Drug misuse Joint Strategic Needs Assessment

Key message: Over a third of the population aged 15-59 years are estimated to have taken drugs at some point in their lives, although fewer people are using drugs than 10 years ago. The social and economic cost of drug supply in England and Wales is estimated to be £10.7 billion a year.

1. Why is reducing drug misuse a priority?

Illicit drug use is engrained in British culture, with over a third of the population aged 15-59 years estimated to have taken drugs at some point in their lives[1]. In 2015-16, around 2.7 million (8.4%) of 16-59 year olds in England and Wales reported using a drug in the last year, a proportion which has reduced over the last decade but remained stable over the last seven years[2]. The trend is similar for younger people, but the proportion of them taking drugs is higher; 18% of 16-24 year olds[2]. Although fewer people are using drugs than 10 to 15 years ago, an increase in hospital admissions and drug-related deaths, indicate that drug-related harm is increasing[1]. The evidence suggests this increase is largely among a small but growing number of vulnerable people e.g. older entrenched heroin users[1].

The social and economic cost of drug supply in England and Wales is estimated to be £10.7 billion a year, just over half of which, (£6 billion), is attributed to drug-related crime[1]. Currently, there are no estimates of the social and economic cost of drug misuse in Cheshire West and Chester, although, the cost to local organisations e.g. Police, Local Authority, NHS etc., is significant, at a time when Public Sector resources are being reduced.

In line with the available evidence and national guidelines, Cheshire West and Chester commission a Substance Misuse Service focused on recovery; recognising the wider support needed to achieve and sustain a life free from drugs[1]. Those in decent housing, employment and with good social networks are more likely to recover and remain drug-free[1]. There is clear evidence that programmes which are least effective in preventing substance misuse, are those that focus solely on scare tactics, knowledge-only approaches, mass media campaigns or the employment of ex-users and the Police as drug educators in schools, where their input is not part of a wider evidence based prevention programme[4].

The harms caused by drug misuse are far-reaching and affect our lives at every level. It includes health issues, drug dependency, crime committed to fuel drug dependence; organised criminality, violence and exploitation, and, irreparable damage and loss to the communities, families and individuals[1]. The harm drug misuse causes can be seen clearly in the headline statistics for the local area, for example,

- An estimated 15,629 adults aged 15-59 years in Cheshire West and Chester have taken an illicit drug in the last year.
- Locally, there were 1,485 clients in treatment for drug misuse during 2016-17.
- During 2016-17, there were 9,564 syringe exchange transactions in Cheshire West and Chester, people using this service were taking psychoactive drugs, steroids and image/performance enhancing drugs.
- In Cheshire West and Chester in 2016, up to 3,700 thefts could be attributed to offenders who use heroin, cocaine or crack cocaine.
- Locally, there were 38 deaths from drug misuse in Cheshire West and Chester in 2013-2015.

The complexity and pervasiveness of drug misuse and the harms it causes means that no one organisation can tackle it alone. It is vital that we do this together, using a coordinated, partnership-based approach which recognises the common goals we all share, in order to build a fairer and healthier society, to reduce crime, improve life chances and protect the most vulnerable.

2. Current context

Key messages: The National Drug Strategy 2017 focuses on:

- Reducing demand
- Restricting supply
- Building recovery
- Global action.

It sets out clear expectations for action from a wide range of partners, including those in education, health, safeguarding, criminal justice, housing and employment. Together with the Modern Crime Prevention Strategy (2016), it provides the basis for developing a local Drug Misuse Strategy and Action Plans.

Reducing the harm caused by drug misuse is a national priority. There are two key strategic documents that need to be taken into account in order to inform and shape our local response, these are the National Drug Strategy 2017[1] and the Modern Crime Prevention Strategy 2016[5]. Both strategies are covered in brief below, however, both documents contain a raft of information and it is recommended that anyone interested in this area read them in full. Drug misuse is not mentioned in the NHS Five Year Forward Plan (2014), however, alcohol misuse is highlighted and there are established links between drug and alcohol misuse, (further information on Alcohol can be found in a separate section of the JSNA). 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' (2010), does include drug misuse as a key Public Health Priority[6].

National Drug Strategy 2017[1] - This sets out clear expectations for action from a wide range of partners, including those in education, health, safeguarding, criminal justice, housing and employment. The approach is balanced over four key themes: Reducing demand, restricting supply, building recovery and global action.

<u>Reducing Demand</u>

- Universal action to promote health and wellbeing, and, to build resilience and confidence in young people in partnership with them.
- Develop drug and alcohol specific resources for use in universal settings.
- The need for high quality Personal, Social, Health and Economic education for children and young people.
- Colleges and universities have a key role in instilling a positive healthy living and drug-free culture for students, staff, and the public who utilise campus facilities.
- Provide professional guidance for midwives, health visitors and school nurses under the Healthy Child Programme.
- Support to school nurses, teachers and wider community services, including, youth workers to work together to promote health and wellbeing.
- Promote prevention strategies at primary and secondary schools.
- Support commissioners, schools, educators and prevention practitioners to take an evidence-based approach to preventing substance misuse.
- Further develop the Talk to FRANK service so that it remains a trusted and credible source of information.
- Continue to update the New Psychoactive Substances Resource Pack for educators.
- A targeted approach for evolving and emerging threats, such as, new psychoactive substances, image and performance enhancing drugs and dependence on medicines, such as, benzodiazepines and opioids.
- Piloting a new system (RIDR - Report Illicit Drug Reactions) to collect information about adverse reactions and harms caused by NPS and other drug use.

Restricting Supply

- The Misuse of Drugs Act 1971 (MDA) continues to be the primary legislative framework for drug control in the UK.
- The Government has re-confirmed that there is no intention of decriminalising drugs.
- The Psychoactive Substances Act 2016 fundamentally changes the way we tackle the supply of psychoactive substances not already covered by the MDA.
- Invest in detection capabilities through the use of targeting and technology to prevent drugs at our boarders.
- Action to reduce domestic cannabis production and related exploitation.
- Managing information and intelligence through the National Crime Agency.
- Re-energise the UK's world leading Forensic Early Warning System (FEWS) to meet new challenges and address emerging threats.
- Take forward plans for a new intelligence unit dedicated to tackling the criminal use of the 'darknet' which has been linked to distribution and marketing of controlled substances.
- Tackling specific crime types:
    - A new offence of driving with a specified drug in the body was introduced in March 2015 with zero tolerance limits for eight illicit drugs;
    - Anti-Social Behaviour - develop and share effective practice in the use of the ASB powers to support local action on tackling drug-related offending.
- Encourage the wider use of drug testing on arrest to support Police forces in monitoring new patterns around drugs and crime and provide an early opportunity to refer offenders into treatment.
- Build on the Liaison and Diversion services, to enable offenders with mental health, substance misuse and other complex needs to be directed towards appropriate health interventions from police stations or courts.
- Work with local Integrated offender management systems to identify and share effective practice to tackle drug-related offending.

Building Recovery

- Raise the ambition for recovery by enhancing treatment quality and improving outcomes through tailored interventions for different user groups.
- Maintain the condition for local authorities to "have regard to the need to improve the take up of, and outcomes from, drug and alcohol services".
- Commissioners should support and develop quality governance structures for drug treatment which must be clearly linked to local safeguarding procedures for children and vulnerable adults, and, give consideration to the specialist nursing and medical care that some service users require.
- Commissioners need to ensure that the services they commission have a workforce which is competent, motivated, well-led, appropriately supervised and responsive to new challenges.
- Service users - It is important that service users have a full stake in the decision-making process about how their needs are met.
- Drug Misuse and Dependence (2017): UK Guidelines on Clinical Management focuses on providing high quality advice on pharmacological and psychosocial interventions known to be effective; commissioners and services need to implement these guidelines moving forwards. Improve data sharing to understand drug (and alcohol) use and the impact of offending careers.
- Committed to looking towards a joint approach for the commissioning of health services, including drug and alcohol treatment in prisons.

- Committed to looking towards a joint approach for the commissioning of health services, including drug and alcohol treatment in prisons.
- Drug misuse is often accompanied and complicated by physical and mental health problems; coordinated and integrated care pathways should be in place treat people's needs. Peer support is an essential component of effective recovery and should be easily accessible before, during and after formal structured treatment.
- Stable and appropriate housing is crucial to enabling sustained recovery from drug misuse.
- Families and carers can also play a key role in supporting recovery, which is often unrecognised, and can enhance outcomes. However, family members and carers also have their own support needs.

Modern Crime Prevention Strategy 2016[5] The strategy focuses on drugs as a driver for crime which can occur in several ways: the economic motivation to obtain money to fund drug use; the psychopharmacological effects of psychoactive drugs; and, the actions of organised crime groups supplying the market. In addition, drug possession and supply are in themselves offences.

Further reducing the number of heroin and crack users is likely to have the largest impact on crime levels in volume terms. Evidence on drug-related crime prevention focuses on three areas: a) treatment; b) diversion; and c) enforcement. Key messages from the strategy are:

- Being in treatment itself reduces levels of offending and the Criminal Justice System offers a number of routes into treatment.
- Full recovery from dependence should be the aim of treatment. Evidence suggests that recovery is more likely to be achieved and sustained if users are given support to improve their 'recovery capital', particularly around housing and meaningful employment.
- For entrenched, long-term opiate users, who have not achieved recovery through optimised oral substitution treatment, there is evidence that heroin assisted treatment (supervised injectable heroin) reduces crime.
- There is little evidence that drug education, focused solely on information giving or media campaigns alone, can change behaviour and they should only be used as part of a wider strategy.
- Good quality Personal, Social and Health Education and school-based interventions, designed to improve behaviour generally (e.g. by building confidence, resilience and effective decision-making skills) can have a preventative impact on drug use.
- For those in the early stages of drug use, brief interventions (including motivational interviewing techniques) at early contact points with health, criminal justice and social care services can help prevent escalation.
- Geographically targeted, problem-oriented policing interventions, aimed at drug hotspots and which involve partnerships between the Police and wider community groups, are likely to be more effective at reducing drug-related problems (street-level dealing, crime and other forms of anti-social behaviour) than conventional law enforcement-only approach.
- Enforcement may also be effective at suppressing emerging markets of dependence-inducing drugs before they become well established.

3. What are the key issues locally

Detailed in brief below are the key issues relating to drug misuse for Cheshire West and Chester. These have been identified using analysis of local data, published research, knowledge of service provision and the local response to drug misuse, and, are drawn from the key messages from each section of this Drugs JSNA.

Nationally, one-third, (35.0%), of adults aged 16 to 59 had taken drugs at some point during their lifetime. This equates to around 65,119 people in Cheshire West and Chester. An estimated 8.4%, (15,629), of adults aged 15-59 years in Cheshire West and Chester had taken an illicit drug in the last year. This increased to around 18%, (6,326), in young people aged 16-24 years.

Cannabis was the most commonly used drug in the 16-59 age group, with 6.47% of adults aged 16 to 59 having used it in the last year (significantly lower than a decade ago), followed by Powder Cocaine (2.2%) and Ecstasy (1.5%).

There are an estimated 1,619 people aged 15-64 in Cheshire West and Chester who are opiate/crack users. 1,215 are opiate users and 736 are crack users. Of these, 480 are injecting substances.

Around 1 in 40, (2.6%), of young adults (16-24 years of age) reported taking a New Psychoactive Substance (NPS) in the last year. This equates to around 1,914 young adults in Cheshire West and Chester. The prevalence for NPS's in younger adults remains similar to that reported in 2014/15. Young men were more likely to have used an NPS than women, and around 84.9% had used another drug in the last year. Herbal smoking mixtures were the most commonly used NPS.

Young people in Cheshire West and Chester are generally less likely to take drugs compared to England as a whole. Boys in Cheshire West and Chester were more likely to have tried cannabis and other drugs compared to the national average, whereas, girls were less likely to have tried cannabis or other drugs.

Several groups are identified in the literature as being at high risk of drug misuse. These include: young people; offenders; the homeless; veterans; sex workers; families of drug users; victims of intimate partner violence and a growing number of older people, in particular long-term drug users. These groups are not exclusive and individuals may have a range of interlinked vulnerabilities that increase their overall risk of drug misuse. It is noteworthy, that over a quarter, (25.7%), of opiate clients in treatment in Cheshire West and Chester live with children under the age of 18 years of age (lower than the national average 26.7%).

In 2016-17 there were 1,485 clients in treatment for drug misuse in Cheshire West and Chester. Of these, 830 were in treatment for opiate use, 92 for non-opiate use and 98 for alcohol and non-opiate use. The number of clients in treatment for drug misuse has been falling in Cheshire West and Chester, as have new presentations to treatment.

Cheshire West and Chester has a higher rate of clients in treatment for four years or more compared to the national average. This suggests that Cheshire West and Chester has a high proportion of complex clients who are not completing treatment successfully and staying drug free. Cheshire West and Chester has a higher re-presentation rate for opiate clients compared to the England average.

3. What are the key issues locally *(continued)*

During the financial year 2016-2017, there were a total of 2,039 clients accessing syringe exchange services and non-structured interventions in the Cheshire West and Chester area. This accounted for 9,564 syringe exchange transactions. The largest number of individuals accessing treatment was in the 30-34 year age group, primarily made up of users of steroids and image and performance enhancing drugs. In addition, the 40-44 year old age group also makes up a large proportion of clients accessing services. This age group is mainly made up of users of psychoactive drugs.

Analysis of A&E attendance, due to drugs misuse, is very limited due to the way data is recorded on the A&E record system; this needs addressing as we move forwards in order to reduce drug related harm and focus resources. Hospital admissions with a primary (or primary/secondary diagnosis) of drug related mental and behavioural disorders, or, a primary diagnosis of poisoning by illicit drugs, all follow a similar pattern to that displayed nationally. Locally, hospital admission rates for a primary diagnosis of drug related mental and behavioural disorders, and, primary or secondary diagnosis of drug related mental and behavioural disorders are lower than the national average. However, the rate of hospital admissions with a primary diagnosis of poisoning by illicit drugs in Cheshire West and Chester is slightly higher than the national average.

Deaths from drug misuse substantially increased in England in 2013 and 2014, with a 42% total increase in these two years. Consequently, there is considerable political, media and public interest in these figures. Locally, there were 38 deaths from drug misuse in Cheshire West and Chester during 2013-2015, producing a rate of 3.9 deaths per 100,000, the same as the drug misuse death rate for England. The rate of deaths from drug misuse has risen slightly since 2012-2014 in Cheshire West and Chester, following the national trend.

In Cheshire West and Chester, up to 3,700 thefts can be attributed to offenders who used heroine, cocaine or crack cocaine in 2016. Cheshire West and Chester trends in drug crime have shown an increase since 2002-2003, peaking in 2011-2012 at 3.5 crimes per 1,000. However, by 2016-2017 drug crimes in Cheshire West and Chester had fallen to 2.1 crimes per 1,000, in-line with the national average.

Currently, there are no estimates of the social and economic cost of drug misuse in Cheshire West and Chester, although the cost to local organisations e.g. the Police, Local Authority, NHS etc., will be significant at a time when Public Sector resources are being reduced. It is estimated that the cost of healthcare alone for adult drug users, not in structured treatment, is £5,380 per year, whilst the overall cost is estimated to be over 26,000 per year. Conversely, the Drug Treatment Outcomes Study suggests, that every £1 invested in drug treatment results in a £2.50 benefit to society.

There is a need to improve local intelligence so that decisions taken about drug misuse are based on reliable data. In addition, there has been little in the way of insight work untaken in Cheshire West and Chester to capture the views, hopes and aspirations of our communities and services users in relation to drug misuse.

Over time there is a need to change the focus from treatment and recovery to prevention and early detection.

4. Commissioning priorities and recommendations

The main focus in reducing drug misuse within our community needs to be on prevention and early intervention. However, we recognise that some people will require treatment for drug dependency. Public Health, within Cheshire West and Chester Council, are committed to commissioning a service on an equitable basis, which is focused on recovery. The current service is an integrated Substance Misuse Service, working out of a number of locations across the Cheshire West and Chester footprint. Moving forward, there is evidence that:

- Providers should base the delivery of their service on the new version of Drug misuse and dependence, UK guidelines on clinical management 2017 (AKA the Orange book).
- Drug Misuse Services should be recovery focused.
- Drug Misuse Services must be accessible and able to effectively deal with a wide range of drug related issues e.g.. Opiates, Crack, and Powder Cocaine, through to Marijuana, New Psychoactive Substances, Performance Enhancing Drugs etc.
- Provide effective solutions to dealing with a cohort of clients who have been in long-term treatment i.e. over four years.
- Be aligned with other lifestyle and public health services, such as, Sexual Health, Stop Smoking etc., where drug misuse is associated with risk-taking behaviour.
- Drug Misuse Services should work closely with NHS Mental Health Services and Primary Care, in order to provide effective recovery pathways for people with dual diagnoses.
- Specialist services should work in close partnership with other organisations/agencies to provide an effective multi-agency response to Drug Related Harm.
- Substance Misuse Services should fully implement NICE Guidance, Quality Standards etc.
- Ensure effective referral pathways are in place across partner organisations/agencies and local communities.
- Provide a community based needle exchange scheme and encourage people who are injecting drugs to take tests for hepatitis and tuberculosis, in accordance with NICE Guidance.

The current service will be routinely reviewed as part of the commissioning cycle, and, where the elements above are not already included in the service specification, they should be considered for inclusion. Furthermore, consideration should be given to whether commissioning the service on a larger footprint might improve effectiveness, and/or, cost effectiveness. An additional cost-benefit analysis would need to be undertaken to aid in this decision making process.

Although specialist substance misuse services are a vital part of reducing the harm caused by drugs, they are only a small part of the multi-factorial evidence based approach needed to reduce Drug Misuse in Cheshire West and Chester. As such, a further set of recommendations are included below.

- A multi-agency Drug Strategy and Action Plan should be developed for Cheshire West and Chester and an Operational Group formed to oversee its delivery. Our local approach should reflect themes within the national strategy: Reducing Demand, Restricting Supply and Building Recovery.

4. Commissioning priorities and recommendations (*continued*)

- There is clear evidence that programmes which are least effective in preventing substance misuse are those that focus solely on scare tactics, knowledge-only approaches, mass media campaigns, information giving, or the employment of ex-users and the Police as drug educators in schools, where their input is not part of a wider evidence based prevention programme. These approaches should only be supported, and/or, commissioned as a fully integrated part of a wider strategy.

- Partners should consider providing information about drug use in settings where groups who use drugs, or, are at risk of using drugs e.g. nightclubs or festivals, may attend wider health services, such as, sexual and reproductive health services, primary care supported accommodation, hostels for people without permanent accommodation and gyms (to target people who are taking, or considering taking, image/performance enhancing drugs). Information should be provided in different formats and signpost people to self-assessment tools, ensuring that the type of information provided is in line with NICE Guidelines.

- All services and professionals which have contact with young people should identify those who are at risk of using drugs and refer them to services that can support them. These services should include family based support and parental skills training. In addition, NICE has produced a pathway called 'Reducing substance misuse among vulnerable children and young people', this should be reflected in local pathways as part of children's safeguarding arraignments.

- Good quality Personal, Social and Health Education and school-based interventions, designed to improve behaviour generally (e.g. by building confidence, resilience, improving mental health and wellbeing, and effective decision-making skills) should be part of every school and academy curriculum.

- Drug misuse prevention activities should be delivered for groups at risk of drug misuse through a wide range of existing statutory, voluntary or private services. This includes, health services, such as primary care services, community-based health services, mental health services, sexual and reproductive health services, drug and alcohol services, 0-19 children's and young people's services, risk community-based criminal justice services, including adult, youth and family justice services accident and emergency services etc.

- Routine appointments and opportunistic contacts with statutory and other services should routinely assess whether someone is vulnerable to drug misuse e.g. health assessments for children and young people who are looked after or care leavers, initial assessments and reviews with GPs, nurses, emergency departments (where contact is linked to drugs or alcohol), 0-19 children's and young people's service and the community criminal justice system.

- All adults who are assessed as vulnerable to drug misuse should be offered the following: clear information on drugs and their effects, advice and feedback on any existing drug use information on local services and where to find further advice and support. Information should be provided at the same time as the assessment and information should be offered both verbally and in writing.

- Recovery is more likely to be achieved and sustained if clients are supported to improve their 'recovery capital'. As such, partner organisations need to consider how to increase the availability of long-term housing and employment opportunities for clients on recovery programmes.

4. Commissioning priorities and recommendations (*continued*)

- New psychoactive substances (NPS) are being targeted at some of the most vulnerable sections of our population i.e. children and young people and the homeless population. More local research needs to be undertaken to understand the use of these drugs within the local population. Targeted work should be undertaken to reduce the negative effects of new psychoactive substances within our communities.

- Partner organisations need to improve the availability of data and intelligence relating to drug misuse, in order to plan interventions and target resources. A Task and Finish group should be established to deal with this, in particular, improving intelligence from A&E departments, data quality and data sharing between organisations.

- A Local Drugs Information System needs to be set-up across Cheshire West and Chester, or larger footprint, to provide an early warning system for contaminated or harmful drugs.

- There is currently very little insight work available that captures the views of our local communities and service users on drug misuse, and/or, service provision; this needs to be undertaken as part of the JSNA and the commissioning cycle.

- Encourage the wider use of drug testing on arrest, to support police forces in monitoring new patterns around drugs and crime and provide an early opportunity to refer offenders into treatment.

5. Who is most at risk

Key messages: Several groups are identified in the literature as being at high risk of drug misuse. These include: young people, offenders, the homeless, veterans, sex workers, families of drug users, victims of intimate partner violence and a growing number of older people, in particular long-term drug users. These groups are not exclusive and individuals may have a range of interlinked vulnerabilities which increase their overall risk of drug misuse.

Young People

Young people's drug misuse overlaps with a range of other vulnerabilities which can also exacerbate their risk of abuse and exploitation[1]. In 2015-16, 17% of the young people accessing specialist substance misuse services nationally were not in education, training or employment and 12% were 'looked after children[7]. Most young people who have developed substance misuse problems are not at the stage where they are dependent on drugs or alcohol, and, therefore, require a response focused on preventing more problematic use[1]. Young people accessing specialist substance misuse services are usually experiencing other problems, such as, self-harm or other manifestations of poor mental health, truanting, offending and sexual exploitation, which may be driving the young person's substance misuse[1].

Offenders

Around 45% of acquisitive offences are committed by regular heroin/crack cocaine users[3]. Therefore, the criminal justice system provides a prime opportunity to tackle substance misuse and ensure the individual has access to the support they need to stop[1].

Families

Parental drug and alcohol dependence can have a significant impact on families, particularly children, and can limit the parent's ability to care for their child and/or children[1]. Parents are role models for their children, and parental dependence increases the likelihood of children misusing drugs and alcohol themselves[1]. It can also mean that children take on inappropriate caring roles for their parents[1]. For some families, substance misuse is one of a number of other complex problems which can have a compound effect[1].

Intimate partner violence and abuse

Research indicates that women with experience of extensive physical and sexual violence are more likely to have an alcohol problem or be dependent on drugs, compared to women with little experience of violence and abuse[8].

Sex workers

Those selling sex are at greater risk of drug misuse; a way of coping with what they are doing, because they are being coerced (into both prostitution and drug use), or, because they become involved in prostitution to fund an existing drug dependence. The government's response to this issue in women is captured in the National Violence Against Women and Girls Strategy[9].

Homeless

Homelessness can be both a cause and consequence of drug misuse and is often compounded by substance misuse, as well as poor physical and mental health[10]. The most disadvantaged and vulnerable people in society, including those who are homeless, may be at greater risk from the most dangerous NPS's[1]. The longer someone experiences homelessness or rough sleeping, the bigger the impact on their wellbeing, which leads to increasingly complex needs, such as, substance misuse[1]. Just over a quarter of NPS users, entering treatment in 2015-16, used them alongside opiates, of this group, half reported housing problems at the point of treatment entry, twice the level reported by drug users overall[11].

5. Who is most at risk *(continued)*

Veterans

As with civilian members of the community, veterans can be vulnerable to substance misuse[1]. Veterans sometimes use alcohol, and/or, drugs to cope with the physical and psychological effects of military service[1]. These risks can be increased if their physical, and/or, mental health reduces their ability to find and hold long-term, fulfilling employment and secure accommodation[1].

Older cohort

The proportion of older people reporting substance misuse issues is increasing[12]. This may be because people who started using drugs when they were younger either continue to misuse drugs and alcohol and experience more problems as they age, or, perhaps return to their misuse because of the challenges of ageing, including pain, loneliness, or depression[1]. The average age of people in treatment is rising, with increasing proportions in their 40s, 50s and 60s[1]. This cohort of people will need the usual health screening and monitoring that a non-drug user might be offered, appropriate to their age and general health status, but they may also have special health needs due to the complications of long-term drug (and alcohol) use and of treatment[1].

6. Level of need in the population

Key Message: Nationally, one-third, (35.0%), of adults aged 16 to 59 had taken drugs at some point during their lifetime, this equates to around 65,119 people in Cheshire West and Chester. An estimated 8.4%, (15,629), of adults aged 15-59 years in Cheshire West and Chester had taken an illicit drug in the last year, this increased to around 18%, (6,326), in young people aged 16-24 years. Cannabis was the most commonly used drug in the 16-59 age group, with 6.47% of adults aged 16 to 59 having used it in the last year (significantly lower than a decade ago), followed by Powder Cocaine (2.2%) and Ecstasy (1.5%). There are an estimated 1,619 people aged 15-64 in Cheshire West and Chester who are opiate/crack users. Of these, 1,215 are opiate users and 736 crack users. Of these, 480 are injecting substances. Around 1 in 40, (2.6%), of young adults (16-24 year of age) reporting taking an NPS in the last year, this equates to around 1,914 young adults in Cheshire West and Chester. The prevalence for NPS's in younger adults remains similar to that reported in 2014/15. Young men were more likely to have used an NPS than women, and around 84.9 per cent had used another drug in the last year. Herbal smoking mixtures were the most commonly used NPS.

This section covers the extent and trends in illicit drug use amongst adults aged 16 to 59, measured by the 2015/16 Crime Survey for England and Wales: Drug Misuse[2]. Additional analysis for the sub-group of young adults aged 16 to 24 is also provided. The survey is recognised as a robust measure of recreational drug use for the drug types it covers. However, it may not provide as good coverage of problematic drug users as they may not necessarily be a part of the household resident population, or, be concentrated in specific and relatively small sub-groups of the population[2].

The survey results are not produced at Local Authority level, therefore, the figures in this section are derived by applying the results of the National Survey to our Cheshire West and Chester population. No resonance test was undertaken to establish how accurate this method predicts local drug use. However, with the absence of a local survey, this provides a best possible estimate of drug use locally, which might help in the planning of services. As the method is likely to become less accurate if used on smaller populations, data was not produced at locality level.

In addition to the Crime Survey for England and Wales[2], Public Health England/John Moores University, has produced local estimates of the number of opiate and crack users at local authority level (section 6.2). This uses a method that combines the estimated number of opiate and crack users, together with information from the National Drug Treatment Monitoring System; this may provide a more robust estimate of problematic drug users at a local level, although, the last data using this method was produced in 2011/12, and, as such, may be dated.

Prevalence of drug use within the Cheshire West and Chester population

- Around 1 in 12, (8.4%), adults aged 16 to 59 in England and Wales had taken an illicit drug in the last year[2], this equates to around 15,629 people in Cheshire West and Chester. This level of drug use was similar to the 2014/15 survey, (8.6%), but is significantly lower than a decade ago (10.5% in the 2005/06 survey)[2].
- Nationally, around 1 in 5, (18.0%), of young adults aged 16 to 24 had taken an illicit drug in the last year[2], this equates to around 6,326 young people in Cheshire West and Chester. This level of drug use was similar to the 2014/15 survey (19.5%), but is significantly lower compared with a decade ago (25.2% in the 2005/06 survey)[2].

- Under 1 in 20, (4.3%), of adults aged 16 to 59 in England and Wales reported taking a drug in the last month[2], this equates to around 8,000 people in Cheshire West and Chester. Whilst around 1 in 11, (9.1%), of young adults aged 16 to 24 had done so, that is, around 3,198 young adults in Cheshire West and Chester. Neither proportion has changed significantly compared with the 2014/15 survey, but both are significantly lower compared with a decade ago[2].

- Nationally, one-third, (35.0%), of adults aged 16 to 59 had taken drugs at some point during their lifetime[2], this equates to around 65,119 people in Cheshire West and Chester. This is an increase from 30.4 per cent in the 1996 survey, but similar to more recent figures; 35.1 per cent a decade ago in the 2005/06 survey. Use of illegal drugs in a person's lifetime is likely to be affected by generational effects[2].

Drug use by specific substance

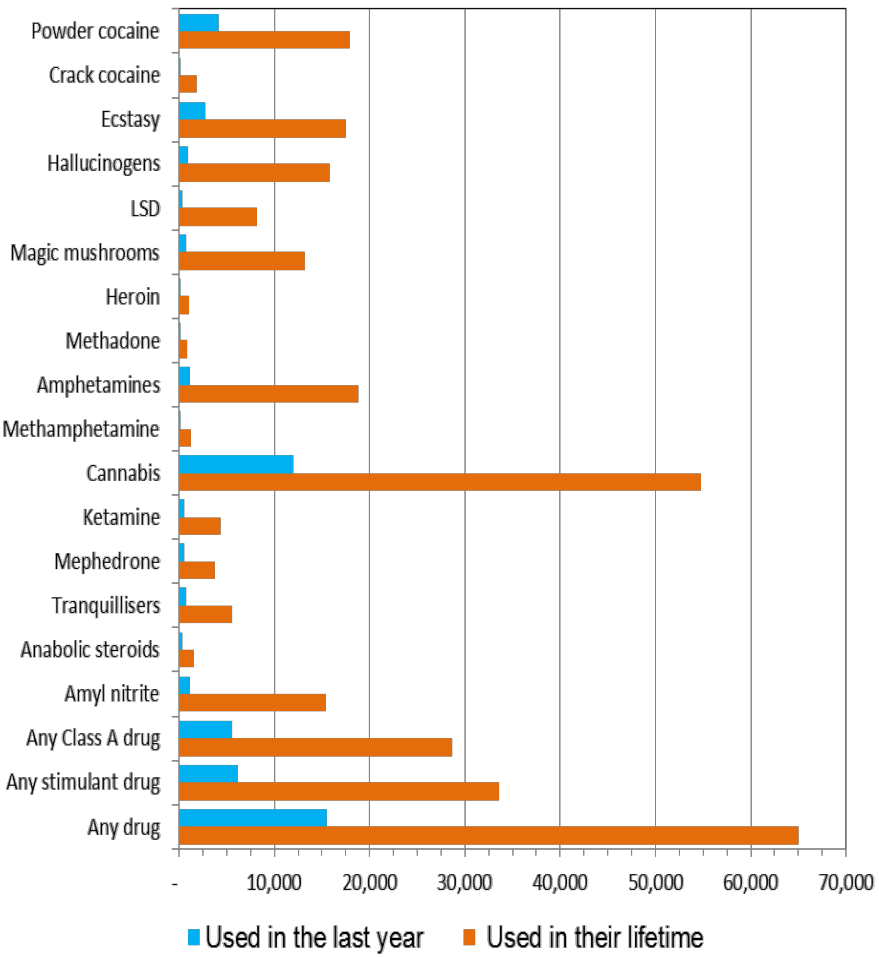
Nationally, Cannabis was the most commonly used drug in the 16-59 age group, with 6.47% of adults aged 16 to 59 having used it in the last year[2]. This equates to around 12,044 people in Cheshire West and Chester (based on 2015/16 data). This was similar to the 2014/15 survey, (6.7%), but showing a significant fall compared with a decade ago (8.7%)[2].

Powder Cocaine was the next most frequently used drug, with around 2.21% of people reporting using this in the last year[2]. This equates to 4,116 people in Cheshire West and Chester.

Ecstasy remains popular with around 1.50% of people nationally reporting using this in the last year[2], around 2,792 in Cheshire West and Chester.

Interestingly, the national survey showed that men were almost three times more likely than women to take powder cocaine (3.3% compared with 1.2%) and ecstasy (2.2% compared with 0.8%) in the last year[2].

Estimated numbers of people aged 16 to 59 years who have used illicit drugs in the last year or over their lifetime in Cheshire West and Chester by drug type 2015/16.



Source: British Crime Survey 2015/16 applied to ONS mid-year populations

In general, being single was associated with a higher proportion of people using drugs in the last year[1]. Furthermore, higher proportions of drug use in the last year varied in different income groups and by drug type. High proportions of powder cocaine and ecstasy use in the last year was observed at either end of the income scale, whilst the highest proportion of cannabis use in the last year was associated with the lowest income group[2].

For the younger age group, (16-25 years of age), cannabis was the most commonly used drug, with around 15.8% of people nationally reporting using it in the last year[2]. This equates to around 5,554 young people in Cheshire West and Chester. Nationally, ecstasy and powder cocaine were also popular in this age group, with 4.5% and 4.4% respectively, of young people reporting using these substances in the last year[2]. Based on this, around 1,582 younger people in Cheshire West and Chester use ecstasy, whilst around 1,546 use powder Cocaine.

Proportion of 16 to 59 year olds in England and Wales (E&W) reporting use of drugs in their lifetime and last year in 2015/16. Together with the estimated numbers of drug users by drug type in Cheshire West and Chester (CW&C) based on national findings

Class of Drug	Type of Drug	Used in their lifetime		Used in the last year	
		% in E&W	Number in CW&C	% in E&W	Number in CW&C
A	Powder cocaine	9.7	17,962	2.21	4,116
	Crack cocaine	1.0	1,864	0.09	175
	Ecstasy	9.4	17,469	1.50	2,793
	Hallucinogens	8.5	15,825	0.50	926
	LSD	4.4	8,228	0.17	324
	Magic mushrooms	7.1	13,158	0.39	734
	Heroin	0.6	1,082	0.08	151
	Methadone	0.4	817	0.08	143
A/B	Amphetamines	10.1	18,836	0.60	1,123
	Methamphetamine	0.7	1,276	0.05	87
B	Cannabis	29.4	54,730	6.47	12,044
	Ketamine	2.4	4,413	0.29	535
	Mephedrone	2.0	3,741	0.27	504
B/C	Tranquillisers	3.0	5,573	0.38	713
C	Anabolic steroids	0.8	1,541	0.16	304
Not	Amyl nitrite	8.3	15,444	0.63	1,181
-	Any Class A drug	15.4	28,638	2.98	5,553
	Any stimulant drug	18.0	33,575	3.31	6,156
	Any drug	35.0	65,031	8.35	15,537

Source: Crime Survey for England and Wales 2015/16: Drug Misuse and The ONS Mid-Year Population Estimates

6.2 New psychoactive substances (NPS)

This section covers the use of new psychoactive substances (NPS) amongst adults aged 16 to 59. In this context, 'NPS' refers to newly available drugs that mimic the effect of drugs such as cannabis, ecstasy and powder cocaine. Respondents to the 2015/16 Crime Survey for England and Wales may have associated such substance with the term 'legal highs', as some NPS may, or may not, have been illegal to buy during the period they were asked to recall[2].

Nationally, the prevalence of NPS use is low among adults aged 16 to 59 years, with fewer than 1 in 100, (0.7%), adults reporting having used an NPS in the last year[2]. This equates to around 1,302 adults in Cheshire West and Chester. The prevalence rate reported in 2015/16 is similar to that reported in 2014/15[2]. Nationally, NPS use in the last year is concentrated in young adults aged 16 to 24 years, with 1 in 40, (2.6%), of young adults reporting taking an NPS in the last year[1]; a proportion more than three times higher than amongst the wider age group[1], this equates to around 1,914 young adults aged 16 to 24 years of age in Cheshire West and Chester. Again, the national prevalence for younger adults remains similar to that reported in 2014/15[2].

In general, young men were more likely to have used an NPS in the last year than young women[1]. In addition, the majority of NPS users had also used another drug in the last year; amongst adults aged 16 to 59, who had used an NPS, 84.9 per cent had used another drug in the last year. This proportion was similar for young adults aged 16 to 24, (85.2%)[2].

Several lifestyle factors were associated with using NPS in the last year. These included visits to a pub or a nightclub in the last month, consumption of alcohol in the last month and use of another drug in the last year[2]. Herbal smoking mixtures were the most commonly used NPS in the last year, and, NPS were most commonly obtained from a friend, neighbour or colleague (35%)[1]. Other common sources were shops (25%), known dealers (9%) or the Internet (8%)[2].

6.3 Prevalence adults opiate and crack users

Latest prevalence rates for substance misuse at a local authority level were produced for the financial year 2011-2012 by Liverpool John Moores University. Rates of drug use in Cheshire West and Chester are lower than the estimated England rate for opiate/crack use and opiate and crack use individually, levels of injecting are also thought to be lower in Cheshire West and Chester than nationally.

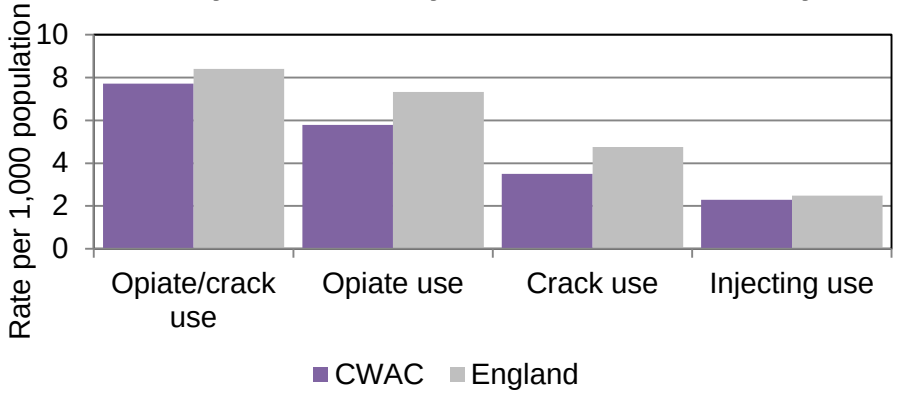
Area	OCU prevalence per 1,000	Opiate users prevalence per 1,000	Crack users prevalence per 1,000	Injecting users prevalence per 1,000
Cheshire West and Chester	7.71	5.78	3.50	2.29
England	8.40	7.32	4.76	2.49

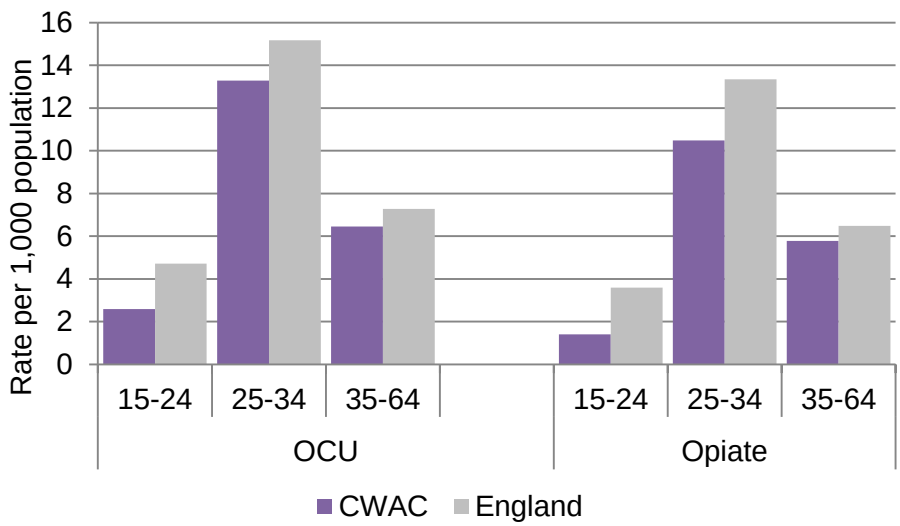
Source: National prevalence estimates 2011/12, national Treatment Agency, Office for National Statistics mid year estimates 2015

There are estimated to be 1,619 people in Cheshire West and Chester aged 15-64 who are opiate/crack users (OCU). 1,215 are thought to be opiate users and 736 crack users. There are estimated to be 480 people in the borough who are injecting illegal substances.

Estimated prevalence by broad age group suggests that prevalence of both OCU and opiate use is highest in the 25-34 year old age group for Cheshire West and Chester and England. It is lowest in the 15-24 year old age group. It is estimated that there are 102 opiate/crack users aged 15-24, 497 aged 25-34 and 860 aged 35-64 in Cheshire West and Chester. There are an estimated 55 opiate users in Cheshire West and Chester aged 15-24, 392 aged 25-34 and 770 aged 35-64.

Prevalence rates for opiate and crack use in Cheshire West and Chester produced for financial year 2011/12 by John Moores University





Source: National prevalence estimates 2011/12, National Treatment Agency, Office for National Statistics mid year estimates 2015

7. Drug misuse amongst children and young people

Key Message: Young people in Cheshire West and Chester are generally less likely to take drugs compared to England as a whole. Boys in Cheshire West and Chester were more likely to have tried cannabis and other drugs compared to the national average, whereas, girls were less likely to have tried cannabis or other drugs.

The What About YOUth survey 2014 (WAY 2014) survey is designed to collect robust local authority level data on a range of health behaviours amongst 15 year olds, including drug misuse, smoking and alcohol consumption. Illegal drug use, particularly amongst young people, continues to be one of the most significant public health challenges in England and is a key policy concern for the Government. The 'What About Drugs?' section of the WAY 2014 survey consisted of eleven questions about drug use. These provide the data for the local authorities to monitor the proportion of young people who have ever taken cannabis, frequency of taking cannabis, and frequency of taking other drugs, to inform local policy making. A further question was asked regarding young peoples attitudes towards drug use.

What about YOUth survey 2014 (15 year olds)			
	Yes (%)	Yes (%)	
		Boys	Girls
Have you ever tried cannabis?			
Cheshire West and Chester	9.0%	10.8%	7.1%
England	10.7%	10.6%	10.8%
Have you ever tried other drugs?			
Cheshire West and Chester	2.4%	2.9%	1.8%
England	2.5%	2.2%	2.8%

The survey indicates that Cheshire West and Chester 15 year olds are generally less likely to take drugs than the England average. Boys in Cheshire West and Chester are more likely to have tried drugs than girls and also are more likely to have tried drugs when compared to the England average.

Under 18's in treatment

There were 52 young people in treatment for substance misuse in Cheshire West and Chester during 2016-2017 aged between 13-17. Two thirds were male and one third female; similar to the national gender breakdown of young people in treatment. 81% of young people in Cheshire West and Chester cited cannabis as their problematic substance; lower than the 88% of young people in treatment nationally. Alcohol was the second most frequently mentioned problematic substance, with 31% of young people in treatment in Cheshire West and Chester citing it; lower than the average of 49% for all young people in treatment in England.

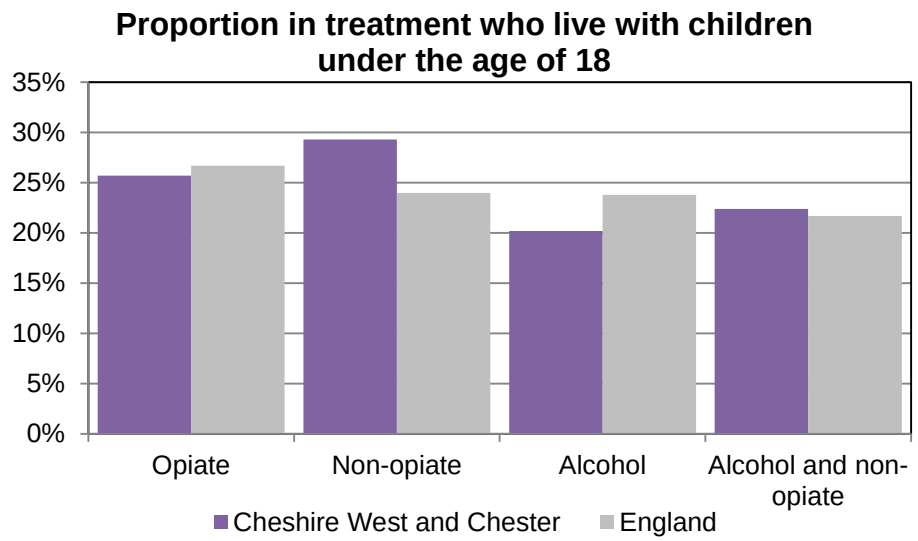
Young people in treatment	Cheshire West and Chester 2016-2017	England 2016-2017
Cannabis	81%	88%
Alcohol	31%	49%
Cocaine	12%	9%
Other	25%	40%

8. Parental substance misuse

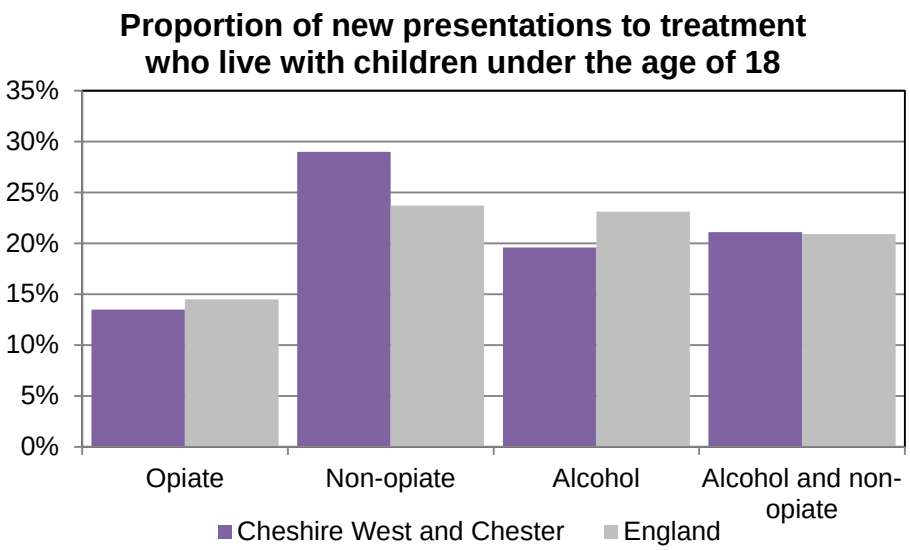
Key message: Over a quarter, (25.7%), of opiate clients in treatment in Cheshire West and Chester live with children under the age of 18 years of age, slightly lower than the national average (26.7%)

Almost 1 million children in the UK live with drug users (Manning et al 2009). Substance misuse within families can have serious and long-lasting consequences for children and adults. Research has shown that children of parents with long-term substance misuse issues are more likely to develop behavioural problems, experience low educational progress, suffer from significant social and emotional harm and develop substance misuse problems themselves. Families with substance misuse problems may also be experiencing domestic violence, unemployment, poverty or housing instability. At the same time, the demands of being a parent may impact on a service user's ability to engage in treatment.

Over a quarter, (25.7%), of opiate clients in treatment in Cheshire West and Chester live with children under the age of 18. National data shows that 26.7% of clients in treatment for opiates were living with children under the age of 18 years of age.



The proportion of new presentations to treatment who live with children under the age of 18 in Cheshire West and Chester is higher in the non-opiate group (29.0%) compared to the National average (23.7%). Whilst the figure for the opiate Group is similar to that displayed nationally.

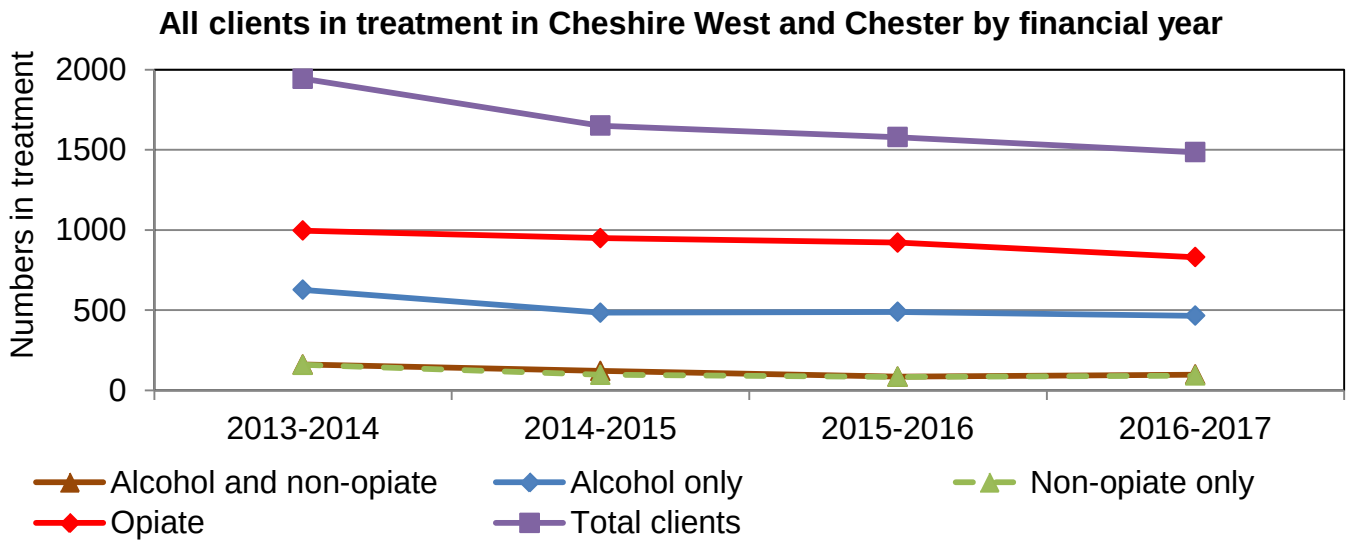


9. Drugs misuse – clients in treatment

Key message: Numbers of clients in treatment for drug misuse have been falling in Cheshire West and Chester, as have new presentations to treatment. Cheshire West and Chester has a higher rate of clients in treatment for four years or more, compared to the national average, suggesting that Cheshire West and Chester has a high proportion of complex clients who are not completing treatment successfully and staying drug free. Cheshire West and Chester has a higher re-presentation rate for opiate clients compared to the England average. During the financial year 2016-2017, there were a total of 2,039 clients accessing syringe exchange services and non-structured interventions in the Cheshire West and Chester area.

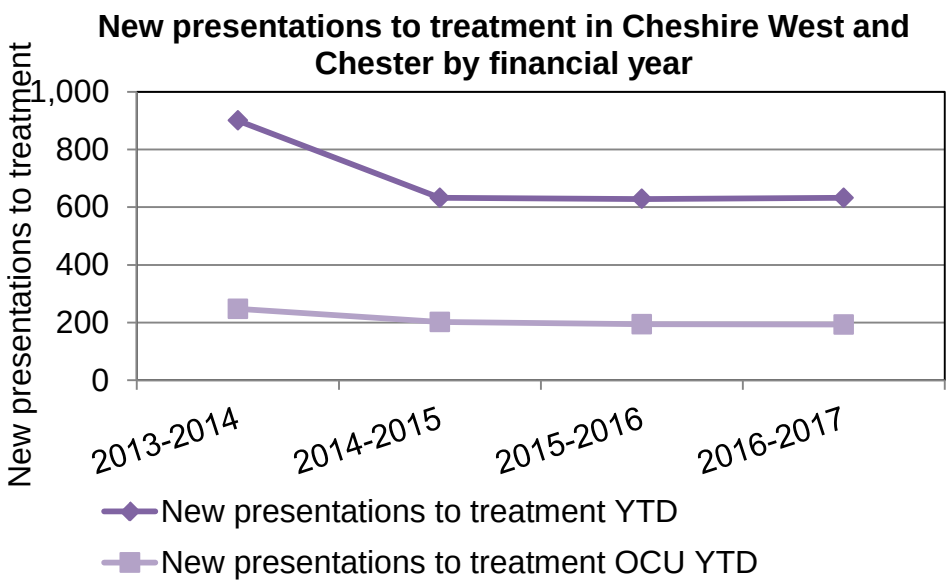
9.1 Adults in treatment for drug misuse

In 2016-2017, there were 1,485 clients in treatment in Cheshire West and Chester for substance misuse. Of these, 830 were in treatment for opiate use, 92 for non-opiate use and 98 for alcohol and non-opiate use. The remaining 465 were in treatment for alcohol use. Numbers in treatment in Cheshire West and Chester have been steadily falling over the last four years. Since 2013-2014 numbers of clients in treatment have fallen by nearly 25%.



9.2 New presentations

New presentations to treatment have also been falling in Cheshire West and Chester since 2013-2014, however, the previous three years have remained fairly constant at around 630 new presentations each year, 200 of which are for opiate/crack use.



Source: NDTMS Adult Partnership Activity Report

9.3 Successful completions

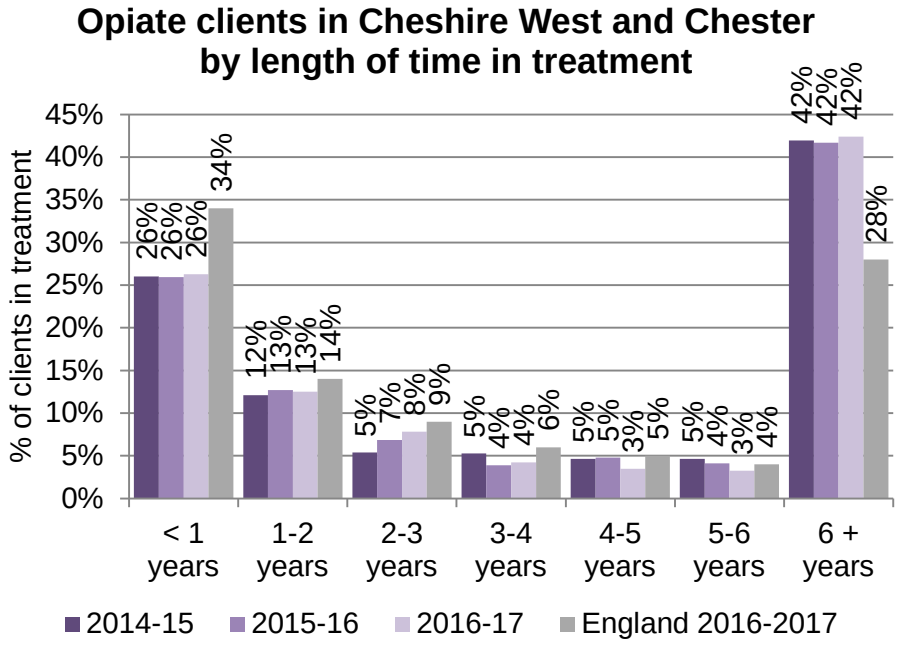
Successful completion rates for opiate users in treatment in Cheshire West are the highest they have been in the previous four years at 10%, this is higher than the national successful completion rate of 7.1%. However, successful completion rates for non-opiate users stands at 37% in 2016-2017, lower than the national rate of 40.2%.

Opiate clients	2014-15	2015-16	2016-17
Opiate clients in treatment	949	921	830
Successful completions	76	66	83
% completions of all in treatment	8%	7%	10%

Source: Diagnostic Recovery toolkit

9.4 Length of time in treatment

According to NDTMS data, clients who have been in treatment continuously for four years or more, or have very long drug use and treatment careers, are most likely to remain in treatment. In 2016-2017, 49% of opiate clients in Cheshire West and Chester had been in treatment for four or more years, compared with 37% nationally. Cheshire West and Chester traditionally experiences more opiate clients in treatment for extended periods of time compared to the England average.



Source: Diagnostic Recovery toolkit

9.5 Re-presentations

Re-presentations are the proportion of clients who successfully completed treatment in the first six months of each financial year and then re-presented within six months of completing treatment. In 2016-2017, 56 clients completed in the first six months and 21% re-presented to treatment within the next six months, this is slightly lower than the rate for 2015-2016. However, Cheshire West and Chester has a higher re-presentation rate for opiate clients compared to the England average.

Opiate clients	2014-15	2015-16	2016-17
Number of opiate clients completing	52	37	56
Of which, re-presented	7	8	12
% re-presented following completion	13%	22%	21%

Source: Diagnostic Recovery toolkit

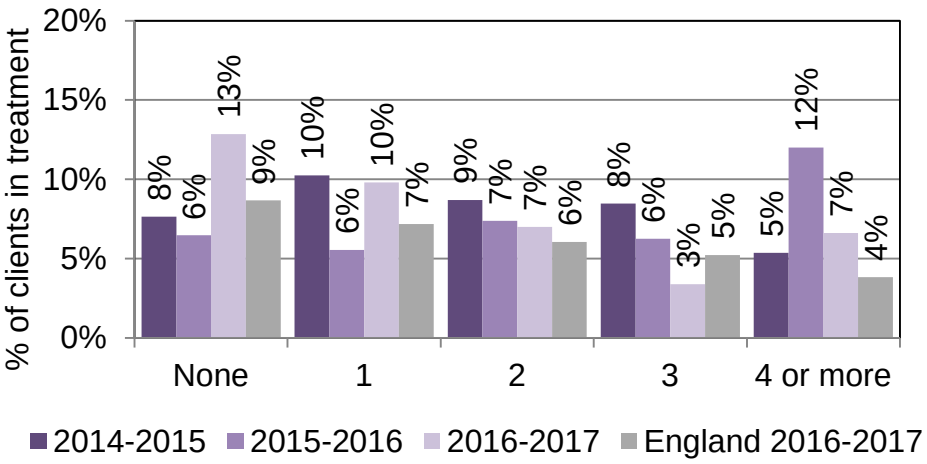
Re-presenting clients (those who have had prior episodes of treatment especially multiple previous journeys/unplanned exits) are less likely to complete treatment successfully.

9.6 Previous treatment journeys

According to NDTMS data, clients with previous unsuccessful treatment journeys are less likely to complete treatment successfully. Reasons for this may include a belief that treatment cannot deliver successful results, they may have a history of failure, with repeated cycles of recovery and relapse, leading to demoralisation and low expectations, their needs may not have been met previously, and they may, or may not, have complex needs.

Of the 830 opiate clients in treatment in Cheshire West and Chester during 2016-2017, 344, (41%) ,had been in treatment 1-3 time\s before and 180, (22%), had been in treatment 4 or more times before. 38% of these clients had between 1-3 previous unplanned exits and 121 had 4 or more previous unplanned exits. Clients in Cheshire West and Chester are less likely to have had previous treatment journeys end in an unplanned way. 48% of clients had no previous unplanned journeys, compared to 32% nationally.

Cheshire West and Chester opiate clients who successfully completed treatment and the number of previous unplanned journeys/exits they had



Source: Diagnostic Recovery toolkit

Clients that have no previous treatment history and are entering treatment for the first time are known as treatment naïve.

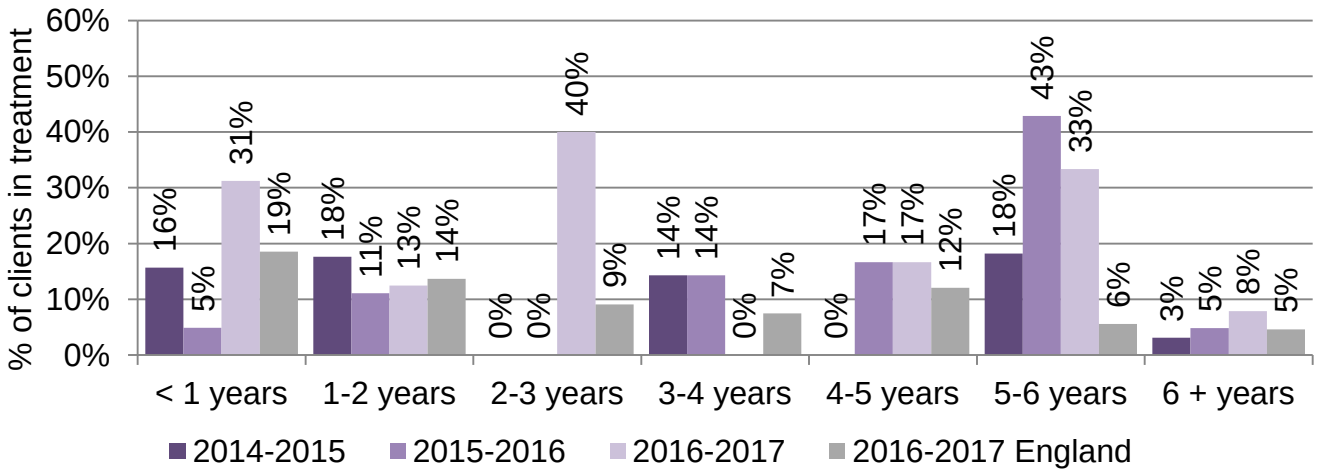
9.7 Treatment naïve clients

Nationally, opiate use is generally falling in most areas, and the number of new users is decreasing. A similar trend locally can be seen by the reducing numbers of treatment naïve clients accessing services. Treatment naïve clients are more likely to successfully complete treatment. Cheshire West and Chester has more opiate clients in treatment who are treatment naïve (35%) compared to England (22%).

Opiate clients	2014-15	2015-16	2016-17
Numbers in treatment	949	921	830
Number in treatment who are treatment naïve	390	355	294
% in treatment who are treatment naïve	41%	39%	35%

Source: Diagnostic Recovery toolkit

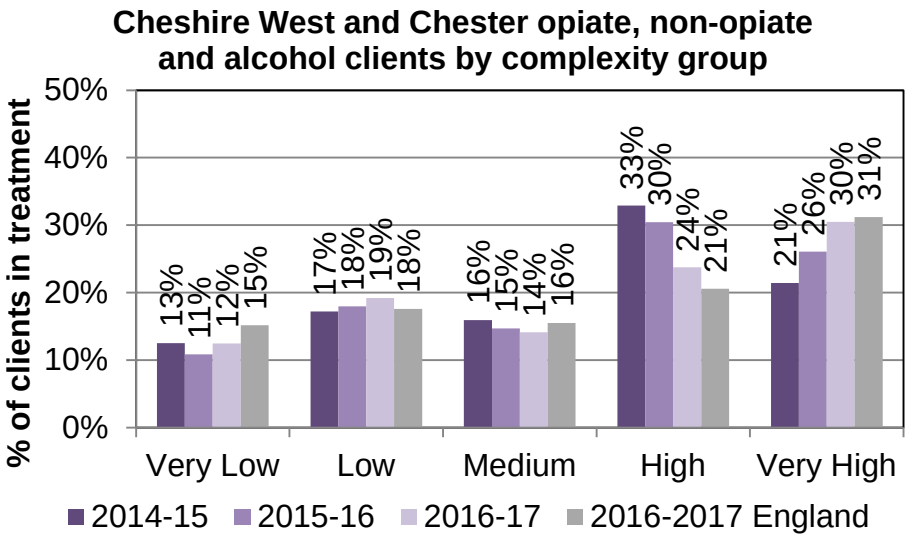
Percentage of Cheshire West and Chester opiate clients who were treatment naive and successfully completed treatment by length of time in treatment



Source: Diagnostic Recovery toolkit

9.7 Complexity (all opiate, non opiate and alcohol clients)

Clients present to treatment with various characteristics, such as, the substances they are using, their employment and housing status, their physical, and emotional health which will affect their chances of successfully completing treatment.

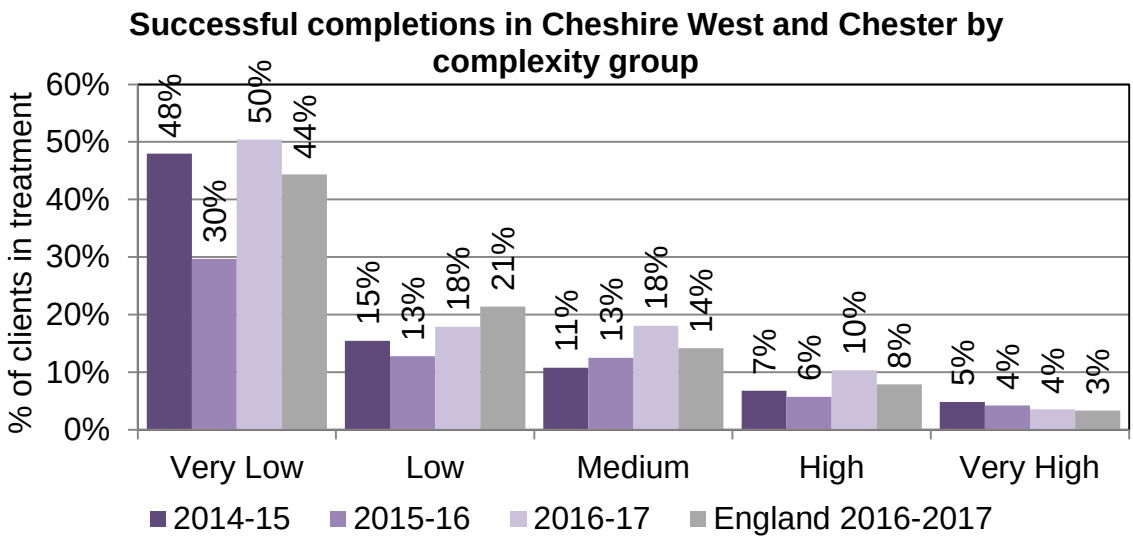


Source: Diagnostic Recovery toolkit

The treatment population in Cheshire West and Chester is becoming more complex. More complex clients are less likely to successfully complete their treatment. 41% of Cheshire West and Chester clients who were treatment naïve in 2016-2017 had high or very high complexity, this compares to 62% of non-treatment naïve clients having high or very high complexity. The chances of successful completions reduce as clients complexity increases.

Complexity					
Client type	Very low	Low	Medium	High	Very High
Treatment naïve	23%	22%	13%	22%	20%
Non-treatment naïve	6%	17%	15%	25%	37%

Source: Diagnostic Recovery toolkit

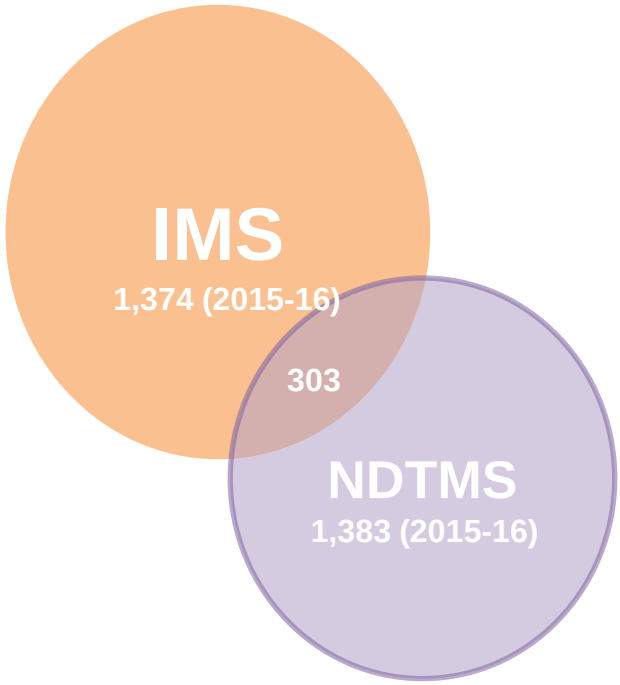


Source: Diagnostic Recovery toolkit

9.8 Integrated Monitoring System

The Integrated Monitoring System is a tool for recording activity including Drug and Alcohol brief interventions, health & wellbeing reviews, and needle and syringe exchange transactions. It is run by the Public Health Institute at John Moores University and covers the local authorities of Cheshire and Merseyside. The non-structured monitoring systems provided by PHI include the data from systems formerly known as ATMS (Alcohol Treatment Monitoring System), NSTMS (Non Structured Treatment Monitoring System, recorded using the GOLIATH system) and IAD (Inter Agency Database), which cover interventions delivered from low threshold drug, alcohol and syringe exchange services. It does not cover structured drug and alcohol treatment, which is part of the National Drug Treatment Monitoring System (NDTMS).

It is estimated that there is some cross matching between clients appearing on the IMS and the NDTMS, meaning that some clients using needle exchange services and brief interventions (recorded by the IMS) are also receiving structured treatment within Cheshire West and Chester (recorded by the NDTMS). It is thought that about 300 clients appeared on both systems during 2015-2016, this is about 21% of all IMS clients recorded during 2015-2016.



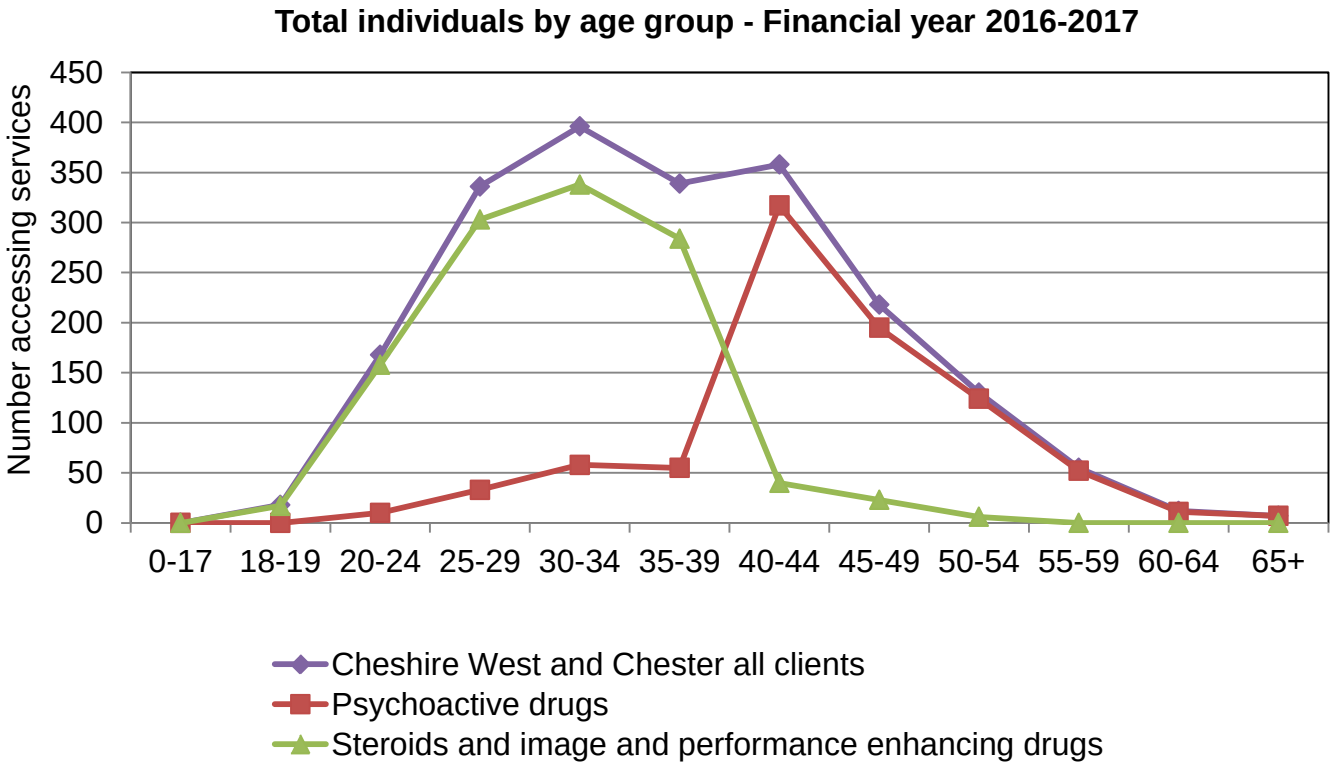
The IMS brings together activity from both low threshold drug and alcohol services delivering brief interventions and Needle and Syringe Programme services delivered in both agency and pharmacy settings across Merseyside and Cheshire. For the financial year 2016-2017 there were a total of 2,039 clients accessing syringe exchange services and non-structured interventions in the Cheshire West and Chester area, with a total of 1,404 brief interventions carried out, this equates to an average of 0.67 interventions per person. 862 individuals accessed services for psychoactive drugs, and 1,175 accessed services for steroids and image and performance enhancing drugs.

	No of clients	No of brief interventions	Interventions per person	Syringe exchange transactions	Syringe exchange returns	Syringe returns rate
2014-15	1,946	-	-	8,647	3,317	38.4%
2015-16	919	-	-	5,195	2,709	52.2%
2016-17	2,039	1,404	0.69	9,564	4,847	50.7%

The gender split of people accessing IMS services is heavily skewed towards males, 1,863, (91%), clients accessing services were male, and 177, (9%), were female. By cohort group it is even more starkly in favour of males, with 99% of clients accessing services for steroids and image and performance enhancing drugs being male. For those accessing services for psychoactive drugs, 81% were male and 19% were female.

There were 9,564 syringe exchange transactions between April 2016 and March 2017, and 4,847 syringe exchange returns in the same period, this equates to a syringe return rate of 50.7%. There was 1 syringe returned for every 2 syringe exchange visits in Cheshire West and Chester in the financial year 2016-2017.

The age group with the largest number of individuals accessing treatment is the 30-34 year age group, primarily made up of users of steroids and image and performance enhancing drugs. The 40-44 year old age group also makes up a large proportion of clients accessing services, and this age group is mainly made up of users of psychoactive drugs. Clients accessing services for IPED use tend to come from a younger demographic compared to clients using psychoactive drugs.



Source: IMS Quarter 4 Monitoring Report 2016-17, Public Health Institute

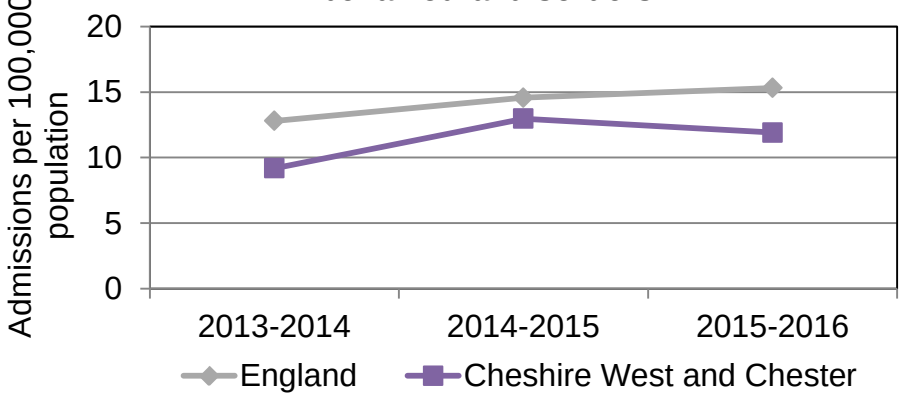
10. Drug Related Hospital Admissions

Key message: Hospital admissions with a primary (or primary/secondary diagnosis) of drug related mental and behavioural disorders, or, a primary diagnosis of poisoning by illicit drugs all follow a similar pattern to that displayed nationally. Locally, hospital admission rates for a primary diagnosis of drug related mental and behavioural disorders, and, primary or secondary diagnosis of drug related mental and behavioural disorders are lower than the national average. However, the rate of hospital admissions with a primary diagnosis of poisoning by illicit drugs in Cheshire West and Chester is slightly higher than the national average.

10.1 Hospital admissions with a primary diagnosis of drug related mental and behavioural disorders

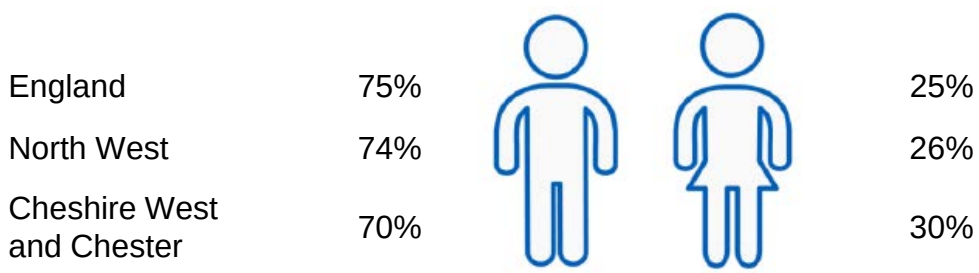
There were 37 hospital admissions with a primary diagnosis of drug related mental health and behavioural disorders in 2015-2016 in Cheshire West and Chester. This is a 23% increase since 2013/14. The rate of admissions in Cheshire West and Chester, have followed the national rising trend but remain lower than the England average of 15.3 admissions per 100,000 at 11.9 admissions per 100,000 in 2015-2016.

NHS Hospital admission episodes where there was a primary diagnosis of drug related mental health and behavioural disorders



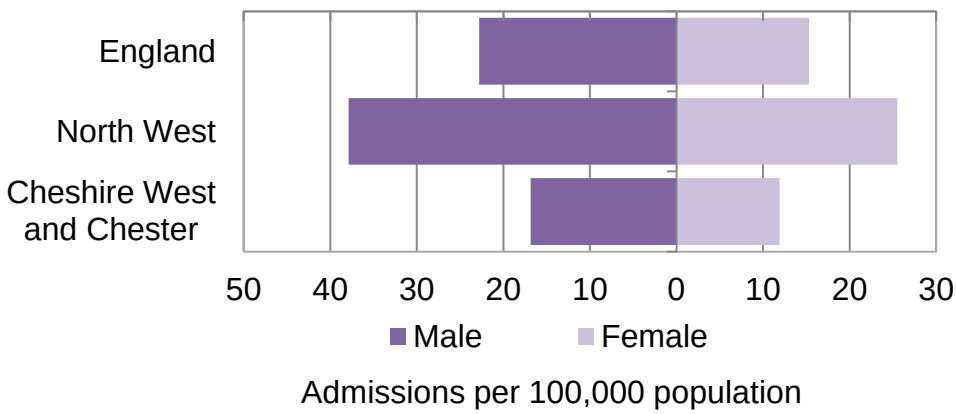
Hospital Episode Statistics, HES. Health and Social Care Information Centre

Total number of admissions by sex 2015-2016



In 2015-2016, the North West had the highest rate of admissions per 100,000 population for both males and females at 37.9 and 13.2 respectively. Cheshire West and Chester had rates of 16.8 and 7.2 per 100,000 for males and females respectively, lower than both the North West and England.

NHS Hospital admission episodes where there was a primary diagnosis of drug related mental health and behavioural disorders



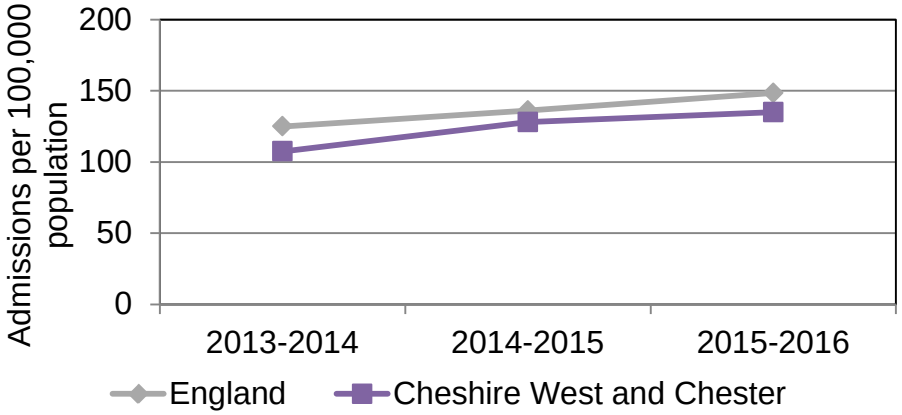
Hospital Episode Statistics, HES. Health and Social Care Information Centre

10.2 Hospital admissions with a primary or secondary diagnosis of drug related mental and behavioural disorders

There were 430 hospital admissions with a primary or secondary diagnosis of drug related mental health and behavioural disorders in 2015-2016 in Cheshire West and Chester. This is a 25% increase since 2013/14.

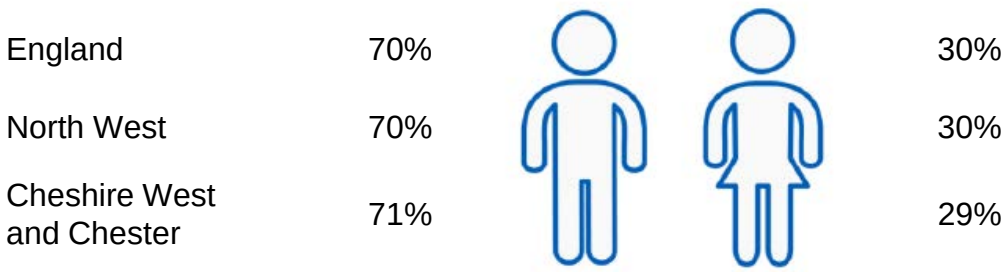
The rate of admissions in Cheshire West and Chester, has followed the national rising trend but remains slightly lower than the England average of 148.4 admissions per 100,000 at 134.9 admissions per 100,000 in 2015-2016.

NHS Hospital admission episodes with a primary or secondary diagnosis of drug related mental health and behavioural disorders



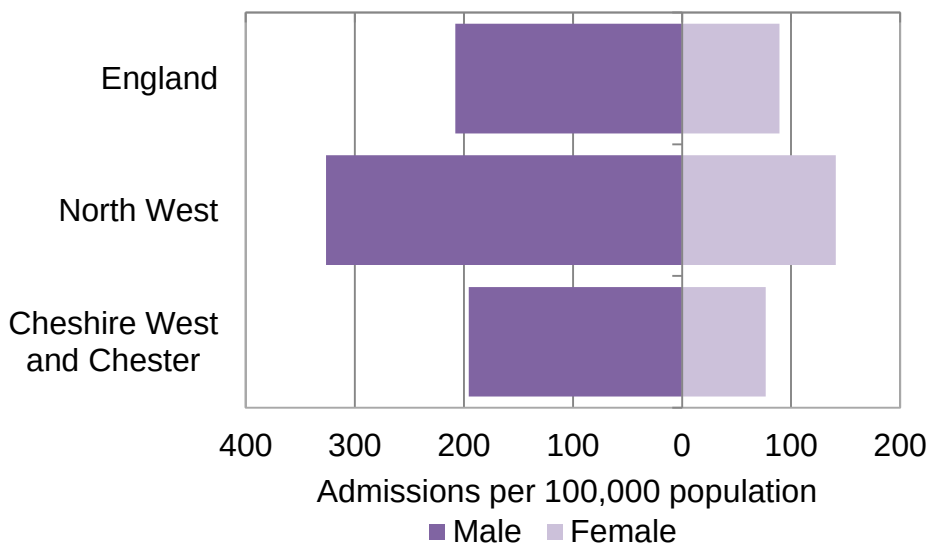
Hospital Episode Statistics, HES. Health and Social Care Information Centre

Total number of admissions by sex 2015-2016



In 2015-2016, similar to admissions with a primary diagnosis, the North West had the highest rate of admissions per 100,000 population for both males and females, with a primary or secondary diagnosis at 326.4 and 140.9 respectively. Cheshire West and Chester had rates of 195.6 and 76.6 per 100,000 for males and females respectively, lower than both the North West and England.

NHS Hospital admission episodes where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders



Hospital Episode Statistics, HES. Health and Social Care Information Centre

10.3 Hospital admissions with a primary diagnosis of poisoning by illicit drugs

There were 97 hospital admissions with a primary diagnosis of poisoning by illicit drugs in 2015-2016 in Cheshire West and Chester. This is identical to the number of admissions in 2013-2014. There was a fall in admissions in 2014-2015 when 95 people were admitted.

The rate of admissions in Cheshire West and Chester , have followed the national rising trend but remains slightly higher than the England average i.e. In 2015-16 the admissions rate was 30.2 compared to 27.2 nationally.

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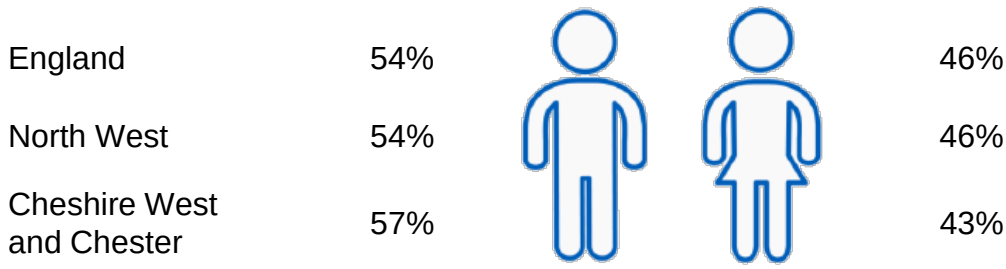
NHS Hospital admission episodes with a of poisoning by illicit drugs

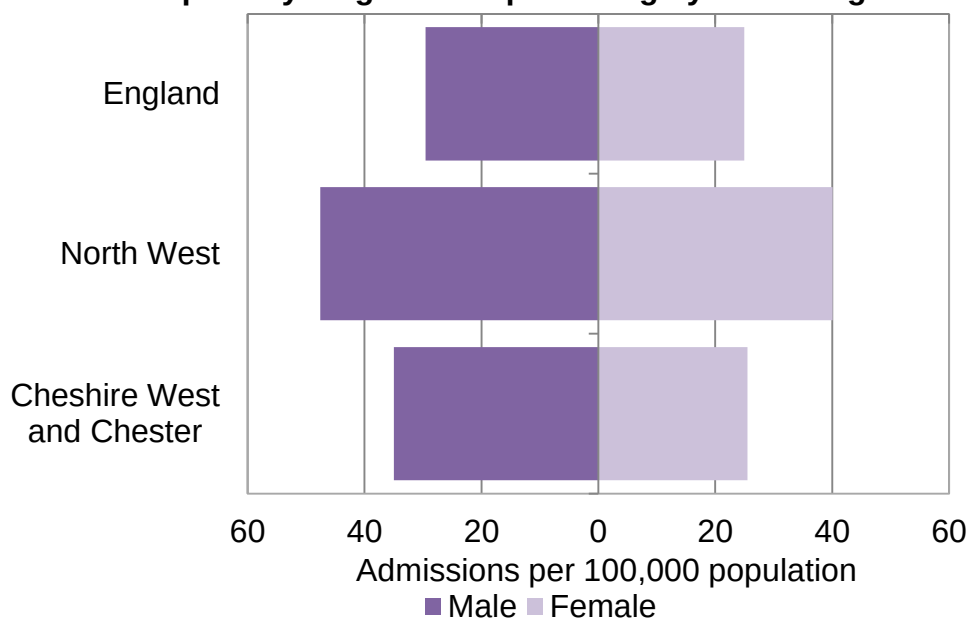
Hospital Episode Statistics, HES. Health and Social Care Information Centre

Total number of admissions by sex 2015-2016



In 2015-2016 the North West had the highest rate of admissions per 100,000 population for both males and females ,with a primary diagnosis of poisoning by illicit drugs at 47.6 and 40.1 respectively. Cheshire West and Chester had rates of 35.0 and 25.5 per 100,000 for males and females respectively, higher than the England average.

NHS Hospital admission episodes where there was a primary diagnosis of poisoning by illicit drugs



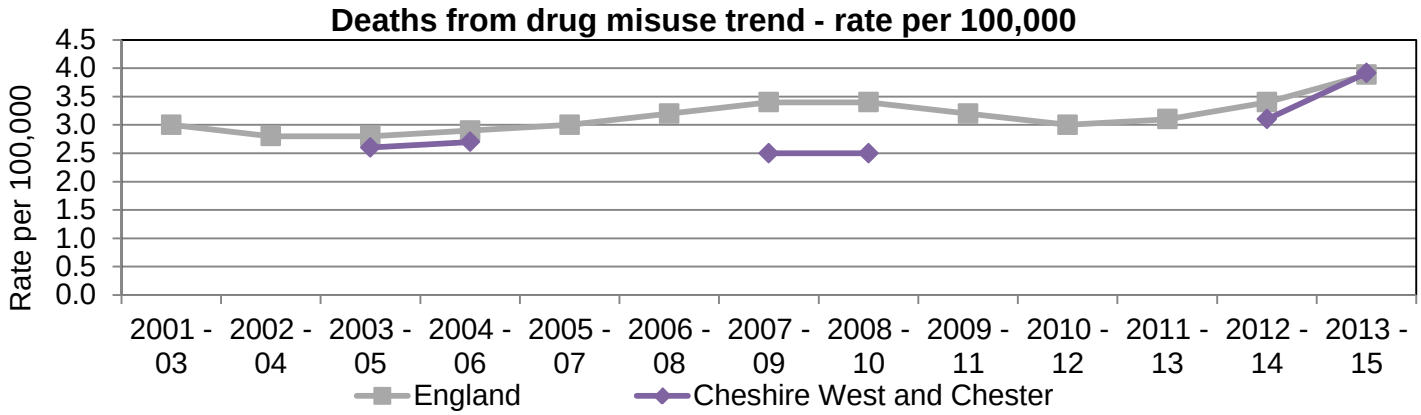
Hospital Episode Statistics, HES. Health and Social Care Information Centre

11. Mortality from drugs misuse

Drug misuse is a significant cause of premature mortality in the UK. Analysis of the global burden of disease survey 2013, shows that drug use disorders are now the third ranked cause of death in the 15-49 age group in England. Nearly one in nine deaths registered amongst people in their 20's or 30's in England and Wales in 2014 were related to drug misuse. Deaths from drug misuse substantially increased in England in 2013 and 2014, with a 42% total increase in these two years. Consequently there is considerable political, media and public interest in these figures.

Locally, there were 38 deaths from drug misuse in Cheshire West and Chester in 2013-2015, producing a rate of 3.9 deaths per 100,000, the same as the drug misuse death rate for England. The rate of deaths from drug misuse has risen slightly since 2012-2014 in Cheshire West and Chester, following the national trend. Due to low numbers of drug misuse deaths during some 3 year periods, rates have not been calculated. However, the number of deaths in Cheshire West and Chester from drug misuse since 2001-2003 has seen an increase from 18 in 2001-2003 to 38 in 2013-2015.

	Cheshire West and Chester				England			
Year	Count	Value	LCI	UCI	Count	Value	LCI	UCI
2001-2003	18	-	-	-	4,651	3.0	2.9	3.1
2002-2004	19	-	-	-	4,395	2.8	2.7	2.9
2003-2005	26	2.6	1.7	3.8	4,404	2.8	2.7	2.9
2004-2006	27	2.7	1.8	3.9	4,569	2.9	2.8	3.0
2005-2007	24	-	-	-	4,758	3.0	2.9	3.1
2006-2008	23	-	-	-	5,053	3.2	3.1	3.3
2007-2009	25	2.5	1.6	3.7	5,356	3.4	3.3	3.4
2008-2010	25	2.5	1.6	3.7	5,422	3.4	3.3	3.5
2009-2011	18	-	-	-	5,142	3.2	3.1	3.3
2010-2012	17	-	-	-	4,808	3.0	2.9	3.1
2011-2013	23	-	-	-	4,886	3.1	3.0	3.1
2012-2014	29	3.1	2.1	4.4	5,424	3.4	3.3	3.5
2013-2015	38	3.9	2.8	5.4	6,232	3.9	3.8	4.0



Note: Where the observed total number of deaths is less than 25, the rates have been suppressed as there are too few deaths to calculate directly standardised rates reliably. Source: Office for National Statistics (ONS)

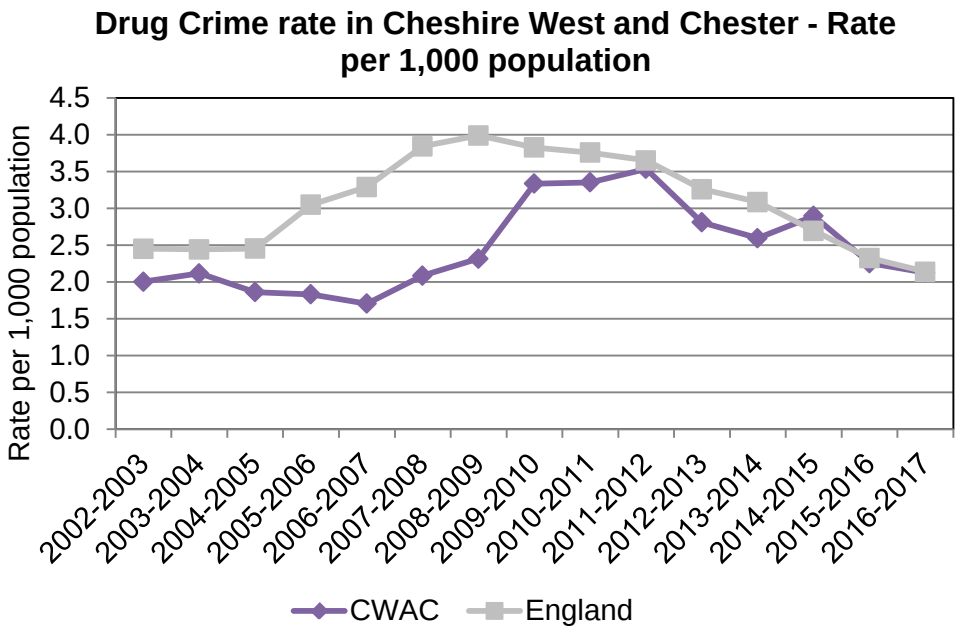
12 . Drug related Crime

Key message: The Home Office estimates that in Cheshire West and Chester up to 3,700 thefts can be attributed to offenders who used heroine, cocaine or crack cocaine in 2016. Cheshire West and Chester trends in drug crime have shown an increase since 2002-2003, peaking in 2011-2012 at 3.5 crimes per 1,000. However, by 2016-2017, drug crimes in Cheshire West and Chester had fallen to 2.1 crimes per 1,000, in-line with the national average.

12.1 Official recorded drug Crime

Official crime figures relating to drugs offences, refer to the possession, consumption, supply of or the intent to supply illegal drugs, primarily the crimes of drug trafficking and the possession of drugs. These figures do not include crimes that were committed while under the influence of drugs or where the offender was carrying out a crime for financial gain to pay for drugs.

Drug offences nationally have been dropping since 2009-2010, and by 2016-2017 have reached a 15 year low of 2.14 crimes per 1,000 population. In Cheshire West and Chester trends in drug crime have shown an increase since 2002-2003, peaking in 2011-2012 at 3.5 crimes per 1,000. However, by 2016-2017, drug crimes in Cheshire West and Chester had fallen to 2.1 crimes per 1,000, in-line with the national average.



Financial year	No of drug crimes	CWAC Rate per 1,000	England Rate per 1,000
2002-2003	646	2.0	2.5
2003-2004	686	2.1	2.4
2004-2005	606	1.9	2.5
2005-2006	599	1.8	3.1
2006-2007	560	1.7	3.3
2007-2008	687	2.1	3.8
2008-2009	763	2.3	4.0
2009-2010	1,098	3.3	3.8
2010-2011	1,105	3.4	3.8
2011-2012	1,165	3.5	3.7
2012-2013	928	2.8	3.3
2013-2014	859	2.6	3.1
2014-2015	962	2.9	2.7
2015-2016	753	2.3	2.3
2016-2017	714	2.1	2.1

Source: Office for National Statistics: Crime in England and Wales, March 2017

12.2 Acquisitive crime in Cheshire West and Chester

There is a well established, but complex relationship between illicit drug use and crime. This relationship differs between individuals and even for the same individual over time. For some, committing crime preceded drug use and for others drug use preceded criminality. Not everyone with a treatment need commits drug related crime, for instance, roughly half of treatment clients do not. Also some treatment clients will commit crime which is not drug related[5].

The Home Office estimates that drug related crime costs £13.9bn per year[5] and that offenders who use heroin, cocaine or crack cocaine commit between 33% and 50% of all acquisitive[5].

Acquisitive crime in Cheshire West and Chester between 2016-2017 estimated to be drug related

Crime type	No of offences	Drug related lower estimate	Drug related upper estimate
Burglary	1,514	500	757
Domestic burglary	600	198	300
Non-domestic burglary	914	302	457
Vehicle offences (incl. theft of and from)	963	318	482
Theft from the person	177	58	89
Bicycle theft	442	146	221
Shoplifting	2,294	757	1,147
All other theft	2,014	665	1,007
Theft offences	7,404	2,443	3,702

Source: Office for National Statistics: Crime in England and Wales, March 2017

Based on Home Office estimates, it can be assumed that between 2,400 and 3,700 thefts (of different types) in 2016-2017 can be attributed to offenders who use heroine, cocaine or crack cocaine.

The National treatment agency estimates that any drug addict not in treatment costs society an average of £26,074 per year, based on their criminal activity.
This includes:

- £5,513 – Robbery crimes
- £4,798 – Shoplifting crimes
- £1,228 – House burglaries

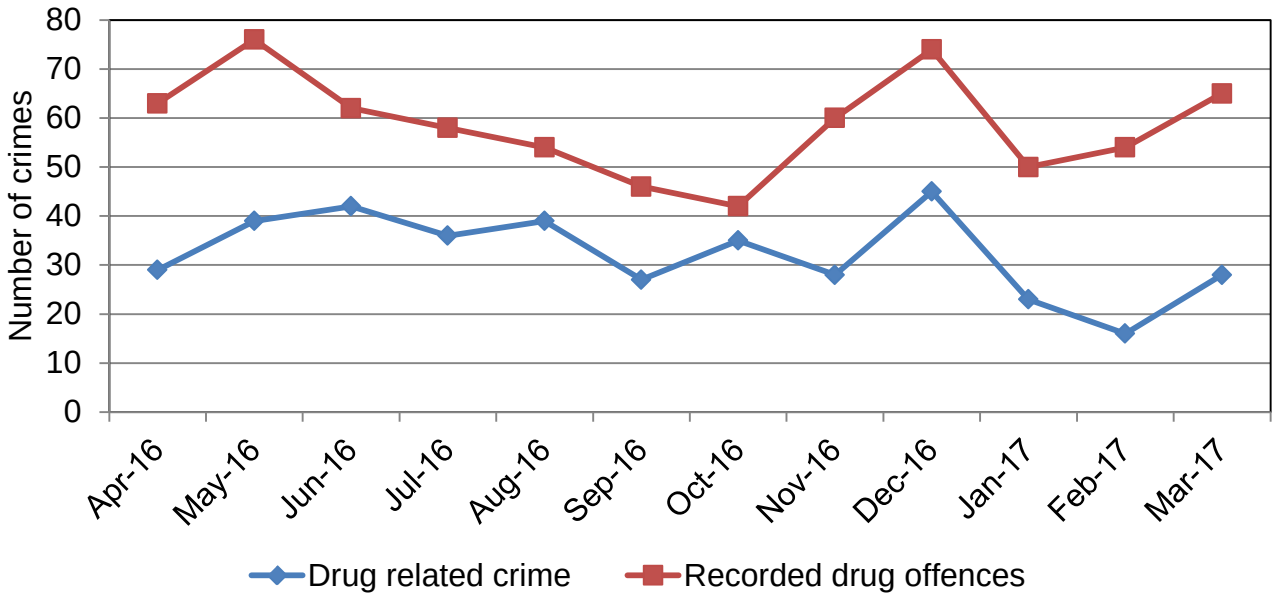
National Drug Treatment Agency (May 2012)

12.3 Local drug related crime figures

When recording crimes, Cheshire Constabulary consider, (where possible), if drugs were a contributing factor to the crime being committed. Where it is thought that drugs were a contributing factor, the crime is flagged as drug related. 'Drug related' refers to offenders who were 'affected by drugs', 'offenders who were 'affected by drugs and alcohol' and offenders who were 'affected by drugs and solvents'. It does not refer to those acquisitive crime of burglary, car thefts etc., where the offender may be carrying out the offence to pay for drugs.

During the financial year 2016-2017, within the three local policing units of Chester, Ellesmere Port and Northwich, covering Cheshire West and Chester, there were nearly 400 drug related crimes, with approximately 30 drug related crimes per month throughout the year. The trend for these drug related crimes tends to follow a similar trend to the recorded drug offences trend.

Recorded drug crime and drug related crime in Local Policing Units covering Cheshire West and Chester 2016-2017 by month

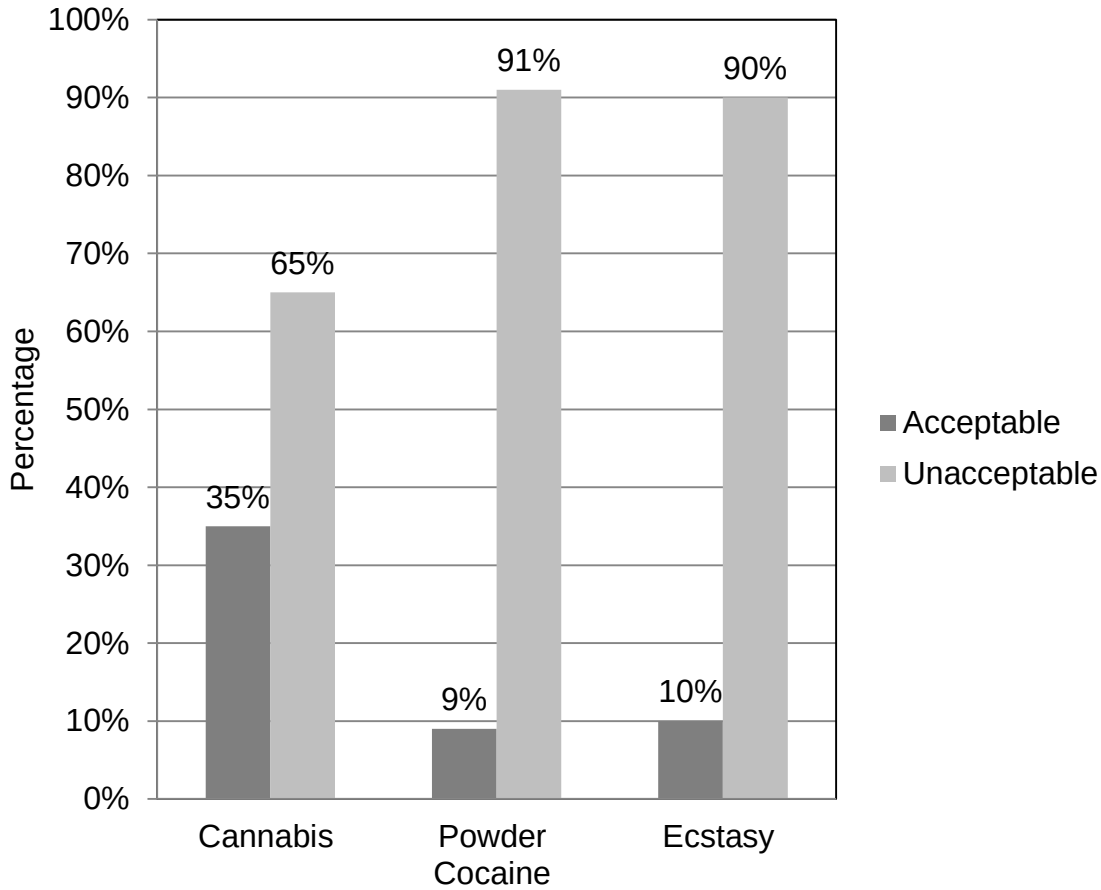


Source: Cheshire Constabulary 2017

13 . Public Attitudes to taking illicit drugs

National data from the Crime Survey for England and Wales (Drugs) 2015-16 shows around a third (35%) of people find the use of cannabis acceptable[2]. Whilst, peoples attitude to the use of ecstasy and powder cocaine is significantly different with around 90% of people finding the use of these drugs unacceptable[2]. In general, there is very little locally produced insight work on the views of the Cheshire West and Chester population on drug use and or recovery services and this needs addressing moving forwards.

Acceptability of people of the same age taking illicit drugs 2015/2018



Source: Crime Survey for England and Wales 2015-16.

14. What the evidence says is effective to reduce drugs misuse

There are literally thousands of research papers, evidence reviews and a wide range of NICE Guidance available on Drug Misuse, many of which focus on prevention and the clinical aspects of treatment. This section provides a brief look at the key messages in the literature and highlights some high-level reviews and guidance which might be useful to commissioners, service providers and members of the public looking to increase their knowledge and understanding of the subject area.

In general, services and professionals should identify young people who are at risk of using drugs, and refer them to services that can support them[15]. These services should include family based support and parental skills training[15]. Also see NICE's pathway on 'Reducing substance misuse among vulnerable children and young people'.

There is clear evidence, that programmes which are least effective in preventing substance misuse, are those that focus solely on scare tactics, knowledge-only approaches, mass media campaigns or the employment of ex-users and the Police as drug educators in schools, where their input is not part of a wider evidence based prevention programme[4]. Good quality Personal, Social and Health Education and school-based interventions, designed to improve behaviour generally (e.g. by building confidence, resilience and effective decision-making skills) can have a preventative impact on drug use[5].

NICE recommend delivering drug misuse prevention activities for people in groups at risk through a range of existing statutory, voluntary or private services, including[16]: health services, such as primary care services, community-based health services, mental health services, sexual and reproductive health services, drug and alcohol services, school nursing and health visiting services specialist services for people in groups at risk, community-based criminal justice services, including adult, youth and family justice services and accident and emergency services etc.

At routine appointments and opportunistic contacts with statutory and other services, such as those listed above, assess whether someone is vulnerable to drug misuse. Examples of routine appointments and opportunistic contacts include: health assessments for children and young people who are looked after or care leavers, including initial assessments, any reviews and contacts appointments with GPs, nurses, school nurses or health visitors, attendances at emergency departments as a result of alcohol or drug use and community-based criminal justice system[16].

Skills training should be considered for children and young people who are assessed as vulnerable to drug misuse[16]. If skills training is delivered to children and young people, ensure that their carers or families also receive skills training[16]. For older children and young people, think about whether providing information may be a more appropriate approach (See below).

All adults who are assessed as vulnerable to drug misuse should be offered the following: clear information on drugs and their effects, advice and feedback on any existing drug use and information on local services and where to find further advice and support[16]. Information should be provided at the same time as the assessment and information should be offered both verbally and in writing[16]. Ensure that information and advice is delivered in- line with NICE's guidelines on general and individual approaches to behaviour change and patient experience in adult NHS services.

Consider providing information about drug use in settings where groups who use drugs or are at risk of using drugs e.g. nightclubs or festivals may attend wider health services[16], such as sexual and reproductive health services or primary care supported accommodation, hostels for people without permanent accommodation and gyms (to target people who are taking, or considering taking, image and/or performance enhancing drugs). Information should be provided in different formats, including web-based information (such as digital and social media) and printed information (such as leaflets). Consider providing information on: drugs and their effects (for example, on NHS Choices) support online self-assessment and feedback to help people assess their own drug use.

Ensure that information provided is in-line with NICE Guidelines on general and individual approaches to behaviour change and patient experience in adult NHS services. It is noteworthy, that there is little evidence that drug education, focused solely on information giving or media campaigns alone, can change behaviour and they should only be used as part of a wider strategy[5].

For many drug users, especially the most entrenched, engaging in treatment is the catalyst for getting the medical help they need to address their physical and mental health problems[14]. Drug treatment affects a broad range of outcome domains, including: drug use, abstinence, crime, harm, health, mortality, and social functioning, including employment, accommodation, family relations, and recovery self-perceptions[14]. Evidence suggests that recovery is more likely to be achieved and sustained if users are given support to improve their 'recovery capital', particularly around housing and meaningful employment[5].

Opioid substitution treatment is the most widely studied intervention. Opioid substitution treatment is associated with a marked reduction in heroin use (66% abstinent), with the majority of patients retained in treatment (77% retention)[14]. Flexible (usually higher dose) treatment is associated with longer time spent in treatment and greater heroin abstinence[14]. Opioid substitution treatment is associated with a marked reduction in illicit drug injecting and sharing of injection equipment and substantially reduces the risk of fatal opioid poisoning (overdose) and reduces the risk of blood-born viral infection[14]. Many of the experts by experience who were consulted in longitudinal studies said that Opioid substitution treatment was an effective means of bringing people into contact with treatment and bringing stability to lives. However, some said that services could do more to ensure prescribing/dispensing arrangements were right for them[14]. People who inject drugs should be encouraged to take tests for hepatitis and tuberculosis in accordance with NICE's pathways on Hepatitis B and C and Tuberculosis. Also see ‘Interferon alfa (pegylated and non-pegylated) and ribavirin for the treatment of chronic hepatitis C (NICE technology appraisal guidance 75).

Psychosocial interventions are an important element of drug treatment, but there is mixed evaluation literature on their effectiveness[2]. Opportunistic brief motivational interventions for people with stimulant and opioid dependence are associated with reductions in drug use[2]. Contingency Management is effective at reducing illicit drug use and Contingency Management during methadone maintenance is associated with abstinence[2]. CBT is an effective treatment for drug dependence (compared to no treatment), but when compared to other psychosocial interventions, CBT is only effective for stimulant and cannabis dependence with co-morbid depression and as an adjunctive therapy for those who are abstinent from heroin during OST[2]. treatment[2].

Family and couples-based interventions are effective at achieving abstinence from cocaine and heroin. Mindfulness-based therapies (specifically acceptance and commitment therapy) may be an effective treatment for drug dependence[2]. Self-help support groups and mutual aid are associated with abstinence from illicit drugs and fewer drug-related problems[2] Residential care is recommended for people who have significant co-morbid physical, mental health or social problems and NICE recommends particularly for people who have not benefited from previous community-based psychosocial treatment[2].

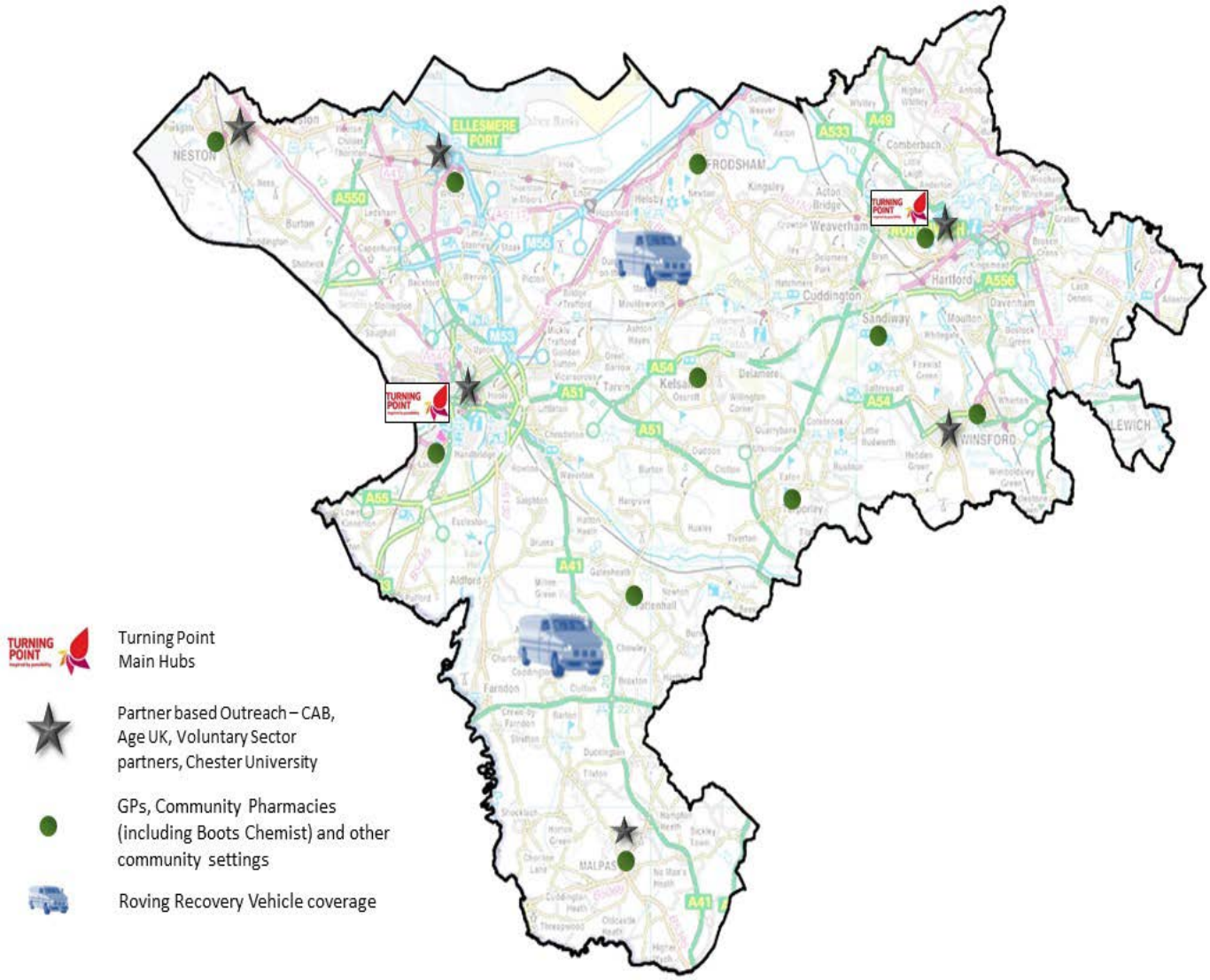
Continuing after care is associated with a positive effect on substance use in the criminal justice system[14]. Prison diversion initiatives are effective at reducing drug use and therapeutic community work release programmes in prisons are associated with reductions in relapse to drug use and reductions in post-release criminal activity and re-offending (review evidence is low-moderate quality)[14]. Specialist drug treatment is associated with reductions in offending[2]. Retention in OST is an important driver of crime reduction outcomes and crime reduction outcomes improve with increased time in treatment, community-based needle and syringe programmes, with extensive coverage, can reduce population-level HIV and HCV infections[2]. The NICE pathway on 'Needle and syringe programmes' provides details for commissioning and coordinating needle and syringe programmes. It sets out a 3-tier model of service provision and advocates assessing local need, to ensure that services are targeted to where they are most needed, including information about providing needle and syringe programmes to young people and people who use image and performance enhancing drugs[15]. The NICE pathway demonstrates how these programmes provide an opportunity to engage people in a range of harm reduction services and can act as a gateway to both drug treatment services and other health and social care services.

In July 2017, the government published Drug misuse and dependence, UK guidelines on clinical management (AKA the Orange book)[13], the document updates and replaces the 2007 edition of the guidelines.These guidelines contain over 300 pages of detailed information and are intended primarily for doctors, nurses, psychologists, pharmacists, keyworkers and other workers providing drug treatment, as well as health and social care professionals providing drug treatment for people who misuse, or, are dependent on drugs. Local commissioners and providers have a responsibility to develop services that enable the guidelines to be applied. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

A proportion of our local population will be diagnosed as having co-existing severe mental illness and substance misuse issues, NICE have produced specific Guideline (NG58) which covers how to improve services for these people. The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing. NICE has also produced a guideline on 'coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings'.

15. Assets

Community assets are key to the development and sustainability of recovering communities, treatment services linked to recovery groups, local GPs, pharmacies and third sector organisations (such as, Age UK, CAB, Narcotics Anonymous. Alcoholics Anonymous, homeless services, lifestyle services, mental health and wellbeing services, faith groups, housing providers etc., are all vital interlinked elements that support recovery of individuals and communities, some of these are shown on the map below.



16. What does drug misuse cost Cheshire West and Chester?

The social and economic cost of drug use and supply to society is estimated to be around £10.7bn per year. Currently, there are no estimates of the social and economic cost of drug misuse in Cheshire West and Chester, although, the cost to local organisations e.g. the Police, Local Authority, NHS etc., will be significant at a time when Public Sector resources are being reduced e.g. It is estimated that the cost of healthcare alone for adult drug users not in structured treatment is £5,380 per annum, whilst the overall cost is estimated to be over £26,000 per year, Conversely, the Drug Treatment Outcomes Study suggests that every £1 invested in drug treatment results in a £2.50 benefit to society.

What does drug misuse cost Cheshire West and Chester?

The social and economic cost of drug use and supply to society is estimated to be around £10.7bn per year, of which £6bn is attributed to drug-related crime[5]. Currently, there are no estimates of the social and economic cost of drug misuse in Cheshire West and Chester, although, the cost to local organisations e.g. the Police, Local Authority, NHS etc., will be significant at a time when Public Sector resources are being reduced e.g. the estimated cost of healthcare alone, for adult drug users not in structured treatment, is £5,380 per annum[17] and the National Treatment Agency estimates that any drug addict not in treatment costs society an average of £26,074 per year (Section 12.2).

Investment in drug treatment can substantially reduce the economic and social costs of drug-related harm. The most recent evidence on the value for money of drug treatment comes from the Drug Treatment Outcomes Study 36 The findings suggested that there are net benefits from drug treatment, with an overall benefit-cost ratio of approximately 2.5:1. This suggests that every £1 invested in drug treatment results in a £2.50 benefit to society[17].

17. What needs might be unmet?

In general, there is difficulty in identifying un-met need within our communities due to issues with the availability of data and lack of local insight work. The analysis provided in the JSNA suggests, that the needs of long-term and complex clients in treatment, may not be being fully met, and/or, the service model may need to evolve to improve recovery within this client group. Historically, it has been recognised that the needs of people with a dual diagnosis of high risk drinking/drugs dependency and mental health, may not be fully met and work should be undertaken to understand the level of need locally.

There are a large number of younger males using needle exchange for steroid and image enhancing drugs and further work is needed to better understand this client group in order to develop interventions and work with partners in the fitness industry. New Psychoactive Substances pose a significant but currently unquantifiable risk to certain groups and are being targeted at young people and the homeless population. Moving forward there is a need to work across organisations to better understand local issues, patterns of use and develop effective interventions.

Finally, there are a number of well established high risk groups e.g. deprived communities, young people, offenders, sex workers, the homeless, veterans etc., (see section 5), where there is a high likelihood that the need is not being fully met.

18 What are the challenges in meeting needs

The nine key challenges to tackling Drug Misuse across Cheshire West and Chester are:

- Around a third of the population have taken illicit dugs at some point in their lives and drug misuse is in-ground within our culture; there is a fundamental need to address this problem.
- New Psychoactive Substances are being targeted at some of the most vulnerable sections of our population i.e. children and young people and the homeless population; more needs to done to address this.
- Cheshire West and Chester have a high number of people who have been in treatment for over four years, further work needs to be untaken to understand how this cohort could (where appropriate) progress through the recovery system.
- The need to increase partnership working, including further developing the Substance Misuse Partnership.
- Increasing work on prevention and early detection against a backdrop of reducing Public Sector Resources.
- Good quality housing and employment is key to Recovery, partners need to work together to increase the opportunities for worthwhile employment for people on recovery pathways.
- Improving data and intelligence on drug related harm, including, A&E data and the development of a Local Drugs Information System (early warning system for contaminated or harmful drugs).
- There needs to be more insight work undertaken within our communities, in particular service users, to ensure that local interventions, initiatives and services meet their needs.
- Shaping specialist Substance Misuse Services so that they meet the needs of the population whilst being both effective and cost-effective.

20. Discussion

Estimates based on the British Crime Survey (Drugs) 2015-16, indicate that around 15,629 adults aged 15-59 years in Cheshire West and Chester had taken an illicit drug in the last year. Of these, 6,326, (40.5%), were young people aged 16-24 years of age (Section 6.0). This highlights the need to develop resilience, mental health and wellbeing in our younger people through high quality PHSE in our schools and academies. The high number of people using drugs in the last year demonstrates the need for all organisations to adopt a Making Every Contact Counts approach, focusing on promoting healthy lifestyles, improving mental health and wellbeing and the early detection of drug and alcohol issues.

The British Crime Survey is recognised as a robust measure of recreational drug use for the drug types it covers. However, it may not provide as good coverage of problematic drug users as they may not necessarily be a part of the household resident population, or, be concentrated in specific and relatively small sub-groups of the population. Therefore, for the development and planning of treatment and recovery services, the John Moores University estimates, using a mixed methodology, have been included in this report (Section 6.3). Using these, it is estimated, 1,619 people aged 15-64 in Cheshire West and Chester are opiate/crack users. Of these, 1,215 are opiate users and 736 are crack users. Of these, 480 are injecting substances. In 2016-17, there were 1,485 clients in treatment in Cheshire West and Chester for drug misuse, of these, 830 were in treatment for opiate use. This suggests that around 140 opiate and crack users may not be in contact with treatment and recovery services, however, the John Moores University estimates are slightly dated and this may account for the difference.

Cheshire West and Chester has a higher rate of clients in treatment for four years or more, compared to the national average, suggesting that Cheshire West and Chester has a high proportion of complex clients who are not completing treatment successfully and staying drug free (Section 9.0). In addition, local services have a higher re-presentation rate for opiate clients compared to the England average, suggesting the service model may need to evolve to improve recovery within this client group. Historically, it has been recognised that the needs of people with a dual diagnosis of drug dependency and mental health, may not be fully met and this may be contributing to the issues mentioned above. Analysis within this JSNA chapter shows there is a need to undertake further work to better understand clients with complex needs and explore how partner organisations can further develop clinical pathways that could improve recovery.

During the financial year 2016-2017, there were a total of 2,039 clients accessing syringe exchange services and non-structured interventions in the Cheshire West and Chester area (Section 9.8). This cohort forms two distinct groups, older clients using psychoactive drugs and a younger group, primarily made up of users of steroids and image and performance enhancing drugs. Every needle exchange transaction should be used as an opportunity to influence risk taking behaviours, improve the general health of clients and collate more detailed information on this cohort of people. In addition, the high number of people using steroids and image and performance enhancing drugs suggests there is a need to undertake targeted work with this cohort and partners in the fitness industry.

There is a reoccurring theme throughout the Drug JSNA relating to the need to improve local intelligence, so that decisions taken about drug misuse are based on reliable data that is available, in a timely manner, at locality (or neighbourhood) level and highlights the needs of high risk groups, this would allow services and interventions to be planned on an equitable basis. An example of this is the lack of clarity around the use of New Psychoactive Substances locally, whereby several years after the emergence of these drugs, high profile media attention and public concerns, there is still very little local intelligence readily available. However, moving forwards the Local Drug Information System should help to provide some robust information. In addition, there is an absence of local insight work to capture the views, hopes and aspirations of our communities and service users in relation to drug misuse and this needs to be addressed moving forwards. Given the range of issues locally, data analysts and information specialists should consider developing a forum with the aim of facilitating cross-organisational working and data sharing.

Deaths from drug misuse substantially increased in England in 2013 and 2014, with a 42% total increase in these two years (Section 11.0), as such, there has been considerable political, media and public interest in these figures. Locally, there were around 13 drug related deaths per year during 2013-2015, which equates to a mortality rate of 3.9 deaths per 100,000, similar to the national average. The analysis for hospital admissions due to drugs, in Cheshire West and Chester, was, in general, lower than that observed nationally. However, the rate of drug related hospital admissions due to poisoning locally, was higher than the national average, which suggests, there may be a need for a focused piece of work to reduce avoidable hospital admissions, which in turn could reduce the number of drug related deaths.

In Cheshire West and Chester, up to 3,700 thefts can be attributed to offenders who used heroin, cocaine or crack cocaine in 2016 (Section 12.0). Cheshire West and Chester trends in drug crime have varied over time but have fallen over recent years to be in-line with the national average. All the available evidence shows that getting people into recovery is the most effective way of reducing crime, and, as such, the Health and Wellbeing Board and the Cheshire West and Chester Community Safety Partnership should consider how best to facilitate closer partnership working between the Police, Community Safety Integrated Substance Misuse Service and the wider NHS, to promote early intervention within high risk groups and ensure there is a rapid referral and seamless pathway in place for criminal justice clients.

As highlighted in section 16.0, there are no detailed estimates of the social and economic cost of drug misuse in Cheshire West and Chester, although, the cost to local organisations e.g. Police, Local Authority, NHS etc., is significant, at a time when Public Sector resources are being reduced. A best estimate of the potential financial impact of opiate and crack users, not in structured treatment, comes from the National Drug Treatment Agency, which estimates, it costs £2.6 million for every 100 opiate and crack users who are not in structured treatment. Given this, there is a strong argument to ensure timely and equitable access to recovery services which are backed up by the financial analysis from the Drug Treatment Outcomes Study, that suggests, that every £1 invested in drug treatment results in a £2.50 benefit to society.

Finally, over time, there is a need to change the focus from treatment and recovery to prevention and early detection. Although, the development of a recovery focused, integrated Substance Misuse Service, working across Cheshire West and Chester, over the last few years, has represented a significant development, which reflects guidance and is ahead of some other local authorities in implementing evidence based practice.

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