for the person engaged for 42 weeks, the estimated cost of treatment is in excess of £25,000.

Figure 46. Number of Reading residential rehabilitation applications by referral source 2013/14

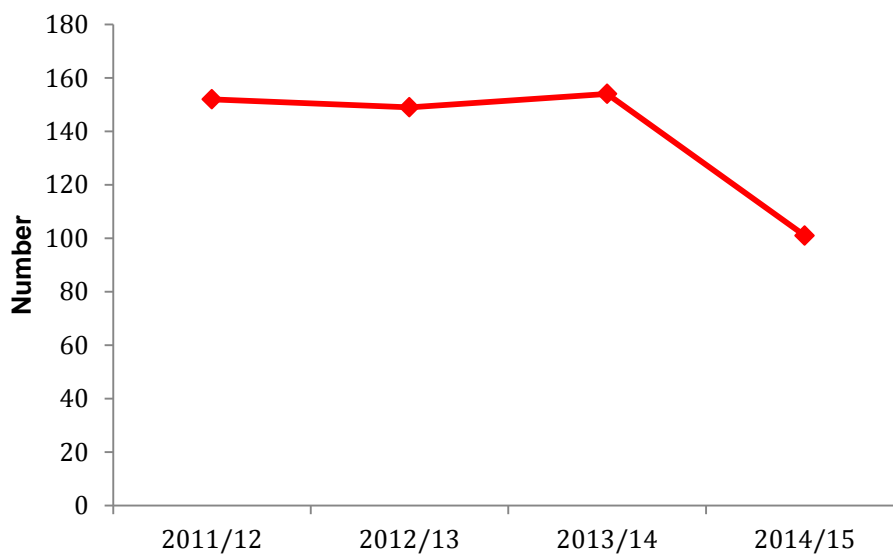


Source: RBC, Integrated Review Panel case records, 2014

8.5 Alcohol users in treatment

The number of adults engaged in treatment who use alcohol and no illicit drugs is much smaller than the proportion of opiate users in treatment and represents only a tiny proportion of those estimated in Reading's population to have problematic drinking. As shown in Figure 47, there were 53 fewer people in alcohol treatment between 2013-14 and 2014-15, representing a very small proportion of the estimated 4,500 adults in Reading drinking at harmful levels.

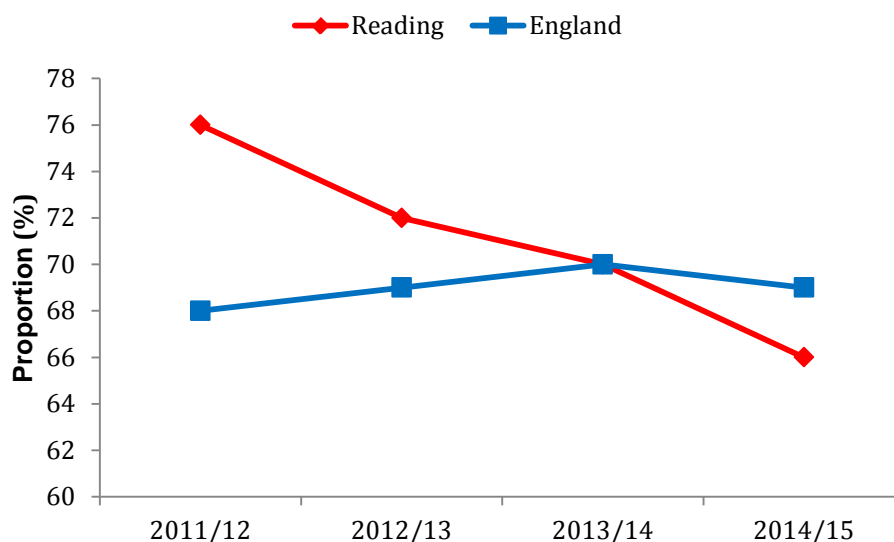
Figure 47. Number of alcohol users in treatment, Reading, 2011/12 – 2014/15.



Source: Public Health England, JSNA Support Pack, Alcohol Data 2011/12 – 2015/16

The proportion of adults starting new treatment in the year as a percentage of all in treatment in Reading has also seen a decline (Figure 48). This suggests that, in contrast to the rest of England, the amount of treatment being provided to alcohol misusers in Reading is decreasing and that the number of alcohol misusers in the area receiving treatment may fall even further the current low number.

Figure 48. The proportion (%) of adults starting new treatment, Reading and England, 2011/12 – 2014/15.



Source: Public Health England, JSNA Support Pack, Alcohol Data 2011/12 – 2015/16

8.6 Drug treatment completion rates

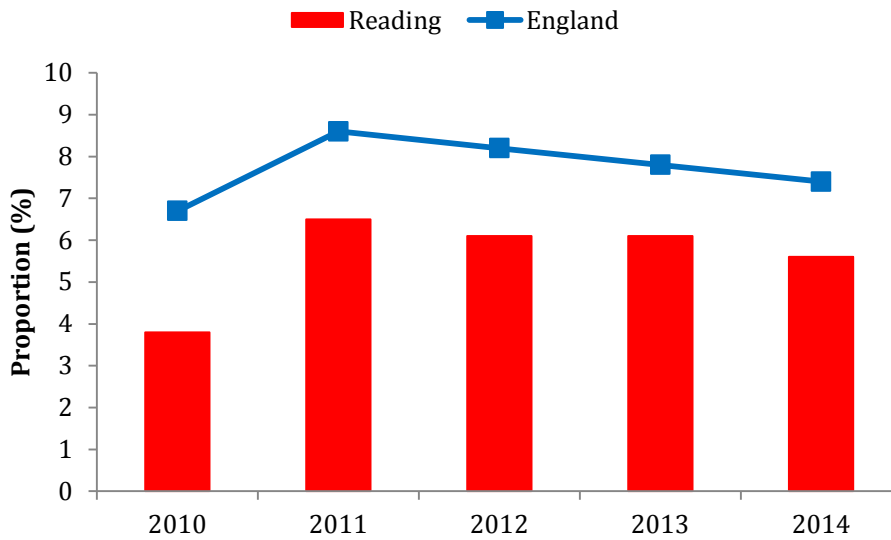
The Public Health Outcomes Framework indicators 2.15 (i), *opiate using* and 2.15(ii), *non-opiate using*, report the proportion of adults in the treatment population who are discharged with completed treatment. Successful drug treatment completion can be defined as people who have used drugs being free of drugs on leaving treatment and not presenting for treatment again for at least six months. To be effective, such treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.¹⁵⁴

8.6.1 Drug treatment completion – opiate users

The proportion of opiate users who leave treatment drug-free is low in Reading: 5.6% left drug-free in 2014, compared to an England average of 7.4% (Figure 49). There has been little change in Reading in performance on this indicator since 2011. The proportion completing treatment has remained consistently below the England average and compares poorly with comparable areas (see Figure 50).^{xxvi}

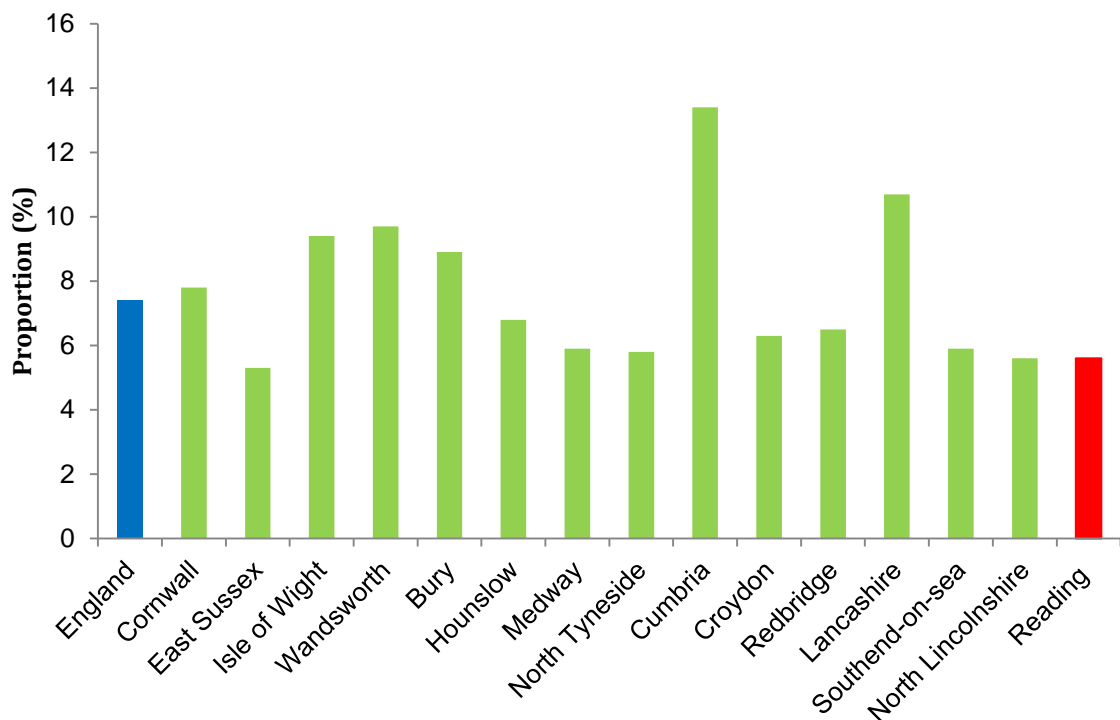
xxvi In 2014/15 a new method of comparators was devised by Public Health England which aimed to improve comparisons between local performance and that of other areas. Local outcome comparators are based specifically on the complexity of the populations in substance misuse treatment and not on broader similarity between the general population of each local authority.

Figure 49 – PHOF 2.15i Proportion (%) of successful completion of drug treatment – opiate users, Reading and England 2012-2015



Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS

Figure 50 – PHOF 2.15i Proportion (%) of successful completion of drug treatment – opiate users, by comparator authorities, 2014

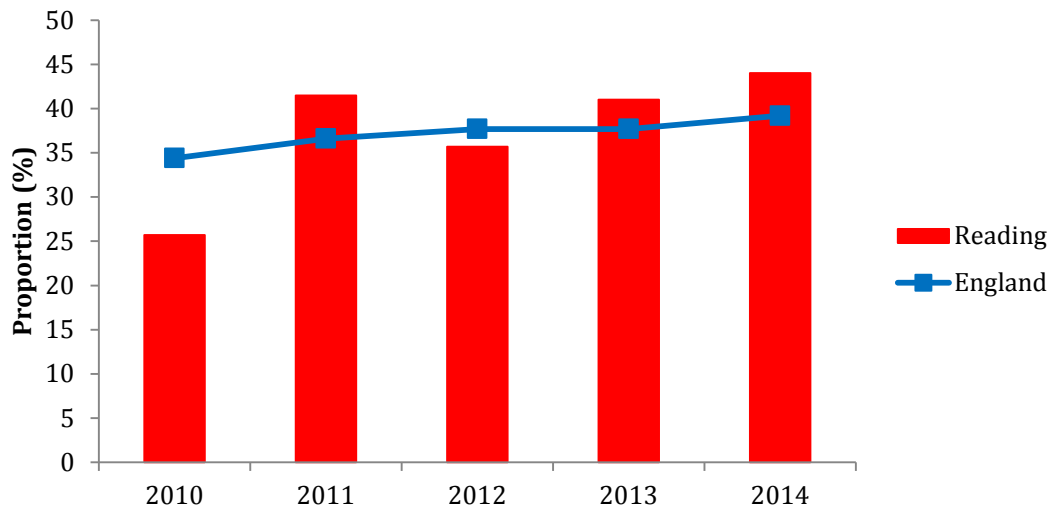


Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS.

8.6.2 Drug treatment completion – non-opiate users

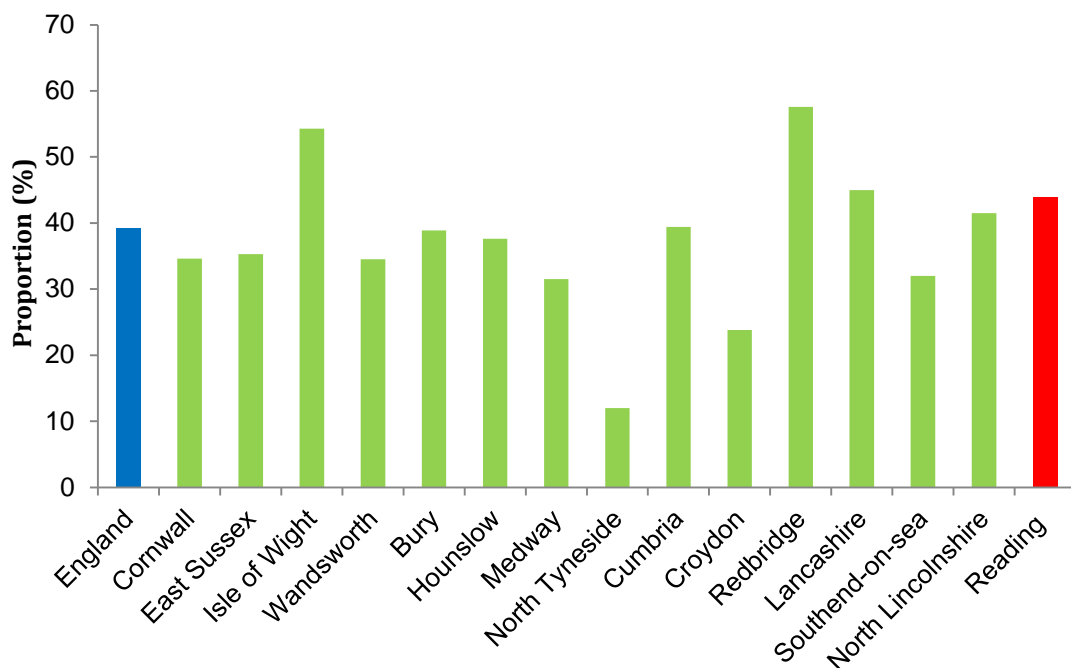
The proportion of adult non-opiate users in Reading who leave treatment drug-free is much larger and, at 44% at the end of 2014, was higher than the England average of 39.2%. Reading performs well against local authority areas with similar deprivation levels (see Figure 51 and Figure 52). It should be remembered, however, that this represents a small proportion of the treatment population so differences may not be statistically significant.

Figure 51 – PHOF 2.15ii Proportion (%) of successful completion of drug treatment – non-opiate user, Reading and England, 2010 - 2014



Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS.

Figure 52 – PHOF 2.15ii Successful completion of drug treatment – non-opiate user, 2014

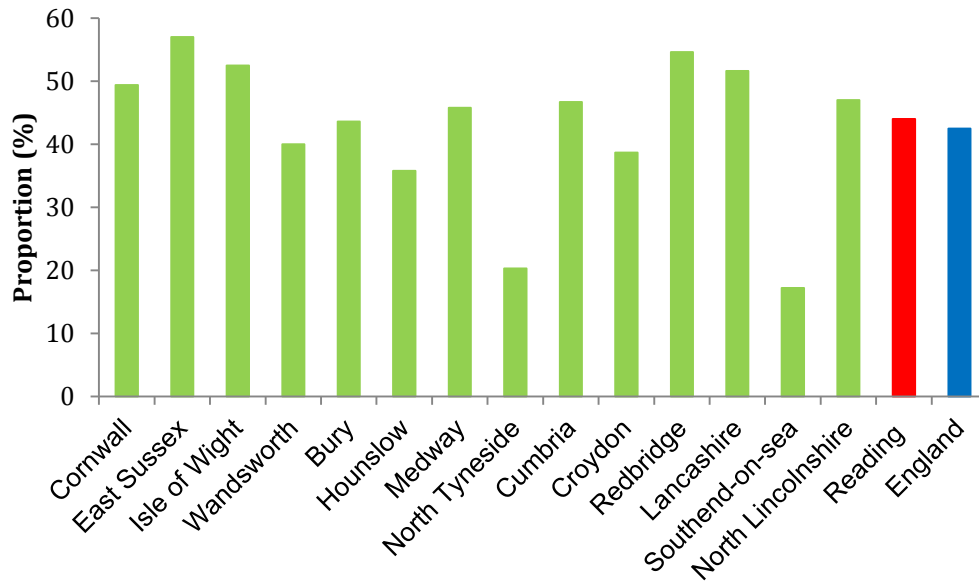


Source: Calculated by Public Health England Knowledge and Intelligence Team (North West) using data from the NDTMS.

8.7 Alcohol completion treatment rate

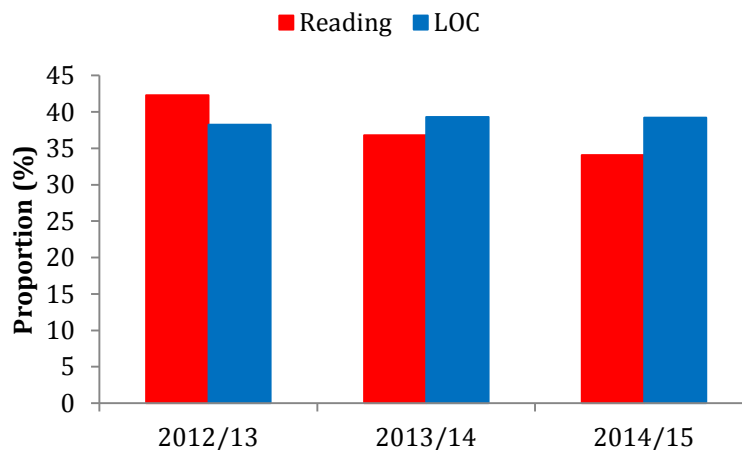
The proportion of clients completing treatment alcohol-free is much the same as the national average (see Figure 53). Again, it should be remembered that this represents only a small proportion of the total alcohol misusing population as the number of alcohol users receiving treatment is very small. As the completion of alcohol treatment is not measured by PHOF, using the data from NDTMS (figure 54), we can see this shows a similar trend.

Figure 53. Successful completion of treatment for alcohol 2013 (in comparison with areas with similar level of deprivation)



Source: Healthier Lives, Public Health England 2015

Figure 54 – Successful completion of alcohol treatment, Reading and LOC^{xxvii} 2012/13-2014/15 – non-opiate users



Source: NDTMS, Recovery Diagnostic Tool, 2014/15

xxvii Reading's 'Local Outcome Comparators' are the 32 areas considered most similar to Reading based on measures of treatment population complexity, determined by NDTMS and PHE.

8.8 Complexity

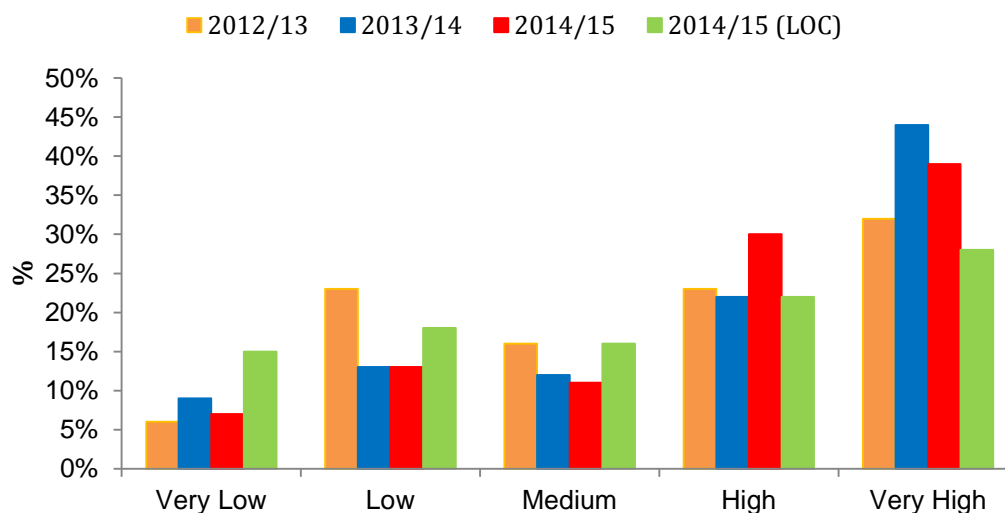
One of the difficulties in comparing treatment engagement and outcomes for drug and alcohol treatment in different localities is the diversity in populations and differences in the needs of those seeking treatment. A small population of individuals with needs that are difficult to meet may require more resources than a larger population whose needs could be considered straightforward.

Public Health England assigns a complexity score to individuals in drug and alcohol treatment that enables the characteristics of treatment populations in different areas to be compared. Complexity scores are based on:

- whether they use heroin, methadone or other opiates;
- the frequency of heroin use;
- the frequency of injecting;
- the frequency of crack use;
- the frequency of amphetamine use;
- the frequency of alcohol use;
- whether they use benzodiazepines; and
- the number of previous unsuccessful episode of treatment.

As shown in Figure 55, of the 669 individuals in treatment in drug and alcohol treatment in Reading in 2014/15, 258 (39%) scored 'very high' for complexity. This indicates that, based on criteria developed by Public Health England and measured through NDTMS, Reading's treatment population appears to have very complex needs that require more resources to meet. This is higher than the national average of 28% 'very complex' individuals.

Figure 55 – Complexity scores for all in drug and alcohol treatment in Reading

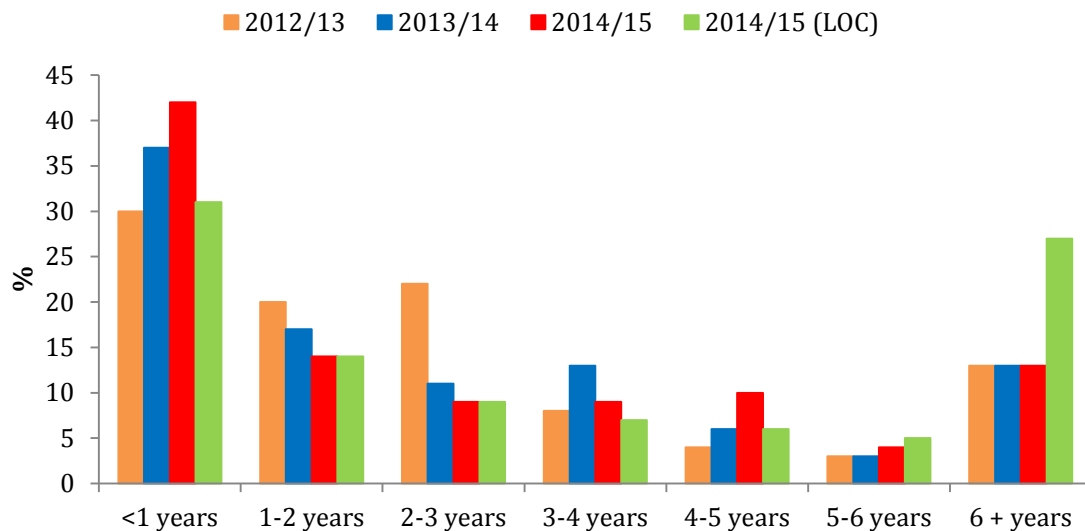


Source: NDTMS, Recovery Diagnostic Tool, 2014/15

In part, it is likely that this reflects the high proportion of heroin and other opiate users in Reading's treatment population. It may also be a reflection of the long-term heroin use amongst this growing cohort. As shown in Figure 56, the proportion of those in treatment in Reading for opiate use who have remained in treatment for four years or more increased from 20% to 27% between 2012-13 and 2014-15 (112 individuals in

2012-13, 127 in 2013-14 and 161 in 2014-15). The proportion of the population with four or more previous episodes of treatment has also increased from 21% to 30% in the same period and in 2014/15 was higher than in Reading's comparable local authority areas (LOC) (figure 56). This suggests a growing proportion in treatment who have been in treatment for a long time or have moved in and out of treatment over a number of years.

Figure 56 – Length of time in treatment opiate users in treatment in Reading compared to areas with similar treatment populations



.Source: NDTMS, Recovery Diagnostic Tool, 2014/15

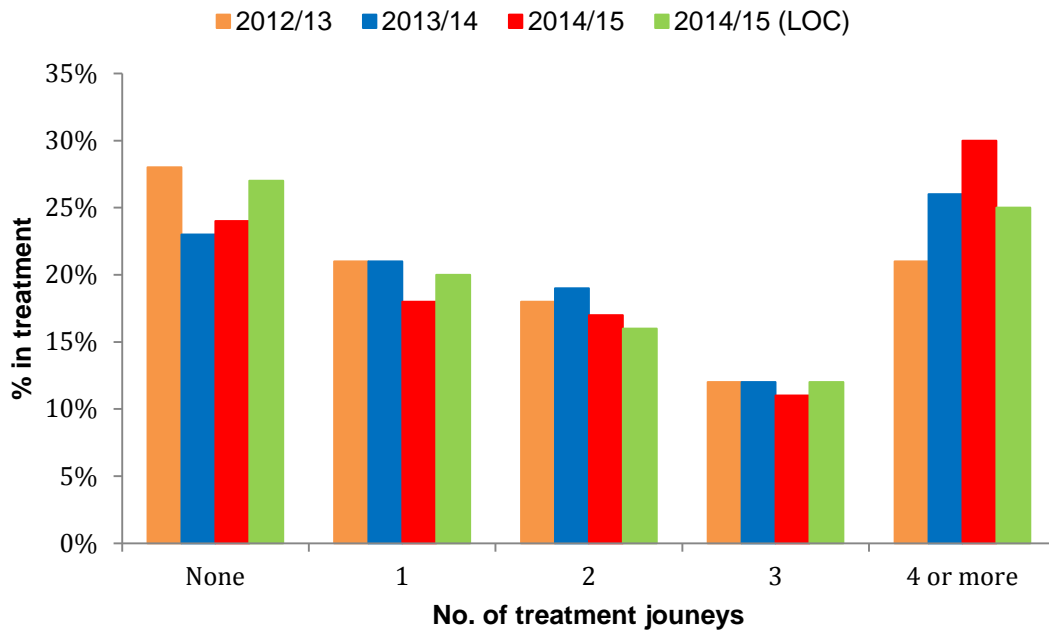
Figure 56 shows how long opiate users in treatment in Reading have been in treatment. The proportion in each 'treatment length' category for Reading is shown for each year alongside the percentage in comparison with areas with treatment populations of similar complexity (shown in green).

The chart demonstrates a large and increasing proportion in treatment for less than one year (most of these are unsuccessful). For the last three years around 13% of those in treatment have been in treatment for 6 years or more.

Figure 57 shows how many previous episodes of treatment opiate users in Reading have had. The proportion in each 'number of previous episodes' category for Reading is shown for each year alongside the percentage in comparison with areas with treatment populations of similar complexity (shown in green).

The chart indicates that the largest proportion (30%) have had four or more treatment journeys, suggesting that most people in treatment in Reading have moved in and out of treatment several times without successfully addressing their opiate use. The proportion of those in treatment in this category is higher than the average amongst comparable areas and is on an upward trend.

Figure 57 – Number of previous treatment journeys of opiate users in treatment in Reading compared to areas with similar treatment populations



Source: NDTMS, Recovery Diagnostic Tool, 2014/15

By comparison, alcohol users and non-opiate users in treatment in Reading are less likely to have had multiple previous treatment episodes and more likely to have a successful outcome from treatment. (In 2013/14, no non-opiate users and 7% of alcohol users had four or more treatment journeys, 86% of non-opiate users and 43% of alcohol users had never entered treatment before). This suggests that non-opiate and alcohol users are more likely to have a single episode of successful treatment, while opiate users are more likely to move in and out of treatment for a number of years and not to leave treatment free of addiction.

8.9 Young people and treatment

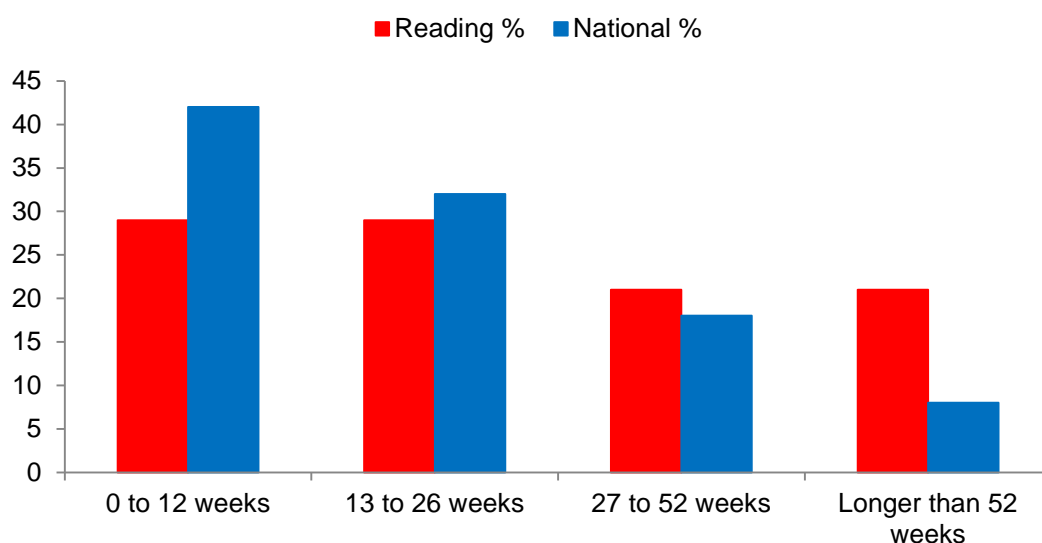
This section describes the length of time, interventions delivered and planned exit of young people who accessed specialist substance misuse treatment services in Reading. Whilst young people with complex needs often require extended support, for the most part, it is expected that young people will spend less time in specialist interventions.

Figure 58 shows that the proportion of young people in specialist services is similar to the national figure, except for those that in services between 0-12 weeks and, longer than 52 weeks. Whilst the numbers are very small, having more young people in treatment longer than 52 weeks could indicate Reading has more complex cases, or younger people with wider vulnerabilities that need ongoing support.

Having available a wide range of interventions which can be delivered to meet the specific needs of a young person will often result in better outcomes, particularly

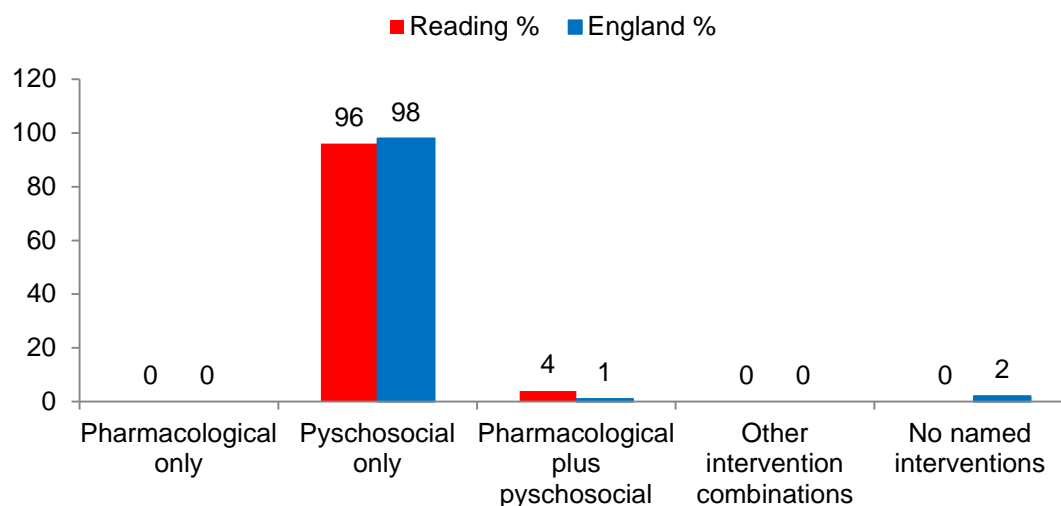
when supported by care. As shown in Figure 59, the most common intervention is psychosocial^{xxviii} which is designed to encourage behaviour change.

Figure 58 Young people length of time in specialist substance misuse services, Reading, 2014-15.



Source: Young people’s substance misuse data: JSNA support pack. Public Health England 2015.

Figure 59. Interventions offered to young people in treatment services, Reading and England, 2014-15.



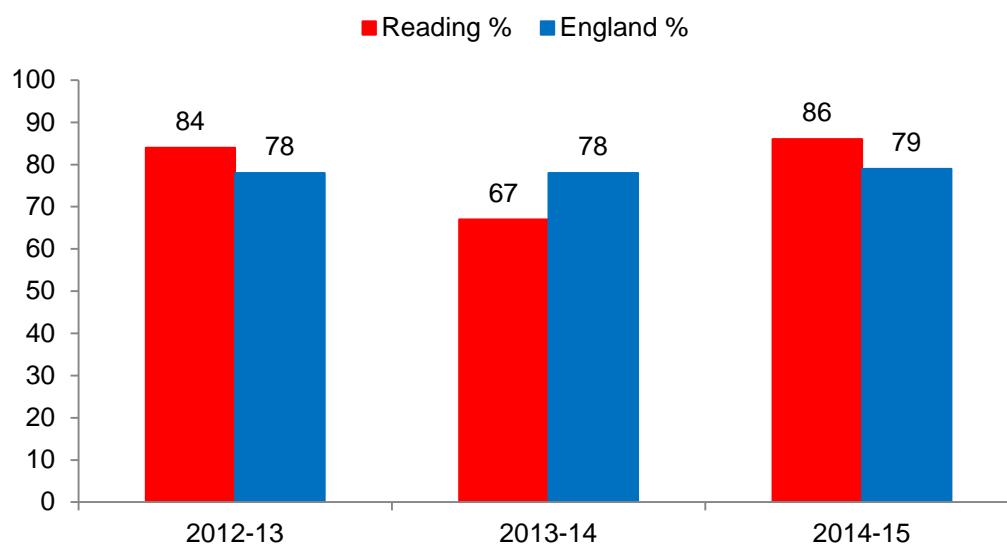
Source: Young people’s substance misuse data: JSNA support pack. Public Health England 2015.

Leaving specialist interventions in a planned way is the measure of success for young people, however if they re-present to treatment, this is not necessarily considered a failure. Re-presentations may occur if a young person’s circumstances change and, this creates an opportunity for reassessment and a personalised plan

xxviii Psychosocial interventions are a range of talking therapies designed to encourage behaviour change. Data produced and published by Public Health England includes family interventions and harm reduction as well as other specific psychosocial interventions types.

that can support them to address the challenges they face. Figure 60 shows that the proportion of young people leaving substance misuse services in Reading in a planned way is similar to the England for 2014-15, having seen an increase between 2013-14 and 2014-15. There were no planned exits with re-presentation in Reading between 1 January 2014 and 31 December 2014.

Figure 60. Proportion of those leaving young persons treatment in a planned way as a percentage of all exits, Reading and England, 2012-13 to 2014-15.



Source: Young people's substance misuse data: JSNA support pack. Public Health England 2015.

Commissioning of local specialist services for young people enables us to engage quickly and effectively with young people and the Department of Education cost-analysis estimates that for every £1 invested, savings of between £1.93 (within 2 years) and £8.38 (long term) could be achieved.

9 Discussion

In Reading, understandably, there has perhaps been a greater emphasis put on the treatment of drug misuse rather than alcohol misuse. Whilst drug-related deaths rates in the local population are higher than the England average, and in comparison with the other Berkshire local authorities, the numbers remain small. In contrast, the figures in this report show that the health and social care and the wider societal effects of alcohol misuse are substantially greater than those of drug misuse. This may be in part because, with the possible exception of cannabis and NPSs, only a relatively small number of people use drugs (principally opiates, cocaine, and their derivatives, all of which are illegal), the use of almost all of which leads to a variety of significant and very complex problems. In contrast, a very large number of people use alcohol (which is a legal substance that is a significant part of the culture in the UK) and which has a proportionately smaller risk of significant problems. But, because the number of alcohol users is so large, the number of people who develop health and social problems is very much higher and the wider societal issues associated with it are very much more extensive.

Next to tobacco, alcohol is the most commonly used substance in Reading that leads to significant health problems. We know that nationally there has been a decrease in the estimated numbers of people drinking alcohol; but there is still a sizable proportion of people drinking at hazardous and at harmful levels. Modelled estimates

for Reading suggest that there are likely to be a large number of people (almost 30,000) drinking in excess of current recommended weekly amounts, with nearly 4,500 residents drinking to harmful levels. Taking into consideration that surveys on which national and local estimates are based consistently reported lower levels of consumption that would be expected using data on alcohol sales, we can conclude that the modelled estimates for Reading are likely to substantially underestimate the alcohol consumption in our community, perhaps by about a half.

More adult males than females drink alcohol at high risk levels, however alcohol misuse is increasingly more common amongst young females. There is also evidence of higher than average rates of alcohol-related ill health and mortality in adults in Reading, which reflects a cohort of people who have been drinking chronically (probably for between 10 and 30 years), and reported admissions to hospital are increasing (possibly because detection of previously undiagnosed alcohol related conditions has improved, particularly notable in some conditions in females) but mostly because more alcohol is being consumed. We also know that alcohol misuse is not confined to young people but to people of all ages and that a sizable cohort of people now aged 46-65 years consume more alcohol every day than any previous generation. It is also noteworthy that alcohol consumption is generally greater amongst people in higher socio-economic groups.

Alcohol is estimated to be implicated in 40% of violent crimes and 78% of assaults (such as domestic violence) and 88% of criminal damage cases, and figures suggest there is a growing number of alcohol-related crimes in Reading. Reading also has a statistically significant higher proportion of alcohol misusers who had not engaged with treatment in the community before entering prison.

In addition to low engagement of treatment by offenders entering prison in Reading, in comparison to the estimated number of people drinking to harmful levels, there are low numbers of people in the general community in Reading engaged with adult treatment services citing alcohol as their primary substances of misuse. It is unclear if this is due to lack of awareness, low screening rates of patients in Reading of their alcohol use, and/or referrals into treatment services. Furthermore, we know that there are different reasons that younger and older populations drink alcohol and, perhaps, a greater availability of specialist services, particularly for older people, may result in better engagement.

By comparison, Reading has an estimated population of between 600 and 1,300 opiate and/or crack cocaine users, and drug use incurs physical dependence, unpleasant symptoms of withdrawal and a risky, volatile lifestyle that exposes users to potential overdose, blood borne viruses (for those injecting drugs), and involvement in crime (particularly acquisitive crime). Reading has a statistically significant higher proportion of injecting drug users in comparison to other similar local authorities and, a higher rate of drug-related deaths.

Specialist drug treatment services in Reading engage with around 500-600 opiate users each year, which means that we are potentially only reaching half the drug-using population over a year. (The number is probably lower as many of these 500-600 clients stay in treatment for several years or leave and return to treatment.) Only a very small proportion of these clients (and smaller than other areas with similarly complex treatment populations) leave treatment drug-free.

Finally, while there good evidence from household surveys that suggests that, nationally, cannabis is the most widely used illegal drug, followed by cocaine, and that there is an emerging issue relating to novel psychoactive substances, there are

only a small number of people, particularly young people, in treatment in Reading who cite these drugs as being problematic for them and even fewer citing these as the drugs that they are primarily dependent upon. This could be because, for the most part, people believe they are able to use these drugs recreationally or with seemingly little effect on their lives (and this may be true to a large extent, although there is an increase risk, certainly of health harms, associated with their use).

So what else can be done to identify and help people who misuse drugs and/or alcohol? One simple thing is improving the local provision of 'brief advice' by health services (and, by implication, also by social and community care) professionals; brief advice for hazardous and harmful drinking is effective in reducing harm, but it is important to recognise that people with alcohol dependence and some harmful drinkers will require more specialist alcohol services.¹⁵⁵ This certainly applies in a primary care setting, where there is consistent evidence from a large number of studies of the effectiveness of brief interventions in reducing total alcohol consumption and episodes of binge drinking in hazardous drinkers for periods lasting up to a year.¹⁵⁶ A brief intervention is effective at the point when the hazardous or harmful drinker is newly identified¹⁵⁷ and may occur during attendance for a related or unrelated illness or injury, at health screening for employment or for insurance purposes. With appropriate training, it should be possible to provide such brief interventions in social care and other council service settings as well, especially as alcohol misuse is a common but often unrecognised problem in older people.¹⁵⁸

A particularly authoritative source of evidence for various different approaches to the management of alcohol misuse has been produced by the National Institute for Health and Care Excellence¹⁵⁹ together with a recent update.¹⁶⁰ The key points of these, all of which are based on evidence of effectiveness, are that:

- a combination of approaches is required to manage alcohol misuse at both a population-level and an individual one;
- making alcohol less affordable is the most effective way of reducing alcohol-related harm (all major medical bodies, such as medical royal colleges, advocate a national minimum price policy for alcoholic drinks based on the number of alcohol units contained);
- reducing the availability of alcohol, for example, by limiting the number of outlets selling alcohol in an area, and the number of days and hours when it can be sold: in Scotland, protection of the public's health is part of the licensing objectives;
- reducing the exposure of young people to alcohol advertising;
- using local crime and related trauma data to map alcohol-related problems as part of a review of licensing policy;
- adequately resourcing enforcement services to prevent under-age sales;
- supporting children and young people who are thought to be at risk because of their use of alcohol;
- supporting the use of screening and brief interventions (which applies in both health and social care and voluntary sector settings);
- supporting the use of extended brief interventions, for example, using motivational interviewing, (which applies in both health and social care and voluntary sector settings); and
- referring people to services, as relevant (which requires adequate resourcing of those services).

There is also a role for voluntary organisations (for example Alcoholics' Anonymous) in helping people with drinking problems (and the related organisations, Al-Anon for the significant others of alcoholics, and Al-Ateen for their children). A review of a number of studies of Alcoholics Anonymous (AA) and other self-help 'twelve-step facilitation' (TSF) programmes versus other psychological interventions in reducing alcohol intake, obtaining and maintaining abstinence, improving the quality of life of affected people and their families, and reducing alcohol-related accidents and health problems found no experimental studies unequivocally proving the effectiveness of AA or TSF for reducing drinking problems, but attending AA meetings was shown to help people to accept treatment and to stay in treatment, and both AA and TSF helped people to reduce drinking, but not necessarily to achieve complete abstinence, in comparison with other psychological programmes.¹⁶¹

Helping people with drug problems, and – especially – helping them to avoid starting misuse in the first place, is more difficult. Not only do many drug misusers have a myriad of health and social problems which require interventions from a range of providers (who ideally should work in an integrated way), drug misuse can also place an enormous strain on families, including children, and can have a serious negative impact on the long-term health and wellbeing of family members: protecting children from the potential impact of drug misuse is thus also an important issue.¹⁶² Specialist-provider involvement is especially important for drug misusers, as injecting drug users especially, which is a particularly issue in Reading, are particularly vulnerable to contracting and spreading blood-borne viruses such as hepatitis B, hepatitis C and HIV. For example, a long-term follow-up of heroin addicts showed they had a mortality risk nearly 12 times greater than the general population,¹⁶³ and another study of injecting drug users showed that they were 22 times more likely to die than their non-injecting peers.¹⁶⁴

A large proportion of people who misuse drugs do not limit their use to any particular one and a very high proportion also misuse alcohol and also smoke tobacco. Pharmacological approaches are the primary treatment option for opioid misuse, with psychosocial interventions providing an important element of the overall treatment package. Opportunistic brief interventions focused on motivation should be offered to people in limited contact with drug services (for example, those attending a needle and syringe exchange service and in primary care settings) if the service user or staff member identifies concerns about drug misuse. These interventions should:

- normally consist of two sessions each lasting 10–45 minutes; and
- explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour, and provide non-judgmental feedback.¹⁶⁵

Addressing broad social problems, improving levels of educational attainment and opportunities for work, in common with reducing health inequalities and improving people's health, are also relevant to helping people to avoid getting drawn in to the downward spiral that usually accompanies drug use.

Whilst helping to address drug misuse issues in Reading is important, the sheer size of the alcohol misuse problem should make this a much greater priority.

10 Conclusion

Alcohol misuse is a much bigger issue in Reading than drug misuse: it affects far more people individually and has much wider societal impacts. Significant problems

are related to both, but especially to alcohol misuse, are getting bigger year-on-year in Reading, as elsewhere.

The lives of most drug users and of a sizeable group of alcohol misusers are complex and often chaotic. A multidisciplinary approach that truly joins up the various different services provided (for example, general practice, A&E, other hospital services, community services, specialist drug and alcohol services, social services and voluntary and community services) will enable benefit for them and their families and for society more generally.

Our current service has been commissioned to concentrate mainly on people with significant opioid drug dependency (with, recently, a slight increase in the number of people with severe alcohol dependency being treated) with many having been in 'treatment' for many years: we currently have a cohort of between 500-600 opiate users many of whom have multiple occasions of engagement with specialist services, but with only a very small proportion leaving treatment drug-free each year. This begs the question: are they content with their current lifestyle and have no real motivation to change? Whatever the reasons, within the current allocation of resources for drug and alcohol services, there are very many people who would benefit from short-term, semi or high intensity interventions that would have a high likelihood of preventing them from developing significant drug or alcohol-related problems but whose needs are not being addressed. We thus need to consider providing a different type of specialist service to the one currently being provided so that many more people with alcohol misuse problems, and those with early drug use problems, who can benefit from specialist intervention and be much more likely to avoid long-term misuse and dependency, can benefit from specialist interventions.

There is also a need to develop services for people who use NSPs. Currently, there are only one or two specialist units in the country yet this is becoming an increasing problem. The scale of physical and mental health risk in using NSPs is not clear, and, for many, it may be that 'recreational use' of these substances, and cannabis, is no more an issue than the 'recreational use' of alcohol. However, it is important that, for 'recreational' users of both drugs (such as cannabis and NSPs) and alcohol, there are services available to help those at risk of dependency and significant harm.

It is clear that current drug and alcohol services are not meeting local needs. Principally the needs of people that are not being met are:

- alcohol misuse – there are very many more people in Reading who could benefit from specialist treatment than are able to receive it under current arrangements; and
- prevention – there are many people in Reading with either (or both) 'early' misuse of alcohol and drugs who could benefit from specialist intervention to help them avoid a descent into more damaging use of substances.

11 Recommendations

Reading needs a revised approach to its drug and alcohol services that:

- puts a much greater emphasis on the problems of alcohol misuse at all ages (that is, younger people and older ones), and for people with different problems causing them to use drugs and/or to misuse alcohol;
- puts a much greater emphasis on prevention, particularly targeting 0-18 year-olds, with specialist family support for children at risk, but also helping to address the issue that both young and older adults face;

- ensures that all health and social care services, and those of the police and judicial system, work together more effectively so that people do not fall into gaps between services and so that it is simple to provide care between different agencies without the service user having to try to negotiate their way from one to another;
- provides services of all types in different locations to improve engagement and thus outcomes;
- enables and encourages front-line staff in all sectors, to do much more to identify people at risk of misusing drugs and/or alcohol and to provide brief interventions, and refer to appropriate services; and
- enables different policies and services and the enforcement of regulations, to take account of the cumulative impact of drug and alcohol misuse to enable greater benefit to people's health and to the community more widely.

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