



Liverpool
City Council

Liverpool's Joint Strategic Needs Assessment Substance Misuse Spring 2017



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Description	This document aims to provide an overview of issues relating to Substance Misuse (drugs & alcohol) in Liverpool. As part of the Joint Strategic Needs Assessment (JSNA), its purpose is to provide an evidence base to support policy makers and commissioners within the City Council, and local NHS. Whilst the document is primarily aimed at policy makers and commissioners, it is also available to members of the public and other organisations.
Related Documents	Liverpool's Joint Strategic Needs Assessment – Statement of Need www.liverpool.gov.uk/jsna
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Executive Summary

Effective integrated services are key to successful recovery from substance misuse. This can be achieved through a coordinated approach to the delivery of drug and alcohol services involving collaboration and partnership with health, social care, the criminal justice system, and voluntary services including mutual aid. Mutual aid refers to the social, emotional and informational support provided by, and to, members of a group at every stage of recovery. There is an active mutual aid network in Liverpool (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) with around 80 meetings every week. Social factors are also important influences on substance misuse treatment effectiveness with those in employment, decent housing and with good social networks more likely to recover and remain substance-free.

A wide range of factors can lead a person to addiction although it is important to recognise that most people exposed to them do not become addicted. These factors include individual characteristics, deprivation and wider environmental influences. Substance misuse has far reaching impacts on health, wellbeing, families and the wider economy. The most harmful effects of drug misuse are evident among opioid users and include the increased risk of infection by blood-borne viruses (Hepatitis B, Hepatitis C and HIV), depression and anxiety disorders, social problems, crime and increased risk of death from overdose.

The key findings below have been developed based on the range of issues that have been identified through this JSNA report, from both an analysis of local intelligence and stakeholder views and the recent review of Liverpool substance misuse services by LJMU¹.

Key Findings

Prevalence

- Analysis of the Global Burden of Disease Study 2015 shows that alcohol and illicit drug use and tobacco smoking including second-hand smoke, are the top three risk factors for death and disability in the 15-49 age group in North West England².
- Patterns of alcohol consumption are changing, and national surveys show that binge drinking is falling in England, particularly among young adults³.
- A 2014 survey of Year 8 pupils in Liverpool found 6.7% of pupils reported taking cannabis in the last year, while 2.9% had inhaled glue, gas, aerosols or solvents.
- Public Health England estimates suggest there were around 5,400 people in Liverpool using opiates and/or crack in 2011/12. Opiate and crack use in Liverpool is significantly above the national average (16.5 per 1,000 population compared to 8.4 per 1,000 population in England) while injecting drug use is significantly lower.

- The number of people in Liverpool accessing either a pharmacy or agency based needle and syringe programme (NSP) is increasing. In 2015/16 around 7,700 people accessed NSP services compared to 5,500 people in 2013/14, an increase of 40%. There were 1,915 individuals (49% of those who had a substance recorded) with heroin, or crack cocaine, or other opiate as either their primary or secondary substance in 2015/16.
- The use of new substances which mimic the effect of more traditional drugs such as cocaine and cannabis remains relatively low but concentrated among young adults and particularly men, with around 3,300 young adults in Liverpool thought to have used them in the last year.

Hospital Admissions

- While there has been a significant reduction in the rate of alcohol admissions among children over the last 6 years, Liverpool's rate of admission to hospital for substance misuse among young people aged 15-24 years is increasing and is now significantly above the England average and the highest among the core cities.
- Provisional figures for 2015-16 show there were around 4,200 alcohol-related admissions to hospital in the city. Liverpool's alcohol-related admission rate was significantly above the national average and the second highest out of the core cities, behind Nottingham⁴. Despite being relatively stable for many years, the rate of admission has increased between 2013/14 and 2015/16 (a 20% increase overall). Men account for just under two thirds of those admitted. There is wide variation in alcohol-related admissions across the city with the rate of admission in Everton ward more than three times higher than in Church ward.
- In 2014/15 Liverpool had the highest rate of hospital admission due to drug-related mental and behavioural disorders in England, while the admission rate for poisoning by illicit drugs was the highest among the eight core cities⁵. Admissions due to poisoning by illicit drugs were up 44% on the previous year, while drug-related mental and behavioural disorders increased by 9%. Males account for around three quarters of admissions due to drug-related mental and behavioural disorders, while admissions for poisoning are more balanced between the sexes.
- Between 2013-14 and 2015-16 there were just over 1,000 hospital admissions in Liverpool relating to drug misuse, an average of almost one a day. Admission rates have been steadily increasing, with numbers greatest in the 25-44 year age group. There is wide variation in drug related admissions across Liverpool with the rate of admission in Everton ward almost seven times higher than in Mossley Hill ward.

Mortality

- Drug use disorders are the leading cause of death in the 15-49 age group in the North West.
- Drug poisoning deaths involving both legal and illegal drugs in England and Wales in 2015 are at their highest since comparable records began, while deaths involving heroin and/or morphine have doubled in the last 3 years to 1,201 deaths in 2015. This increase was driven partly by a rise in heroin

purity and availability over the last 3 years but age is also a factor, as heroin users are getting older and often have other conditions, such as lung disease and hepatitis.

- Around 36 people die in Liverpool from drug misuse each year, significantly higher than for England overall and the second highest after Manchester among the core cities⁶. Liverpool's death rate from drug misuse has doubled between 2001-03 and 2015-16, up from 4 per 100,000 to 8 per 100,000.
- Local analysis shows drug-related deaths are strongly associated with deprivation, with the most deprived ward quintile in the city having a significantly higher death rate than the least deprived quintile.
- In 2014, 243 people in Liverpool died from causes related to alcohol. Liverpool has the 18th highest alcohol-related mortality rate out of 326 local authorities in England and the third highest rate among the core cities². Alcohol-related death rates among men are around double those among women, with levels highest among those aged 55-64 years. Despite the improvements seen in recent years, the level of alcohol-related deaths is significantly higher in 2014 than 20 years ago⁷.
- Most liver disease is preventable and influenced by alcohol consumption and obesity. Around 112 people in Liverpool die prematurely from liver disease considered preventable each year. In 2013-15, Liverpool's premature mortality rate was the second highest in England, behind Blackpool².
- An audit of deaths from suicide in 2015 showed poisonings was the second most common method of suicide among men and women in Cheshire and Merseyside, with case notes showing a history of alcohol misuse featured in 31% of cases and a history of drug misuse in 28% of cases⁸.

Treatment and Recovery Support

- Liverpool's cohort of opiate users are increasingly older and often have a range of complex physical health illnesses arising from long-term drug use such as COPD and cancer - 50% of Liverpool's opiate users are aged 45+ years compared to 27% nationally⁹. More than a third of heroin smokers attending a drug service in the city were found to have COPD which was undiagnosed.
- In Liverpool the most commonly misused substances by those in treatment services are opiates (53%) and alcohol (34%). Of the estimated 5,400 opiate and crack users in the city, 3,047 were in treatment in 2014/15 (56%).
- Compared to England, Liverpool has higher proportions of people waiting 3 weeks or more for drug treatment (3.2% compared to 2.1%) and alcohol treatment (4.9% compared to 4.1%).
- In all, 1,555 people exited the drug and alcohol treatment system in 2015 having successfully completed their treatment free of dependence. Alcohol clients had the highest rates of successful exits with more than half (50.9%) completing treatment followed by non-opiate clients with 49.8% completing treatment, both significantly higher rates than nationally. Opiate clients had the lowest rate of completion, 6.3% which was similar to England at 6.7%.
- In 2015/16, 452 people in drug treatment services (24.7% compared to 22.1% nationally) and 107 people in alcohol treatment services (10.2% compared to 20.8% nationally) were in touch with mental health services for reasons other than substance misuse.

- Compared to England, Liverpool has a significantly lower proportion of adults with a substance misuse treatment need engaging in structured treatment interventions in the community within 3 weeks of their release from prison (26.4% compared to 30.3%).
- Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (such as methadone and morphine). It is already available on prescription and used by paramedics, including North West Ambulance Service.

Crime

- There are substantial costs to the UK economy from alcohol and drug-related crime, with estimates of between £8bn and £13bn each year¹⁰ and £13.9bn each year respectively¹¹.
- In 2015-16 there were approximately 3,000 drug offences and 3,500 alcohol-related offences recorded in the city.
- Alcohol-related crime is strongly associated with deprivation, with the most deprived areas of the city having the highest alcohol-related crime rates, outside of the city centre.

Licensing and the Night Time Economy

- The city has a vibrant night-time economy recognised by the prestigious award of ‘Purple Flag’ status since 2010 for excellence in the management of the city centre night time economy.
- There are currently over 2,200 premises licensed to serve alcohol in Liverpool, equating to one premise for every 173 adults. By comparison there were 204,400 premises licences in force in England and Wales in 2013¹² equating to one for every 279 adults.
- There are 5 cumulative impact policies (CIPSS) in place in the city to minimise the impact of alcohol in designated areas: Allerton Road, Cavern Quarter, Lark Lane, Ropewalks and Kensington, Fairfield & Central wards.

Stakeholder Views

- Feedback from stakeholders and service providers indicate that Liverpool offers a very good level of provision within the substance misuse treatment system. Being able to access services in the community was seen as important and an effective method of supporting and sign-posting clients to other services.
- Raising awareness of the amount and level of service provision, mutual aid and volunteering opportunities were raised as key issues by stakeholders, as well as training and information on overdose, particularly for peers and people with drug problems.

1. Introduction

1.1 Aims & Objectives

This report forms part of the Joint Strategic Needs Assessment for Liverpool, and provides an in-depth review of substance misuse in the city. Substance misuse is defined as "***The continued misuse of any mind-altering substance that severely affects a person's physical and mental health, social situation and responsibilities.***"¹³, and includes both drugs and alcohol. The purpose is to give all those with an interest in reducing the prevalence and impact of substance misuse a holistic view of the health needs of the population. In particular the document sets out to:

- Provide an overview of the national and local policy context in relation to substance misuse
- Identify the extent of substance misuse within the city, including particular groups that may be more adversely affected
- Provide an overview of the health and socio-economic impact of substance misuse in the city
- Provide an overview of how the city is responding to substance misuse
- Provide an overview of the views of service providers and wider stakeholders on the key pressures, gaps and weaknesses within the current substance misuse treatment and recovery system in need of address
- Provide an overview of key sources of evidence to support local action

1.2 Drugs

Drug misuse is a complex issue, both in terms of the law and in relation to its impact, not only on the individual, but also their family, friends and wider society. Drugs can cause significant and cumulative harm, are often highly addictive, and associated with a wide range of issues such as homelessness, family breakdown and criminal activity¹⁴.

1.3 Alcohol

The way in which we now consume alcohol is changing. Stronger alcoholic drinks, generous home measures and the availability of cheap alcohol result in people consuming more alcohol than they realise and this contributes negatively to health. The cost of alcohol to health is significant and continues to rise. Excessive alcohol consumption can lead to dependence and significantly impact on the lives of individuals, their families and friends. When used irresponsibly alcohol has an impact on the levels of crime, violence and anti-social behaviour experienced in our communities whilst also reducing levels of productivity in the workplace.

2. Policy Context

2.1 National Strategic & Policy Context

2.1.1 Misuse of Drugs Act¹⁵

Under the Misuse of Drugs Act 1971, drugs are categorised into three classes, A, B or C. The classifications are broadly based on the degree of harm they cause to the individual user or to society when they are misused, with Class A being the most harmful.

Class	Drug	Possession	Supply and production
A	Cocaine, Crack cocaine, Ecstasy (MDMA), Heroin, LSD, Magic mushrooms, Methadone, Methamphetamine (crystal meth)	Up to 7 years in prison, an unlimited fine or both	Up to life in prison, an unlimited fine or both
B	Amphetamines, Barbiturates, Cannabis, Codeine, Ketamine, Methylphenidate (Ritalin), Synthetic cannabinoids, Synthetic cathinones (eg mephedrone, methoxetamine)	Up to 5 years in prison, an unlimited fine or both	Up to 14 years in prison, an unlimited fine or both
C	Anabolic steroids, Benzodiazepines (diazepam), Gamma hydroxybutyrate (GHB), Gamma-butyrolactone (GBL), Piperazines (BZP), Khat	Up to 2 years in prison, an unlimited fine or both (except anabolic steroids - it's not an offence to possess them for personal use)	Up to 14 years in prison, an unlimited fine or both
Temporary class drugs*	Some methylphenidate substances (ethylphenidate, 3,4-dichloromethylphenidate (3,4-DCMP), Methylnaphthidate (HDMP-28), Isopropylphenidate (IPP or IPPD), 4-methylmethylphenidate, ethynaphthidate, propylphenidate) and their simple derivatives	None, but police can take away a suspected temporary class drug	Up to 14 years in prison, an unlimited fine or both

Table 1: Drug classifications in the UK

Source: HM Government¹⁶

Note: The government can ban new drugs for 1 year under a 'temporary banning order' while they decide how the drugs should be classified.

It is important to recognise that not all drugs are illegal, however that does not mean they aren't harmful. For example, tobacco and alcohol can seriously damage your health.

2.1.2 National Drug Strategy¹⁷

The Government's National Drug's Strategy focuses on reducing demand for drugs, restricting supply and building recovery. It places an emphasis on shifting power and accountability to the local level through the introduction of Police and Crime Commissioners (PCCs), the reform of the NHS and the creation of Public Health England (PHE), as well as making it clear that individuals are responsible for their actions. The two key aims of the strategy are to:

- Reduce illicit and other harmful drug use; and
- Increase the numbers recovering from their dependence.

The strategy encourages partnerships to develop and commission recovery focused services that take a holistic approach to supporting an individual's needs and not just focusing on their substance misuse.

2.1.3 Psychoactive Substances Act¹⁸

There has been a rise in the use of substances which mimic the effect of more traditional drugs that are controlled under the Misuse of Drugs Act, such as cocaine and cannabis. These are known as psychoactive substances but are often incorrectly called 'legal highs'.

The Psychoactive Substances Act which came into force in May 2016 makes it an offence to possess, produce or supply any substance intended for human consumption that is capable of producing a psychoactive effect. The Act does not list specific substances, but rather classifies a psychoactive substance based on the effect it has on the individual taking it. Specifically, a psychoactive substance is defined as "*a substance which is capable of producing a psychoactive effect in a person who consumes it and is not an exempted substance. A substance causes a psychoactive effect in a person if, by stimulating or depressing the person's central nervous system, it affects the person's mental functioning or emotional state.*"¹⁹

This wider definition reflects an attempt to ensure that the law keeps pace with new substances that emerge.

2.1.4 National Alcohol Strategy²⁰

The Government's National Alcohol Strategy was released in 2012, and sets out proposals to crackdown on the 'binge drinking' culture in the UK, cut levels of alcohol fuelled violence and disorder and reduce the number of people drinking to damaging levels. The strategy identifies six high level outcomes that it seeks to achieve:

- A change in behaviour so that people think it is not acceptable to drink in ways that could cause harm to themselves or others;
- A reduction in the amount of alcohol-fuelled violent crime;

- A reduction in the number of adults drinking above the NHS guidelines;
- A reduction in the number of people “binge drinking”;
- A reduction in the number of alcohol-related deaths; and
- A sustained reduction in both the numbers of 11-15 year olds drinking alcohol and the amounts consumed.

2.1.5 Chief Medical Officers’ Alcohol Guidelines²¹

The UK Chief Medical Officers (CMOs) provide advice and guidance to the general public regarding the health risks of different levels and patterns of drinking, with the aim of ensuring that people can make informed choices in the way they consume alcohol. New alcohol guidelines state that alcohol limits for both men and women are the same:

- **On regular drinking:** To drink no more than 14 units of alcohol per week. If drinking more than 14 units, to spread these over 3 days or more.
- **On single drinking episodes:** To limit the amount of alcohol drunk on any one occasion, drinking more slowly, with food and alternating with water.
- **Pregnant women:** The safest approach is to not drink alcohol at all.

The guidance identifies a number of groups that may be more affected by alcohol than others, including:

- young adults
- older people
- those with low body weight
- those with other health problems
- those on medicines or other drugs

2.1.6 Public Health Outcomes Framework²²

In January 2012, the Government published the 2013-2016 Public Health Outcomes Framework for England 2013-16, ‘*Healthy lives, healthy people: Improving outcomes and supporting transparency*’. The framework sets out: a vision for Public Health in England to improve and protect the nation’s health and wellbeing across the life course, and to reduce inequalities in health; the desired outcomes for Public Health; and the indicators by which improvements are measured.

The document concentrates on two high-level outcomes to be achieved across the Public Health system, and groups further indicators into four ‘domains’ that cover the full spectrum of public health. The outcomes reflect the focus on how long people live, and on how well they live at all stages of life.

Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest

Outcome 1: Increased healthy life expectancy, taking account of the health quality as well as the length of life

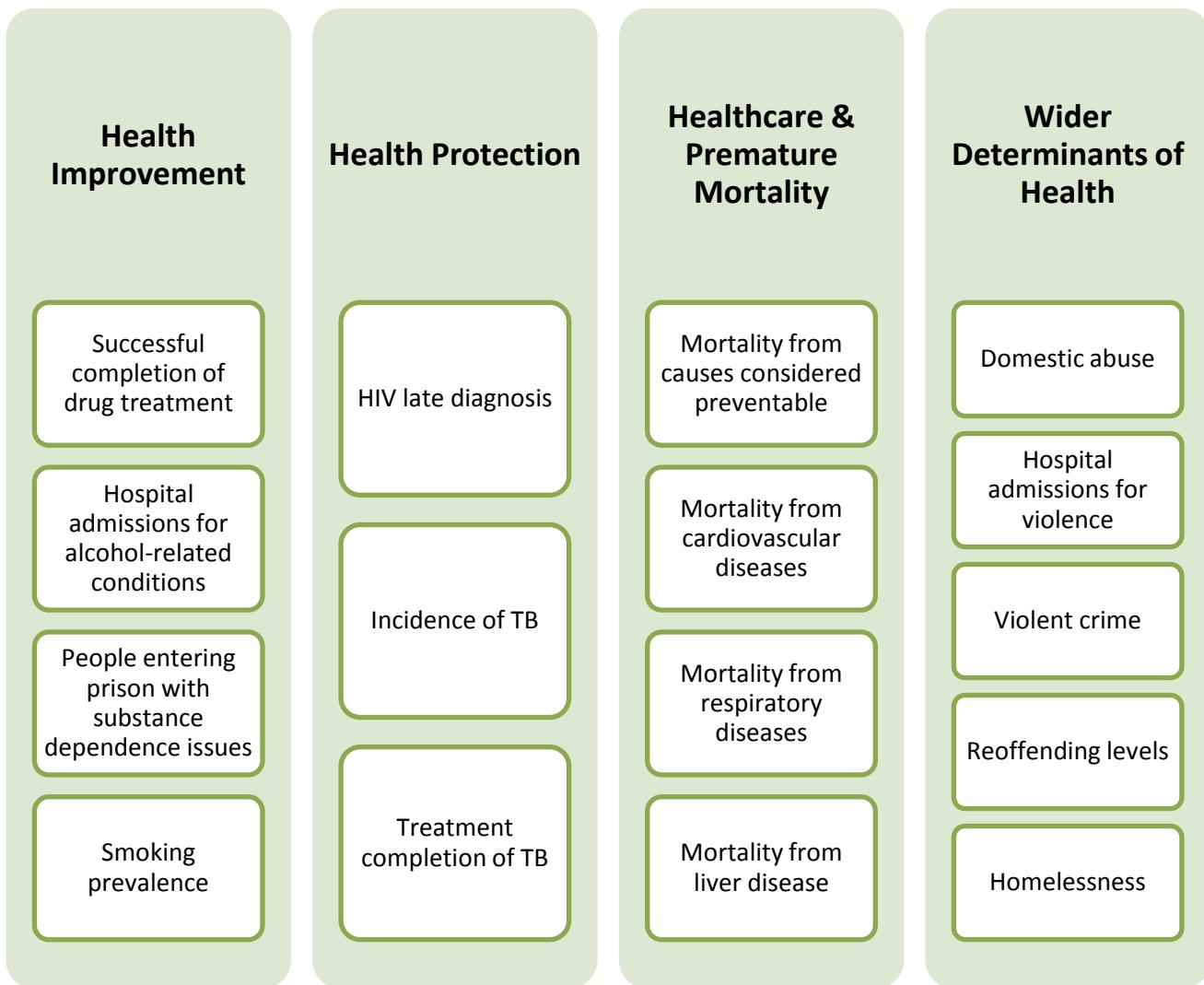
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities, through greater improvements in more disadvantaged communities

DOMAIN 1: Improving the wider determinants of health	DOMAIN 2: Health Improvement	DOMAIN 3: Health protection	DOMAIN 4: Healthcare Public Health & preventing premature mortality
Objective: Improvements against wider factors which affect health and wellbeing and health inequalities	Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Objective: The population's health is protected from major incidents and other threats, whilst reducing health inequalities	Objective: Reduce the number of people living with preventable ill health and dying prematurely, whilst reducing the gap between communities

The Public Health Outcomes Framework contains the following core measures which are of particular relevance to substance misuse:

- 2.15i – Successful completion of drug treatment (opiate users)
- 2.15ii – Successful completion of drug treatment (non-opiate users)
- 2.16 – People entering prison with substance dependence issues who are previously not known to treatment
- 2.18 – Admission episodes for alcohol-related conditions (narrow measure)
- 4.06i – Under 75 mortality rate from liver disease
- 4.06ii – Under 75 mortality rate from liver disease considered preventable

It is important to recognise that the health and social impacts of substance misuse are wide ranging. In addition to the core outcome measures shown above, there are a number of additional measures contained within the Public Health Outcomes Framework that are relevant to the substance misuse agenda.



2.1.7 Public Health Grant

Since April 2013, local authorities in England have taken on responsibility for Public Health, from the NHS, with a duty to reduce health inequalities and improve health outcomes for their local population. In order to fulfil their Public Health functions, each local authority is provided with a ring fenced grant by the Department of Health. Numbers in effective treatment for substance misuse form a significant proportion of the formula used to allocate the ring fenced grant to local authorities²³. While this formula is currently under review it is likely that this will continue to form a significant proportion of Public Health funding.

2.1.8 Modern Crime Prevention Strategy²⁴

The Modern Crime Prevention Strategy outlines the Government's approach to crime prevention, based on targeting six key drivers of crime, including drugs and alcohol. There is a strong association between drugs, alcohol and crime. Drugs are particularly associated with acquisitive crime, with an

estimated 45% of these crimes are committed by regular heroin / crack cocaine users. In addition, it is thought that alcohol is an influence in around half of all violent crime²⁵.

Drug crime prevention is focused around three key themes: treatment, prevention and enforcement, while the prevention of alcohol-related crime is focused on improving local intelligence, establishing effective partnerships and additional powers for police and local authorities.

2.2 Local Strategic & Policy Context

2.2.1 Liverpool's Joint Health & Wellbeing Strategy²⁶

The Joint Health and Wellbeing Strategy sets out a vision to create a '*Fairer, Healthier, Happier Liverpool*'. The strategy is the city's overarching approach to improving the health and wellbeing of children and adults, based on the JSNA and on-going engagement with partners and local communities. The strategy seeks to reduce health inequalities within Liverpool and relative to the rest of the country. It also recognises the needs of those people who face additional challenges in society for improving their health and wellbeing, over and above their physical and emotional needs.

In responding to the issues identified within the JSNA, the strategy identifies four key health and wellbeing priorities for the city, which all partners on the Health & Wellbeing Board work towards:

Giving children the best start in life

Children and young people are at the centre of Liverpool's future sustainability. There is strong evidence that good health and future life chances arise early in childhood, during pregnancy, and even before a baby is conceived. Understanding the importance of key transition points where significant changes occur, such as moving from primary to secondary school, is important in developing policies and interventions that effectively improve health in early years, and give children the best start in life.

Health and independence for all

Building on the skills and experiences we develop through our lives is essential to helping us manage our health and maintain our independence. It is important that support to local people is provided in a way that is based on their needs and circumstances, with greater levels of joined up working between services, in the right place, and at the right time.

Liverpool people are engaged in improving health and wellbeing

No single organisation in the city has the knowledge, skills or resources to bring about sustainable improvement in health and wellbeing on its own. A collaborative approach is required, bringing together all sectors of society and the public, with on-going engagement built into policy making and the design of services.

Building resilient and safe communities

Resilience is the capacity of people to confront and cope with life's challenges; to maintain their wellbeing in the face of adversity at an individual, family and community level. Understanding and harnessing the expertise and assets of local communities is a key element to how they are able to respond to health and wellbeing needs.

2.2.2 Healthy Liverpool – The Blueprint (November 2015)²⁷

Liverpool Clinical Commissioning Group (CCG) has set out its vision for a new health and social care system for the city in their Healthy Liverpool Programme. The programme is designed to respond to the challenge of an ageing population and the rise in long term conditions. The Healthy Liverpool Programme (HLP) vision is that by 2020, all the people of Liverpool will be enjoying longer, healthier lives and Liverpool will have a health and social care system that is person centered, supports people to stay well and provides the very best in care. The Healthy Liverpool blueprint sets out how the transformational change will be delivered across five areas:

- **Living well:** Supporting people to become healthier and more active.
- **Digital care and innovation:** Ensuring all our services make the best use of developing technologies.
- **Community care:** Improving capability and capacity in primary care, community care and social care.
- **Urgent and emergency care:** Developing robust and effective rapid response services.
- **Hospital services:** Ensuring our hospital services are the best they can be.

2.2.3 Liverpool's Alcohol Strategy²⁸

The Liverpool Alcohol Strategy outlines a vision of Liverpool as a city that promotes a responsible attitude towards alcohol and minimises the risks, harms and costs of alcohol misuse to allow individuals, families and communities to lead healthier and safer lives. In working to this vision it identifies 5 key strategic aims:

- Encouraging and supporting responsible attitudes and behaviours towards alcohol consumption (Prevention & Early Intervention);
- Delivering evidenced based, recovery focused treatment support to meet individual needs and reduce the effects on health caused by excessive alcohol consumption (Treatment & Recovery);
- Reducing the number of people who experience crime and disorder related to alcohol misuse (Community Safety);
- Protecting children, young people and their families from harm related to alcohol misuse (Protection);

- Ensuring via local licensing decisions and influencing of government policy that accessibility of alcohol is responsibly controlled (Control).

2.2.4 Liverpool's Statement of Licensing Policy²⁹

The City Council has produced a Statement of Licensing Policy that seeks to reinforce and promote the continuing growth of premises and events which are licensable under the Licensing Act 2003. At the same time, the City Council as licensing authority is committed to carrying out its statutory duties under the Licensing Act 2003 with a view to promoting the four licensing objectives:

- the prevention of crime and disorder;
- public safety;
- the prevention of public nuisance; and
- the protection of children from harm.

The policy aims to ensure a consistent approach to licensing within Liverpool and promote fairness, equal treatment and proportionality, assisting those making a decision on a particular licence application. In addition the policy seeks to provide clarity for applicants and residents to enable them to understand the objectives being promoted and the matters that will be considered in determination of licences.

3. Demographics of Liverpool

3.1 Deprivation

The English Indices of Deprivation 2015 (IMD 2015) combine a range of economic, social and housing indicators to provide the most up to date and comprehensive picture of deprivation in England. They provide a measure of relative deprivation, i.e. they measure the position of areas against each other.

The table below shows the ranking for each Local Authority in the Liverpool City Region for each of the seven domains, in addition to the two sub-domains on income. Results show that Liverpool remains one of the most deprived local authorities in the country, and the City Region is ranked as the most deprived Local Enterprise Partnership area in England.

Domain	Liverpool	Halton	Knowsley	Sefton	St Helens	Wirral	Liverpool City Region
Overall IMD	7	36	5	102	52	106	1
Income	9	51	5	74	50	78	2
Employment	10	28	1	40	18	42	1
Health and Disability	4	17	3	37	13	32	1
Education, Skills and Training	46	83	7	172	127	191	7
Barriers to Housing and Services	291	220	260	323	286	319	38
Crime	46	61	96	154	111	178	7
Living Environment	23	136	106	111	128	115	7
Income Deprivation Affecting Children	14	47	19	115	59	98	2
Income Deprivation Affecting Older People	10	62	8	82	80	100	2

Table 2: Local Authority Rank of Ranks

Source: Indices of Deprivation 2015

Note: Local Authority ranks: 1 = most deprived, 326 = least deprived, Local Enterprise Partnership ranks: 1 = most deprived, 39 = least deprived

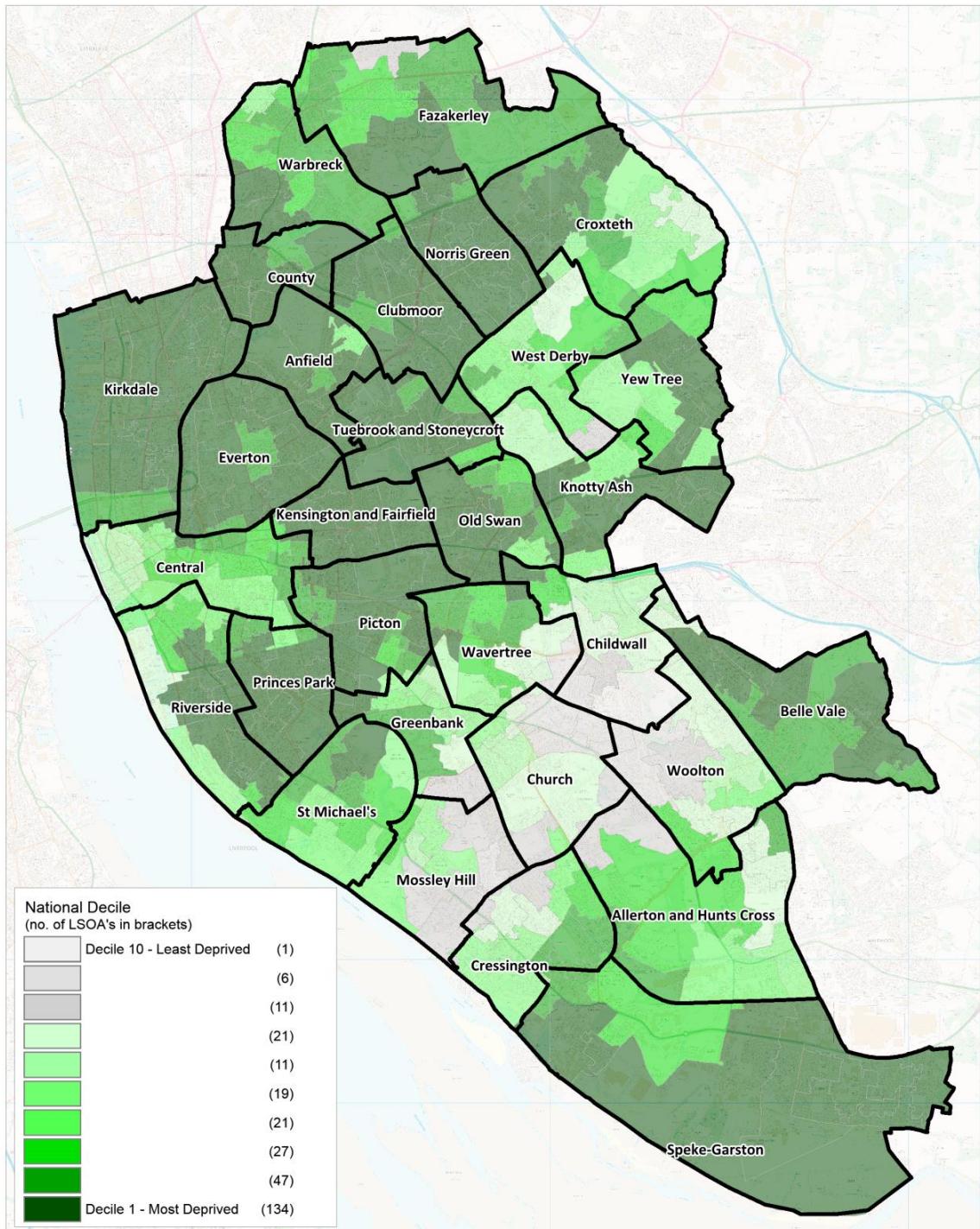
A substantial proportion of Liverpool residents live in areas of high deprivation. The table opposite indicates that almost 45% of the population live within communities ranked within the 10% most deprived in England. This compares to less than a third for the Liverpool City Region as a whole. At the other end of the deprivation spectrum, less than 1% of local residents live in communities ranked as the least deprived in England. The severity and extent of deprivation in the city has significant implications for the health and wellbeing of local people, and is strongly associated with poor health outcomes from childhood through to old age.

Area	Liverpool	Halton	Knowsley	Sefton	St. Helens	Wirral	Liverpool City Region
Most Deprived 10%	44.7%	25.5%	44.4%	19.3%	23.4%	21.3%	31.0%
Decile 2	15.8%	23.0%	16.1%	7.7%	16.6%	9.3%	13.7%
Decile 3	9.6%	8.1%	5.7%	8.0%	9.0%	9.8%	8.8%
Decile 4	7.5%	5.3%	5.9%	6.3%	9.7%	8.3%	7.4%
Decile 5	6.4%	4.5%	13.8%	13.0%	9.2%	5.7%	8.3%
Decile 6	3.6%	6.9%	7.9%	15.7%	5.9%	7.6%	7.6%
Decile 7	6.5%	6.8%	4.5%	8.4%	8.0%	11.6%	7.9%
Decile 8	3.7%	9.3%	1.8%	8.0%	8.3%	10.0%	6.6%
Decile 9	1.9%	10.8%	0.0%	8.3%	7.7%	8.1%	5.6%
Least Deprived 10%	0.4%	0.0%	0.0%	5.2%	2.2%	8.2%	3.1%

Table 3: Local population by national deprivation decile

Source: Indices of Deprivation 2015 and ONS LSOA population estimated 2013

The map opposite shows that levels of deprivation within Liverpool are particularly high in the north of the city, where virtually all of the neighbourhoods are ranked in the most deprived one or ten percent nationally. The map below shows that large areas of Everton, Anfield and Kirkdale are particularly deprived. This concentration of high deprivation also encircles the city centre, this “inner core” area goes from Everton in the north through Kensington and on to Princes Park and Riverside to the south of the city centre. Outside of the inner core, Speke Garston, Belle Vale, Croxteth and Norris Green also have some of the highest levels of deprivation in the country.



Index of Deprivation 2015 - Overall Index National Rank Deciles (Decile 1 = Most deprived)

Date created: 21/10/2015

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Liverpool
City Council

3.2 Population Trends

Latest population estimates from the Office for National Statistics show there are currently around 473,100 people living in Liverpool, representing a 7% increase in the population since 2001. The increase in the population in recent years marks a welcome shift in the long term trend of population decline in Liverpool. The chart below shows how this change began in 2001, with the number of people living in the city increasing each year since.

Population projections suggest the increase in the number of residents in Liverpool will continue in the medium term, with the number of local residents increasing by a further 37,000 by 2030, to over 510,000 people. It is worth noting that population projections should be treated with a degree of caution. As the chart below highlights, each update has led to an upward revision in population projections, with latest projections being significantly higher than those released less than a decade ago.

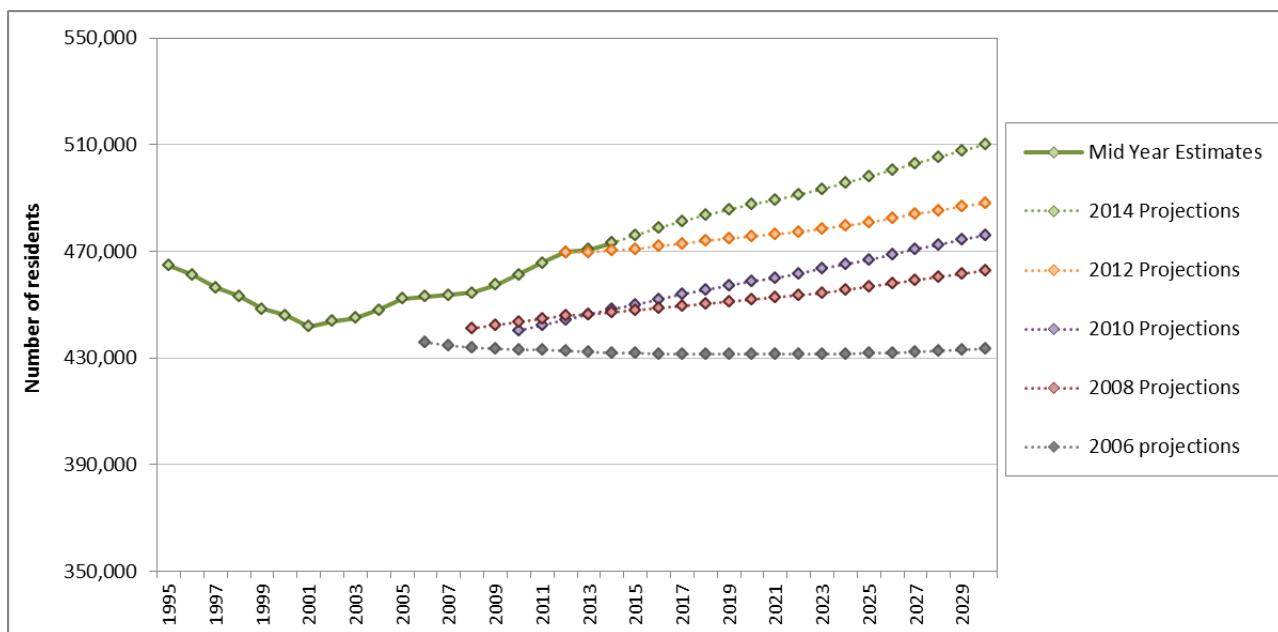


Figure 1: Liverpool population trends and projections

Source: ONS mid-year resident population estimates and 2014 based sub-national population projections

3.3 Age & Sex

Liverpool has a relatively young population when compared to the rest of the country, with an average age of 37.8 years compared to 39.5 years for England. The average age of the population has remained steady in recent years, despite the increase experienced in other areas.

Figure 2 shows the current population structure of the city. The large 20-24 population is immediately apparent, and is reflective of the large student population within Liverpool. There are over 52,000 people in this age group, representing more than 11% of the population, compared to 7% in England.

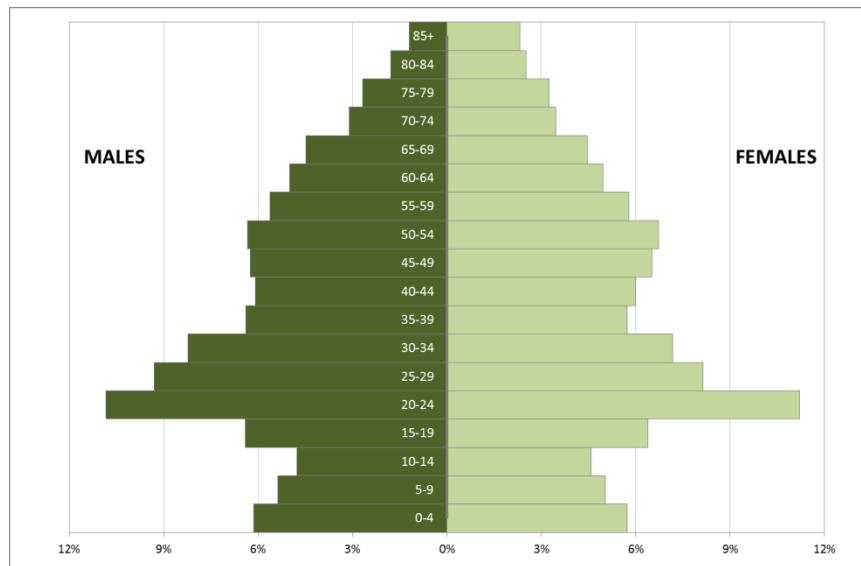


Figure 2: Liverpool population pyramid, 2014

Source: ONS mid-year resident population estimates

We know that the population profile across the city is not uniform, with the average age in Central ward being 27.3 years, reflecting the large student population in the area, compared to 47.0 years in Woolton ward.

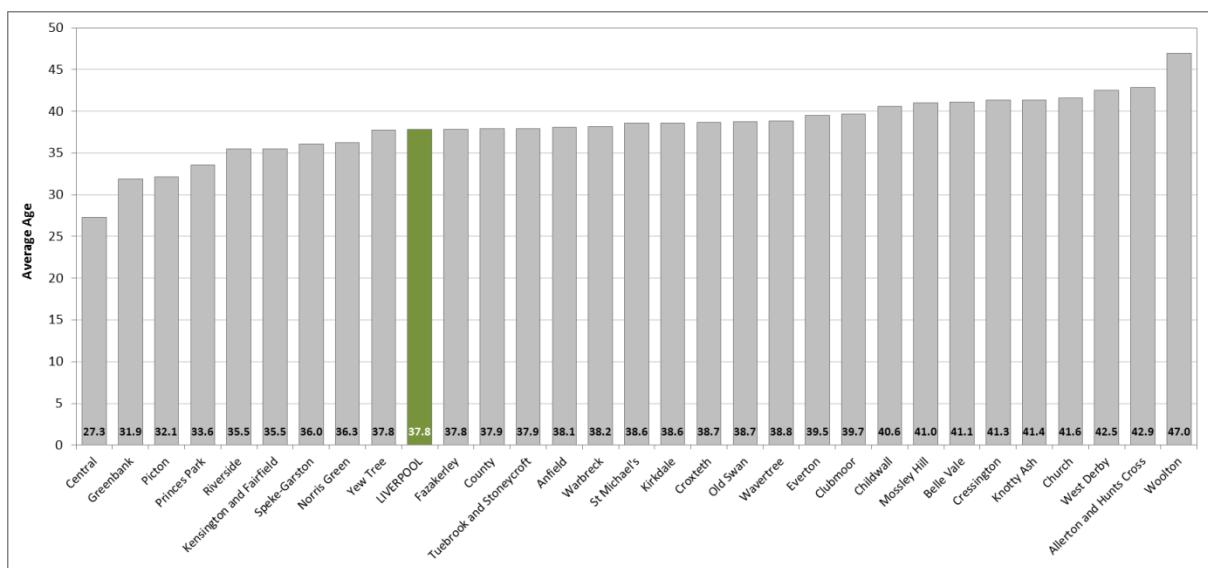


Figure 3: Liverpool average age by electoral ward, 2014

Source: ONS mid-year resident population estimates

3.4 Ethnicity

Our local population is becoming increasingly diverse. At the time of the 2001 Census, just under 93% of people in Liverpool identified themselves as being “White - English/Welsh/Scottish/Northern Irish/British”. However, by the time of the 2011 Census this had decreased to 84.8%, with around 1 in 7 of the Liverpool population now classing themselves as part of a minority ethnic group, equating to almost 71,000 residents. The largest minority groups in the city are:

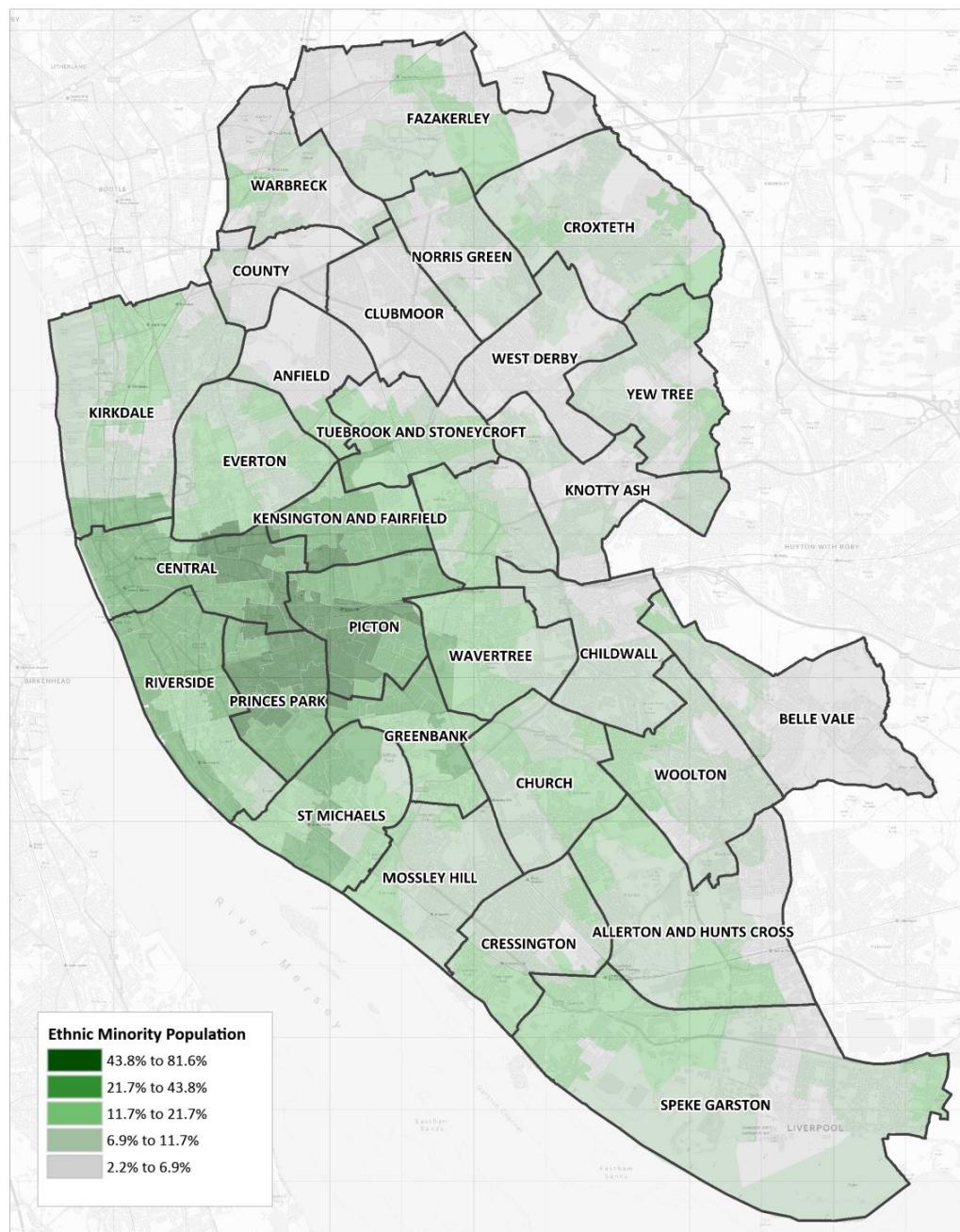
- White Other (including eastern European)
- Black African
- Chinese
- White Irish
- Arab

Ethnic Group	Liverpool		England
	Number	Percentage of Total	
All usual residents	466,415	100.0%	100.0%
White	414,671	88.9%	85.4%
English/Welsh/Scottish/Northern Irish/British	395,485	84.8%	79.8%
Irish	6,729	1.4%	1.0%
Gypsy or Irish Traveller	185	0.0%	0.1%
Other White	12,272	2.6%	4.6%
Mixed/multiple ethnic groups	11,756	2.5%	2.3%
White and Black Caribbean	3,473	0.7%	0.8%
White and Black African	3,164	0.7%	0.3%
White and Asian	2,283	0.5%	0.6%
Other Mixed	2,836	0.6%	0.5%
Asian/Asian British	19,403	4.2%	7.8%
Indian	4,915	1.1%	2.6%
Pakistani	1,999	0.4%	2.1%
Bangladeshi	1,075	0.2%	0.8%
Chinese	7,978	1.7%	0.7%
Other Asian	3,436	0.7%	1.5%
Black/African/Caribbean/Black British	12,308	2.6%	3.5%
African	8,490	1.8%	1.8%
Caribbean	1,467	0.3%	1.1%
Other Black	2,351	0.5%	0.5%
Other ethnic group	8,277	1.8%	1.0%
Arab	5,629	1.2%	0.4%
Any other ethnic group	2,648	0.6%	0.6%

Table 4: Ethnic diversity in Liverpool

Source: 2011 Census

The map below shows there is a significant concentration of the ethnic minority population in the Princes Park, Picton and Central wards in the city, with far fewer people from minority groups living in neighbourhoods on the periphery of the city.



Ethnic minority population in Liverpool in 2011

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4. Scale of Substance Misuse in Liverpool

4.1 Substance misuse among children & young people

4.1.1 Prevalence of substance misuse among children & young people

NatCen Social Research (NatCen) and the National Foundation for Educational Research (NFER) conduct an annual survey on behalf of the Health and Social Care Information Centre (HSCIC) that monitors the extent of smoking, drinking and drug use among children and young people aged 11-15³⁰.

Results from the 2014 survey indicate that a substantial proportion of young people have tried alcohol and drugs; 38% and 15% respectively. Applying these figures to Liverpool would indicate almost 12,700 young people have tried alcohol, and around 5,000 have tried drugs. However, the prevalence of substance use figure falls significantly when asked if they have done so recently, to 8% and 6%, and regular consumption of alcohol and drugs among young people in England has declined substantially since 2005, as illustrated in the table below. These results are comparable to the 2015 survey of Year 8 pupils in Liverpool, which show that the percentage of pupils who have drank alcohol in the week prior to the survey has fallen from 40% in 1995 to just 7% in 2015³¹.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Drunk alcohol in the last week	22%	21%	20%	18%	18%	13%	12%	10%	9%	8%
Taken any drugs in the last month	11%	9%	10%	8%	8%	7%	6%	6%	6%	6%
Taken cannabis in the last month	7%	6%	5%	5%	5%	4%	4%	4%	4%	4%
Taken Class A drugs in the last month	4%	4%	4%	4%	4%	2%	2%	2%	2%	1%
Done any of these recently	29%	27%	29%	25%	26%	20%	19%	17%	16%	14%
Done none of these recently	71%	73%	71%	75%	74%	80%	81%	83%	84%	86%

Table 5: Percentage of children aged 11 to 15 who have recently drunk alcohol, or taken drugs

Source: HSCIC - Smoking, Drinking and Drug Use Among Young People in England - 2014

In 2014, pupils who drank in the last week were most likely to have drunk beer, lager or cider (72%), followed by spirits (59%), alcopops (40%) or wine, martini and sherry (38%). However, whereas boys were more likely than girls to have drunk beer, lager or cider in the last week (85%, compared with 59% respectively), girls were more likely than boys to have drunk spirits (73% of girls, 45% of boys)³².

As in previous years, pupils were more likely to have taken cannabis than any other drug. In 2014, 6.7% of pupils reported taking cannabis in the last year. 2.9% of pupils had inhaled glue, gas, aerosols or solvents in the last year. Very few pupils reported the use of other types of drug³³.

Age & Sex

Results from the 2014 survey indicate that the prevalence of substance misuse in England is similar among both boys and girls, however as might be expected, the prevalence is much higher among older pupils. The step change in consumption is particularly noticeable with alcohol around the aged of 14.

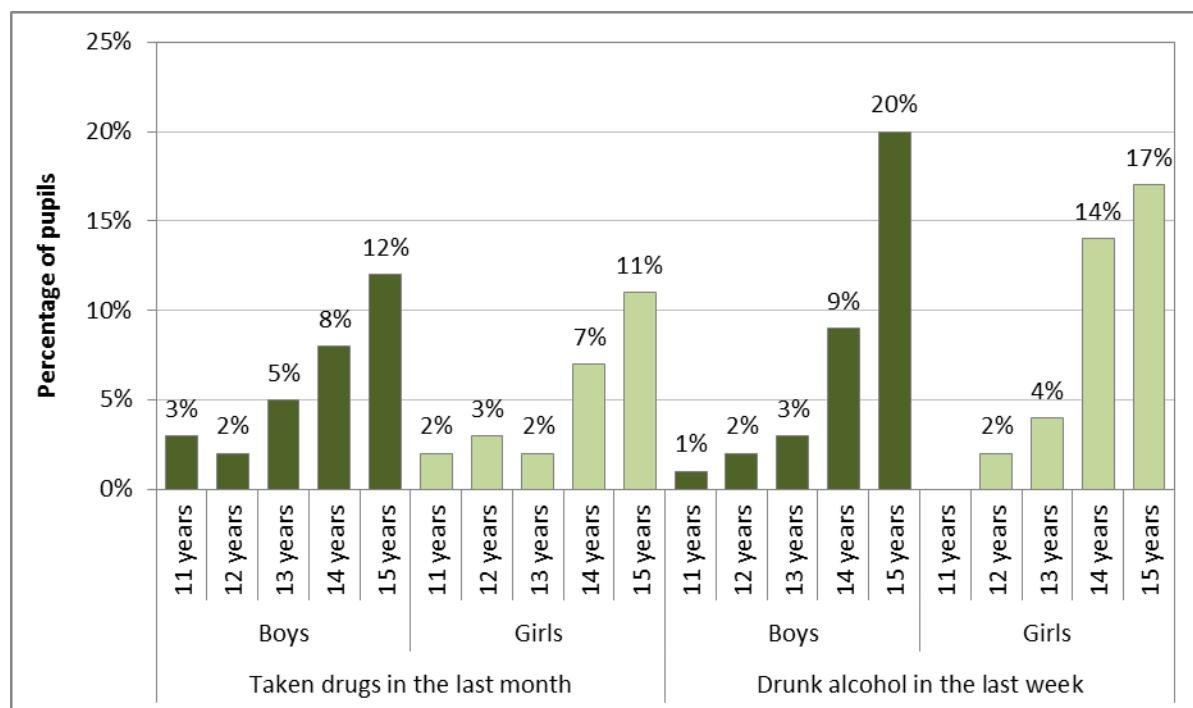


Figure 4: Percentage of children aged 11 to 15 who have recently drunk alcohol, or taken drugs

Source: HSCIC - Smoking, Drinking and Drug Use among Young People in England - 2014

Ethnicity

Analysis of the survey results indicates that in relation to alcohol consumption, no single ethnic group showed a significant difference from the odds of White pupils, apart from the undefined 'other' category. The odds of Asian pupils having drunk alcohol in the last week were reduced compared to White pupils (odds ratio=0.31) but this difference was not quite significant³⁴.

Pupils from Black backgrounds were more likely than White pupils to have taken drugs in the last year (odds ratio=2.21). For other minority ethnic groups, there was no significant difference in the odds of having taken drugs in the last year compared to White pupils³⁵.

4.2 Prevalence of substance misuse among adults

Alcohol

Estimates of alcohol consumption vary widely, and it is difficult to obtain a true picture of the extent of alcohol misuse. While there are a range of definitions of problem drinking, the figures shown in table 6 below show the estimated number of people drinking using the categories and definitions most commonly used in Liverpool.

Category	Definition	Liverpool	England
Lower risk drinkers	Drink within the recommended alcohol guidelines.	249,165 (74.4%)	73.3%
Increasing risk drinkers	Drink above the recommended level which increases the risk of damaging their health.	62,012 (18.5%)	20%
High risk drinkers	Drink at very heavy levels which significantly increases the risk of causing damage to their health and may have already caused some harm to their health. Higher risk drinkers will have a higher alcohol tolerance, which may make them especially vulnerable to alcohol dependency	23,540 (7%)	6.7%

Table 6: Prevalence of alcohol misuse in Liverpool

Source: Alcohol Concern³⁶; ONS mid-year population estimates for local authorities, mid-2015

It is worth noting that the estimates produced by Alcohol Concern potentially underestimate the extent of problem drinking in Liverpool, as surveys can drastically under report the level of alcohol consumption. A study³⁷ in Manchester by the Centre for Public Health at Liverpool John Moores University indicated that normal surveys underreported the amount of alcohol people say they drank by 33%, suggesting the prevalence of high risk drinking in Liverpool could be much higher than these estimates.

We know that patterns of alcohol consumption are changing, with national surveys indicating that the level of binge drinking is falling in England, particularly among young adults. Results from the Opinions & Lifestyles Survey show that among those aged 16 to 24, the percentage that binged drank at least once in the week prior to being questioned fell from 29% in 2005 to 18% in 2013³⁸.

Drugs

The annual Crime Survey for England & Wales (CSEW) is one method of monitoring the pattern of illicit drug use. The survey provides consistent measures of drug use, obtained in the same way for each round of the survey, irrespective of any strengths or weaknesses relating to coverage or response to the survey. Hence, even if drug use estimates are lower than the true value, comparisons over time remain valid, assuming that unwillingness to report has remained at a similar level over time³⁹.

- **Around 1 in 12 (8.6%) adults aged 16 to 59 had taken an illicit drug in the last year.** This equated to around 2.8 million people. This level of drug use was similar to the 2013/14 survey (8.8%), but significantly lower than a decade ago (11.2% in the 2004/05 survey).
- **Around 1 in 5 (19.4%) young adults aged 16 to 24 had taken an illicit drug in the last year.** This proportion was more than double that of the wider age group, and equated to around 1.2 million people. This level of drug use was similar to the 2013/14 survey (19.0%), but significantly lower compared with a decade ago (26.5% in the 2004/05 survey).
- **Around 1 in 20 (4.7%) adults aged 16 to 59 had taken an illicit drug in the last month, while one in ten (10.2%) young adults aged 16 to 24 had done so.** Neither proportion has changed significantly compared with the 2011/12 survey, when the questions on last month use were last asked.
- **The use of ecstasy in the last year increased among 16 to 24 year olds between the 2013/14 and 2014/15 surveys, from 3.9% to 5.4%.**
- **The proportion of young adults aged 16 to 24 who were classed as frequent drug users was 5.1%, over twice the proportion of all adults aged 16 to 59 in the 2014/15 survey (2.2%).**
- **Cannabis was the drug most likely to be frequently used, with 39% of cannabis users being classed as frequent users in the 2014/15 survey.** Tranquillisers were the second most likely drug type to be frequently used.
- **In the combined 2013/14 and 2014/15 surveys, nine per cent of respondents who used drugs in the last year said that the last time they used drugs, they used more than one drug at the same time.** This has increased significantly from 7 per cent in the 2010/11 and 2011/12 surveys.

Box 1: Key findings for the 2014-15 Crime Survey for England & Wales

Source: Home Office⁴⁰

The Crime Survey for England & Wales measures the level of drug use in the last month, year, or ever within the persons' lifetime. The chart below illustrates some of these findings for some of the main

substances being used in 2014-15. Around 1 in 31 adults have used a Class A drug within the last year (3.2%), and results for the survey indicate that while these levels have been stable in recent years, they are significantly above those seen in 1996, with the majority of the increase associated with a rise in the use of cocaine⁴¹.

Cannabis

Cannabis remains the most frequently used drug with 1 in 15 adults in England & Wales using it within the last year, and 1 in 27 using it within the last month. While overall use of cannabis has been relatively stable in recent years, there has been an increase among those aged 16-24, although it is too early to tell whether this is an emerging trend.

Powder Cocaine

Powder cocaine is the second most popular drug among 16-59 year olds in England & Wales, with 1 in 43 adults using the drug in the last year. While there has been an increase in recent years, particularly among young adults, the use of powder cocaine is significantly below the peak in 2008-09.

Ecstasy

The use of ecstasy among adults fluctuates at between one and two percent each year, however use of the drug is heavily concentrated among younger adults where 1 in 18 have used it in the last year⁴².

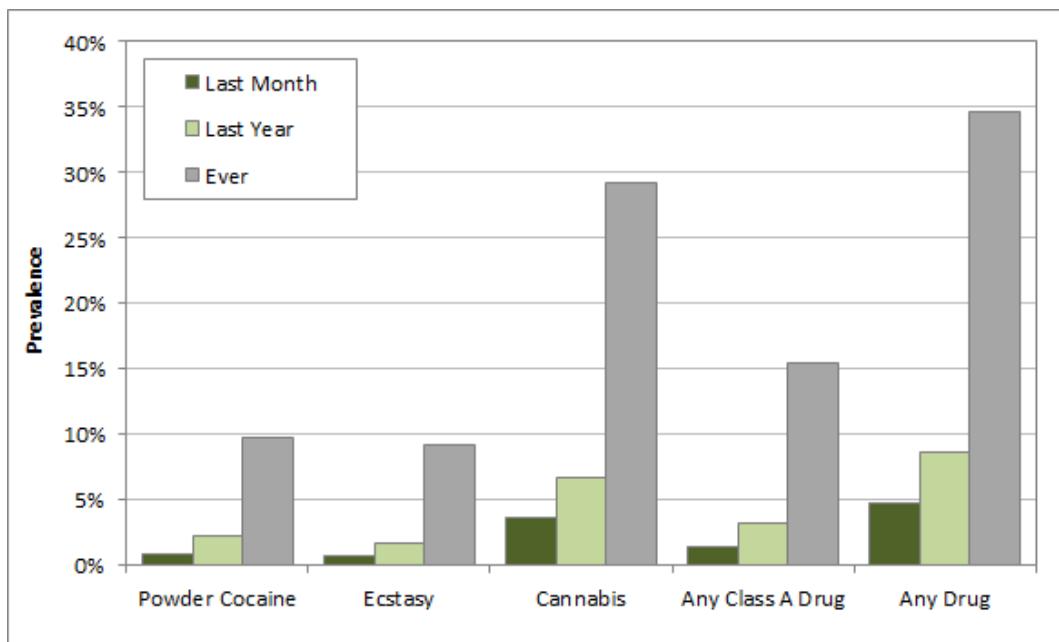


Figure 5: Proportion of 16 to 59 year olds reporting use of drugs in 2014-15

Source: Crime Survey for England & Wales⁴³

The table below applies the prevalence figures from the Crime Survey to the Liverpool population, to give an estimate of the number of people in the city who might be using illicit drugs. These should only be used to give an indication of the prevalence of substance, rather than an exact figure.

Drug	Last Month		Last Year		Ever	
	Prevalence	Liverpool Estimate	Prevalence	Liverpool Estimate	Prevalence	Liverpool Estimate
Powder Cocaine	0.9%	4,100	2.3%	10,500	9.7%	44,200
Ecstasy	0.7%	3,200	1.7%	7,700	9.2%	41,900
Cannabis	3.7%	16,900	6.7%	30,500	29.2%	133,000
Any Class A Drug	1.4%	6,400	3.2%	14,600	15.5%	70,600
Any Drug	4.7%	21,400	8.6%	39,200	34.7%	158,100

Table 7: Estimated prevalence of drug use in Liverpool by type

Source: Crime Survey for England & Wales⁴⁴

In addition to the Crime Survey for England & Wales, Public Health England produce estimates of the prevalence of drug use for each Local Authority in the country. Latest figures indicate that Liverpool has a significantly higher prevalence across three of the four categories of drug users, with the exception being injecting drug users where levels are not significantly different to England.

Category of Drug User	Liverpool		National Rate per 1,000
	Number of People	Rate per 1,000	
Opiate and/or Crack	5,400	16.5	8.4
Opiate	4,850	14.8	7.3
Crack	4,000	12.2	4.8
Injecting	580	1.8	2.5

Table 8: Prevalence of drug use in Liverpool

Source: Public Health England⁴⁵

4.2.1 Image & Performance Enhancing Drugs (IPEDs)

Image and performance enhancing drugs (IPEDs) include substances that promote weight loss, change skin colour, build muscle and allow longer, harder training⁴⁶. Users of IPEDs rarely see themselves as drug users and so are often reluctant to engage with services.

Although possession of IPEDs is not illegal, they are often sourced illicitly with highly variable quality and sterility, posing a significant risk to the health of the user⁴⁷. If users are sharing injecting equipment, they also face many of the same issues as opiate and stimulant injectors. For instance, 1.5% of IPED

injectors across England and Wales are HIV positive, which is equivalent to the rate among opiate injectors⁴⁸.

While obtaining accurate information regarding the overall prevalence of IPED use is difficult, levels are thought to be increasing, and research undertaken by Liverpool John Moores University⁴⁹ has identified a number of key themes regarding this group:

- IPED users are a considerably younger population group than those injecting heroin and crack cocaine.
- The most commonly reported reason for using IPEDs include gaining muscle and strength together with losing fat.
- The majority take IPEDs orally and through injection, with oral use likely to start at a younger age.
- People who use IPEDs commonly report use of a range of other substances typically used to enhance the impact of their steroid use, to counter side effects, for recreational or relaxation and sexual enhancement.

4.2.2 New Psychoactive Substances (NPS)

There has been a rise in the use of substances which mimic the effect of more traditional drugs that are controlled under the Misuse of Drugs Act, such as cocaine and cannabis. These are known as new psychoactive substances, but are often incorrectly referred to as 'legal highs'.

Findings from the Crime Survey for England & Wales⁵⁰ indicate that use of NPS remains relatively low, but is concentrated among young adults, with around 1 in 40 (2.8%) aged 16 to 24 using a new psychoactive substance in the last year, while fewer than 1 in 100 (0.9%) of 16 to 59 year olds had done so⁵¹. Applying these figures to the Liverpool population would suggest over 3,300 young adults have used NPS in the last year. Use of NPS was found to be particularly high among young men.

The use of nitrous oxide, also called 'laughing gas', has also increased in recent years. Whilst nitrous oxide has a number of legitimate uses in the areas of medicine and catering, it is increasingly being inhaled as a recreational drug-using a balloon or a metal canister known as a 'cracker'. Inhaling nitrous oxide can be dangerous with risks including asphyxiation, especially if consumed in a small space, and vitamin deficiency with heavy regular use.

4.2.3 Poly-substance misuse

Poly-substance use is considered to be the use of more than one type of drug or alcohol being taken either at the same time (***simultaneous use***) or more than one type of drug or alcohol being taken within the same period of time, for example, in the last year (***concurrent use***). Simultaneous use is a particular risk due to the potential interaction between substances when consumed together.

The Crime Survey for England & Wales⁵² identified a number of national patterns relating to simultaneous poly-substance misuse:

- In the combined 2013/14 and 2014/15 surveys, nine percent of respondents who used drugs in the last year said that the last time they used drugs, they used more than one drug at the same time.
- Mephedrone (68%), ecstasy (57%), amphetamines (50%), and tranquilisers (35%) were the drugs most likely to be used simultaneously with other drugs.
- The lowest prevalence of polydrug use was found among those who had used cannabis the last time they had used drugs (9% of those who used cannabis last used it alongside another drug).
- Overall, the most common pairing of drugs used together are cannabis and powder cocaine, or cannabis and ecstasy, with these two pairings being used together in 31 percent of all cases of simultaneous polydrug use.
- More than half (56%) of drug use incidents also involve the use of alcohol.
- Over a quarter of respondents (27%) said they took the particular combination of drugs last time as they wanted the combined effect of more than one drug, for example to make the effects stronger or longer lasting. A further quarter (26%) said they just took whatever drugs were available or offered to them at the time, 24 per cent said they used one drug to cancel the effects of the other, for example to ‘come up’ or ‘come down’ and a sixth (18%) said they took them for no particular reason.

Box 2: Poly-substance misuse in England & Wales

Source: Home Office⁵³

4.2.4 Chemsex

“Chemsex” is a term commonly used by gay or bisexual men to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with chemsex are crystal methamphetamine, GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine⁵⁴. There are a number of health risks associated with chemsex, such as transmission of HIV and other sexually transmitted infections as well as the risk of drug overdose.

A study of gay and bisexual men in London in 2014⁵⁵ found that the majority of those engaging in chemsex were experienced drug users and poly-substance misuse during the same sexual session was common. The study found that the use of mephedrone was almost universal among those participating in chemsex, and was favoured due to its relatively low price, reliable quality and ease of availability. GHB/GBL was popular for similar reasons. While the prevalence of injecting drug use is low among those involved in chemsex, participants in the study felt that it was becoming more common.

4.3 Inequalities in substance misuse

There are a wide range of factors that influence the risk of an individual abusing alcohol or drugs, though it is important to recognise that most people exposed to these factors do not go on to abuse alcohol or drugs, or become addicted. Risk factors can be individual characteristics, situational conditions or wider environmental influences. The impact of these is dependent upon the stage in an individual's life when they are exposed to them, and also how they interact with each other.

Characteristic	Alcohol	Drugs
Age	Consumption of alcohol on five or more days a week increases significantly with age, among both men and women. However, levels of binge drinking are far more common among younger age groups ⁵⁶ .	Younger people are more likely to take drugs than older people. The level of any drug use in the last year is highest among 16 to 19 year olds (18.8%) and 20 to 24 year olds (19.8%). The level of drug use is much lower in the oldest age group (2.4% of 55 to 59 year olds) ⁵⁷ . A number of substances are particularly linked with age, such as ecstasy and new psychoactive substances.
Sex	Data from the Health Survey for England 2013 ⁵⁸ shows that: <ul style="list-style-type: none"> • 15% of men and 20% of women did not drink any alcohol in the last year. • 63% of men and 64% of women drank at levels indicating lower risk of harm. • 18% of men and 13% of women drank at an increased risk of harm. • 5% of men and 3% of women drank at higher risk levels. 	Men are more likely to take drugs than women. Around one in eight (11.9%) men aged 16 to 59 had taken an illicit drug in the last year, compared with around one in eighteen (5.4%) women ⁵⁹ . Nationally, women make up 27% of the adults in drug treatment ⁶⁰ .
Race / Ethnicity	Most minority ethnic groups have higher rates of abstinence, and lower levels of frequent and heavy drinking compared to the British population as a whole and to people from white backgrounds ⁶¹ . However it is important to acknowledge that drinking patterns and harm caused by drinking does vary between specific ethnic minority groups.	Adults from mixed ethnic backgrounds are the most likely to have taken any illicit drug in the last year compared with adults from other ethnic groups. Adults from Asian or Asian British ethnic backgrounds generally have the lowest levels of last year drug use ⁶² .

Characteristic	Alcohol	Drugs
Sexual Orientation	LGB people are twice as likely to binge drink at least once a week compared to the general population ⁶³ .	Use of drugs in the last month is 7 times higher among the LGB population than the general population and they are also more likely to be dependent on these substances ⁶⁴ . Gay or bisexual men were the group most likely to have taken any illicit drug in the last year (33.0% had taken drugs in the last year), with higher levels of illicit drug use than gay or bisexual women (22.9%) and heterosexual men (11.1%) ⁶⁵ .
Marriage & Civil Partnership	While married or co-habiting couples are more likely to have drunk alcohol in the last week, levels of consumption for those who do drink are higher among single people ⁶⁶ .	Single people are more than 9 times as likely to have used a Class A drug in the last year compared to those who are married or in a civil partnership ⁶⁷ .
Pregnancy & Maternity	Pregnant women are more than three times as likely to be 'teetotallers' as other women (72% vs. 22%). Results from the Drinking Habits Survey show that fewer than 1 in 10 pregnant women drank in the week before interview compared with more than 5 in 10 of those who were not pregnant or unsure ⁶⁸ .	
Income & Deprivation	The relationship between alcohol consumption and socio-economic status is complex. While those on higher incomes have an increased propensity to drink, the adverse effects of alcohol are more pronounced in those from lower socio-economic groups. This is not solely a result of higher levels of consumption within these groups, but as a result of other confounding factors, such as poverty and unemployment, leading to an inability to 'protect' against the negative health impact.	Use of any illicit drug is highest for those living in the areas defined to be the most deprived (10.2%), and lowest for those living in areas defined to be the least deprived (6.9%). However, use of any Class A drug does not vary with levels of deprivation, with similar levels of use in all areas (3.1% in the most deprived areas, 3.3% in middle areas, and 2.9% in the least deprived areas) ⁷⁰ .

Characteristic	Alcohol	Drugs
	Individuals with an annual income of £40,000 and over are more than twice as likely (18%) to be frequent drinkers compared with those with an annual income less than £10,000 (8%) ⁶⁹ .	
Offenders	Over a third of offenders report drinking heavily, while 1 in 7 are thought to be drink dependent ⁷¹ .	Drug use is a major problem in the prison system: <ul style="list-style-type: none"> ● 70% of offenders report drug misuse prior to prison ● 51% report drug dependency ● 35% admit injecting behaviour⁷² A survey by the Prison Reform Trust has found that 19% of prisoners who had ever used heroin reported first using it in prison ⁷³ .
Homeless	27% of homeless people have or are recovering from an alcohol problem ⁷⁴ .	39% of homeless people take drugs or are recovering from a drug problem ⁷⁵ .

5. The Impact of Substance Misuse

Harm caused by substance misuse can be wide ranging and complex, with the impact varying depending on the substance used and the pattern of use. This section of the report outlines some of the key impacts both in terms of the health of population and also the wider social and economic impacts.

5.1 Health Impacts – Children and Young People

Alcohol misuse in young people is a major contributor to criminal and antisocial behaviour. Although evidence suggests that the number of teenagers who drink has decreased in recent years, the amount drunk by young people who do drink has increased. There is also evidence to suggest that young people who use recreational drugs run the risk of damage to mental health including suicide, depression and disruptive behaviour disorders. Among 10 to 15 year olds, an increased likelihood of drug use is linked to a range of adverse experiences and behaviour, including truancy, exclusion from school, homelessness, time in care, and serious or frequent offending⁷⁶.

5.1.1 Persons under 18 admitted to hospital for alcohol-specific conditions

The rate of children under 18 admitted to hospital for alcohol-specific conditions in Liverpool has fallen significantly over the last 6 years, from around 160 children in 2006/7 to 36 children in 2014/15. Figure 7 below shows the Liverpool rate is not significantly different to the national average, the second highest among the core cities and the lowest on Merseyside.

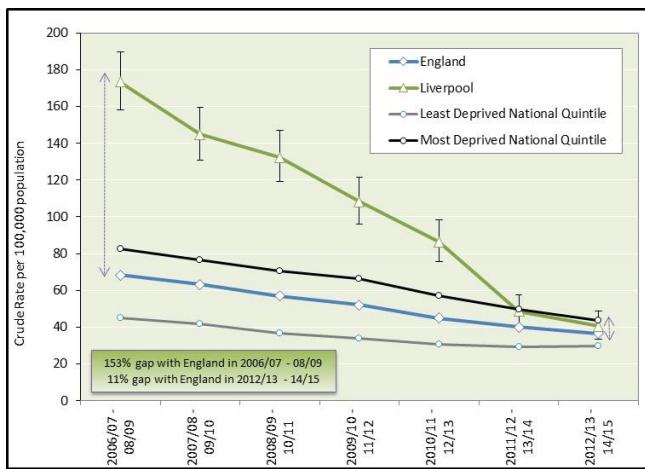


Figure 6: Trends in persons under 18 admitted to hospital for an alcohol-specific condition

Source: Public Health England

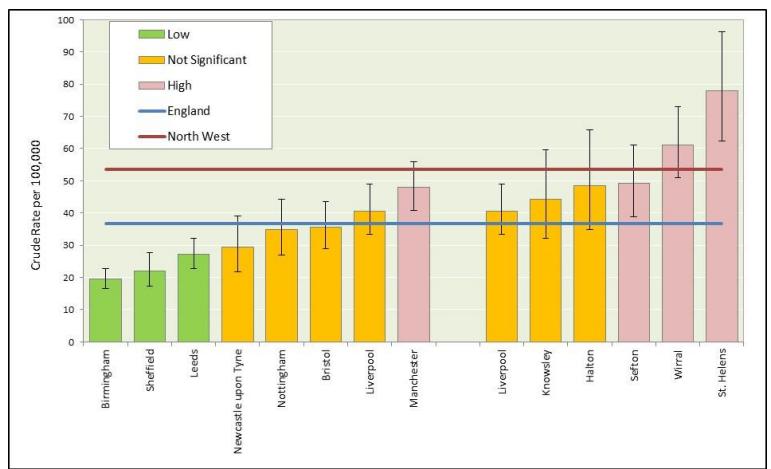


Figure 7: Persons under 18 admitted to hospital for an alcohol-specific condition by statistical peers

Source: Public Health England

5.1.2 Young people's hospital admissions due to substance misuse: aged 15 - 24

Figure 8 shows there was a significant increase in the rate of hospital admissions among 15-24 year olds due to substance misuse in the city over the last 5 years, up from around 49 admissions per year to 87 per year. Liverpool's rate per 100,000 population is significantly higher than the England average, the highest among the core cities and the second lowest on Merseyside.

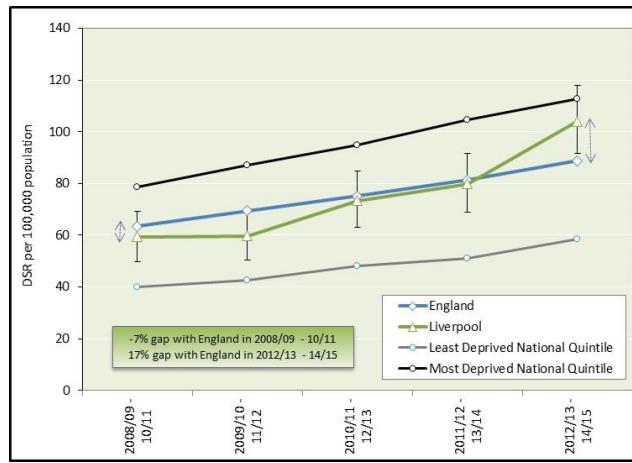


Figure 8: Trends in admission for substance misuse, DSRs per 100,000 population aged 15-24

Source: Public Health England

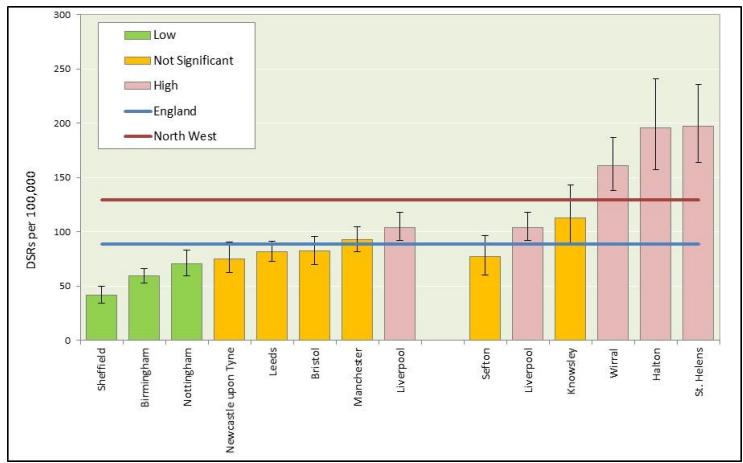


Figure 9: Directly standardised rate of admission for substance misuse, per 100,000 population aged 15-24 by statistical peers

Source: Public Health England

5.2 Health Impacts – Adults

The health impacts of alcohol and drug misuse are significant, both in the short and long term. Analysis of the Global Burden of Disease Study 2015 shows that alcohol and illicit drug use and tobacco smoking including second-hand smoke, are the top three risk factors for death and disability in the 15-49 age group in North West England.

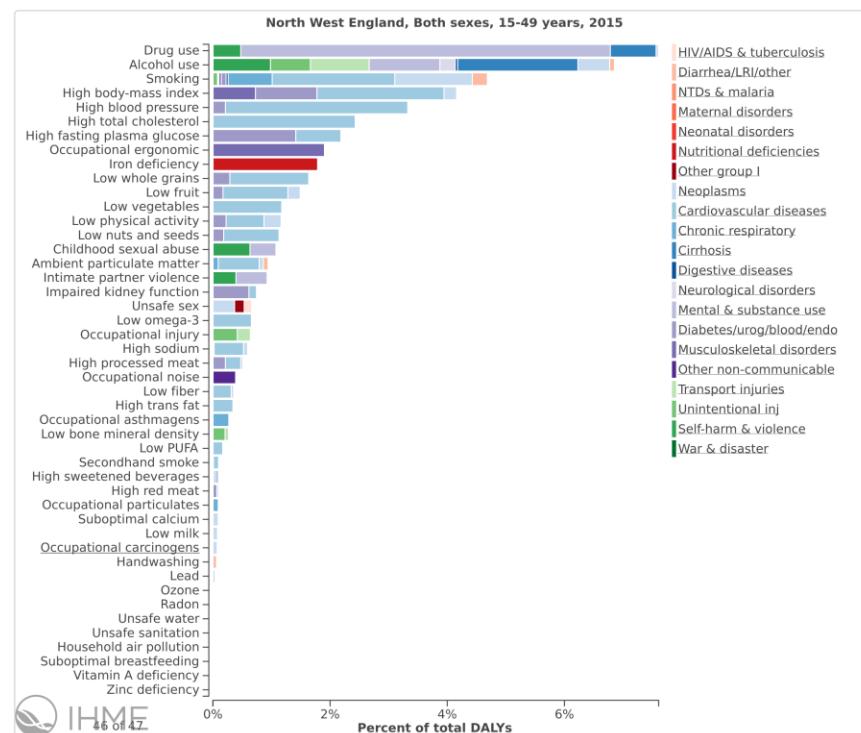


Figure 10: Percentage of total DALYs by risk factor and cause, persons aged 15-49, North West England

Source: GBD Compare, 2015

Note: The disability adjusted life year (DALY) is a summary measure used to give an indication of overall burden of disease - one DALY represents the loss of the equivalent of one year of full health.

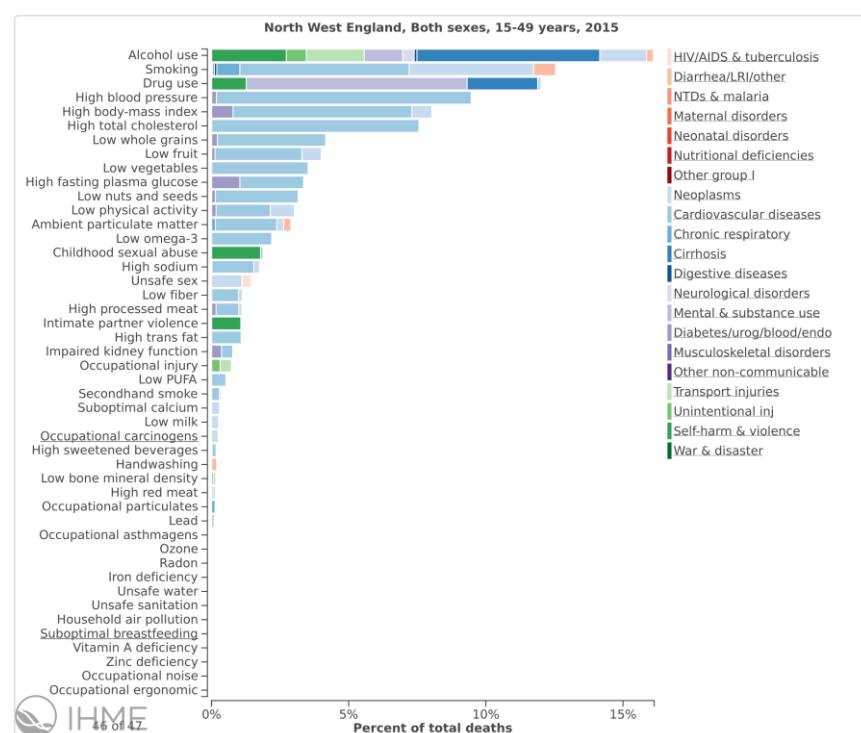


Figure 11: Percentage of total deaths by risk factor and cause, persons aged 15-49, North West England

Source: GBD Compare, 2015

5.2.1 Alcohol-related admissions

Alcohol-related hospital admissions can be a result of regular alcohol use above lower-risk levels as well as chronic heavy drinking and are most likely to be found in increasing-risk drinkers, higher-risk drinkers, dependent drinkers and binge drinkers⁷⁷.

Alcohol-related hospital admissions in Liverpool are significantly higher than the national average, and provisional figures indicate there were around 4,200 admissions in 2015-16¹. Figure 10 shows that despite the rate of alcohol-related hospital admissions in the city being relatively stable for many years, the rate has increased between 2013/14 and 2015/16 (a 20% increase overall). Although the admission rate has been increasing both locally and nationally, the gap between Liverpool and England has widened. Liverpool's directly age standardised admission rate was 49% higher than England in 2015/16 compared to 39% higher in 2008/09.

Men accounted for two thirds of cases in 2015-16, and admission rates among males are significantly higher than among their female counterparts, both locally and nationally.⁷⁸

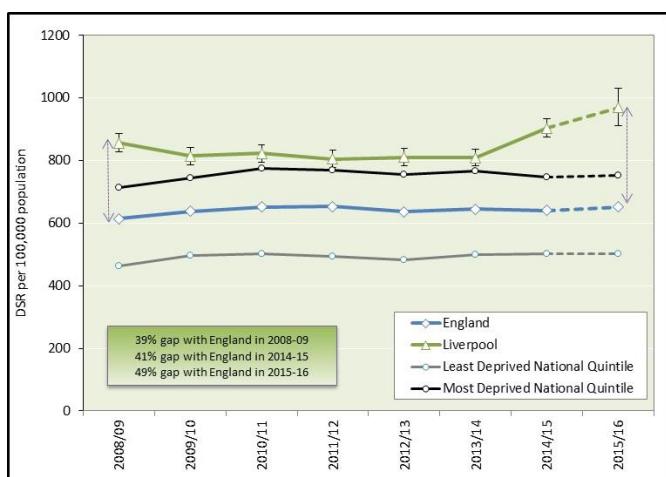


Figure 12: Trends in admission episodes for alcohol-related conditions – narrow measure

Source: Public Health England/LAPE

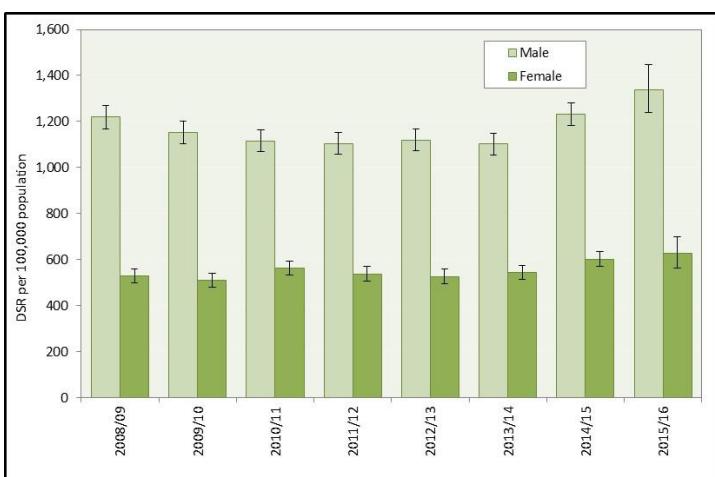


Figure 13: Trends in admission episodes for alcohol-related conditions – narrow measure by gender

Source: Public Health England/LAPE

¹ Please note that 2015/16 data are labelled provisional and subject to significant change. Therefore this data should be treated as an estimate until the final HES annual figures 2015/16 are published by Public Health England.

Provisional figures for 2015/16 show Liverpool was ranked 6th highest out of 326 local authorities in the country for its rate of alcohol-related hospital admission. The chart below shows that Liverpool has the second highest rate of alcohol-related admissions among the eight core cities in England, behind only Nottingham.

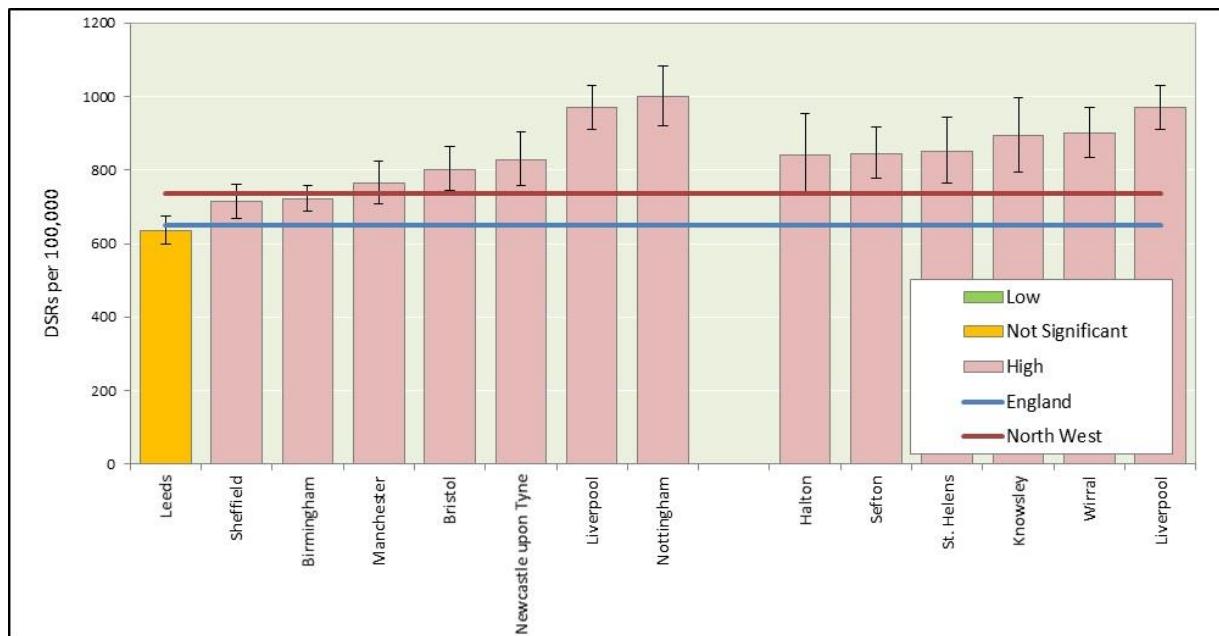
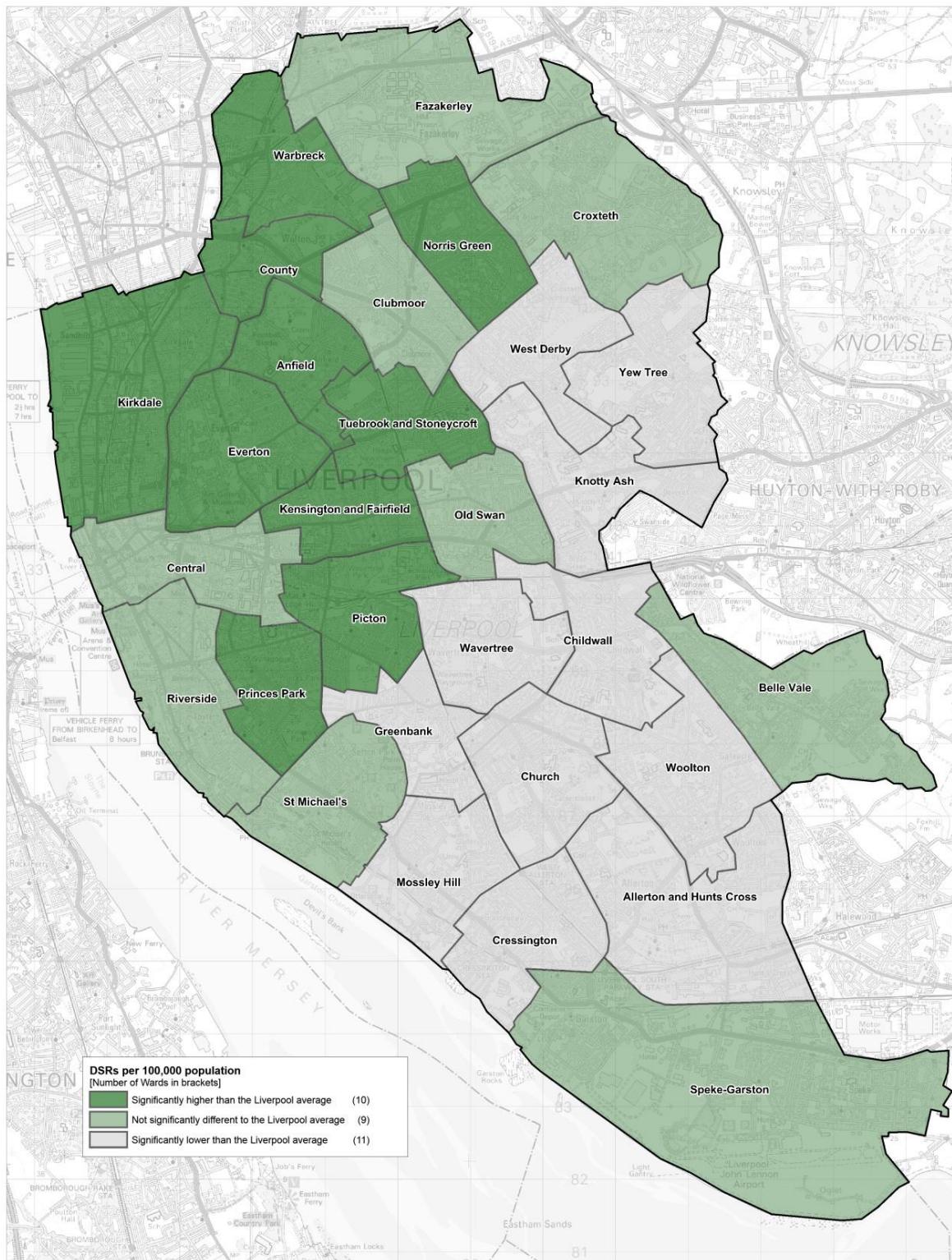


Figure 14: Admission episodes for alcohol-related conditions – narrow measure by statistical peers, 2015-16

Source: Public Health England, Local Alcohol Profiles for England (provisional data)

Analysis of admissions in 2015-16 indicates that three quarters of people who were admitted to hospital for an alcohol specific condition were admitted on only one occasion in the year, with one quarter being admitted more than once within the 12 month period.

The map below shows the rate of alcohol-related hospital admissions within Liverpool. Areas shaded in dark green are those where admission rates are significantly higher than the city average. Data for 2015-16 indicates that levels of admission are particularly within the north of the city and centre of the city, with the rate of admission in Everton ward more than three times that in Church ward.



Alcohol Related Admissions [Broad] DSRs per 100,000 population

[Source: SUS 2015/16]

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5.2.2 Alcohol-related deaths

Alcohol misuse can be directly related to deaths from certain types of disease, such as cirrhosis of the liver, and in some cases, may be associated with other causes of death, such as strokes. Broadly speaking alcohol-related deaths make up around 1% of all deaths each year. Of these, just under two thirds of deaths are due to alcoholic liver disease.⁷⁹

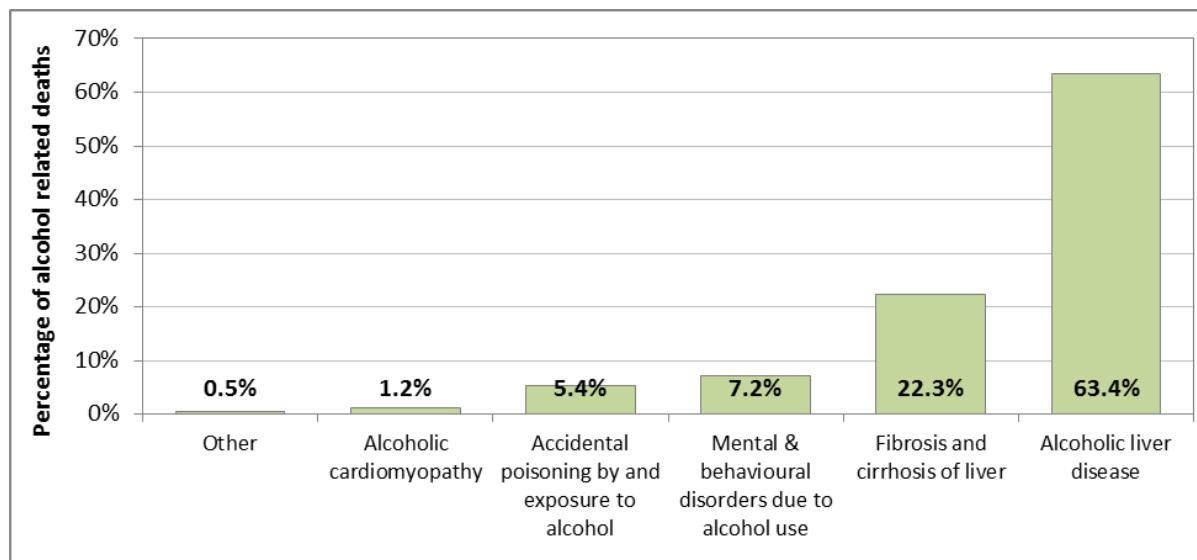


Figure 15: Alcohol-related deaths by individual cause in England, 2014

Source: Office for National Statistics⁸⁰

In 2015 around 257 people in Liverpool died from alcohol-related conditions, at a rate of 64.7 per 100,000 population⁸¹. Alcohol-related death rates among men are more than double those for women, with levels highest among 55-64 year olds. Despite the improvements in recent years, the level of alcohol-related deaths is significantly higher in 2015 than back in 1994⁸².

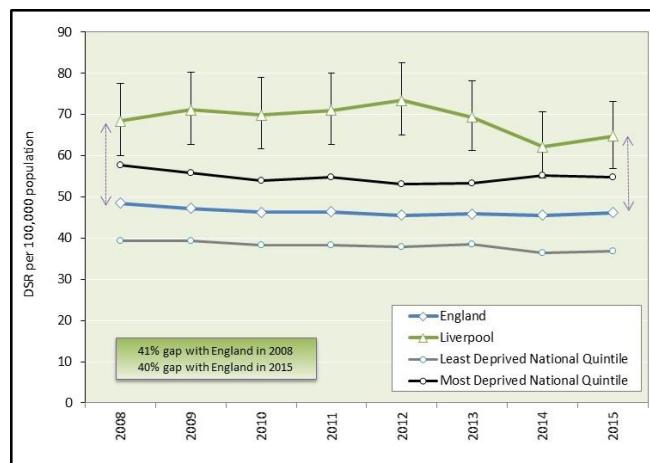


Figure 16: Trends in age-standardised alcohol-related mortality

Source: Public Health Outcomes Framework

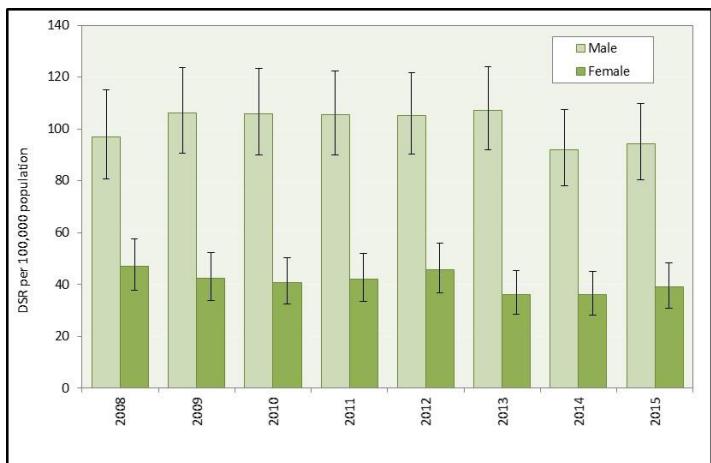


Figure 17: Trends in age-standardised alcohol-related mortality by gender

Source: Public Health Outcomes Framework

In 2015 Liverpool has the third highest alcohol-related mortality rate among the eight core cities in England, was the highest on Merseyside and the 13th highest out of 326 local authorities in the country, indicating a significant proportion of the population drink heavily and consistently over a long period.

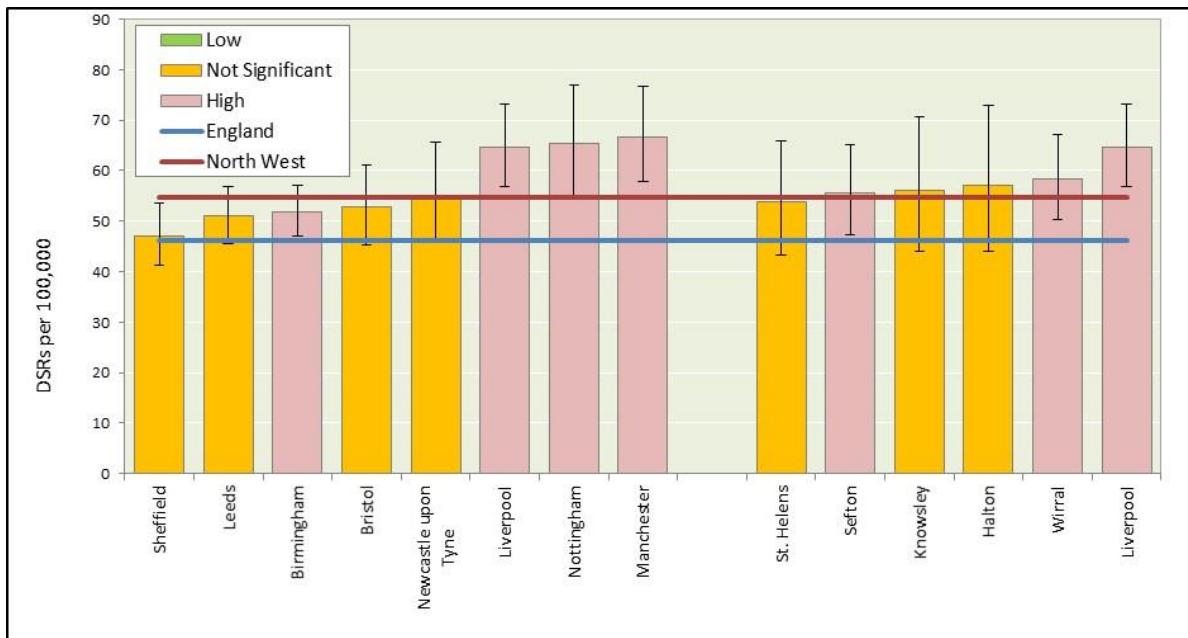


Figure 18: Age-standardised alcohol-related mortality, 2015 by statistical peers

Source: Public Health Outcomes Framework

5.2.3 Liver Disease Considered Preventable

Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions⁸³.

In Liverpool around 112 people die prematurely each year from liver disease considered preventable. Figure 17 shows the trend in the premature mortality rate for both Liverpool and England. The mortality rate locally has remained relatively stable since 2001/03, with no significant change among either males or females. However, Liverpool has the second highest mortality rate from premature liver disease considered preventable in England, behind Blackpool, and remains significantly above the national average.

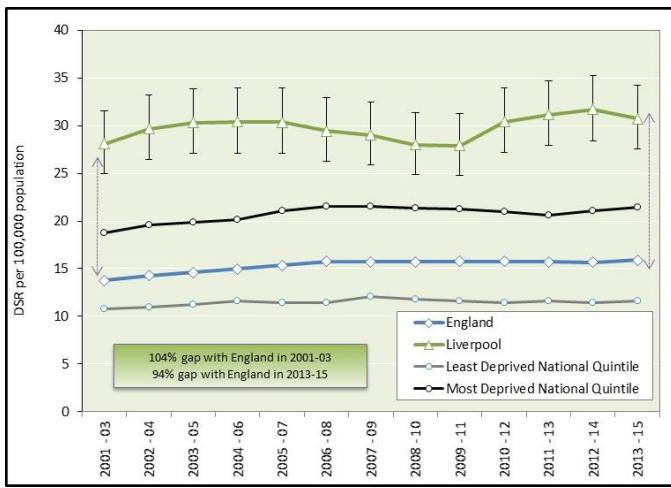


Figure 19: Trends in age-standardised under 75 mortality rate from liver disease considered preventable

Source: Public Health Outcomes Framework

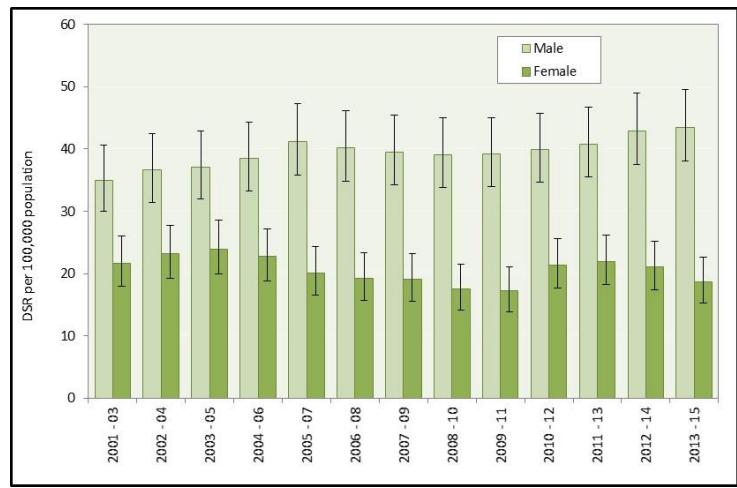


Figure 20: Trends in age-standardised under 75 mortality rate from liver disease considered preventable by gender

Source: Public Health Outcomes Framework

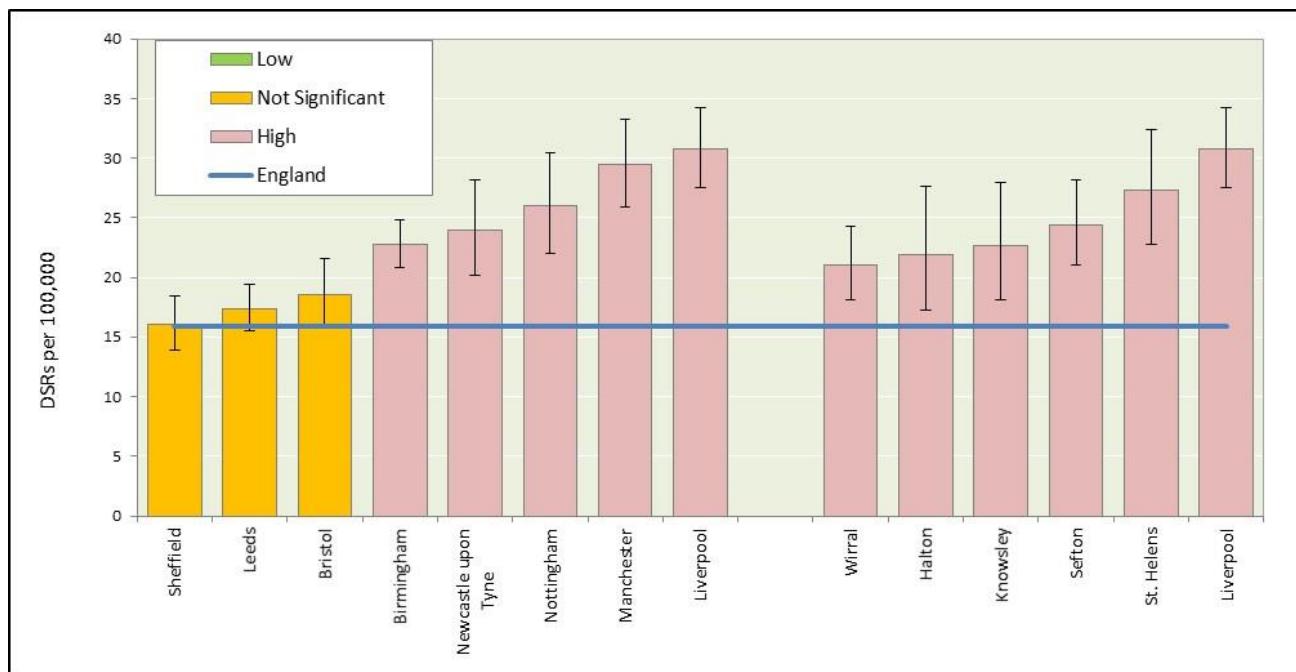


Figure 21: Age-standardised under 75 mortality rate from liver disease considered preventable by statistical peers

Source: Public Health Outcomes Framework

5.2.4 Alcohol-related Brain Injury (ARBI)

Alcohol-related brain injury is an umbrella term that covers a wide range of neuro-psychological conditions which affect the brain and nervous system that are associated with long term alcohol misuse and related vitamin deficiencies. Patients affected by ARBI will usually present with acute confusion

often as a consequence of withdrawal. The confusion experienced may be permanent when associated with severe physical illness and malnutrition as a consequence of Vitamin B deficiency.

Alcohol-related brain injury predominantly affects people in their 40s and 50s, with females often presenting a decade younger than males. At one extreme is presentation of Wernicke-Korsakoff syndrome and at the milder end are the more frequent but subtle frontal lobe dysfunctions. While the number of people affected by ARBI is thought to be small, they have significant health needs and are often difficult to engage in treatment.

This table shows ICD10 codes used to identify patients admitted to hospital with an Alcohol-related Brain Injury related diagnosis (ordinary admissions and day cases). These diagnosis codes include those conditions which are entirely caused by alcohol, apart from WE which is mostly seen in people who drink hazardously or are alcohol dependent, but may also arise solely through malnutrition. This is therefore a conservative estimate of the number of patients diagnosed with ARBI in Liverpool over the last 2 years and who are most likely to be at the severe end of the spectrum.

ICD10 Code	Description	No. of Admissions	No. of Patients
F106	Alcohol amnesic syndrome (KP/KS)	94	55
G312	Degeneration of nervous system due to alcohol (includes cerebellar atrophy)	54	43
E512	Wernicke's encephalopathy (WE)	14	13
F107	Alcohol-related residual and late-onset psychotic disorder	21	18
	Grand Total	183	120

Table 9: Admissions with an ARBI related diagnosis (primary or secondary diagnosis), Liverpool residents

Source: SUS 2014/15-15/16 (2 Year Pooled)

The chart below shows that of those people admitted to hospital (ordinary admission or day case), the most frequent attenders were among the 50-54, 55-59 and 60-64 year age bands. These three age bands accounted for more than half of all admissions (53%) over the 2 year period. The average of patients on admission to hospital was 60 years (62 for males and 55 for females).

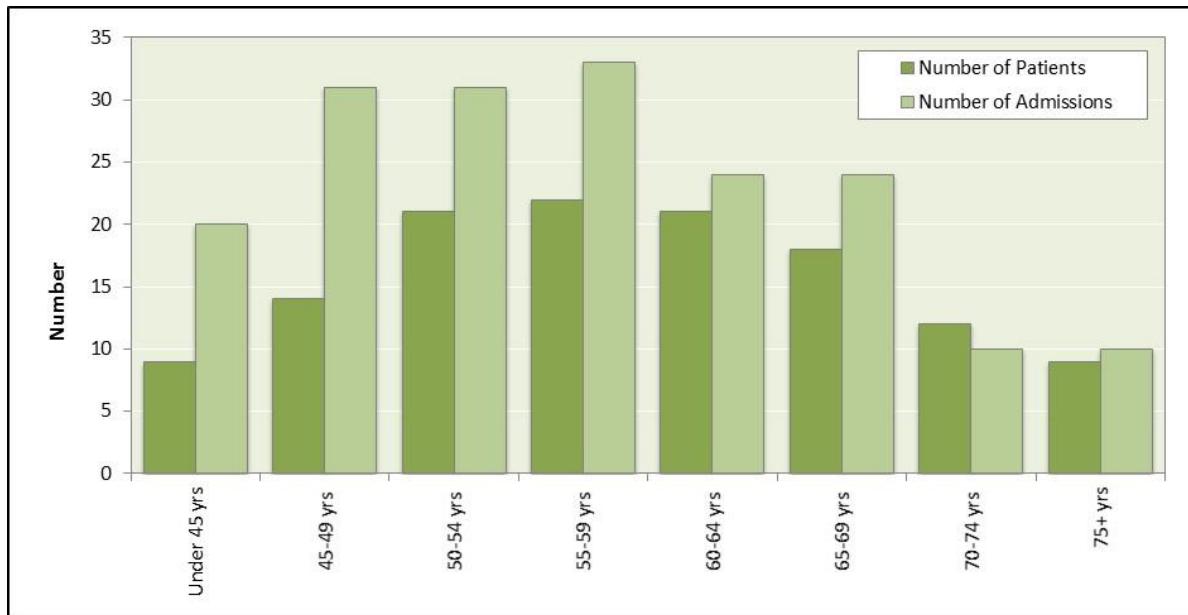


Figure 22: Hospital admissions (Liverpool residents) with an ARBI related diagnosis by age band

Source: SUS 2014/15 - 15/16 (2 Year Pooled)

5.2.5 Blood Borne Viruses (BBVs)

Blood borne viruses are infections that people carry within their blood which can be spread from one person to another through a variety of routes, such as the sharing of needles, or unprotected sex. Injecting drug users who share needles are at particular risk of contracting blood borne viruses.

Hepatitis C

Hepatitis C is a long lasting infection that affects the liver. At the early stages, many people infected are asymptomatic and often unaware they have the infection. However, if left untreated it can lead to serious health complications such as cirrhosis of the liver and liver cancer. Hepatitis C disproportionately affects marginalised population groups who often have poorer access to healthcare and health outcomes, with 9 in 10 cases in the UK being among injection drug users⁸⁴.

Public Health England estimate that there are over 2,600 people in Liverpool who are infected with Hepatitis C⁸⁵. Prevalence is comparable to the North West average and there is some suggestion of a downward trend over recent years. It should be acknowledged that this is a modelled estimate that is based on a range of assumptions, such as the size of the injecting drug user population in the city. As such it should be treated as an indication of the prevalence of the condition, rather than an exact number. In 2014-15, around three quarters of injecting drug users in Liverpool who are in treatment services have received a Hepatitis C blood test⁸⁶.

HIV

HIV is a virus most commonly caught by having unprotected sex, and attacks the body's immune system. If left untreated, the body's ability to fight infection becomes weakened and vulnerable to serious illness. This stage of infection is known as AIDS (Acquired Immune Deficiency Syndrome), and at this point, there is an increased risk of life-threatening illnesses such as tuberculosis, pneumonia and some cancers.

There has been a significant increase in the number of Liverpool residents with diagnosed HIV, with current levels more than 4 times those back in 2002, with implications for both health and social care services. In 2015, the diagnosed HIV prevalence rate in Liverpool was 1.99 per 1,000 population aged 15-59 years, just below the threshold of ≥ 2 per 1,000 at which the British HIV Association rates an area as 'high prevalence'. This compares to a prevalence of 2.26 per 1,000 in England. Whilst there has been a significant increase in the prevalence of HIV in Liverpool, levels are comparable to many of the Core Cities, and significantly below Manchester.

Injecting drug use accounts for a relatively small (<3%) and stable number of Liverpool HIV cases, mirroring the national picture, and is in contrast to outbreaks of HIV seen among injecting drug users seen in other parts of Europe. This has been attributed to harm reduction strategies such as needle exchange programmes⁸⁷. Although injecting drug use accounts for a relatively small proportion of Liverpool HIV cases, national analysis indicates that this group is most likely to be diagnosed at a late stage of infection, leading to poorer health outcomes and increasing the risk of onward transmission⁸⁸.

5.2.6 Respiratory diseases

Tuberculosis

Tuberculosis (TB) is a bacterial airborne infectious disease that spreads between people following prolonged contact. The condition is both preventable and treatable, however if left undiagnosed and untreated it can be life threatening. People who misuse alcohol and other substances are one of the groups considered vulnerable to contracting TB.

There were 120 cases of TB in 2013-15, an average of 40 per year, significantly down on the 189 cases in 2005-07. While the city has the highest infection rate within the Liverpool City Region, we have the lowest levels of any of the eight core cities in England, and we are significantly lower than England.

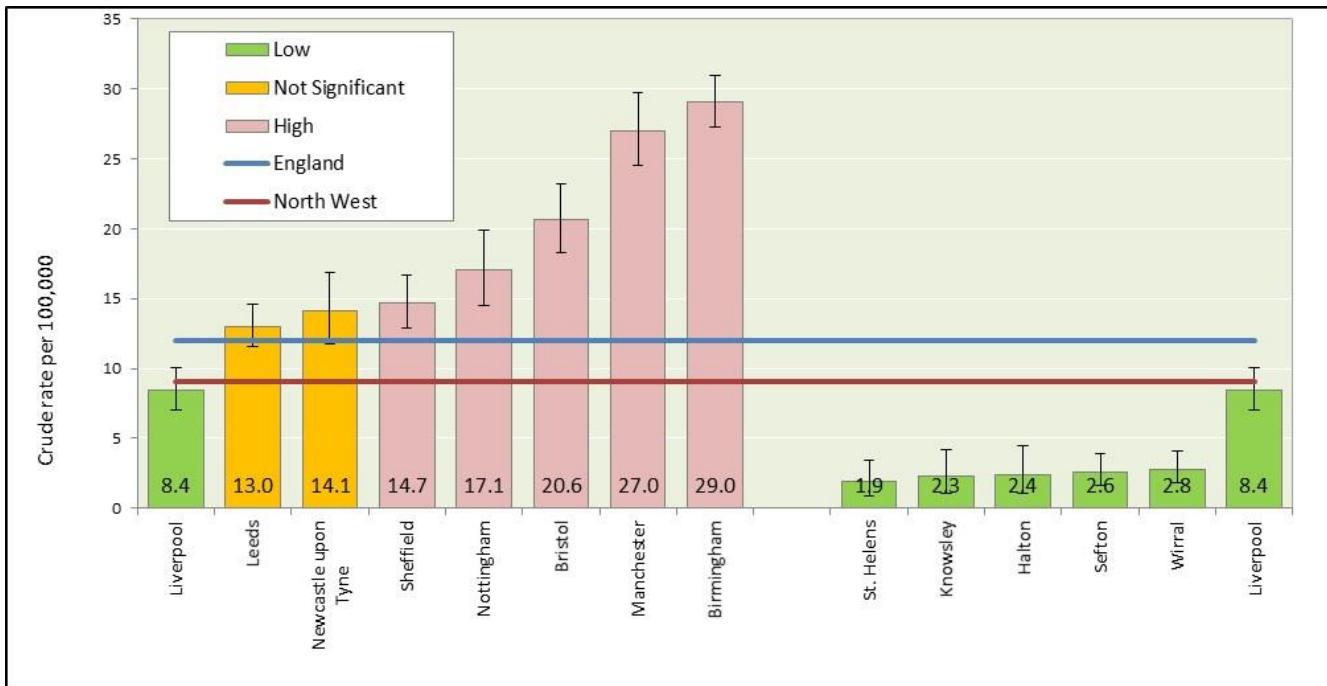


Figure 23: TB case notification rates by statistical peers, 2013-15

Source: Public Health England⁸⁹

Smoking

Tobacco is the single largest behavioural cause of premature death, and is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. Locally, smoking prevalence in Liverpool has reduced from 35% in 2005 to 23.1% in 2015, a decrease of 35,000 smokers, however prevalence remains significantly above national levels. Liverpool Public Health has set a local target to reduce smoking prevalence in the city to 15% by 2021.

We know that there are significant inequalities in smoking prevalence, with some groups much more likely to smoke than others. In particular, smoking is known to be strongly associated with drug misuse, with both regular and occasional smokers more likely to have used illicit drugs in the last year. A UK study in 2014 found that the prevalence of smoking amongst substance misusers was more than four times the level in the general population, with 88% being smokers⁹⁰. While the study found that the majority of substance misusers wanted to quit smoking, there was a widespread failure to deliver stop smoking support to this group.

The extent of this unmet need is important as many of those who go on to recover from their drug or alcohol addiction go on later die prematurely from their tobacco addiction.

Chronic Obstructive Pulmonary Disease (COPD)

COPD is a chronic lung condition causing breathlessness and wheezing, regular coughing and chest infections. Severe COPD is very serious and, the commonest cause of death in heroin smokers in the city is lung disease, with heroin users often dying in their 30s and 40s.

A recent study in Scotland analysed data from General Practices and found that the prevalence of chronic respiratory illness and asthma among drug users is significantly above levels in the general population, even when adjusting for smoking status (17% vs 11%)⁹¹. Analysis by local services has found that more than a third of heroin smokers attending a drug service in the city were found to have COPD, and they are more likely to have developed severe COPD at a younger age than those who have smoked tobacco alone.

We know that despite being at greater risk of developing COPD than former smokers, for a wide range of reasons those smoking illicit drugs are often undiagnosed and under-treated⁹². When drug users do seek medical support during a flare up of their condition, they rarely attend follow up appointments. Earlier diagnosis and treatment could reduce illness within this population, prevent admissions and lead to significant savings in NHS spending⁹³.

5.2.7 Mental health

Dual Diagnosis

Dual diagnosis is the term usually used to describe patients with both severe mental illness (mainly psychotic disorders) and problematic drug and/or alcohol use. Personality disorder may also coexist with psychiatric illness and/or substance misuse. People with dual diagnosis of drug and alcohol misuse and/or mental health problems are frequently the most in need of treatment services, but often struggle to access the care that they need. The nature of the relationship between substance misuse and mental ill-health is complex and sometimes controversial:

- A primary psychiatric illness may precipitate or lead to substance misuse. Patients may feel anxious, lonely, bored, have difficulty sleeping or may want to 'block out' symptoms or medication side-effects.
- Substance misuse may worsen or alter the path of a psychiatric illness.
- Intoxication and/or substance dependence may lead to psychological symptoms.
- Substance misuse and/or withdrawal may lead to psychiatric symptoms or illness. It may act as a trigger in those who are predisposed.

It is difficult to estimate the prevalence of people with a dual diagnosis due to limited data on the subject, however a co-morbidity study⁹⁴ undertaken in 2001 and 2002 in four cities across England, found that co-morbidity was highly prevalent among those people accessing community mental health

teams (CMHT). Of the CMHT patients included in the study, 44% (95% CI 38.1–49.9) reported past-year problem drug use and/or harmful alcohol use; 75% (95% CI 68.2–80.2) of drug service and 85% of alcohol service patients (95% CI 74.2–93.1) had a past-year psychiatric disorder⁹⁵.

The co-morbidity study found that community mental health patients reporting harmful alcohol misuse, and patients in substance misuse services who had psychiatric disorders were largely unrecognised as having co-morbidities by their respective services.

A report for the Mental Health Foundation underlines the large overlap between substance misuse and mental health problems, though it points out that mental illness and substance misuse occurring simultaneously affects a smaller proportion of people⁹⁶. The report found that:

- Between a third and half of people with severe mental health problems consume alcohol or other substances to levels that meet criteria for ‘problematic use’.
- 51% of alcohol-dependent adults say they have a mental health problem.
- 44% of people using services of Community Mental Health Teams in four urban centres reported problematic drug or alcohol use in the preceding year.

Latest figures for Liverpool show that in 2015/16 there were 452 people in drug treatment services (24.7% compared to 22.1% nationally) and 107 people in alcohol treatment services (10.2% compared to 20.8% nationally) who were in touch with mental health services for reasons other than substance misuse.⁹⁷

Toxic Trio

The “Toxic Trio” is a term used to describe the interaction between substance misuse, domestic abuse and mental health. While the number of people affected by all three factors is comparatively small, the impact is significant, particularly on children and young people. Research suggests alcohol is a factor in at least 33% of child protection cases, and drug and alcohol misuse is a factor in up to 70% of care proceedings. Parental substance misuse has been found to feature in 25% of serious case reviews⁹⁸.

Suicide

The number of suicides in any year is relatively small, however they have a huge impact on family, friends and communities, and are largely preventable. While the risk factors for suicide are complex, we know that substance misuse not only increases the risk that an individual will take their own life, but is also used as a means to committing suicide. The National confidential enquiry into suicide and homicide by people with mental illness found that suicides among patients with a history of alcohol or drug misuse (or both) accounted for 54% of the total sample.⁹⁹

Locally, the Public Health teams across Cheshire & Merseyside regularly conduct an audit of suicide cases in the region with the aim of identifying patterns or trends in factors associated with local suicides and informing local action to reduce the number of people taking their own life. Analysis from the 2015 audit found that there poisoning was the second most common method of suicide in Cheshire & Merseyside among both men and women. Case notes also found that there was a history of alcohol misuse in 31% of cases, and a history of drug misuse in 28% of cases.

5.2.8 Drug-related admissions

In 2014-15 Liverpool had the highest rate of hospital admission due to drug-related mental and behavioural disorders in England, while our admission rate for poisoning by illicit drugs was the highest among the eight core cities¹⁰⁰. Admissions due to poisoning by illicit drugs were up 44% on the previous year, while drug-related mental and behavioural disorders increased by 9%. Men in the city account for around three quarters of admissions for drug-related mental and behavioural disorders, while the admissions for poisoning are more balanced between the sexes.

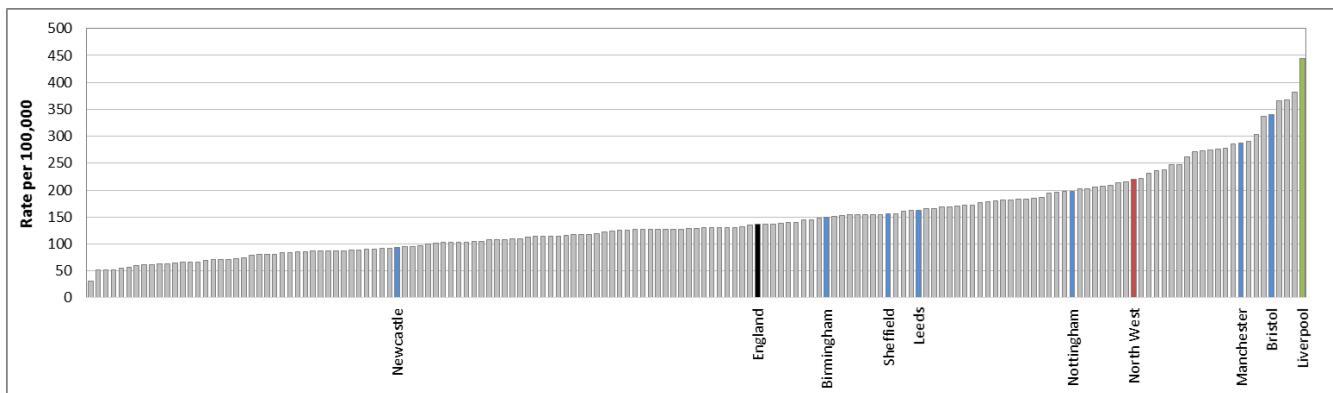
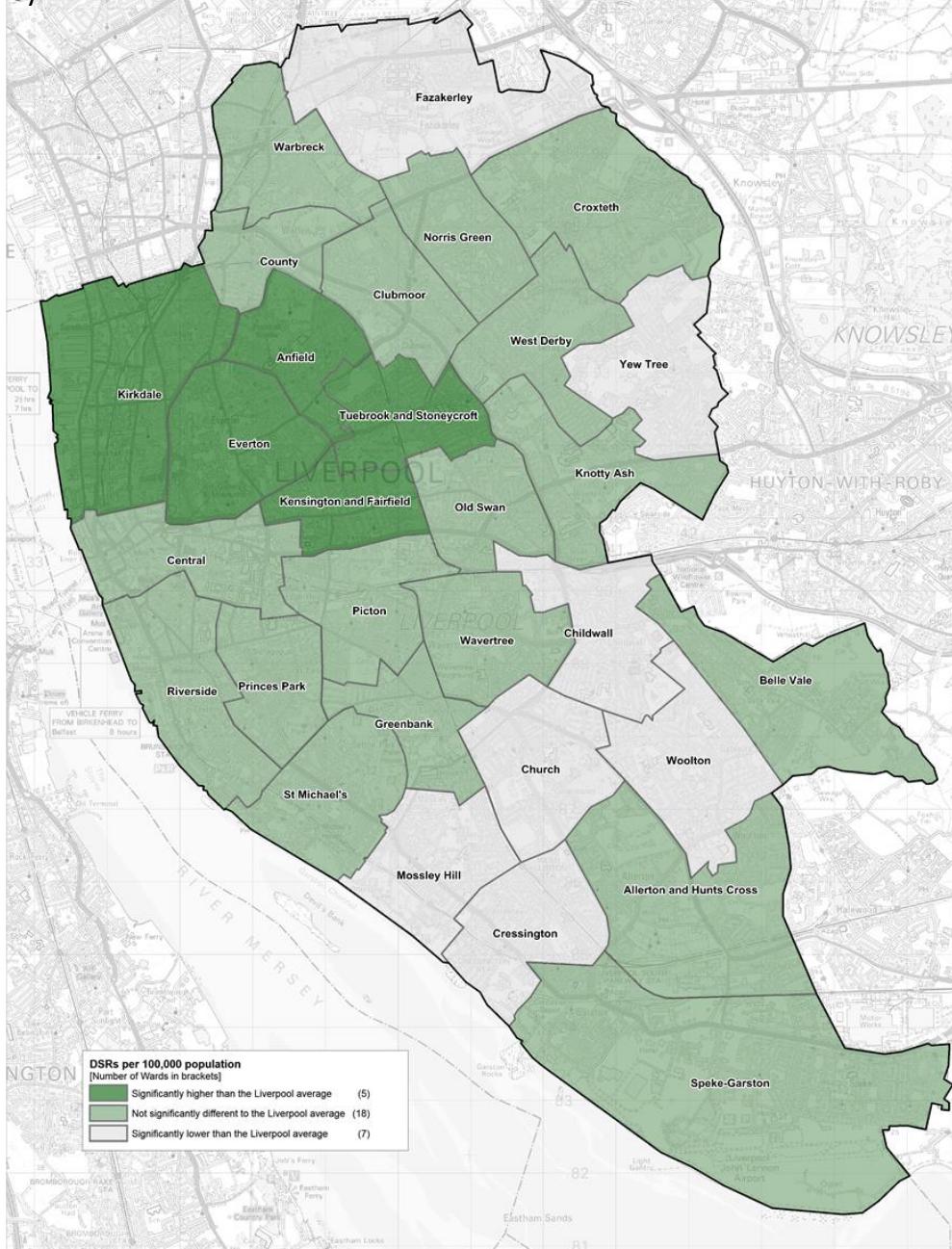


Figure 24: Age-standardised hospital admission episodes with a primary or secondary diagnosis of drug-related mental health and behavioural disorders, 2014-15

Source: Health & Social Care Information Centre¹⁰¹

Over the three year period 2013-14 to 2015-16, there were 1,036 hospital admissions in Liverpool related to drug misuse, an average of almost one a day. The map opposite shows the rate of drug-related hospital admissions across the city, with areas shaded in dark green being those where admission rates are significantly higher than the Liverpool average. Five wards had admission rates that were significantly above the average, with admission rates in Everton almost seven times higher than those in Mossley Hill.



Substance Misuse DSRs per 100,000 population

[Source: SUS 2012/13 - 2015/16 (3 Year Pooled)]

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5.2.9 Drug-related deaths in England and Wales

The main points of the statistical bulletin on drug poisoning deaths in England and Wales for death registrations in 2015 published by the Office for National Statistics are outlined below.

- Drug use and drug dependence are known causes of premature mortality, with drug poisoning accounting for 1 in 6 deaths among people in their 20s and 30s in 2015.
- There were 3,674 drug poisoning deaths involving both legal and illegal drugs registered in England and Wales in 2015, the highest since comparable records began in 1993.
- Of these, 2,479 (or 67%) were drug misuse deaths involving illegal drugs only. The mortality rate from drug misuse was the highest ever recorded, at 43.8 deaths per million population. The pattern of mortality from drug misuse closely matches the overall trend seen for all drug-related deaths as illustrated in Figure 23.
- Males were almost 3 times more likely to die from drug misuse than females (65.5 and 22.4 deaths per million population for males and females respectively). Between 2014 and 2015 drug misuse deaths increased significantly in males but remained stable in females.
- Deaths involving heroin and/or morphine doubled in the last 3 years to 1,201 in 2015, and are now the highest on record. This increase was partly driven by a rise in heroin purity and availability over the last 3 years. Age is also a factor in the record levels of drug deaths, as heroin users are getting older and they often have other conditions, such as lung disease and hepatitis that make them particularly vulnerable.
- Deaths involving cocaine reached an all-time high in 2015 when there were 320 deaths – up from 247 in 2014.
- People aged 30 to 39 had the highest mortality rate from drug misuse (98.4 deaths per million population), followed by people aged 40 to 49 (95.1 deaths per million).
- In 2015, the mortality rate from drug misuse was significantly lower in England than in Wales (42.9 compared with 58.3 deaths per million population).
- Within England, the North East had the highest mortality rate from drug misuse in 2015 for the third year running (68.2 deaths per million population), while the East Midlands had the lowest (29.8 deaths per million).
- All figures presented above are based on deaths registered in a particular calendar year. Out of the 2,479 drug-related deaths registered in 2015, half (1,132) occurred in years before 2015.

Box 3: Main Points: Statistical Bulletin Deaths related to drug poisoning in England and Wales: 2015 registrations

Source: Office for National Statistics¹⁰²

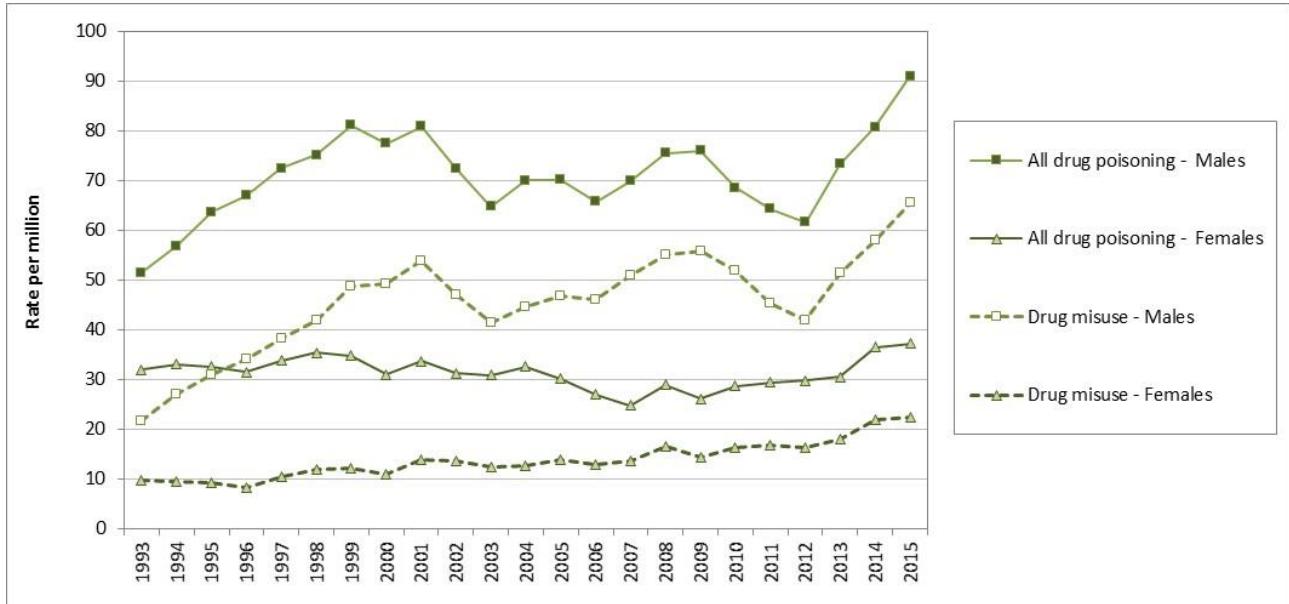


Figure 25: Trends in age-standardised mortality rates for deaths related to drug poisoning and drug misuse, by gender, England and Wales

Source: Office for National Statistics

5.2.10 Drug-related deaths in Liverpool

There are around 36 deaths from drug misuse each year in Liverpool. In 2013-15 Liverpool's directly age standardised mortality rate per 100,000 from drug misuse was significantly higher than the national average and the North West region. Between 2001-03 and 2013-15 the death rate from drug misuse in Liverpool has doubled from 4 per 100,000 to 8 per 100,000 while the gap between Liverpool and England has increased from 33% to 105%. Liverpool's drug misuse death rates are significantly higher among men compared to women.

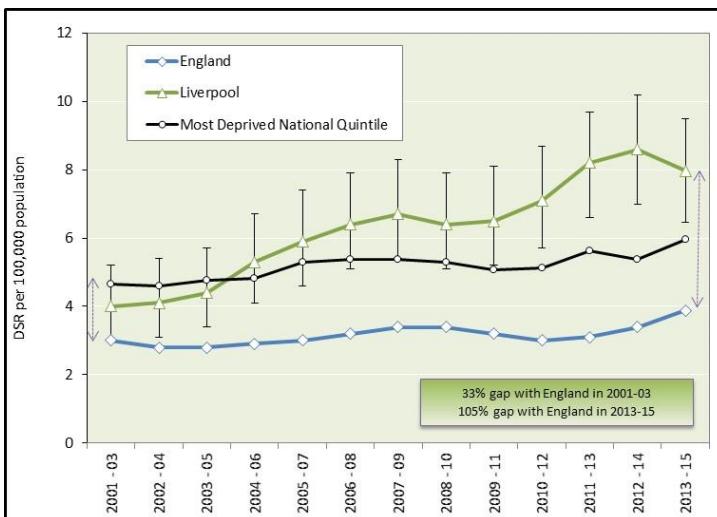


Figure 26: Trends in drug misuse mortality rates

Source: Public Health England

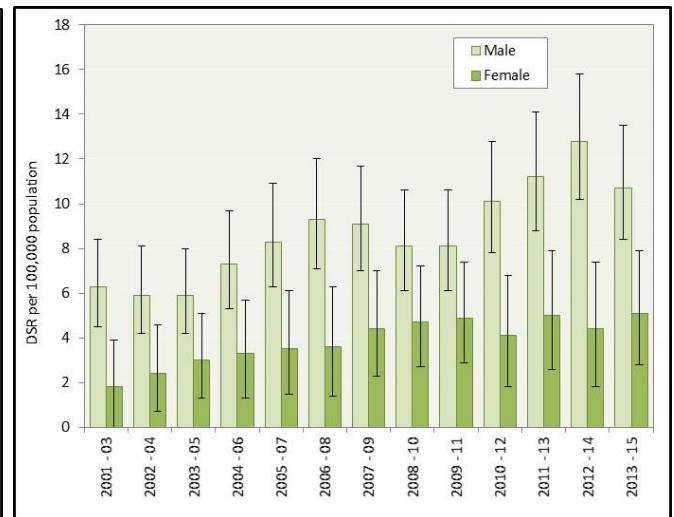


Figure 27: Trends in drug misuse mortality rates by gender

Source: Public Health England

Local analysis of drug-related deaths in 2012-16 (5 year pooled) shows there were 329 deaths registered in Liverpool which had a drug-related cause of death mentioned on the death record. Mortality rates for drug-related deaths were calculated for Liverpool wards, constituencies and deprivation quintiles and adjusted for differences in age and sex of the population.

Figure 26 below shows that at ward level drug-related deaths were significantly above the Liverpool average in Everton, Kensington and Fairfield, Princes Park and Anfield wards. Among Liverpool constituencies the drug-related death rate was significantly higher than the city average in Walton and significantly lower in Garston and Halewood. There is a strong association between drug-related deaths and deprivation, with the death rate in the most deprived ward quintile significantly higher than the Liverpool average and significantly lower in the least deprived. There were 5 Liverpool wards with less than 5 drug-related deaths which are not shown on the chart, these wards are: Woolton; West Derby; Childwall; Church; Cressington and Wavertree.

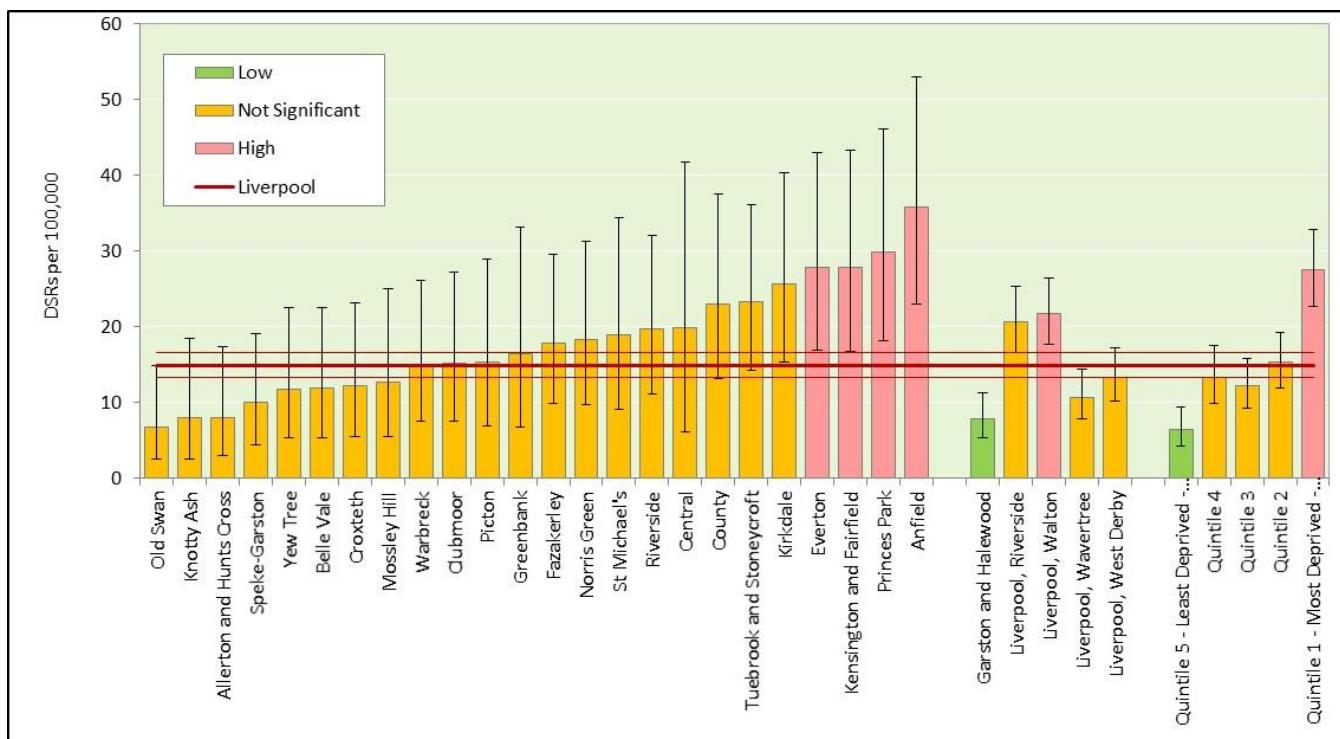


Figure 28: Directly standardised rates per 100,000 for drug-related deaths, 2012-16 (5 Year Pooled)

Source: Open Exeter Primary Care Mortality Database (PCMD)

Notes: Deaths with a drug-related underlying or contributory cause of death: IDC10 Codes: F11–F16, F18–F19 or X40–X44, X60–X64, X85, Y10–Y14.

This definition is not directly comparable to the Office for National Statistics definition for drug-misuse deaths which counts deaths where the underlying cause of death has been coded to one of the aforementioned categories and where a drug controlled under the Misuse of Drugs Act 1971 was mentioned on the death certificate.

5.3 Socio-Economic Impacts

5.3.1 Safeguarding

Roughly one in three adults being treated for substance misuse has a child living with them at least some of the time, and data indicates that parents in treatment have similar outcomes to the rest of the treatment population. Nationally, women make up 27% of the adults in drug treatment and most are mothers.

The data below shows the number of adults in alcohol and drug treatment services who live with children; users who are parents but do not live with children; and users for whom there is incomplete data. This last item is included to allow commissioners to consider the possible hidden population(s) of drug-dependent parents, or those with childcare responsibilities in contact with local treatment services.

Figures indicate that while the parental status of Liverpool adults accessing drug treatment services is comparable to national levels, the profile of adults in alcohol treatment is substantially different. Far fewer adults in Liverpool using alcohol treatment services are living with children compared to the national average (21%, compared to 27%).

Parental Status	Drug Treatment			Alcohol Treatment		
	Liverpool		England	Liverpool		England
	N	%		N	%	
Living with children (own or other)	1,473	33%	32%	354	21%	27%
Parents not living with children	1,159	26%	24%	496	29%	27%
Not a parent / no child contact	1,825	40%	43%	870	50%	44%
Incomplete data	64	1%	2%	3	0%	2%

Table 10: Parental status of adults in drug and alcohol treatment services

Source: PHE JSNA Support Packs 2015-16

Over the past decade there have been substantial improvements in recognising and supporting the needs of children who live with parental substance misuse. However in 2012, the Office of the Children's Commissioner identified three major limitations to progress¹⁰³:

- Greater emphasis has so far been placed on children identified as 'at risk', or who are known to children's services, with much less attention paid to the larger cohort of children that may require support but who are unknown to services.
- While a much larger number of children experience parental alcohol abuse, this is often hidden within a wider drugs agenda.

- While alcohol problems often co-exist with other issues, such as domestic violence and mental health disorders, opportunities are often missed for different policy areas to form an integrated response to support children and their families where there is parental substance misuse.

Public Health England released guidance¹⁰⁴ in 2013 to support the development of local joint protocols between drug and alcohol services and children and family services. The purpose of having a local protocol is to safeguard and promote the welfare of children and young people, including young carers, whose lives are affected by substance misusing parents or carers. The protocols should also promote effective communication between adult drug and alcohol services and children and family services, and to set out good working practice for the services involved.

5.3.2 Homelessness

There are strong links between substance misuse and homelessness, with drug users seven times more likely to be homeless than the general population¹⁰⁵. In a health audit conducted in 2014, Homeless Link found that there was a high prevalence of substance misuse among the homeless population in England, with 39% stating they either take drugs or are recovering from a drug addiction, and 27% stating they either have or are recovering from alcohol addiction¹⁰⁶. While around 5% of the general population have used illicit drugs in the previous month, this increases to 36% of those who are homeless¹⁰⁷. Cannabis is by far the most frequently used drug, however a significant minority use heroin and prescription drugs not prescribed for them.

There are a comparatively small but persistent group of rough sleepers who maintain high levels of alcohol use, often spending the majority of the day intoxicated. Relationship breakdown is often the trigger to a pattern of rough sleeping and drinking. Alcohol use becomes the central organising principle for this group of people, with any physical ailments having a low priority¹⁰⁸.

5.3.3 Domestic Abuse

Domestic abuse is defined as; “*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality*”¹⁰⁹. This encompasses but is not limited to the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Substance misuse, particularly alcohol abuse, is known to be both a driver and a response to violence and domestic abuse¹¹⁰. Research typically finds that between 25% and 50% of those who perpetrate domestic abuse have been drinking at the time of assault, although in some studies the figure is as high as 73%¹¹¹. Cases involving severe violence are twice as likely as others to include alcohol.

However it is important to recognise that the relationship between substance misuse and domestic abuse is complex. While alcohol is strongly associated with perpetrators of domestic abuse, there is evidence to suggest that this is a compounding factor rather than the root cause¹¹². For those suffering from domestic abuse, alcohol can often be used as a coping mechanism¹¹³.

5.3.4 Crime & Criminal Justice

Although it is difficult to estimate the exact level of crime that is related to alcohol or illicit drug use, it is well established that there is a link between substance use and criminal activity. Alcohol is thought to be involved in around half of all violent crime¹¹⁴, and between a third and half of acquisitive crime is thought to be related to illegal drug use¹¹⁵. There are also substantial costs to the UK economy from alcohol and drug-related crime, with estimates of between £8bn and £13bn each year¹¹⁶ and £13.9bn each year respectively¹¹⁷.

Substance misuse and crime are linked in a variety of different ways, including:

- People who use or supply illegal drugs
- People who commit violent offences when under the influence of drugs, alcohol in particular
- Alcohol and drug-related driving offences
- People who commit acquisitive crime (stealing) to pay for their addiction

The availability and accessibility of alcohol is also a key driver in levels of violence, with communities that have a high density of alcohol outlets typically experiencing higher levels of violence¹¹⁸.

Between 2011-12 and 2015-16 the number of alcohol-related offences in Liverpool increased by just under 8%, with over 3,500 recorded offences in the city in the last financial year. Two thirds of all offences involving alcohol were due to violence. Such offences have increased by more than a third since 2011-12, though some of this change is thought to be related to changes in recording methods.

Crime Type	Year					Change between 2011-12 and 2015-16	
	2011/12	2012/13	2013/14	2014/15	2015/16	Numerical	Percentage
Violence	1,735	1,678	1,866	2,255	2,370	+635	+36.6%
Criminal Damage	346	343	300	389	354	+8	+2.3%
Drugs	516	451	380	463	297	-219	-42.4%
Theft	433	385	432	412	277	-156	-36.0%
Other	179	135	155	170	142	-37	-20.7%
Sexual	72	65	87	130	98	+26	+36.1%
Total	3,281	3,057	3,220	3,819	3,538	+257	+7.8%

Table 11: Number of alcohol-related offences in Liverpool

Source: City Safe Partnership, Merseyside Police Delphi System

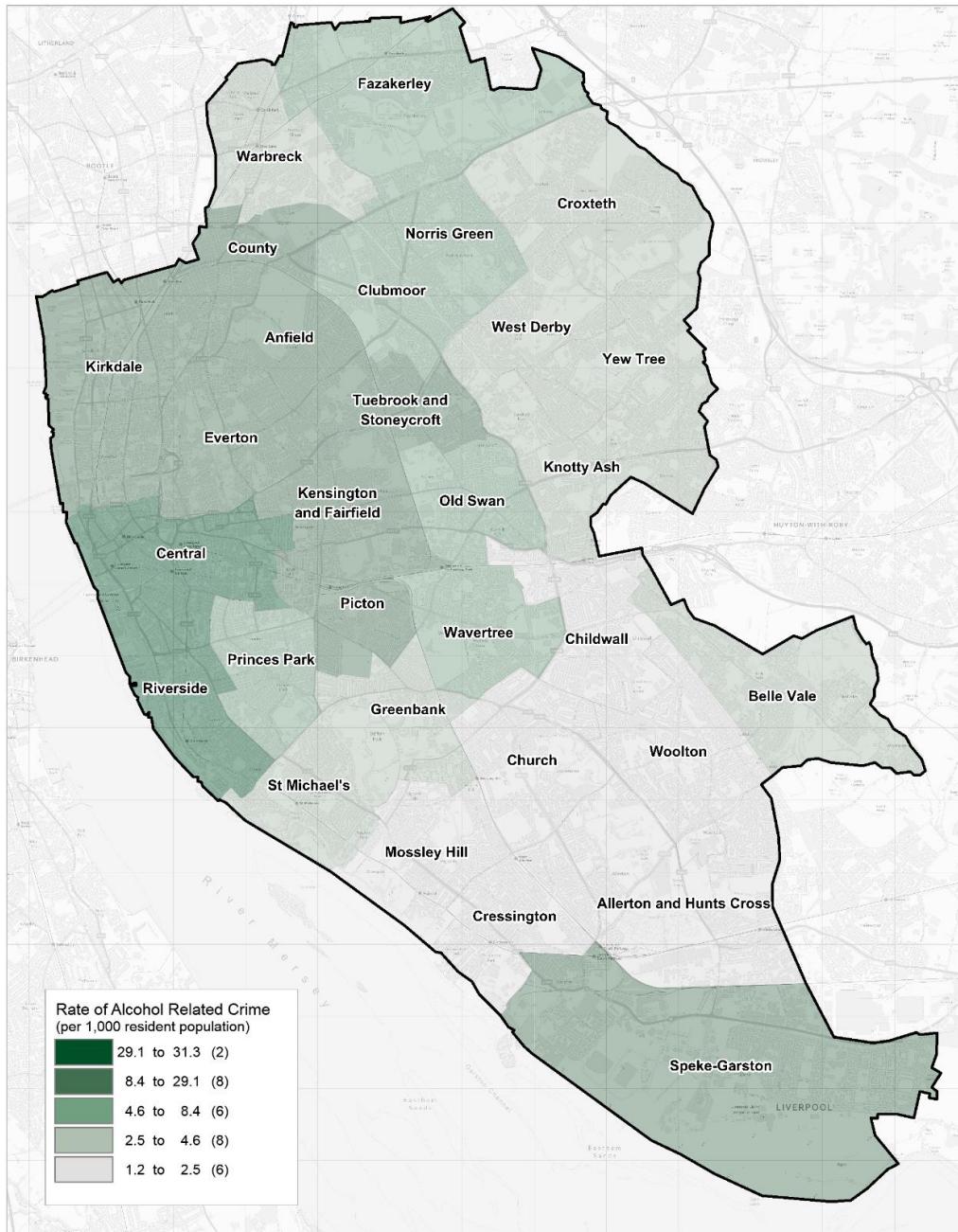
Table 11 shows the number of recorded drug offences in the city over the last five years. It is important to recognise that changes in the number of drug offences are often driven by policing activity and intelligence gathering, and do not necessarily equate to a 'real term' change in drug use or drug supply. As such changes over the five years need to be interpreted with caution. Figures show that the possession of controlled drugs accounts for the bulk of drug offences in the city, with possession of cannabis accounting for just under two thirds of all drug offences in the city. However there are over 500 offences a year related to drug trafficking.

Crime Type	Year					Change between 2011-12 to 2015-16	
	2011/12	2012/13	2013/14	2014/15	2015/16	Numerical	Percentage
Possession of controlled drugs - Cannabis	4,505	3,839	3,440	2,507	1,951	-2,554	-56.7%
Possession of controlled drugs – Excluding Cannabis	1,014	860	813	798	586	-428	-42.2%
Trafficking	576	584	662	559	510	-66	-11.5%
Other Drugs offences	33	25	23	14	12	-21	-63.6%
Total	6,128	5,308	4,938	3,878	3,059	-3,069	-50.1%

Table 12: Number of drug offences in Liverpool

Source: City Safe Partnership, Merseyside Police Delphi System

The map below illustrates the level of alcohol-related crime across the city in 2015-16. Central and Riverside wards had the highest levels of crime, reflecting the fact that they cover the heart of the city centre and night time economy (see section 5.2.4). Outside of the city centre it is apparent that levels of alcohol-related crime are higher within the more deprived parts of the city.



Alcohol related crime in 2015-16

Date created: July 2016

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5.3.5 Night Time Economy

Licensed premises, events and festivals attract large numbers of visitors to Liverpool each year, contributing significantly to the city, economically, socially and culturally.

The main concentration of premises providing late night licensable activities is in the city centre with the suburbs benefiting from public houses and members clubs. The City Council, as the licensing authority under the Licensing Act 2003, has issued current premises licences for 2,241 premises, equating to one premise for every 173 adults. By comparison there were 204,400 premises licences in force in England and Wales in 2013¹¹⁹ equating to one for every 279 adults.

In addition there were 45 club premises certificates and approximately 4,600 personal licences issued¹²⁰. The City Council administers approximately 670 Temporary Events Notices received each year. In addition to fixed premises, the city also hosts numerous large cultural events each year, attracting many thousands of visitors such as: Africa Oye, the Liverpool Food and Drink Festival, Liverpool LightNight, the International Mersey River Festival, the International Music Festival, Liverpool Arabic Arts Festival, Brazilica, Liverpool Pride, Sound City and On the Waterfront.

6. The Local Response

While Local Authority Public Health teams are responsible for commissioning drug and alcohol services, it is important to recognise that for interventions to be truly effective, partnership working is crucial. Public Health, Children's Services, Adult Services, the NHS, Police and other criminal justice agencies, Jobcentre Plus and the Work Programme, mutual aid networks and many others, all have a vital role to play. The diagram below illustrates the wide range of partners that have a role to play in tackling substance misuse.

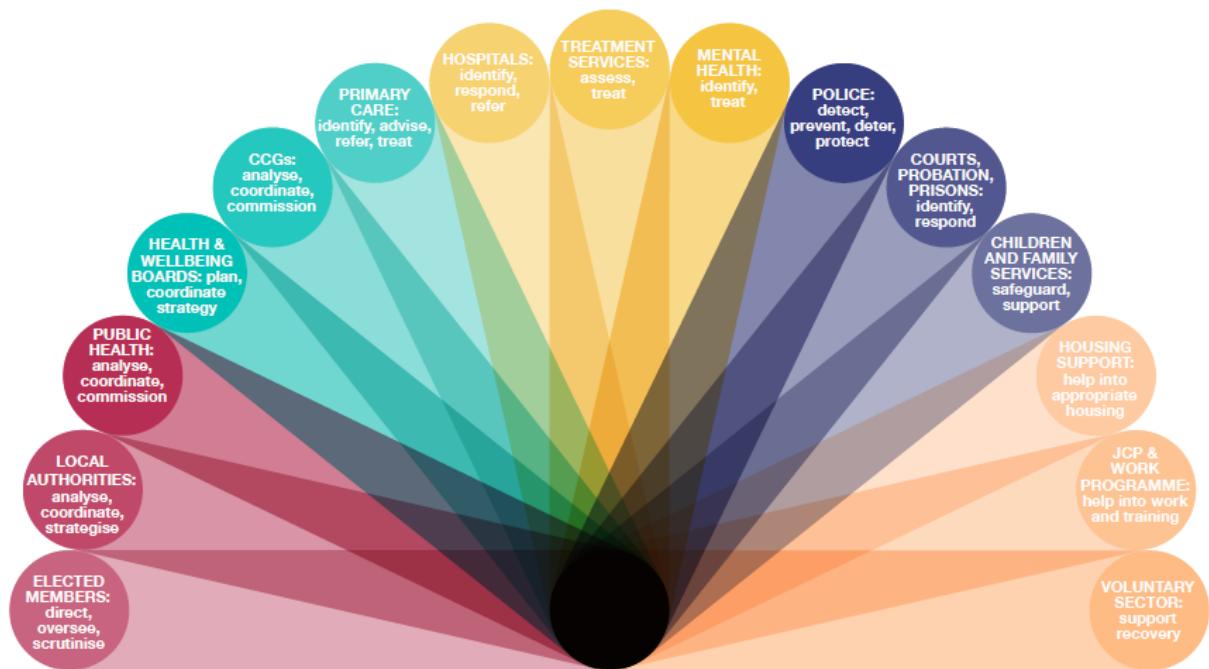


Figure 29: Partners involved in tackling substance misuse

Source: Public Health England¹²¹

6.1 Prevention & Early Identification

6.1.1 Insight & Social Marketing

Local insight work was conducted in 2012 speaking to people who drank harmful amounts of alcohol, to explore attitudes, behaviours, motivations, barriers and beliefs around harmful drinking, and engagement with local health services. The insight consisted of hour long in-depth interviews and found that heavy drinkers in the city could be categorised into four segments:

Population Group	Characteristics
Chardonnay socialites	<p>These people are typically middle aged men and women with families who drink to socialise. They are more likely to report that they do not get drunk and know their limits. They tend to drink wine throughout the week with an evening meal and drink more heavily at weekends when socialising with friends at home or in a restaurant. This group is often shocked to realise they are heavy drinkers and surprised to see how much they have been drinking in their diary. They have often noted the short term consequences of drinking especially putting on weight and there has been an 'under current' of unease about their alcohol consumption.</p> <p><i>Key barriers to stopping drinking or cutting down are that drinking is seen a key part of their social life.</i></p>
Balanced bingers	<p>Typically younger people with no children (although some family people also fall into this category). They usually drink heavily at weekends in social settings, usually at a pub, bar or club and like to mix different strengths in one evening. They know that they drink a lot on these nights out but feel this is balanced by not drinking on other nights of the week. They often cite other healthy behaviours as balancing out their alcohol consumption such as gym/sport. They tend to believe their drinking will naturally decrease over time as they 'settle down'.</p> <p><i>Key barriers to stopping drinking or cutting down are that they do not feel their drinking is problematic and that they have a healthy lifestyle.</i></p>
Ritual relaxers	<p>Tend to be single people of all ages. They are often single parents or may work unsocial hours and typically drink on their own as a way of relaxing at the end of the day. They drink throughout the week as a way to unwind and relax. Like chardonnay social-lites, they are often shocked to see how much they have been drinking, will be aware of short term consequences and will feel uneasy about their alcohol consumption.</p> <p><i>Key barriers to stopping drinking or cutting down are that a drink at the end of the day is considered a 'reward'.</i></p>

<p>Drinker in denials</p>	<p>Tend to be older males (although some women also fall into this category). They typically drink at the pub when socialising with friends or watching the match. Some also drink at home. This group has a strong preference for pints and spirits and tend to drink often – many are retired so have lots of spare time and fewer responsibilities. This group are unwilling to change their alcohol consumption. They enjoy drinking and have been doing so for a long time so it is part of their identity. Whilst they recognise the health consequences they would rather continue to drink.</p> <p><i>Key barriers to stopping drinking or cutting down are they do not think their drinking is problematic and they would not consider going to the pub and not having a drink.</i></p>
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Using this insight Liverpool has developed and delivered social marketing programmes to influence responsible drinking behaviours. A brand '*Fewer Units = More Happy Hours*' has been established to promote sensible drinking, used most recently within the Alcohol Concern '*Drier January*' 2014 programme.

Drink Less, Enjoy More

The sale of alcohol to individuals who are drunk is illegal and is currently regulated under Section 141 of the Licensing Act 2003 and it is also illegal to buy alcohol for someone who is clearly drunk. However, until recent times, public awareness, bar server compliance and police enforcement of this legislation has appeared to be low. Critically, UK nightlife environments are often characterised by high levels of intoxication and alcohol-related harms. In 2013, a study by LJMU found that in 84% attempts by 'drunk' actors to purchase alcohol in Liverpool bars were successful¹²².

Liverpool City Council, Merseyside Police, City Safe, Liverpool NHS Clinical Commissioning Group and other partners have committed to reducing drunkenness in the city centre of Liverpool. The #DrinkLessEnjoyMore campaign is an ongoing initiative that started in 2015 that aims to reduce drunkenness in Liverpool city centre by improving awareness that it is illegal to serve or buy alcohol for someone who is clearly drunk, and to improve compliance with these laws.

The campaign hoped to influence the local drinking culture, in particular the amount of alcohol 18-30s drank before a night out and when in the city-centre on a weekend through:

- Raising awareness amongst 18-30s that they won't get served if they are drunk
- Raising awareness that it's illegal to buy alcohol for someone (e.g. a friend) who is drunk
- Raising awareness amongst bar staff that it's illegal to serve drunks and potential repercussions
- Reducing the number of bar staff serving drunks
- Encouraging binge drinkers to drink less before visiting the city-centre
- Encouraging binge drinkers to drink less whilst in the city-centre

The initiative features:

- An insight-based marketing campaign to encourage people to drink less
- Training and support for bar staff to enable them to confidently recognise and refuse service to people that are clearly drunk
- Extra police patrols to enforce the laws

The campaign is ongoing with extra activity focused during periods where drinking levels are expected to be higher for example over the European Championships and during the Christmas period. Results from last Christmas showed a significant impact on behaviours, with the number of 'drunk' actors able to buy alcohol in bars in Liverpool city centre falling from 84% before the campaign, to just 26% afterwards¹²³.

The evaluation of the Drink Less, Enjoy More initiative made a series of recommendations, in particular that this should form part of an on-going programme or work in order to maximise its impact.

6.1.2 Screening

The Alcohol Use Disorder Intervention Toolkit (AUDIT) is used in Liverpool to screen alcohol consumption. Consisting of 10 questions (each with a scoring option of 0-4) AUDIT allows the professional conducting the screening to identify the extent to which an individual's drinking is a risk (lower, increasing, higher) and where the risk is of sufficient concern to offer and activate a referral into specialist community alcohol support. In Liverpool an alcohol screening target of 67% for all patients in the last 3 years was set within the GP Specification 2016/17.

6.1.3 Interventions & Brief Advice (IBA)

Evidence shows that provision of brief advice on alcohol consumption will have a beneficial effect on the drinking behaviours of 1 in 8 individuals drinking at increasing and higher risk. In recognition of the impact of brief advice provision an IBA training programme has been established and directed to the 93 GP Practices across the city. The work is being delivered by the Liverpool Community Alcohol Service (LCAS). The training provides a framework for intervention to help increasing and higher risk drinkers reduce or cease alcohol consumption and thereby avoid the harmful consequences of their drinking.

In addition to the primary care IBA programme a further 1,500 professional stakeholders (ranging from midwives to probation officers and health visitors to pharmacists) have accessed IBA training in Liverpool over the past 5 years. Many of these stakeholders have also taken advantage of the follow-up refresher and update training that has also been made available to support the longer term sustainability of skills developed.

6.1.4 Rehabilitation, Education, Support & Treatment (REST) Centre

Street drinkers are amongst the most vulnerable people in our society, with complex needs that incur high costs to themselves, their families and communities as well as local services. Aside from health problems, street drinkers also experience high levels of offending behaviour, suicide and self-harm. Although they tend to use costly emergency health and criminal justice services at high rates, street drinkers often have difficulty in gaining access to more routine healthcare services, especially psychiatric services. Street drinking can also be associated with poor use of specific alcohol dependence services.

In order to seek a solution to this issue, Liverpool Public Health in partnership with the Citysafe Partnership commissioned a REST (Rehabilitation, Education, Support and Treatment) Centre to operate over the summer months of 2015 when street drinking is at its peak. The aim of the centre was to provide a method to diffuse the anti-social behaviour that is associated with street drinking, and also to provide support and pathways into treatment and other services such as accommodation, health and addiction services. The work resulted in a range of positive outcomes including:

- Staff and service users reported reduced speed and quantity of alcohol consumption
- The Centre referred 8 street drinkers into detox - 6 attended
- Increased feeling of safety of street drinkers
- Improved health and wellbeing of street drinkers using the Centre
- Increased support networks and social integration
- Improved family relationships
- Two had job interviews and one secured a volunteering post

An independent evaluation of the REST Centre conducted by Liverpool John Moores University¹²⁴ made a number of recommendations, including:

- Any future location for the REST Centre needs to be accessible to street drinkers. Ideally in a central location and preferably near to areas that street drinkers often inhabit.
- Improved facilities and extended opening hours would enable the operation of services to provide additional support.

- Pathways for those who use NPS and illicit substances need to be considered. Developing formal links with drug services would help to provide appropriate referrals. Pathways for homeless people who do not engage in street drinking also need to be considered.
- The REST Centre should consider incorporating more formalised pathways and agreements with external agencies to provide support on-site. Services including housing, substance use and health could be invited to the REST Partnership Group.
- If the future implementation of the REST Centre is temporary, an aftercare process for service users should be established. Linking in with external services is needed for the periods when the Centre is closed in order to continue the support that service users receive.
- Early engagement with local businesses and residents is imperative in the setup of the Centre and should be replicated to ensure that the local community support the development of the REST Centre.
- Data collection and monitoring needs to be a priority to further evidence the effectiveness of the REST Centre. Future provision should incorporate further data collection for progress and updates specifically around service users alcohol consumption, health and housing status.

6.1.5 Chronic Obstructive Pulmonary Disease (COPD) Screening

Spirometry is a simple test which is used to help diagnose and monitor certain lung conditions by measuring how much air can be breathed out in one forced breath. Heroin and crack smoking is associated with early onset severe COPD yet this population are known to engage poorly with non-emergency medical services.

To improve the detection and treatment of COPD in this population, Liverpool CCG has offered a spirometry screening service to clients attending key worker appointments in drug treatment services, at the same time as they collect their opiate substitute prescription. Just under three-quarters of the eligible client group have participated in the programme (807 out of 1,100 clients). Airways disease was found to be present in a majority of clients with 47% having mostly undiagnosed but symptomatic COPD. When asked for feedback, 96% of respondents said they were happy with the process and 93% indicated they would be willing to attend future COPD appointments at drug centres. This model of screening and treatment was found to be effective in improving healthcare access among this population.¹²⁵

6.1.6 Needle and syringe programmes

Needle and syringe programmes (NSPs) are a type of harm reduction initiative that provide clean needles and syringes to people who inject drugs, the primary aim of which is to reduce the transmission of viruses and other infections caused by sharing injecting equipment, such as HIV, hepatitis B and C. In turn, this will reduce the prevalence of blood-borne viruses and bacterial infections, so benefiting wider

society. The majority of NSPs are run by drug services and pharmacies. Needle exchange services in Liverpool are concentrated in the north of the city where the need is greatest.

The number of people in Liverpool accessing either a pharmacy or agency based needle and syringe programme (NSP) is increasing. In 2015/16 around 7,700 people accessed NSP services compared to 5,500 people in 2013/14, an increase of 40%. The latest figures for 2015/16 show that 87% of clients were male, partly due to the high numbers of men who use steroid and performance and image enhancing drugs (PIED). Reporting of main substance of use for NSP clients is around 51% and for whom the main substance was recorded, heroin was the most common (47%) followed by steroids and IPEDS (43%) and crack cocaine (3%). “Other drugs” comprised of just under 9% of primary substance recorded.

There were 1,915 individuals (49% of those who had a substance recorded) with heroin, or crack cocaine, or other opiate as either their primary or secondary substance in 2015/16. This is made up of 1,904 who recorded either heroin, crack cocaine, or other opiate as the primary substance, and an additional 11 individuals where one of these substances was recorded as the secondary (but not primary) substance. In total 20,655 needle and syringe transactions were delivered in 2015/16, of which 96% were in a pharmacy setting.¹²⁶

6.2 Community Treatment Services

A range of treatment services provided in community settings are commissioned by Liverpool City Council (LCC) in order to promote awareness of and ease of access to services which can support people with substance misuse issues. A re-procurement exercise in 2015/16 involving a number of prescribing and recovery services led to a rationalisation in the number of providers in the city.

Addaction were successful in retaining their existing services listed below as well as gaining a number of recovery-specific services covering activities to engage people in treatment as well as support those who have completed structured treatment into employment, training and education. The other key provider, Mersey Care NHS Trust, delivers a range of substance misuse services in community and in-patient settings.

- Addaction provides a range of services for those suffering from drug misuse:
 - Initial and comprehensive assessment
 - Care planning coordination and review
 - Substitute prescribing, including a shared care service in partnership with Liverpool GPs
 - Psychosocial treatment and support
 - Structured counselling
 - Needle exchange
 - Assertive outreach

- Liverpool Community Alcohol Service (LCAS) provides:
 - Assessment, support and treatment, including detoxification, within a community setting.
 - Seventy-five clinic sessions per week from a range of community settings across the city as well as at the Royal Liverpool University Hospital (part of the Royal Liverpool and Broadgreen University Hospitals NHS Trust).
 - Referral to inpatient service when required and, when access to inpatient service is not immediately available, development of care plan to support the client.
- Mersey Care NHS Trust provides:
 - Assessment, care planning and prescribing services for more complex clients with clear links to mental health services, as it is the main mental health provider in the city.

Treatment services have extended their scope from purely treating substance misuse to providing a more holistic approach which looks at the client's wider health and personal circumstances. This covers areas such as physical health, accommodation needs and family situation. There have been a number of successful initiatives addressing issues such as COPD (Chronic obstructive pulmonary disease), HIV and Blood Borne Viruses, all of which can have a significant negative impact on the health of those with substance misuse issues and can act as a major obstacle to recovery.

Numbers in Treatment	Liverpool			National		
	Number 2015-16	% Change from 14-15	Number 2014-15	Number 2015-16	% Change from 14-15	Number 2014-15
Opiate	3,047	-2.6	3,127	147,907	-2.1	151,120
Non-opiate only	787	14.6	687	25,964	2.4	25,354
Alcohol and Non-opiate only	712	-23.9	935	28,413	-1.5	28,838
Alcohol only	1,227	1.0	1,215	82,679	-4.7	86,757
Total	5,773	-3.2	5,964	284,963	-2.4	292,069

Table 13: Numbers in Treatment

Source: National Drug Treatment Monitoring System – Public Health England

Successful Completions	Liverpool			
	Number 2015-16	% of Number in Treatment	Number 2014-15	% of Number in Treatment
Opiate	186 / 3,047	6.1	197 / 3,127	6.3
Non-opiate only	419 / 787	53.2	310 / 687	45.1
Alcohol and Non-opiate only	358 / 712	50.3	460 / 935	49.2
Alcohol only	560 / 1,227	45.6	566 / 1,215	46.6

Table 14: Successful completions

Source: National Drug Treatment Monitoring System – Public Health England

It should be noted that Liverpool's cohort of opiate users are increasingly older and often have a range of complex physical health illnesses arising from long-term drug use such as COPD and cancer - 50% of Liverpool's opiate users are aged 45+ years compared to 27% nationally.¹²⁷ The spine chart below summarises the latest figures for drug and alcohol treatment services and benchmarks Liverpool against the England average. Compared to nationally, Liverpool has higher proportions of people waiting 3 weeks or more for drug treatment (3.2% compared to 2.1%) and alcohol treatment (4.9% compared to 4.1%).

In all, 1,555 people exited the drug and alcohol treatment system in 2015 having successfully completed their treatment free of dependence. Alcohol clients had the highest rates of successful exits with more than half (50.9%) completing treatment followed by non-opiate clients with 49.8% completing treatment, both significantly higher rates than nationally. Opiate clients had the lowest rate of completion, 6.3% which was similar to England at 6.7%. The recovery rates for non-opiates and alcohol have remained higher and relatively stable largely because users of these substances are more likely to have access to the personal and social resources that can aid recovery, such as employment and stable housing¹²⁸.

Compared to England, Liverpool has a significantly lower proportion of adults with a substance misuse treatment need who engage in structured treatment interventions in the community within 3 weeks of their release from prison (26.4% compared to 30.3%).

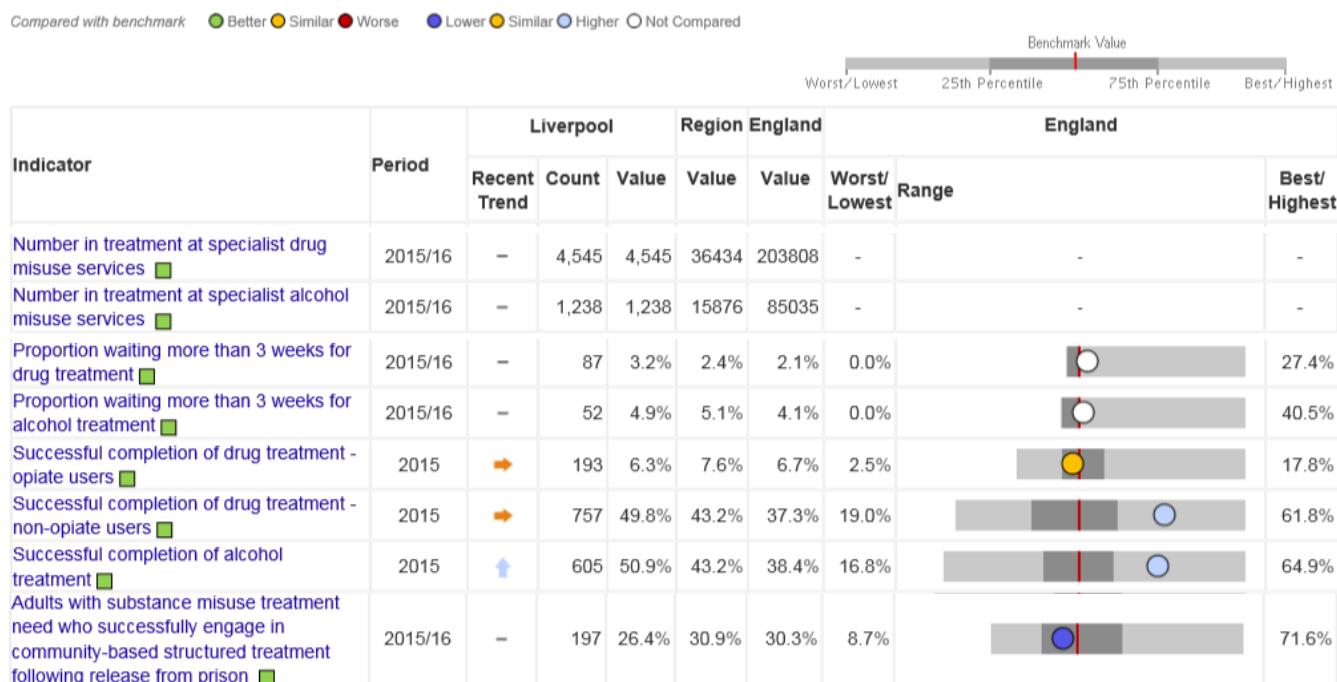


Figure 30: Drug and alcohol treatment services

Source: Public Health England¹²⁹

6.3 Specialist Treatment Services

In-patient services are provided where appropriate to support those in need of more intensive treatment. Mersey Care NHS Trust provides the services from the Kevin White Unit for drug treatment and the Windsor Clinic for alcohol treatment.

The purpose of the specialist treatment service is to provide medically managed detoxification and stabilisation programmes to aid the recovery and reintegration of drug and alcohol users with complex needs. The service is available to those who meet the following criteria:

- Have not benefited from previous formal community-based detoxification.
- Need 24 hour special substance misuse medical and/or nursing care because of significant co-morbid physical or mental health problems.
- Require complex polydrug detoxification, for example concurrent detoxification from alcohol or benzodiazepines.
- Are experiencing significant vulnerabilities or social problems that will limit the benefit of community-based detoxification.
- Have complex needs that require admission for medical stabilisation, for example, patients on injectable or high-dose opioids or those with features of chaotic drug misuse and high risk taking behaviors linked to substance misuse.

The particular aims of the Service are:

- To provide a safe period of medically managed and monitored (by exception) withdrawal and detoxification, with 24 hour medical supervision.
- To encourage, educate, motivate and enable realistic lifestyle changes.
- To ensure that treatment gains are maintained by developing robust links with aftercare support available within the community.
- To address the safeguarding and welfare needs of vulnerable adult service users or the children of substance misusing parents, ensuring that needs are identified and planned for prior to a person's discharge from inpatient care.
- To ensure that the principles of harm minimisation underpin the delivery of all interventions thereby contributing to a reduction in drug and alcohol-related deaths and the transmission of blood borne viruses.

The service aims to achieve the required outcomes by:

- Providing high quality assessment, observation, case management, therapeutic and harm reduction interventions to service users.
- Ensure that co-morbidities, physical, mental health and social problems are addressed to stabilise physical and mental health.

- Facilitating joint working and appropriate information sharing to all other professionals involved in the care of the individual, including GPs, the specialist community core treatment provider, Social Care and voluntary agencies and ensuring that all referrals are appropriately followed up.
- Ensuring that service users have robust relapse prevention strategies in place which may include the prescription of medication. This includes, as priority, liaising with Sefton Local Authority to address housing needs for service users who do not have safe, stable accommodation upon discharge.

6.4 Recovery & Rehabilitation

A range of recovery and rehabilitation services are available in line with clients' individual requirements:

- Psychosocial interventions form a core part of a service user's move towards recovery and are offered to service users in both one to one and group-work sessions. Where a service user is receiving more than one intervention, all modalities will be integrated into a co-ordinated package of care.
- Counselling support will be provided, based on comprehensive assessment of need.
- Participation in creative, arts-based and physical activities plays a key role in support of the Five Ways to Well Being - Connect, Be Active, Take Notice, Keep Learning and Give - which can influence and sustain people who are in active substance misuse or in recovery. Activities include creative writing, music and sport as well as links to other community-based activities.
- Community rehabilitation service where people follow an intensive abstinence-based structured day programme, which runs for 48 days over 11 weeks.
- Residential rehabilitation service following 12-step model.
- Joint working with Job Centre Plus to support clients into employment.
- An active mutual aid network (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) with approximately 80 meetings every week across the city.

6.5 Licensing and the Night Time Economy

The significant role the City Centre plays in Liverpool's night-time economy has been recognised by the prestigious award of "Purple Flag" status since 2010 for its night-time economy – a type of national "gold-standard" accreditation for quality nightlife awarded by the Association of Town Centre Management which recognises the strides that have been made in the City Centre becoming a safer, cleaner and more pleasant place to be after dark with varied offerings both in the type of entertainment, goods and the audience that the nightlife appeals to. In 2013 Liverpool retained its Purple Flag status and achieved 'Beacon' Status – an accolade which holds up the City's night time experience as an example for other towns and cities to follow - being the first city in the UK to do so without any recommendations from the assessors.

There are currently over 2,200 premises licensed to serve alcohol in Liverpool, equating to approximately one licensed premise for every 173 adults. By comparison there were 204,400 premises licences in force in England and Wales in 2013¹³⁰ equating to one for every 279 adults. Sales of alcohol and related harm increase in line with both the number of shops and bars selling alcohol and the number of hours permitted to sell alcohol. Liverpool takes a proactive partnership approach in managing this provision.

Working with the licence trade

Over the period 2011-16 there have been over 2,500 visits to licensed premises. These visits may be either of a routine nature, advisory visits where a trader makes an enquiry, or assistance following a complaint about a premise. Over the two years 2014/15 – 2015/16 a total of 34 separate licence reviews have been initiated, 1,323 bar staff have been trained to refuse service to individuals who are excessively drunk and 1,108 litres of illicit alcohol has been seized.

Voluntary removal of super strength products

High strength low cost alcohol (most usually cider, lager and wine) are products most frequently purchased by those most vulnerable to its impact (young people and street drinkers). In the absence of minimum unit price legislation for alcohol Liverpool has worked with the licensed trade located in the closest proximity to where street drinking is known to occur, to voluntarily remove single cans of 6.5% strength cider and lager from sale as a step to control access to cheap alcohol.

Special Cumulative Impact Policy

A special cumulative impact policy (SCIP) is a tool that can be used by Licensing Authorities to limit the concentration of licensed premises in designated areas, where there are unacceptable levels of crime, disorder or public nuisance. There are currently 5 SCIPs in place across Liverpool:

- Allerton Road SCIP
- Cavern Quarter SCIP
- Lark Lane SCIP
- Ropewalks SCIP
- Kensington, Fairfield & Central Wards SCIP

The effect of adopting a SCIP is to “*create a rebuttable presumption*” that applications for licences which are likely to add to the existing cumulative impact will normally be refused, or subject to certain limitations, unless the applicant can demonstrate that there will be no negative cumulative impact on the licensing objectives¹³¹.

6.6 Housing

Access to stable, safe and sometimes supported, housing is a critical factor in enabling a service user to sustain a recovery journey. Substance misuse services liaise with homelessness service providers across the city to ensure that the most appropriate housing solution is obtained for service users in housing need, homeless or in inappropriate housing.

6.7 Criminal Justice System

Substance misuse services (Addaction and Mersey Care) work closely with criminal justice agencies in the community to ensure treatment provision is available for those referred via the criminal justice system. Services covered include:

- Arrest Referral – substance misuse services maintain a presence in the principal custody suites in the city to carry out initial assessments for offenders testing positive for class A drugs. Harm minimisation advice and information on local treatment options is delivered to encourage voluntary referrals into treatment. This includes alcohol users and non-opiate and crack cocaine users (non-OUCUs).
- Drug Rehabilitation Requirement - The main purpose of the DRR is to reduce or eliminate illicit drug use and associated offending. The offender is required to attend appointments with the treatment provider and to submit to regular drug testing. The offender is also required to attend appointments with the officer of the provider of probation services or another person determined by the officer of the provider of probation services.
- The Alcohol Treatment Requirement (ATR) is targeted at offenders assessed as alcohol dependent, who will often have complex coexisting needs e.g. mental health, social and housing problems and require intensive, specialist, care-planned treatment e.g. day programmes, detoxification.
- Restriction on Bail (ROB) enables someone who is charged with an offence and tested positive for a Class A drug to undergo drug treatment as part of their bail conditions.
- Substance misuse services have a presence at Liverpool Magistrates Court to support DRRs, ATRs and ROB, deliver harm minimisation and information on local treatment options to individuals in the waiting rooms and cells.
- Integrated Offender Management (IOM) brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.
- Multi Agency Risk Assessment Conference (MARAC) is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies.

7. Stakeholder Views

In 2015, Liverpool City Council commissioned Liverpool John Moores University to conduct research¹³² to inform the future design and makeup of substance misuse services in the city. As part of the research process the university facilitated a stakeholder engagement session and a range of in-depth interviews with service providers and wider stakeholders. The research was designed with two key aims in mind: to explore both the experiences and perceptions of the existing treatment and recovery system, and to identify key pressures, gaps and weaknesses within the existing treatment and recovery system.

Generally, providers felt that substance misuse services in Liverpool were good, and that there was a good range and level of support for clients. A number of sub-themes were identified through the research, and the information presented below is taken directly from the LJMU research paper that summarises the stakeholder interviews¹³³.

7.1 Needle & syringe programmes

Many of the stakeholders interviewed for the present Liverpool research described the importance of ensuring people are able to access services within the community, and highlighted that transactions with clients in a community setting were an effective method of meeting those who may need support and signposting them to other services.

7.2 Investment

Some service providers described that current funding arrangements could make it difficult to be responsive to the needs of their clients. This theme was also echoed in the previous evaluation of the drug treatment system in Liverpool, where budgetary constraints were seen to have potential and actual impacts upon service provision in terms of appropriate resourcing.

7.3 Person centred approaches

Interviews with both stakeholders and service providers described the importance of services taking a person centred approach. Many discussed the need to consider holistic approaches to support the wider needs of individuals, and highlighted that many drug and alcohol problems are fuelled by problems such as homelessness, debt, unemployment, and broken family relationships. These findings were supported by Integrated Monitoring Service (IMS) data, which identified homeless services, housing providers and welfare advice agencies as high in terms of onward referrals. Many interviewees described the need to help people to navigate changes to welfare benefits, and some stated that this was exacerbating existing issues.

Providers described the need to ensure that resources were available within the community to support with people re-engaging with services. This notion of increasing or improving outreach within the community was also highlighted within the stakeholder mapping phase of the research. Some stakeholders who were interviewed discussed the need to consider the personal motivation of people who had disengaged or dropped out of treatment, to empathise and communicate effectively to ensure these people were aware that the door is always open.

7.4 Joined up approaches between services

During the stakeholder mapping phase of this research, it was identified that provision for a seamless treatment journey was required, and this was echoed in the interviews with stakeholders and services providers. Here, respondents all described the strong relationships and working practices that they had with other organisations across the local treatment system. However, some providers felt that there could be stronger links between services, particularly in terms of support for mental health and in sharing information about support offered. Some felt that funding arrangements could lead to a competitive environment and one in which some providers may be reluctant to be transparent about the levels of support they provide. Stakeholders and providers also felt that a joined up approach to measuring outcomes would be beneficial, and that this would enhance the level of person-centred support available to individuals.

7.5 Level of provision

Generally, all stakeholders and service providers felt that Liverpool offers a very good level of provision within the substance misuse treatment system. When this issue was explored further, a theme emerged regarding whether the amount of provision was potentially a barrier to success. Many described the potential confusion in key messages or access into services that could emerge as a result of ‘too many services’. This is an important issue, as many felt that they were not able to keep up with the services on offer, which made signposting and referrals difficult. The issue described in Liverpool could possibly be attributed to the evolving nature of services, and a need for increased awareness regarding availability of provision. Some providers described that this could be tackled by providing a menu of support that could be given to providers, clients, and those in need of support, and gave examples of areas that had undertaken a similar approach.

In addition to the number of providers, the longevity of provision was raised by some as a potential issue. Here, some described the short-term nature of pilots and projects, and that even if projects are only delivered for a short period of time, key learning (both positive and negative) should be disseminated across the system.

7.6 Infrastructure to support volunteers

All interviewees described the importance of ensuring that volunteering opportunities are available, and generally, all felt that there was adequate provision for this across the city. IMS data illustrated that just over half of these clients were unemployed or seeking work. Some providers described the importance of ensuring that a range of volunteering opportunities are available to people outside of the treatment system. These providers described how systems often encourage people to volunteer within the service/s which supported them to recovery, and that this is not always a positive step. Previous research has, however, suggested that peer support should be encouraged and that peers should be positive role models used to effectively deliver health and wellbeing and awareness information (e.g. detox, overdose and withdrawal). Some described how a clean move away from the treatment and recovery system is sometimes needed to help people to move away from a negative lifestyle. Pathways need to be strengthened to ensure that a range of opportunities are offered to people who wish to volunteer, outside of the treatment system.

7.7 Mutual aid

Stakeholders and service providers had differing views regarding mutual aid. Some felt that mutual aid is offered consistently across Liverpool, whilst others felt it was not actively promoted by all. Some felt that transparency and choice were important, in terms of promoting a range of abstinent and non-abstinent recovery support systems. Some service providers felt that not everyone fully understood mutual aid, and that it would be beneficial for all people to attend mutual aid meetings as part of their induction into service provision within Liverpool.

7.8 Awareness of services

Stakeholders and service providers highlighted a number of areas where they felt they (or others across the system) would benefit from further education and awareness. This was also highlighted in previous research undertaken in Liverpool. Mutual aid, volunteering opportunities outside the treatment and recovery system, and the amount and level of provision were all raised as key issues here. In addition, service providers felt awareness could be improved regarding overdose training and information; here, some service providers described that this was particularly necessary for peers, and that awareness needed to be raised amongst people with drug problems.

A small number of service providers felt that information about the Hepatitis C pathway could be better promoted, particularly in terms of the need to inform clients about what the pathway way provides and what it will involve. One person specifically noted the importance of increasing options for emotional support.

8. Evidence of What Works

There is a wide range of guidance and evidence to support local partnerships in their work to improve the outcomes for people involved and affected by substance misuse. The following section is not intended to be an exhaustive list, only to highlight a number of the key sources of guidance and evidence.

8.1 Public Health England Resources

Public Health England has published a range of materials to support commissioners and services involved in tackling substance misuse. Key documents are highlighted here.

8.1.1 Drug misuse treatment in England: evidence review of outcomes¹³⁴

An evidence review of the outcomes that can be expected of drug misuse treatment in England was published by Public Health England in January 2017. The findings indicate that good progress has been made in reducing drug-related harm and promoting recovery through the commissioning of evidence-based treatment. The evidence review has also shown that social factors including housing, employment and deprivation are linked with substance misuse and have an impact on the effectiveness of drug treatment outcomes. This highlights the importance of population-level approaches to tackle social determinants of substance misuse – as well as the importance of providing a wrap-around support package to individuals throughout their recovery. The review also recommends broadening the range of outcomes that are assessed to understand an individual's progress. Outcomes such as social integration and harm reduction are very important for fully appreciating the benefits of drug treatment services to individuals.

8.1.2 Public Health England Guidance: Health matters: preventing drug misuse deaths¹³⁵

This professional resource from Public Health England outlines how providers and commissioners can prevent deaths from drug abuse - one of the eight good practice outcomes of the national drug strategy and a continuing priority for PHE and local commissioners and services. The resource includes information on:

- The scale of the problem: gender, age, geography, costs to society and why invest?
- Factors causing the rise in drug misuse deaths: increase in the availability and purity of heroin, ageing heroin users, as well as established risk factors for drug misuse;
- Preventing drug misuse deaths: Identifying drug users in the community, needle and syringe programmes, drug treatment services, drug treatment services and what makes an effective treatment service, the widening availability of naloxone;
- Call to action: Local authorities and the NHS, drug services, primary and secondary care; and
- Resources.

Public Health England has also published a briefing in the 'Turning evidence into practice' series which has practical advice for commissioners and services on preventing drug-related deaths¹³⁶. This briefing provides a checklist for services and local areas that want to improve their practices in this area. The content is drawn from published evidence, authoritative guidance, and feedback from drug treatment services.

8.1.3 Take-home naloxone for opioid overdose in people who use drugs¹³⁷

Public Health England has published advice for local authorities and local partners on promoting the wider availability of naloxone to reduce overdose deaths from heroin and similar drugs. Naloxone is the emergency antidote for overdoses caused by heroin and other opiates/opioids (such as methadone and morphine). The main life-threatening effect of heroin and other opiates is to slow down and stop breathing; Naloxone blocks this effect and reverses the breathing difficulties.

Naloxone is already available on prescription and used by paramedics, including North West Ambulance Service and can be supplied to people who are currently using illicit opiates, such as heroin, those who are receiving opioid substitution therapy or leaving prison with a history of opioid use and who have previously used opiate drugs (to protect in the event of relapse). On 1 October 2015, new regulations came into force, which allow for widening of the availability of naloxone. This means that a range of drug treatment services can order naloxone from a wholesaler so that people engaged or employed in their services can, as part of their role, make a supply of the naloxone available to others without a prescription. With the agreement of the individual at risk, it could also be prescribed to family members, friends and peers.

Guidance from Public Health England, the Department of Health and the Medicines & Healthcare Products Regulatory Agency on widening the availability of naloxone was published in June 2016¹³⁸ and includes advice on:

- What the new regulations mean
- Who can supply naloxone
- Products that drug services can supply
- Responsibility for deciding who can actually supply naloxone locally
- People who can be supplied naloxone
- Patient Group Directions and Patient Specific Directions
- Naloxone's status as a prescription only medicine
- Using naloxone to save a person's life without their permission
- Clinical governance in drug treatment services
- Guidance for hostels/homeless shelters/housing associations, etc

- Cost-effectiveness of widening availability
- Risks associated with widening availability

8.1.4 JSNA Support Pack: Young people's drug, alcohol and tobacco use¹³⁹

This support pack outlines four key principles that local areas might consider when commissioning universal and targeted drug, alcohol and tobacco prevention interventions, and specialist interventions for young people already experiencing harm:

- Effective evidence-based interventions are being commissioned universally and in a targeted way to prevent young people's use of drugs, alcohol and tobacco.
- A full range of specialist drug alcohol and tobacco interventions are available to young people in need.
- Commissioning is integrated across prevention and specialist interventions and the wider children's agenda.
- A skilled workforce is in place to provide effective interventions.

Within each principle there are a range of questions and prompts for local commissioners to consider, to ensure that they are following current evidence and best practice guidelines.

8.1.5 JSNA Support Pack: Drug prevention, treatment and recovery for adults¹⁴⁰

This support pack outlines six key principles that local areas might consider when developing plans for an integrated alcohol and drugs prevention, treatment and recovery system:

- Drug misuse and dependence are prevented by early identification and interventions
- There is prompt access to effective treatment
- There are interventions to address the health harms of drug use
- Treatment is recovery-orientated, effective, high-quality and protective
- Treatment supports people to sustain their recovery
- Local authority public health commissioners work closely with all relevant partners to commission high-quality, evidence-led alcohol and drug services based on outcomes

Within each principle there are a range of questions and prompts for local commissioners to consider to check that they are following current evidence and best practice guidelines.

8.1.6 Why Invest?¹⁴¹

Public Health England have produced a series of infographics to support local commissioners in making the case for investment in substance misuse prevention, treatment and recovery. The "Why Invest?" pack highlights a number of actions local areas for both alcohol and drugs:

- ***What needs to be done – Alcohol:***
 - Improve awareness of alcohol harm among young people and delay the age of first use.
 - For people who drink, make lower risk drinking the norm and an easy choice to make.
 - Target those who are most at risk.
 - Respond to and reduce the harm experienced by those who have already developed problems.

- ***What needs to be done – Drugs:***
 - Prevention measures to build resilience among young people and to promote drug-free environments.
 - Develop effective responses to the harm of new drugs and help people who are addicted to medicines.
 - Respond to the growing number of older drug users, many of whom have serious addiction and health problems.
 - A package of support (treatment, housing, employment, positive social networks) to help people recover and rebuild families and communities.

8.1.7 Recovery Diagnostic Toolkit¹⁴²

The Recovery Diagnostic Toolkit provides a series of prompts for commissioners, substance misuse treatment providers and keyworkers. They can guide local thinking around improving outcomes for the different groups of clients identified in treatment data. They support appropriate clinical responses to common issues such as clients who are in treatment for long periods of time or using on top of prescribed medication. They summarise and include links to existing clinical guidance on each issue, and can be read alongside your current treatment data. Clinical prompts are provided for the following groups:

- Treatment naive clients
- Re-presenting clients
- Long term clients
- Clients who are still using their presenting substances, especially on top of their script
- Most complex clients (in terms of likelihood of success)
- Increasing recovery capital
- Optimising treatment outcomes in the first six months of treatment
- Early unplanned exit

The clinical prompts are not a comprehensive response to the issues raised, but are intended to guide, inform and support appropriate solutions to issues within local treatment populations.

8.1.8 Co-existing alcohol and drug misuse with mental health issues¹⁴³

This draft guidance from Public Health England is currently out to consultation (at time of publication) and aims to support commissioners, providers and users of alcohol, drug and mental health services. The guidance outlines the following principles for commissioning and delivery of care to help local areas successfully meet the needs of individuals with co-existing alcohol, drug and mental health issues:

- Commissioners and providers of alcohol and drug misuse and mental health services have a joint responsibility to meet the needs of individuals with co-existing alcohol and drug misuse and mental health issues.
- Commissioning enables services to respond effectively and flexibly to presenting needs and prevent exclusion
- Providers in alcohol and drug, mental health and other services should have an open door policy for individuals with co-existing alcohol and drug misuse and mental health issues, and should make every contact count.
- Vulnerable children and young people are able to access the support they need, when and where they need it.
- People can and do recover from alcohol and drug misuse and mental ill health.

Accompanying these principles are suggested priorities to guide commissioning, and implementation prompts for both commissioners and providers.

The guidance is supported by Public Health England's co-existing substance misuse and mental health issues (CESMMHI) profiling tool. This tool collates and analyses a range of publicly available data on prevalence, risk, access, treatment and outcomes that support people with co-existing substance use and mental health issues. Commissioners, service providers, clinicians, service users and their families can benchmark their area against similar populations and gain intelligence about what works in meeting the needs of people experiencing these issues. The tool is available from:

<http://fingertips.phe.org.uk/profile-group/mental-health/profile/drugsandmentalhealth>

8.1.9 Improving access to, and completion of, hepatitis C treatment¹⁴⁴

This briefing forms part of the “Turning Evidence in Practice” series from Public Health England, and provides an overview of the key issues that local providers and commissioners of drug and hepatitis treatment should consider. Much of the content is based on the more detailed public health commissioning report of the London Joint Working Group for Substance Misuse and HCV. The briefing provides a series of prompts for local areas to consider, across a range of themes:

- Drug treatment and criminal justice services
- Hepatitis treatment services

- Commissioning

8.1.10 Providing effective services for people who use image and performance enhancing drugs¹⁴⁵

In many parts of the country, image and performance enhancing drugs (IPED) users make up a significant proportion of people using needle and syringe programmes and many have complex health needs¹⁴⁶. This briefing forms part of the “Turning Evidence in Practice” series from Public Health England, and provides a series of prompts for those commissioning drug misuse prevention and treatment services to consider. The prompts cover a range of themes, including:

- Blood-borne viruses and injecting-related problems
- Poly-drug and alcohol use
- Outreach services
- Staff competence in working with IPED users
- Engaging IPED users in prison

8.1.11 Commissioning treatment for dependence on prescription and over-the-counter medicines¹⁴⁷

Local responses to drug misuse and dependence are also expected to cover dependence and other problems with medicines (sometimes called addiction to medicines)¹⁴⁸. This short guide from Public Health England provides an overview of how primary care, secondary care, public health and social care can work together to address the issue of addiction to medicines.

8.1.12 New psychoactive substances: A toolkit for substance misuse commissioners¹⁴⁹

This toolkit from Public Health England is designed to support local substance misuse commissioners to address the issues arising from the use of new psychoactive substances in their areas. The toolkit covers a number of themes, including:

- Tackling supply of new psychoactive substances
- Prevention
- Monitoring and information sharing
- Interventions and treatment
- Competence in working with NPS users
- NPS in prisons and the children and young people’s secure estate

8.2 NICE Guidance

The National Institute for Health & Care Excellence publish a range of guidance, quality statements and treatment pathways relating to substance misuse, aimed at improving health outcomes. Below are a number of key pieces of guidance, though more are available via the NICE website.

8.2.1 Alcohol: preventing harmful use in the community¹⁵⁰

This quality standard covers a range of approaches at a population level to prevent harmful alcohol use in the community by children, young people and adults. These statements are particularly relevant to trading standards, other local authority teams, the police, and schools and colleges. This quality standard does not cover screening and brief interventions, which are covered by NICE's quality standard on alcohol dependence and harmful alcohol use.

8.2.2 Alcohol use disorders: diagnosis and management¹⁵¹

This quality standard covers the care of children (aged 10-15 years), young people (aged 16-17 years) and adults (aged 18 years and over) drinking in a harmful way and those with alcohol dependence in all NHS-funded settings. It also includes opportunistic screening and brief interventions for hazardous and harmful drinkers. The quality standard addresses the prevention and management of Wernicke's encephalopathy but does not cover the separate management of other physical and mental health disorders associated with alcohol use.

8.2.3 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence¹⁵²

This clinical guideline offers evidence-based advice on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and in young people aged 10–17 years.

8.2.4 Alcohol-use disorders: prevention¹⁵³

This guidance is for government, industry and commerce, the NHS and all those whose actions affect the population's attitude to, and use of, alcohol. This includes commissioners, managers and practitioners working in: local authorities, education, and the wider public, private, voluntary and community sectors.

8.2.5 Needle and syringe programmes¹⁵⁴

This guidance makes recommendations on needle and syringe programmes, including those provided by pharmacies and drugs services for adults and young people (including those under 16) who inject drugs, including image- and performance-enhancing drugs.

8.2.6 Severe mental illness and substance misuse¹⁵⁵

This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having coexisting severe mental illness and substance misuse. 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. The guideline includes recommendations on:

- First contact with services
- Referral to secondary care mental health services

- The care plan: multi-agency approach to address physical health, social care, housing and other support needs
- Partnership working between specialist services, health, social care and other support services and commissioners
- Improving service delivery
- Maintaining contact between services and people with coexisting severe mental illness and substance misuse who use them

NICE has also produced a guideline on coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings.

8.2.7 Drug use disorders. NICE Quality Standards QS23¹⁵⁶

The NICE Quality Statement (QS23) for drug use disorders sets out what high-quality care should include, based on NICE drug misuse technology appraisals and clinical guidelines. Mutual Aid refers to the social, emotional and informational support provided by, and to, members of a group at every stage of recovery, and is one of the most commonly travelled pathways to recovery. Mutual aid groups come in different types, with the most widely provided being based on 12-Step principles, for example Narcotics Anonymous and Cocaine Anonymous. Other forms include SMART Recovery and locally derived peer support networks.

This quality standard recommends that the benefits of these mutual groups can be further enhanced if keyworkers and other staff in services facilitate contact with them, for example by making an initial appointment, arranging transport or possibly accompanying patients to the first meeting and dealing with any subsequent concerns. These interventions can be of benefit to a wide range of people at different levels of the care and treatment system¹⁵⁷.

8.3 Other Sources of Evidence

8.3.1 RCGP Substance Misuse and Associated Health¹⁵⁸

The Royal College of General Practitioners has released a series of factsheets designed to improve the effectiveness and safety of prescribing decisions and the importance of complying with regular medication reviews where the prescriber assesses the need and risk. The factsheets are also intended to support the identification and management of patients at risk. They have also produced a range of guidance regarding the management of substance misuse in primary care.

8.3.2 Alcohol and brain damage in adults: with reference to high risk groups¹⁵⁹

This report from the Royal College of Psychiatrists reviews the literature regarding alcohol-related brain damage (ARBD) and the implications for medical treatments, service organisation and provision,

assessment, and psychosocial interventions. Specific recommendations are presented in the context of four specialist settings:

- Alcohol treatment services
- Prisons
- Acute hospitals
- Pregnancy/fetal alcohol spectrum disorder (FASD)

8.3.3 Blue Light Project: Working with change resistant drinkers¹⁶⁰

The Blue Light project is Alcohol Concern's national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services. It is supported by Public Health England and 23 local authorities across the country¹⁶¹. This guide is designed to support specialist and non-specialist staff working with change resistant drinkers in managing risk and reducing associated problems, from health implications to wider issues such as domestic abuse.

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