

Blackpool Drug Health Needs Assessment

April 2014

Blackpool Council



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Blackpool Drugs Health Needs Assessment

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Key Points - Service Overview

Children & Young People's Services

- The majority of referrals (62%) to Blackpool's young people's specialist substance misuse services were received from Youth Justice and Education services.
- There were 76 drug and alcohol clients aged under 18 years in specialist services in 2012/13, compared to 140 and 176 in 2011/12 and 2010/11 respectively.
- 70% of young people in treatment services had 2 to 4 identified risks/vulnerabilities in 2012/13.
- Young people in treatment services are more likely to be not in education, employment or training / have a contracted sexually transmitted infection / have a child / be in contact with the youth justice system / be receiving benefits by the time they are 18 / half as likely to be in full-time employment.
- 98% of young people entering the treatment service in 2012/13 began using the main problem substance (includes alcohol) under the age of 15 years.
- 42% of young people entering the treatment service in 2012/13 were using two or more substances.
- 40% of young people entering the treatment service in 2012/13 were involved in offending.

Adult Services

- In 2012/13 there were an estimated 1,946 Opiate and/or Crack users in Blackpool (21.89 per 1,000 population – compared to 8.67 per 1,000 for England).
- In 2012/13 there were an estimated 958 injecting drug users in Blackpool (10.77 per 1,000 population – compared to 2.71 per 1,000 for England).
- 63% of all those in treatment in 2012/13 were 'opiate only' users. 28% were opiate and crack users.
- As at 31/3/2012, 771 adults (63%) in treatment reported the use of a second drug. 363 (30%) reported the use of a third drug.
- In 2012 there were 18 suspected drug-related deaths – a 50% reduction from 2006, when Blackpool had the highest number in England.
- In 2012/13 68% of eligible new clients accepted a hepatitis B vaccination.
- In 2012/13 approximately 491,000 needles were distributed through the needle exchange programme.
- In 2012/13 87 individuals starting treatment were receiving care from mental health services for reasons other than substance misuse.
- In 2010/11 there were 545 hospital admissions where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders.
- In 2010/11 there were 82 hospital admissions where there was a primary diagnosis of poisoning by drugs.
- In 2012/13 26% (n=92) of new clients reported a housing problem i.e. of no fixed abode or staying with friends/family as a short-term guest or residing at a short-term hostel.
- Drug-related offences committed in Blackpool increased 107% (from 240 to 498 offences) between 2008 and 2013.
- 73% of new clients in 2012/13 were unemployed, and 5% were long-term sick or disabled.
- 88% of clients in treatment services are aged 30+. 62% are aged 35 to 50 years.
- 68% of all clients in treatment in 2012/13 were male.
- 74% of new clients starting treatment in 2012/13 were self-referrals.
- During 2012/13, 26% of Blackpool clients (n=105) who exited treatment did so drug free. 23% of clients (n=90) who exited treatment dropped out of, or didn't commence treatment.
- As at September 2013, 43.3% of opiate users had been in treatment up to two years. 25.9% had been in treatment for six years or more.
- Approximately 491,000 needles were distributed through the Blackpool needle exchange programme in 2012/13.

Scope

This Health Needs Assessment (HNA) provides an overview of the current patterns of drug use in Blackpool and the impact on the population, along with regional and national comparisons. It considers both adult and young person groups, and also the current use of drug services. As such it is a comparative, epidemiological HNA using existing data and evidence. It is intended to act as a foundation from which further information gathering can develop, and to inform the direction of service provision and resource use according to need.

1. Introduction

The Misuse of Drugs Act 1971, with amendments, is the main law regulating drug control in the United Kingdom. It divides controlled substances into three classes (A, B, C) based on harm, with Class A being the most harmful. These classes provide a basis for attributing penalties for offences. Each class attracts different levels of penalties for a range of unlawful activities, including possession, supply and production of a controlled drug. The Home Secretary has the power to make a temporary class drug order (TCDO) for an emerging drug that is causing a concern. A TCDO can be made within a matter of days and lasts for up to 12 months.

Drug Classification:

Class A: Crack cocaine, cocaine, ecstasy (MDMA), heroin, magic mushrooms, methadone, methamphetamine (crystal meth).

Class B: Amphetamines, barbiturates, cannabis, codeine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (e.g. mephedrone, methoxetamine).

Class C: Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), ketamine, piperazines (BZP).

National drug strategy for England

Launched on 8 December 2010, the *Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery* is primarily concerned with illicit drugs, but also includes alcohol use. The strategy has two overarching aims: (i) to reduce illicit and other harmful drug use; and (ii) to increase the numbers recovering from their dependence. This document replaced the 2008 strategy published by the previous government and has a greater emphasis on recovery, with more responsibility placed on individuals to seek help and overcome dependency. Increased weight is given to providing a more holistic approach by addressing other issues in addition to treatment. This is designed to support people dependent on drugs or alcohol by addressing issues such as offending, employment and housing. The strategy aims to reduce demand and takes an uncompromising approach to targeting those involved in supplying drugs in the United Kingdom and internationally. In addition, it places more power and accountability in the hands of local communities to tackle drugs and the harms they cause. The strategy's aims are addressed through three thematic areas: (i) reducing demand; (ii) restricting supply; and (iii) building recovery in communities.

2. Children and Young People

i. Demographics

[Please see the JSNA Core Document Chapter 1 for general demographic information.](#)

Smoking, drinking and drug use among young people in England in 2012¹:

In 2012, the prevalence of illegal drug use was at its lowest since 2001, when the current method of measurement was first used. 17% of pupils had ever taken drugs, 12% had taken them in the last year and 6% in the last month.

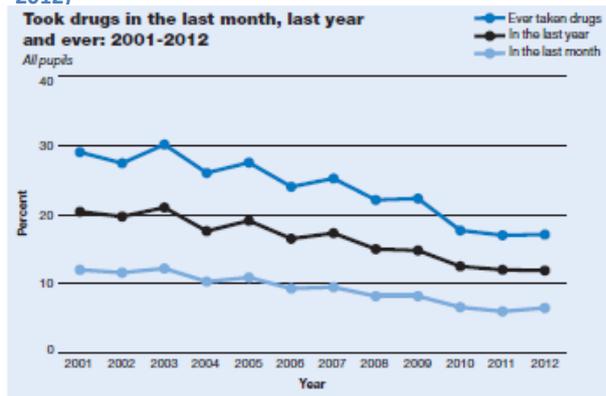
Boys and girls were equally likely to have taken drugs, and older pupils were more likely than younger ones to have done so. The prevalence of ever having taken drugs increased with age from 7% of 11 year olds to 31% of 15 year olds. There were similar patterns for drug use in the last year (from 4% to 24%) and in the last month (from 2% to 13%).

In 2012, as in previous years, cannabis was the most widely used drug among 11 to 15 year olds; 7.5% of pupils reported taking it in the last year. This figure is similar to that seen in 2011 (7.6%), but continues the overall downward trend in prevalence of cannabis use since 2001.

In 2012, 28% of pupils reported that they had ever been offered drugs.

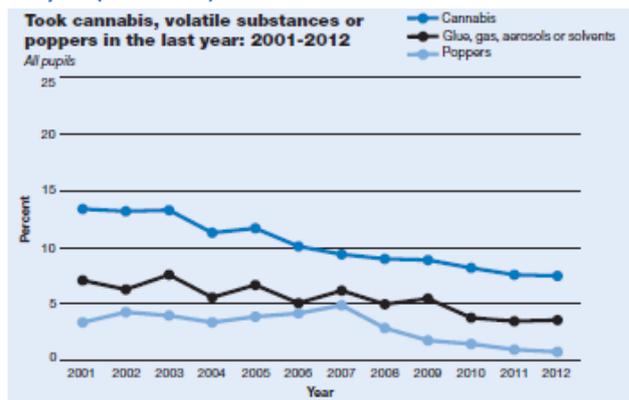
Around half (52%) of pupils aged between 11 and 15 said that they had tried smoking, drunk alcohol or taken drugs at least once in their lives. 17% had done one or more of these recently. They were more likely to have drunk alcohol in the last week (10%) than to have smoked in the last week (6%) or to have taken drugs in the last month (also 6%). There was considerable overlap between behaviours. For example, 6% of pupils reported taking drugs in the last month and most of those (4% of all pupils) had smoked or drunk alcohol in the last week, or had done both.

Figure 2: Took drugs in the last month, year and ever (2001-2012)



Source: HSCIC, 2013

Figure 1: Took cannabis, volatile substances or poppers in the last year (2001-2012)



Source: HSCIC, 2013

In 2012, Class A drug use remained relatively rare among pupils; 2.2% reported taking one of the eight Class A drugs asked about in the last year. From 2001 to 2009, this proportion was around 4% but fell to 2.4% in 2010 and has remained at a similar level since.

¹ Statistics on Drug Misuse: England 2013 (Health and Social Care Information Centre)

In 2012, 75% of pupils who had taken drugs in the last year reported only having taken one type of drug, and 25% had taken two or more. Boys were more likely than girls to have only taken cannabis in the last year (50% and 41% respectively). Conversely, girls were more likely than boys to have only used volatile substances (26% and 20% respectively). Other differences between boys and girls in patterns of drug use over the last year were not significant.

Of those who reported any drug use in the last year, older pupils were more likely than younger pupils to have taken two or more types of drug in that time (17% of 11 - 13 year olds, rising to 29% of 15 year olds). Younger pupils were more likely to report that their only drug use in the last year was volatile substances (52% of 11 to 13 year olds compared with 9% of 15 year olds), whilst older pupils were most likely to have taken cannabis, but not other drugs (56% of 15 year olds compared with 21% of 11 to 13 year olds).

In 2012, pupils who had ever truanted or had been excluded from school were more likely to report usually taking drugs at least once a month than those who had never truanted or had never been excluded (10% compared with 1%). This proportion is lower than in 2011 (12%) and maintains the overall decline in the prevalence of frequent drug use amongst this group of vulnerable pupils since 2003, when it was 21%. Pupils who had ever played truant or been excluded were more likely to report taking Class A drugs in the last year (9%) than those who had never truanted or been excluded (1%). This is at a similar level to recent years, although lower than in 2003, when it was 14%.

Awareness of individual drugs

As in previous years, there was a widespread awareness of illegal drugs among pupils in 2012. Around nine in ten pupils had heard of cocaine (92%), heroin (89%) and cannabis (87%). Fewer pupils had heard of the other drugs listed. Poppers (35%), ketamine (35%) and mephedrone (44%) were the least well-known.

Polydrug Use

The broad definition of 'polydrug' used by many EU Member States is the use of more than one drug or type of drug by an individual — consumed at the same time or sequentially. According to the broad definition, all illegal drug users would be defined as polydrug users as they almost always use alcohol and/or tobacco at some time in their life.

Polydrug use can lead to multiple adverse health consequences. Such consequences can occur (generally as acute toxicity) shortly after the consumption of several substances, or within a short time. They can also occur following a long period of use, due to various mechanisms affecting body systems, including the liver and the central nervous, cardiovascular or respiratory systems.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) states that polydrug use encompasses wide variations in user populations and patterns of use: from occasional alcohol and cannabis use to the daily use of combinations of heroin, cocaine, alcohol and benzodiazepines. The EMCDDA therefore looks at three different populations, for which patterns of polydrug use and their consequences are likely to differ: adolescents aged 15–16 years, young adults and problem drug users.

Polydrug use among adolescents aged 15-16 years

Use of alcohol, cigarettes, cannabis and other psychoactive substances by young Europeans has increased since the 1990s, in a variety of drug-using repertoires (EMCDDA, 2008a). School population surveys invariably show that alcohol consumption and cigarette smoking are far more prevalent than the use of illicit drugs. They also confirm that cannabis is the most commonly used illicit drug, with prevalence estimates generally reaching much higher levels than those for other substances such as ecstasy, amphetamine, cocaine, heroin, LSD and hallucinogenic mushrooms.

Intensive patterns of drug use, with the possible exception of tobacco smoking, usually remain limited among adolescents. However, the use of any psychoactive substance in this age group is of concern as the brain and other organs are still developing during adolescence, and exposure to toxic substances may cause damage, though it might only appear later in life. In addition, early initiation during adolescence has been associated with higher probability of drug use later in life and greater difficulties in reducing or ceasing drug use (von Sydow et al., 2002). Polydrug use among adolescents, defined as the use of at least two different psychoactive substances at a young age, could be considered an indirect indicator for early initiation. Furthermore, the use of illicit substances that are uncommon at this age — depending on the local context, these might be cannabis or other drugs such as cocaine — could also reflect higher levels of risk behaviours, social exclusion or deviance among adolescents.

Individual data from surveys carried out in 2003 by the European school survey project on alcohol and other drugs (ESPAD) were used to examine the characteristics of polydrug use among over 70 000 15 to 16-year-old students from 22 European countries. In order to attain sufficiently large samples for statistical analysis, while also allowing exploration of differences in polydrug use patterns in different contexts, the countries were divided into three distinct groups based on their prevalence levels of substance use during the last 30 days (last month use). The United Kingdom was assigned to the high-prevalence group. The proportion of polydrug users was nearly 40% in the high-prevalence country group, 36% in the medium-prevalence country group and 22.5% in the low-prevalence group.

ii. Factors associated with drug use

Sex and age

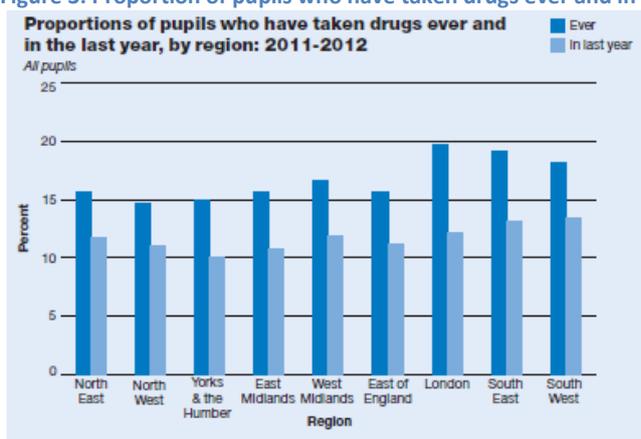
After controlling for other factors, there was no significant difference between boys and girls. Although age was strongly associated with drug use in the last year, once other variables were taken into account, the increase in the odds of having taken drugs in the last year with each additional year of age was not statistically significant (HSCIC, 2013). This is because some of the variables that were most strongly associated with drug use in the last year (for example, smoking, drinking alcohol and truancy) were also strongly associated with age.

Ethnicity

Compared with White pupils, pupils of Mixed, Asian and Black ethnicity were more likely to have taken drugs in the last year (odds ratios: 1.80, 2.36, 1.97 respectively).

The proportions of pupils who had ever tried drugs were generally higher in the south of England than elsewhere. In the north and midlands, between 15% and 17% of pupils reported having tried drugs. In the south, the proportion who had ever taken drugs varied between 18% (the South West) and 20% (London). There was little variation between regions in the proportion of pupils who had taken drugs in the last year and in the last month.

Figure 3: Proportion of pupils who have taken drugs ever and in the last year, by region (2011-2012)



Source: HSCIC, 2012.

iii. AACCE (Alcohol, Amphetamine, Cannabis, Cocaine or Ecstasy use)

Drug Misuse: Findings from the 2012/13 Crime Survey for England and Wales (CSEW)

Young adults (those aged 16 to 24) were more likely to have used drugs in the last year than older adults. However, the proportion of adults aged 16 to 24 taking any drug in the last year was 16.3%, down from 19.3% in 2011/12.

iv. Legal Highs

The pattern of drugs use is constantly evolving, and there are always new drug threats to consider. New psychoactive substances (so-called 'legal highs') frequently contain substances that are not legal and cannot be assumed safe. New psychoactive substances have become a particular concern in recent years with supply and demand increasing. The availability of these substances, especially over the internet and in 'head shops', has radically changed the nature of the drugs market.

For the 2012/13 CSEW, questions were added for the first time on the 'last year use' of legal emerging drugs salvia and nitrous oxide:

For young adults, aged 16 to 24:

6.1% had taken nitrous oxide in the last year

1.1% had taken salvia in the last year

Findings from the Lancashire Night Time Economy survey (NTE) in November 2010 by Lancaster University revealed that 1% of the sample reported having had a 'legal high' in the last month². Mean age of the respondents was 23.8 years.

² Emerging Drug Trends in Lancashire: Night Time Economy Surveys – Phase One Report (2011)

v. *Child and young person deaths*

Males

Mortality rates in younger males have continued their downward trend and are now at their lowest level since records began (2.5 and 47.6 deaths per million population in 2012 for under 20s and 20-29-year-olds respectively).

Females

As with males, the lowest female mortality rates in 2012 were in those aged under 20 (1.2 deaths per million population). Mortality rates for females aged 20-29 has reduced significantly from 18.9 deaths per million population in 2008 to 10.7 per million in 2012. These trends mean that the female mortality rate in 20 to 29-year-olds is now slightly lower than the rate in 50 to 69-year-olds.

Blackpool

During the 2012/13 reporting year the Pan-Lancashire Child Death Overview Panel (CDOP) was notified of 129 child deaths (8 Blackpool residents, 11 Blackburn with Darwen (BwD) residents, 93 Lancashire residents and 17 out of area). In the same reporting year the Panel completed 150 reviews (15 BwD reviews, 11 Blackpool reviews and 124 Lancashire reviews). Of the 150 child deaths reviewed, 36 were deemed to have modifiable factors (defined as those factors which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths) and 114 of which were deemed to have no modifiable factors. Blackpool was deemed to have had seven unexpected deaths, of which five had modifiable factors.

During the period April 2008 – March 2013, the Pan-Lancashire CDOP completed 633 reviews, of which 140 were deemed to have modifiable factors. The most common risk factors identified from the 140 cases deemed to have modifiable factors were:

1. 32% of cases identified issues in relation to service provision: including engagement with services, language barriers or access to services
 - 28% of cases identified alcohol/ substance misuse by a parent or carer
 - 24% of cases identified smoking by a parent/ carer
2. 21% of cases identified issues relating to safer sleep for baby (80% also had either smoking, alcohol and/or substance misuse as risk factors)
3. Other factors noted by CDOP included mental health of a parent/ carer, domestic violence, chaotic lifestyles and housing issue

[Experian Mosaic Public Sector](#) was used to profile all the child death data, and it was identified that families from the following socio-economic backgrounds suffered more child deaths:

- i. Lower income workers in urban terraces in often diverse areas
- ii. Families in low-rise social housing with high levels of benefit need

Further analysis identified the following specific groups of being more at risk of child deaths:

- i. South Asian communities experiencing social deprivation
- ii. Families living in older town centre terraces with transient, single populations
- iii. Low income families occupying poor quality older terraces
- iv. Vulnerable young parents needing substantial state support

vi. Families in Need

Children and families affected

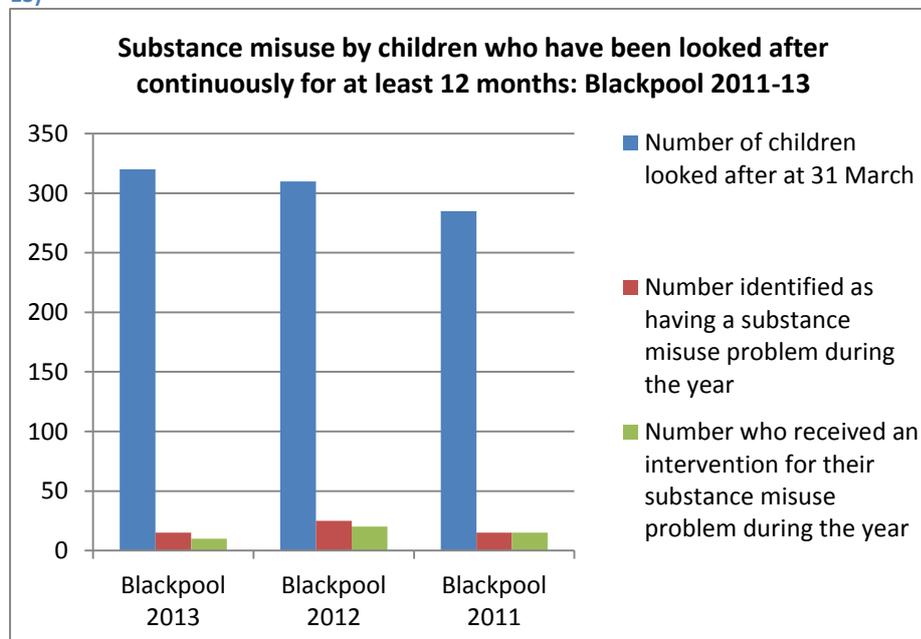
Information obtained from the National Drug Treatment Monitoring System (NDTMS) indicate that there were 201 individuals in treatment in Blackpool with children, which was 54% of those starting treatment during 2012. This includes 15 (31%) of those starting treatment at the Hub (Young Peoples service).

Looked After Children

Studies have shown that young people from more than one vulnerable group are more at risk of drug and alcohol misuse (DfES, 2005; The NHS Information Centre, 2011). The groups at risk are:

- i. Young offenders
- ii. **Looked after children**
- iii. Care leavers
- iv. Children affected by parental substance misuse
- v. Children affected by domestic violence
- vi. Homeless young people
- vii. Young people at risk from sexual exploitation
- viii. Young people in gangs or at risk of gang recruitment
- ix. Excludes and persistent truants

Figure 4: Substance misuse by children who have been looked after continuously for at least 12 months (Blackpool 2011-13)



Source: Dept. for Education, 2013

vii. Referrals

Young people come to specialist services from various routes but are typically referred by youth justice; education; self; family & friends and children & family services. In Blackpool in 2012-13, 34% of referrals into Young Peoples specialist substance misuse services were from Youth Justice, followed by 28% from Education Services (Table 1).

Table 1: Young people referral sources - local & national (2012-13)

Young People Referral Sources: 2012-13	Local		National
	n	%	%
Youth Justice (incl. the Secure Estate)	28	34%	34%
Education Services	23	28%	24%
Self, Family & Friends	8	10%	11%
Children & Family Services	8	10%	10%
Other Substance Misuse Services	4	5%	9%
Health & Mental Health Services (excl. A&E)	6	7%	7%
Accident & Emergency	0	0%	1%
Other	6	7%	3%

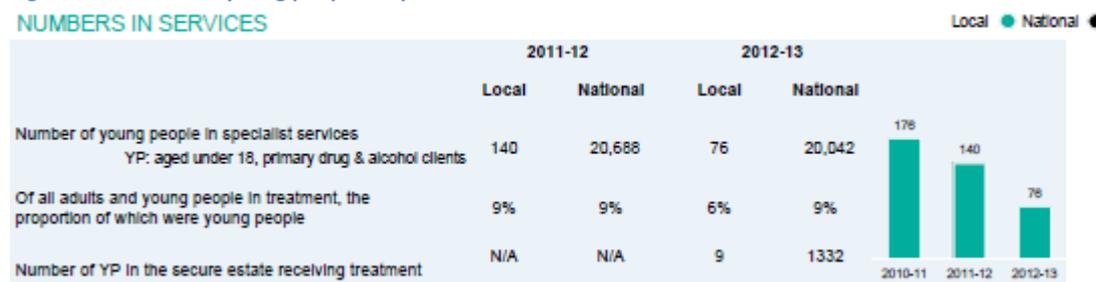
Source: NDTMS

viii. Service Overview

In Blackpool, there is a specialist treatment service (The Hub) for young people under the age of 25 years. This service provides a central point of contact for initial introduction to treatment for all drug and alcohol users under the age of 25 years.

The figures below reflect the number of young people aged under 18 years in specialist substance misuse services in Blackpool during 2011-12 and 2012-13, and as a proportion of the entire treatment population for the area. Also included is the number of young people who have received specialist treatment within a secure setting in the youth justice system. *Reporting to NDTMS by the secure estate began with Young Offender Institutions (YOI) in 2012-13 and has been rolled out to Secure Training Centres and Secure Children's Homes since April 2013. The figures for 2012-13 therefore only reflect those detained within the YOI estate and a partial picture of the total number of specialist interventions delivered to young people whilst in custody.*

Figure 5: Numbers of young people in specialist services - local and national 2012-13

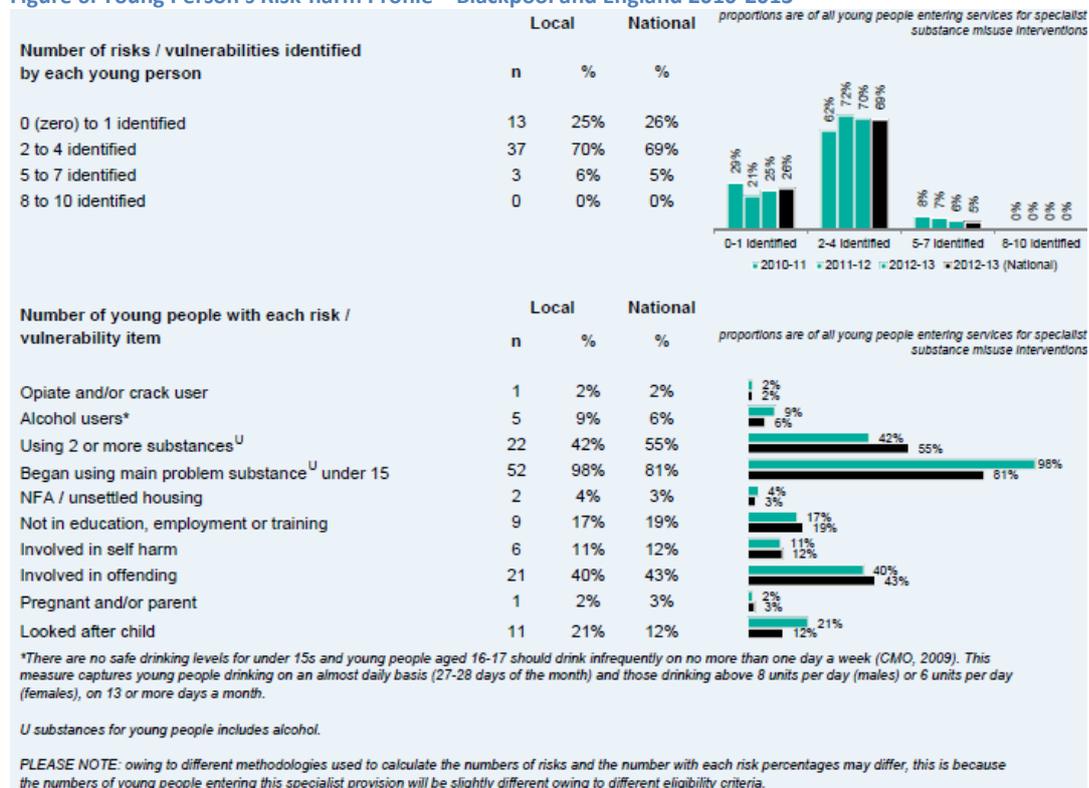


Source: NDTMS

The risk-harm profile (Fig. 5) identifies 10 key items to gauge the vulnerability of young people entering specialist substance misuse services. The higher the score, the more complex the need. Age of initiation is often the strongest predictor of the length and severity of substance misuse problems, the younger the age they start to use, the greater the likelihood of them becoming adult problematic drug users. The data below (Fig. 6) gives the age of young people in specialist services but not the age of initiation.

Many young people receiving specialist interventions have a range of vulnerabilities. They are more likely to be not in education, employment or training (NEET), have contracted a sexually transmitted infection (STI), have a child, be in contact with the youth justice system, be receiving benefits by the time they are 18, and half as likely to be in full-time employment. Universal and targeted services have a role to play in providing substance misuse support at the earliest opportunity, specialist services should be provided to those whose use has escalated and is causing them harm.

Figure 6: Young Person’s Risk-harm Profile – Blackpool and England 2010-2013



Source: NDTMS

Criminal Justice

Whilst the above figures relate to young people aged under 18 years, The Hub Young People’s Substance Misuse service also provides a service to individuals aged 18 to 24 years. The Hub therefore receives referrals from the Lancashire Probation Service, who supervise 18-24 year olds in the community.

The following referrals were received by The Hub for young people on probation with assessed substance misuse problems:

- x. 2011/12 – 15
- xi. 2012/13 - 22

3. Adults

i. Estimated problematic drug use prevalence rates and geographic variations

Table 2 presents the 2010-11 national (England) estimates and prevalence rates for those using opiates and/or crack cocaine or injecting. Overall in 2010-11 there were an estimated 298,752 opiate and/or crack users in England; this corresponds to 8.67 per thousand of the population age 15-64.

Table 2: England prevalence estimates and rates per 1,000 population aged 15-64 (2010-11)

Drug	Estimate	Rate
Opiate and/or crack	298,752	8.67
Opiate	259,260	7.59
Crack cocaine	165,877	4.95
Injecting	90,974	2.71

Source: NTA, 2013

In terms of regional differences, the **North West** has the highest prevalence of opiate and/or crack use at 10.83 per thousand population aged 15-64. The South East and the East of England have the lowest prevalence of opiate and/or crack use at 5.98 and 6.30 per thousand, respectively.

When considering opiate use prevalence, the highest prevalence rates are in the **North West** at 9.58 per thousand and the North East at 9.51. The lowest prevalence rates of opiate use are in the South East and the East of England at 5.27 and 5.44 per thousand, respectively. London has the highest estimated prevalence of crack cocaine use at 7.30 per thousand population compared to a prevalence of 6.01 in the **North West**.

Table 3 shows that, nationally, the markedly highest prevalence rate is in the 25-34 age group. This was also the case across individual regions. The **North West** has the highest prevalence rate in the 35-64 age range which, at just over ten per thousand, is much greater than the other Government Office Regions.

Table 3: Opiate and/or crack use prevalence rates per thousand population, by age group and region

Region	15-24 years	25-34 years	35-64 years
	Rate	Rate	Rate
East of England	5.33	11.96	4.87
East Midlands	5.84	19.85	5.57
London	8.61	11.24	9.13
North East	7.58	28.05	6.26
North West	5.69	17.45	10.57
South East	4.41	12.04	4.67
South West	4.42	17.94	6.55
West Midlands	6.85	23.48	6.52
Yorkshire and the Humber	6.22	21.79	7.49
ENGLAND	6.04	16.46	6.94

Source: NTA, 2013

Table 4 compares the prevalence estimates for 2009-10 and 2010-11. Overall in 2010-11 there were an estimated 298,752 opiate and/or crack users in England; in 2009-10 it was 306,150. There was a slight decrease in the number of opiate users and a statistically significant decrease in the number of crack cocaine users. The decrease in the number of injectors was also statistically significant.

Table 4: National (England) estimates of opiate and/or crack use, and crack cocaine use 2009-10 and 2010-11

Drug	2009-10 Estimate	2010-11 Estimate
Opiate and/or crack	306,150	298,752
Opiate	264,072	259,260
Crack cocaine	184,247	165,877
Injecting	103,185	90,974

Source: NTA, 2013

The results here show that there has been a decrease in the national estimate of problem drug use between 2009-10 and 2010-11. There were statistically significant decreases in crack use and injecting, in the younger (15 to 24) and middle (25 to 34) age group, but a statistically significant increase in the older (35 to 64) age group.

Blackpool has an opiate and/or crack cocaine use (OCU) rate of 21.89 per 1,000 population, compared to 10.83 and 8.67 for the North West and England respectively. The rate for opiate users is 20.27, compared to 9.58 and 7.59 for the North West and England; 10.77 for injecting drug users, compared to 3.23 and 2.71 for the North West and England; and 8.11 for crack users, compared to 6.01 and 4.95 for the North West and England.

Table 5: National and local OCU prevalence estimates and rates per 1,000 population aged 15-64 (2010-11)

	15-64 population	Number of users				Rate per thousand of the population			
		OCU	Opiate users	Crack users	Injecting	OCU	Opiate users	Crack users	Injecting
Blackpool	88,900	1,946	1,802	721	958	21.89	20.27	8.11	10.77
North West	4,562,100	49,426	43,704	27,407	14,731	10.83	9.58	6.01	3.23
ENGLAND	34,476,900	298,752	261,792	170,627	93,401	8.67	7.59	4.95	2.71

Source: NTA (2013)

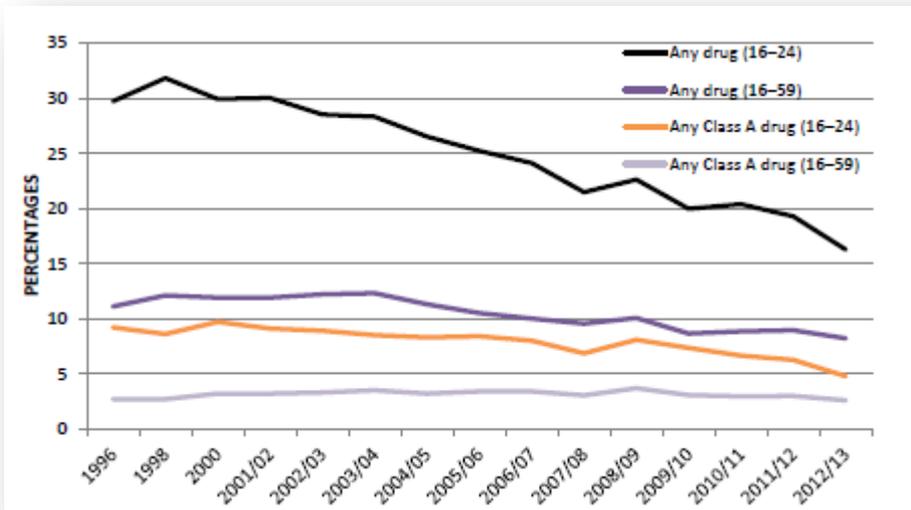
ii. AACCE (Alcohol, Amphetamine, Cannabis, Cocaine or Ecstasy use)

Drug Misuse: Findings from the 2012/13 Crime Survey for England and Wales:

- Around 1 in 12 (8.2%) adults in England and Wales had taken an illicit drug (excluding mephedrone) in the last year, a fall compared with 2011/12 (8.9%). This equates to around 2.7 million people;
- According to the 2012/13 CSEW, 2.6% of adults aged 16 to 59 had taken a Class A drug in the last year (equivalent to almost 850,000 people);
- Cannabis was the most commonly used drug, with 6.4% of adults aged 16 to 59 using it in the last year.
- The next most commonly used drugs in the last year were powder cocaine (1.9%) and ecstasy (1.3%). Along with cannabis, these were also the most used drugs in 2011/12;
- For all adults, the use of mephedrone in the last year has fallen from 1.1% in 2011/12 to 0.5% in 2012/13;

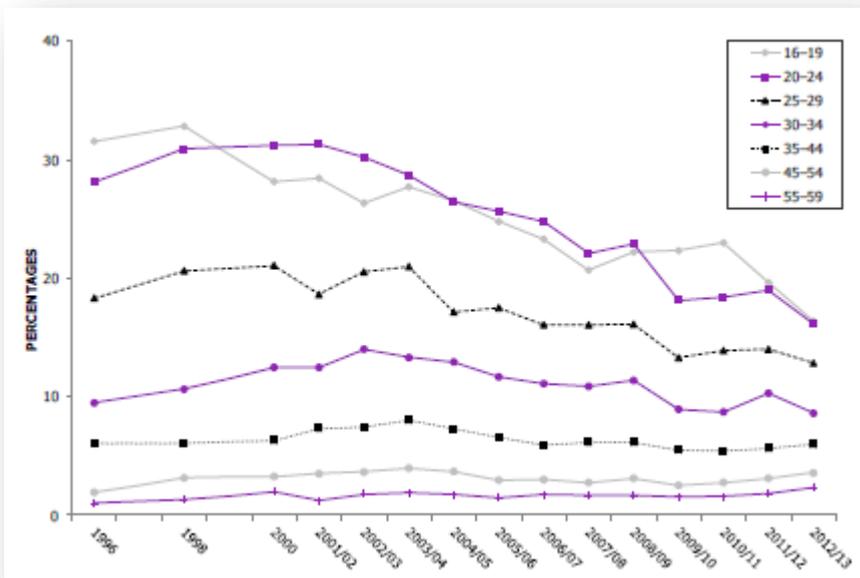
- Young adults (those aged 16 to 24) were more likely to have used drugs in the last year than older adults. However, the proportion of adults aged 16 to 24 taking any drug in the last year was 16.3%, down from 19.3% in 2011/12.

Figure 7: Trends in illicit drug use (excluding mephedrone) in the last year among adults, 1996 to 2012/13, Crime Survey for England and Wales



Source: Home Office, 2013

Figure 8: Proportion of 16 to 59 year olds reporting use of any drug in the last year by age group, 1996 to 2012/13, Crime Survey for England and Wales

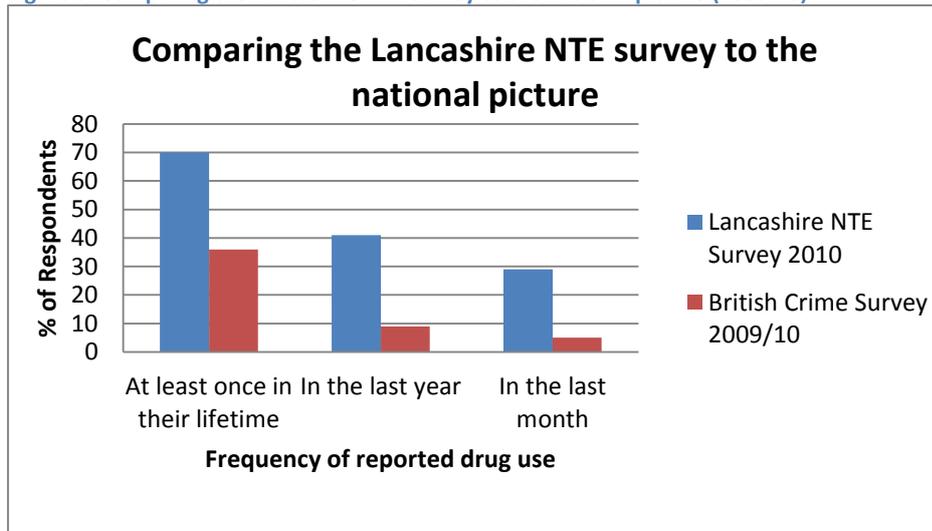


Source: Home Office, 2013

iii. Emerging Drug Trends in Lancashire: Night Time Economy Surveys - Phase One Report

The authors state that the respondents in Lancashire’s NTE appear to be more drug experienced than those in the general population – at least compared to those captured by lifetime, past year and past month drug use figures in the British Crime Survey (BCS) 2009/10 (Figure 9). The number of adults (16-59 year olds) in the UK who have ever used an illegal drug was 36% according to this latest BCS. By way of comparison, 70% of the 207 respondents surveyed across Lancashire’s NTE reported that they had tried an illegal drug at least once in their lifetime.

Figure 9: Comparing the Lancashire NTE survey to the national picture (2009-10)



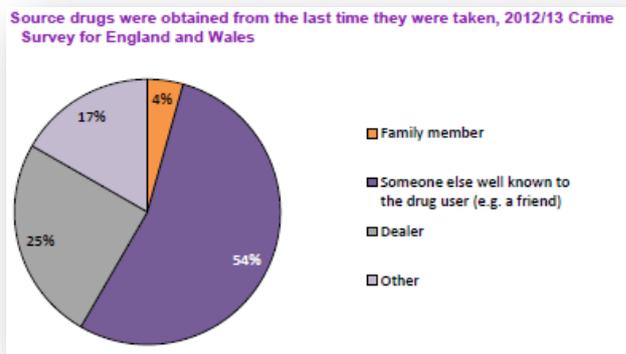
Source: Measham, Moore & Østergaard, 2011

In the terms of past year use of any drug, the BCS 2009/10 figure stands at 9%. This contrasts with the Lancashire NTE survey where 41% of respondents reported having used any illegal drug within the last year. 5% of those in the BCS sample had consumed any illegal drug within the past month, compared with 29% of those in the Lancashire NTE survey.

The BCS 2009/10 data on drug use by the regions of England and Wales highlights that the North West of England (compared to all other regions, including Wales) has the highest proportion of adults (16-59 year olds) reporting past year use of any drug at 10.4%, cannabis at 8%, ecstasy 2.3%, amphetamines 1.7% and hallucinogens 0.8%. These regional figures are all higher than UK national averages. The North West of England is second only to the North East of England for the proportion of adults using any Class A drug in the past year and for the proportion of adults using powder cocaine in the past year (Hoare and Moon, 2010:49).

Between 1996 and 2012/13 CSEW last year use of any illicit drug fell overall, due in large part to the declines in illicit drug use among 16 to 24 year olds (as shown in Figure 10) for the most prevalent drug types (cannabis, ecstasy, amphetamines and hallucinogens).

Figure 10: Source drugs were obtained from (2012-13)



Source: Home Office, 2013

iv. Legal Highs

[Please click here to see 'Legal Highs' section under Young People.](#)

v. Adverse Effects/Consequences

a. Drug related deaths³

The following data covers accidents and suicides involving drug poisonings, as well as deaths from drug abuse and drug dependence, but not other adverse effects of drugs (for example anaphylactic shock) in England and Wales. Drug poisoning deaths involve a broad spectrum of substances, including legal and illegal drugs, prescription drugs (either prescribed to the deceased or obtained by other means) and over-the-counter medications. Some of these deaths may also be the result of complications of drug abuse, such as deep vein thrombosis or septicaemia resulting from intravenous drug use, rather than an acute drug overdose.

- There were 2,597 drug poisoning deaths (involving both legal and illegal drugs) registered in England and Wales in 2012, and as in previous years, the majority (just over two-thirds) of these deaths were in males.
- All figures are based on deaths registered in a particular calendar year, and out of the 2,597 drug-related deaths registered in 2012, 1,358 (just over half) occurred in years prior to 2012.
- There were 1,706 male drug poisoning deaths (involving both legal and illegal drugs) registered in 2012, a 4% decrease since 2011, and the lowest since 1995.
- Female drug poisoning deaths have increased every year since 2009, reaching 891 in 2012. An increase of 1% since 2011, and the highest since 2004.

³ Deaths Related to Drug Poisoning in England and Wales, 2012 (ONS, 2013)

- The number of male drug misuse deaths (involving illegal drugs) decreased by 9% from 1,192 in 2011 to 1,086 in 2012; female deaths decreased by 1% from 413 in 2011 to 410 in 2012.
- In 2012 males aged 30 to 39 had the highest mortality rate from drug misuse (97.8 deaths per million population), followed by males aged 40 to 49 (85.9 deaths per million population). The male mortality rates in these two age groups were significantly higher than the rates in all other age groups and much higher than females of any age.
- As with males, the highest rates for females were among those aged 30 to 39 and 40 to 49 (28.9 and 28.7 deaths per million respectively), and these rates were significantly higher than the rates in other age groups.
- Over half (52%) of all deaths related to drug poisoning involved an opiate drug, and in men aged 30 to 39, nearly two thirds (63%) of drug-related deaths involved an opiate. In 2012, as in previous years, the most commonly mentioned opiates were heroin and/or morphine, which were involved in 579 deaths.
- The number of deaths involving heroin/morphine fell slightly in 2012 to 579 deaths, but these remain the substances most commonly involved in drug poisoning deaths.
- The number of deaths involving tramadol have continued to rise, with 175 deaths in 2012 – more than double the number seen in 2008 (83 deaths).
- Deaths Involving new psychoactive substances (sometimes referred to as 'legal highs') such as mephedrone have increased sharply - from 29 deaths in 2011 to 52 deaths in 2012. However, the number of deaths from new psychoactive substances are still much lower than the number of deaths from heroin/morphine.
- In England, the North West had the highest mortality rate from drug misuse in 2012 (41.0 deaths per million population).

Table 6: Number of deaths from drug-related poisoning and drug misuse for England and Wales (2008-2012)

Number of deaths from drug-related poisoning and drug misuse, by sex, England and Wales, deaths registered between 2008–2012^{1,2,3}				
Registration year	All drug poisoning		Drug misuse	
	Males	Females	Males	Females
2008	2,075	853	1,506	435
2009	2,098	780	1,510	364
2010	1,890	857	1,382	402
2011	1,772	880	1,192	413
2012	1,706	891	1,086	410

1 Cause of death was defined using the International Classification of Diseases, Ninth Revision (ICD-9) for the years 1993 to 2000 and Tenth Revision (ICD-10) from 2001 onwards. The underlying cause of death codes used to select 'all drug poisonings' and 'drug misuse' deaths are shown in Box 1 on the Definition page. Drug misuse as defined by the current headline indicator shown in Box 2 on the Definition page. Deaths from drug misuse are included in the figures for all drug poisoning.

2 Figures for England and Wales include deaths of non-residents.

3 Figures are for deaths registered, rather than deaths occurring in each calendar. Due to the length of time it takes to complete a coroner's inquest, it can take months or even years for a drug-related death to be registered. More details can be found in the 'deaths related to drug poisoning' statistical bulletin: www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2012/stb---deaths-related-to-drug-poisoning-2012.html

Source: Office for National Statistics

Age-specific mortality rates for deaths related to drug misuse

Males

In 2012, males aged 30 - 39 had the highest mortality rate from drug misuse (97.8 deaths per million population), followed by males aged 40 - 49 (85.9 deaths per million population). The male mortality rates in these two age groups were significantly higher than the rates in all other age groups and much higher than females of any age.

Although males aged 30 - 39 had the highest mortality rate, this has declined sharply in recent years and is now at its lowest level since 1998. The male mortality rate in 40 - 49-year-olds has also declined since its peak in 2009, but not as steeply as the decline seen in 30 - 39-year-olds.

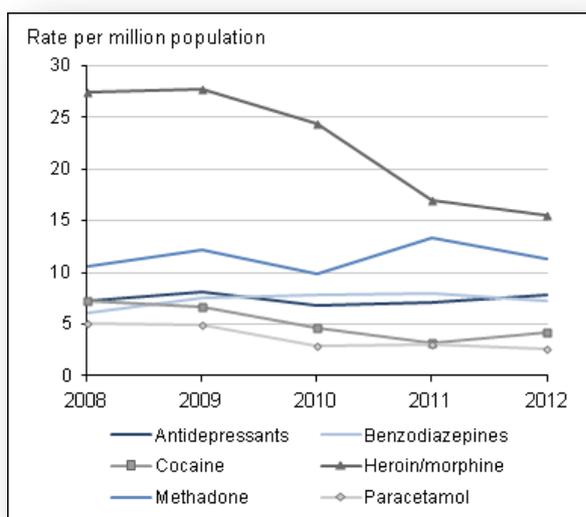
Mortality rates in younger males continued their downward trend and are now at their lowest level since records began (2.5 and 47.6 deaths per million population in 2012 for under 20s and 20 - 29-year-olds respectively).

Mortality rates in males aged 50 - 69 increased significantly between 1998 and 2010, but have remained stable since then, with 24.1 deaths per million population in 2012.

Male mortality rates in the oldest age group (70 and over) have shown no consistent trends over time and remained low in 2012 with 7.3 deaths per million population.

This pattern of drug misuse deaths is broadly in line with treatment figures from Public Health England (PHE – previously the National Treatment Agency), which showed that as the drug-dependent population ages, the over 40s have become the largest age group starting treatment. In contrast, the number of 18 - 24-year-olds newly entering treatment for heroin and crack use has halved over the last five years.

Figure 11: Age-standardised mortality rates for selected substances, males, deaths registered in 2008–2012, England and Wales



Source: ONS

Females

In 2012, mortality rates from drug misuse for females were lower than males in every age group, except those aged 70 and over, where rates were very similar in men and women. As with males, the highest rates were among those aged 30 - 39 and 40 - 49 (28.9 and 28.7 deaths per million population respectively), and these rates were significantly higher than the rate in other age groups.

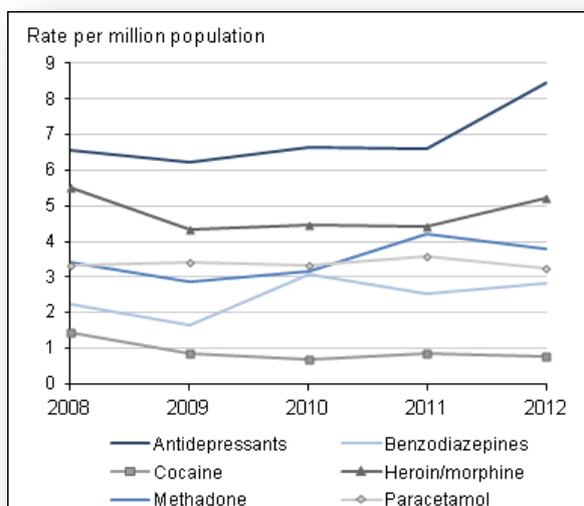
Unlike in males, where the mortality rate fell in 30 - 39 and 40 - 49-year-olds, the female mortality rates in these age groups remained stable in 2012.

The female mortality rate for 50 - 69-year-olds has increased steadily over the last few years and is now at 15.7 deaths per million population – its highest level since records began in 1993.

The opposite trend is seen in females aged 20 - 29, where the mortality rate has decreased significantly from 18.9 deaths per million population in 2008 to 10.7 per million in 2012. These trends mean that the female mortality rate in 20 - 29-year-olds is now slightly lower than the rate in 50 - 69-year-olds.

As with males, the lowest female mortality rates in 2012 were in those aged under 20 (1.2 deaths per million population) and 70 and over (7.9 deaths per million population).

Figure 12: Age-standardised mortality rates for selected substances, females, deaths registered in 2008–2012, England and Wales



Source: ONS

Table 7: Demographic characteristics of 'drug misuse' deaths reported to np-SAD panel of Coroners' areas (2002-2011)

Variable	Category	Number (%)
Total		9,101 (100.0)
Gender	Male	6,973 (76.6)
	Female	2,128 (23.4)
Age (years)	Under 15	10 (0.1)
	15-24	1,006 (11.1)
	25-34	2,889 (31.7)
	35-44	2,935 (32.2)
	45-54	1,372 (15.1)
	55-64	508 (5.6)
	Over 64	381 (4.2)
Ethnicity	White	6,788 (74.6)
	Black	139 (1.5)
	Asian	98 (1.1)
	Other	147 (1.6)
	Not known	1,931 (21.2)
Employment status	Unemployed	4,866 (53.5)
	Employed	2,559 (28.1)
	Childcare/house person	145 (1.6)
	Student/pupil	167 (1.8)
	Retired/sickness/invalidity	763 (8.4)
	Other	62 (0.7)
	Not known	539 (5.9)
Living arrangements	Alone	3,657 (40.2)
	With others	3,844 (42.2)
	No fixed abode	479 (5.3)
	Other	485 (5.3)
	Not known	636 (7.0)
History of drug use	History	5,848 (64.3)
	No history	1,839 (20.2)
	Not known	1,414 (15.5)
Place of death	Defined residential address	6,323 (69.5)
	Hospital	1,880 (20.7)
	Other locations	798 (8.8)
	Not specified	100 (1.1)

Source: International Centre for Drug Policy, 2013

Number of drug-related deaths by underlying cause in England and Wales

In January 2011, ONS introduced a new version of ICD-10. This means figures for 2011 onwards will not be directly comparable with figures for 2001 to 2010.

In both males and females the largest proportion of drug-related deaths were from accidental poisonings (65% of all drug poisoning deaths in males and 49% in females).

- In males the number of accidental poisonings remained virtually unchanged at 1,104 deaths in 2012.
- In females, accidental poisonings decreased slightly from 445 to 437 deaths between 2011 and 2012, a 2% fall.

There were substantial increases in the number of deaths from accidental poisonings between 2010 and 2011, which were almost certainly due to the introduction of ICD-10 v2010.

- In females, just under half of all drug poisoning deaths were suicides (defined as intentional self-poisoning or poisoning of undetermined intent). In 2012, the number of female drug-related suicides increased slightly, from 418 deaths in 2011 to 422 deaths in 2012; this continues the upward trend that has been seen since 2009.
- In males, 31% of all drug poisoning deaths were suicides. The number of deaths went down from 576 to 525 deaths between 2011 and 2012 – a 9% decrease. This reverses the large increase seen in 2011, and the number of drug-related male suicides in 2012 were similar to the levels seen between 2006 and 2009.

- In males the number of deaths where the underlying cause was a mental and behavioural disorder due to drug use reduced by 16%, from 86 deaths in 2011 to 72 in 2012.
- In females, the equivalent number increased 70%, from 17 deaths in 2011 to 29 in 2012. It is not clear what has caused this increase in females, and it may just be a random fluctuation, rather than the start of an upward trend.

Table 8: Male drug-related poisonings

Number of deaths from drug-related poisoning by underlying cause, males, England and Wales, deaths registered between 1993–2012 ^{1,2,3,4}					
Underlying cause of death	2008	2009	2010	Males	
				2011	2012
All drug poisoning deaths	2,075	2,098	1,890	1,772	1,706
Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)	705	586	504	86	72
Accidental poisoning by drugs, medicaments and biological substances	861	983	899	1,107	1,104
Intentional self-poisoning and poisoning of undetermined intent, by drugs, medicaments and biological substances	500	524	482	576	525
Assault by drugs, medicaments and biological substances	9	5	5	3	5

1 Cause of death was defined using the International Classification of Diseases, Ninth revision (ICD-9) codes given in Box 1 in the Definition page for the years 1993-2000 and Tenth Revision (ICD-10) codes from 2001 onwards.

2 In January 2011 ONS introduced a new version of ICD-10, so figures for 2011 onwards are not directly comparable with figures for 2008–10. More information can be found in last year's drug-related deaths statistical bulletin: www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2011/stb-deaths-related-to-drug-poisoning-2011.html#tab-ICD-coding-changes-implemented-in-2011.

3 Figures for England and Wales include non-residents.

4 Figures are for deaths registered, rather than deaths occurring in each calendar. Due to the length of time it takes to complete a coroner's inquest, it can take months or even years for a drug-related death to be registered. More details can be found in the 'deaths related to drug poisoning' statistical bulletin: www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2012/stb---deaths-related-to-drug-poisoning-2012.html

Source: Office for National Statistics

Table 9: Female drug-related poisonings

Number of deaths from drug-related poisoning by underlying cause, females, England and Wales, deaths registered between 1993–2012 ^{1,2,3,4}					
Underlying cause of death	2008	2009	2010	Females	
				2011	2012
All drug poisoning deaths	853	780	857	880	891
Mental and behavioural disorders due to drug use (excluding alcohol and tobacco)	139	101	96	17	29
Accidental poisoning by drugs, medicaments and biological substances	327	305	369	445	437
Intentional self-poisoning and poisoning of undetermined intent, by drugs, medicaments and biological substances	385	374	391	418	422
Assault by drugs, medicaments and biological substances	2	0	1	0	3

1 Cause of death was defined using the International Classification of Diseases, Ninth revision (ICD-9) codes given in Box 1 in the Definition page for the years 1993-2000 and Tenth Revision (ICD-10) codes from 2001 onwards.

2 In January 2011 ONS introduced a new version of ICD-10, so figures for 2011 onwards are not directly comparable with figures for 2008–10. More information can be found in last year's drug-related deaths statistical bulletin: www.ons.gov.uk/ons/rel/subnational-health3/deaths-related-to-drug-poisoning/2011/stb-deaths-related-to-drug-poisoning-2011.html#tab-ICD-coding-changes-implemented-in-2011.

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Source: Office for National Statistics

Number of deaths related to drug misuse

The definition of this indicator is (a) deaths where the underlying cause is drug abuse or drug dependence or (b) deaths where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved. This definition has been adopted across the UK.

3. In 2012 there were 1,496 drug misuse deaths. The number of male deaths decreased by 9% from 1,192 in 2011 to 1,086 in 2012. Over the same period the number of female deaths fell by 1% from 413 to 410.

Since 1993 there has been an upward trend in the proportion of drug poisoning deaths that were related to drug misuse for both males and females. In males this proportion peaked in 2010 at 73%, but went down to 64% in 2012. In females, this proportion peaked in 2008 at 51%, but has since dropped slightly to 46%.

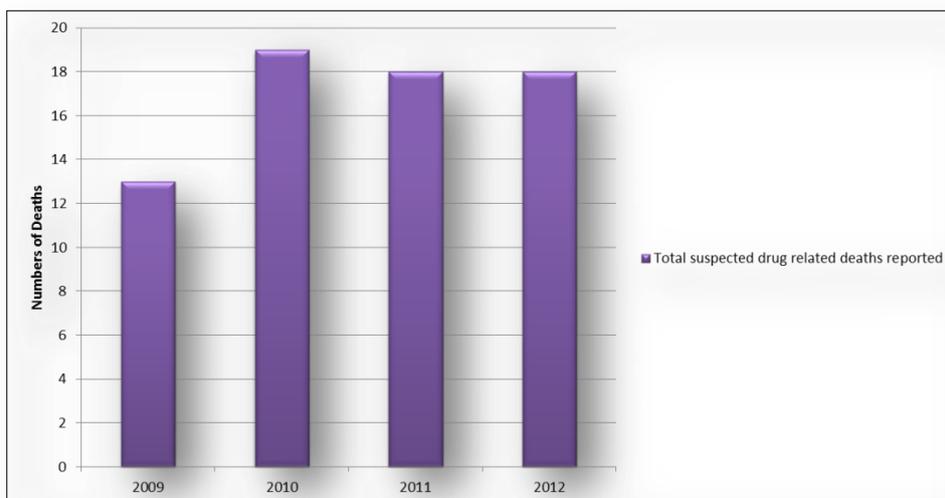
Blackpool

In Blackpool in 2012, there were 18 suspected drug-related deaths – 12 males and 6 females. This is a 50% reduction from 2006, when Blackpool had the highest number in England with 36 deaths. Heroin/morphine continues to be the most prevalent substance implicated in the deaths in Blackpool (Figure 14). The average age for males was 38 years over the period 2009-2012, whilst the average age for females was 39 years (Figure 13).

The majority of both males (75%) and females (50%) lived alone in 2012.

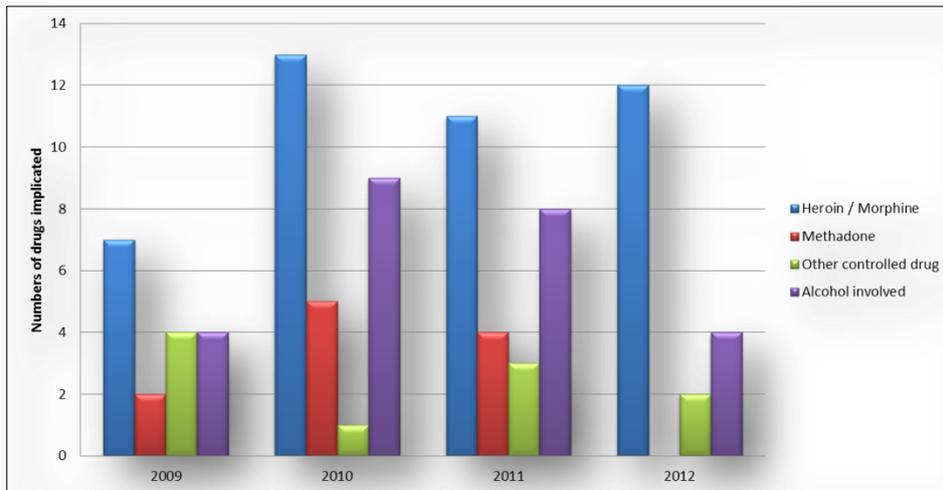
During the period 2009-2012, 31 deaths (41%) were recorded by the coroner as 'misadventure', and therefore could have been prevented.

Figure 13: Suspected drug-related deaths – Blackpool (2009-2012)



Source: Blackpool Coroner.

Figure 14: Substances implicated – Blackpool (2009-2012)



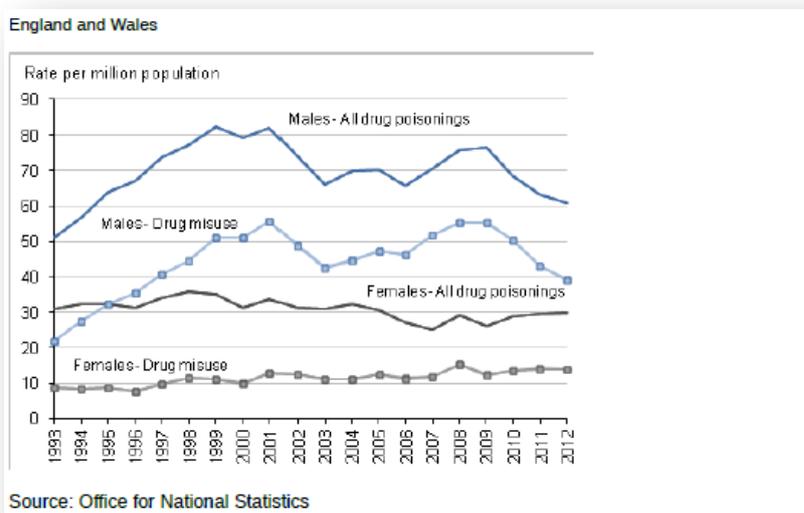
Source: Blackpool Coroner

Figure 15: Age range of drug-related deaths – Blackpool (2009-2012)

Male	2009	2010	2011	2012
Average Age	43	37	34	40
Youngest	23	30	19	23
Eldest	86*	60	46	57
Female	2009	2010	2011	2012
Average Age	31	50	35	46
Youngest	23	34	19	21
Eldest	45	83	52	68

Source: Blackpool Coroner

Figure 16: Age-standardised mortality rates for deaths related to drug poisoning and drug misuse, by sex, deaths registered in 1993-2012



b. Child Deaths

[See section: 'Child and young person deaths' \(above\).](#)

vi. Drug Related Morbidity

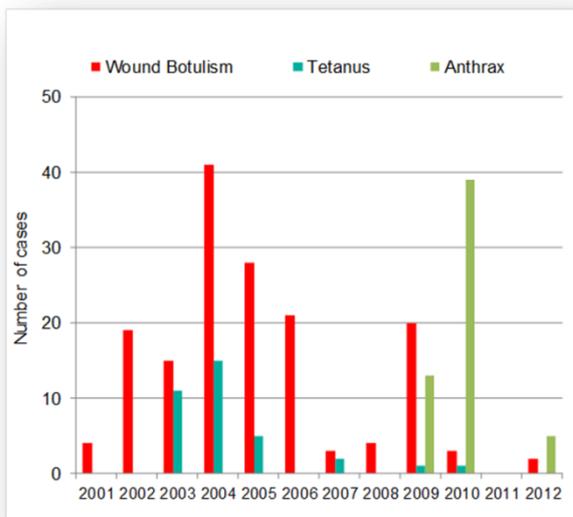
People who inject drugs (PWID) are vulnerable to a wide range of viral and bacterial infections. These infections can result in high levels of illness and in death.

Bacterial infections due to injecting drug use can occur at injection sites or elsewhere on the body. Those affecting the skin and soft tissues include bacterial infections that cause the accumulation of pus (abscesses) or tenderness, swelling and redness (cellulitis) at or near injection sites. Infections elsewhere in the body include those infections causing illness away from injection sites (distal infections) such as infection of the heart lining (endocarditis) and infections that are more widespread or affect the body as a whole (systemic illnesses) such as blood poisoning (septicaemia). In the UK there has been a marked rise in the number of hospital admissions of drug users with skin and soft tissue infections.

In 2012, 29% of participants in the Unlinked Anonymous Monitoring Survey of HIV and Hepatitis in People Who Inject Drugs (UAM Survey) from across England, Wales and Northern Ireland reported that they had experienced an abscess, sore or open wound, all possible symptoms of an injecting-site infection, during the last year. This compares to 35% in 2006. *Staphylococcus aureus* and Group A streptococcal infections continue to cause severe illnesses among PWID. Mandatory enhanced surveillance of methicillin-resistant *S. aureus* (MSSA) bacteraemia cases in England started in 2011, and among the MSSA bacteraemia with risk factor information, 8.6% (234/2,720) were associated with injecting drug use in 2012. There were two wound botulism cases among PWID in the UK during 2012, and anthrax cases among PWID re-emerged.

Between June 2012 and the end of March 2013, 15 cases of anthrax were reported among PWID in Europe: five in England (two in Blackpool – both who died), four in Germany, two in Scotland, two in Denmark, one in France, and one in Wales (PHE, HPS, PHW & PHANI, 2013). The cases are thought to be linked through exposure to heroin contaminated with anthrax spores. These are the first cases of anthrax among drug users in Europe since the outbreak during 2009-10. This earlier outbreak involved 119 cases in Scotland (14 who died), five in England (two in Blackpool – both who died). This indicates that PWID in the UK, and elsewhere in Europe, remain at risk of severe illnesses, such as anthrax, caused by spore forming bacteria.

Figure 17: Spore forming bacterial infections among PWID: reported cases in the UK (2001-2012)



Source: PHE, HPS, PHW & PHANI, 2013.

The most commonly injected psychoactive drug in the UK, either alone or in combination with crack-cocaine, is heroin. Historically, the injection of other psychoactive drugs (such as amphetamine and ketamine) was much less common. However, recent evidence suggests the types of psychoactive drugs being injected in the UK may be changing with the injection of amphetamine type drugs becoming more common. In addition, the injection of image and performance enhancing drugs (IPEDs), such as melanotan and anabolic steroids, also appears to have become more common over the last decade.

a. Blood Borne Virus

There have been recent concerns that the injection of methamphetamine and mephedrone may be increasing among some sub-groups of men who have sex with men (MSM), many of whom are HIV positive. These drugs are typically being used during sex, with injecting equipment often shared and condoms not used. Whilst the scale of this remains unclear, specialist Lesbian, Gay, Bisexual and Transgender drug services are seeing an increase in the number of MSM who report injecting these drugs. The use and injection of these drugs has also been reported to be a factor in a recent sexually transmitted infection outbreak.

People who inject IPEDs are at greater risk of HIV, hepatitis B and hepatitis C infection than previously thought. In England and Wales, the level of HIV infection among this group is similar to that among people who inject psychoactive drugs, such as, heroin and crack-cocaine. The proportion that had ever been infected with hepatitis B is lower than that among people who inject psychoactive drugs, although recent survey findings suggest the level of infection has increased over time.

b. Hepatitis C and B⁴

PWID are the group most affected by hepatitis C in the UK.

In 2012, 13,477 hepatitis C infections were diagnosed in the UK. Around 90% of these infections will have been acquired through injecting drug use. UK-wide data indicate that around half of those who inject psychoactive drugs are hepatitis C antibody positive: with 53% of those surveyed having antibodies to hepatitis C in Scotland, 49% in England, 34% in Northern Ireland and 33% in Wales.

Uptake of voluntary confidential testing for hepatitis C has increased among current or previous injectors of psychoactive drugs, with the proportion reporting having ever been tested in England, Wales and Northern Ireland rising from 58% in 2002 to 83% in 2012 (83% in England, 84% in Wales, and 87% in Northern Ireland in 2012).

It is estimated that in Blackpool, in 2011, there were 833 hepatitis C positive intravenous drug users, and 242 ex-IDU's. In Blackpool, in 2012/13, 69% of eligible clients in treatment, previously or currently injecting, received a hepatitis C test, which is below the England average.

The transmission of hepatitis B continues among PWID, but appears to have declined in recent years as the proportion of participants in the UAM Survey who had ever been infected has fallen from 29% in 2002 to 17% in 2012, with 0.94% currently infected in 2012.

In England, Wales and Northern Ireland, reported uptake of the hepatitis B vaccine (i.e. accepting at least one dose) among participants in the UAM Survey has increased from 43% in 2002 to 75% in 2012 (75% in England, 77% in Wales, and 68% in Northern Ireland in 2012).

In Blackpool, in 2012/13, 68% of eligible new clients to drug services accepted a hepatitis B vaccination, which is below the 75% average for England.

c. HIV

Injecting drug use (IDU) accounts for 4.4% of the total diagnosed HIV infections in the UK to date (Harris et al., 2013). The proportion of new infections acquired by this route in 2012 remained stable at 2%.

There were 120 new HIV diagnoses in the UK associated with injecting drug use in 2012. HIV prevalence among those who have injected psychoactive drugs appears to be stable. In England, Wales and Northern Ireland, 1.3% of the participants in the UAM Survey in 2012 were infected. The HIV prevalence among PWID in the UK is low compared to many other European countries.

Since HIV is less infectious than hepatitis C, those individuals who have had sufficient high risk exposure via IDU to acquire HIV are also likely to have been infected with hepatitis C. Having both infections makes the treatment of each more difficult to manage, increases the progression of hepatic disease and, for women, increases the probability of transmission of HIV to an infant during pregnancy or birth. The level of sharing of injecting-related equipment has declined over recent years. However, estimates suggest that around one sixth

⁴ Shooting Up: Infections among people who inject drugs in the United Kingdom 2012 (PH England, Health Protection Scotland, PH Wales, PH Agency Northern Ireland, 2013)

of people who inject drugs in the United Kingdom still share needles and syringes and 11% of people who inject drugs participating in the UAMS in the North West report direct sharing of injecting equipment in the preceding four weeks. The HPA recommend diagnostic testing for HIV and Hepatitis C (and Hepatitis B where appropriate) in Drug Treatment Agencies and Primary Care services along with appropriate advice, interventions and care pathways for those infected.

Anonymous testing of injecting drug users attending specialist agencies reveals that, in the north west of England, the prevalence of HIV amongst injectors is low (1.8% compared with 3.9% in London in 2011). Prevalence amongst drug users in the UK remains low compared with other countries in Europe. This has been attributed to harm reduction strategies such as needle and syringe programmes. A recent systematic review also suggests that opiate substitution treatment is associated with a 54% reduction in the risk of HIV among people who inject drugs.

The number of HIV-infected people seen for HIV treatment and care in the UK who had acquired their infection through injecting has increased over the past decade, with 1,617 seen in 2012. In 2012, 458 people who acquired their HIV-infection through injecting, and who were seen for care, had CD4 counts of 350 cells/mm³ or less; the recommended level to start anti-retroviral therapy. Among those seen for HIV treatment and care with CD4 counts of 350 or less in 2012, 88% of those who had acquired their infection through injecting were on anti-retroviral therapy.

During the period March 2013 to February 2014, 213 clients in treatment in Blackpool were tested for HIV. There were no positive results seen from these tests.

vii. Risk Behaviours

a. Needle/syringe sharing

The level of needle/syringe sharing (either borrowing or lending a used needle/syringe) reported by participants in the UAM Survey in England, Wales and Northern Ireland has declined from 34% in 2002 to 14% in 2012; (14% in England, 10% in Wales, and 19% in Northern Ireland). These declines have occurred during a period when Needle Syringe Programmes in the UK have been expanding.

In Blackpool, in the 12 month period April 2012 to March 2013, approximately 491,000 needles were distributed to illicit drug injectors and steroid users through the needle exchange programme. This is a similar amount to the preceding 12 month period. Blackpool also has sharps bins located in all public toilets, which are emptied and monitored on a regular basis. In 2013, approximately 10,300 used needles were disposed of in this way.

b. Polydrug Use

The broad definition of 'polydrug' used by many EU Member States is the use of more than one drug or type of drug by an individual — consumed at the same time or sequentially. According to the broad definition, all illegal drug users would be defined as polydrug users as they almost always use alcohol and/or tobacco at some time in their life.

Polydrug use can lead to multiple adverse health consequences. Such consequences can occur (generally as acute toxicity) shortly after the consumption of several substances, or within a short time. They can also occur following a long period of use, due to various mechanisms affecting body systems, including the liver and the central nervous, cardiovascular or respiratory systems. Intensive alcohol use is often a major, but overlooked, component of polydrug use. For example, stimulant drugs such as cocaine may enable users to consume large quantities of alcohol over longer periods than would otherwise be possible.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) states that polydrug use encompasses wide variations in user populations and patterns of use: from occasional alcohol and cannabis use to the daily use of combinations of heroin, cocaine, alcohol and benzodiazepines. The EMCDDA therefore looks at three different populations, for which patterns of polydrug use and their consequences are likely to differ: adolescents aged 15–16 years, young adults and problem drug users.

Polydrug use among adolescents aged 15-16 years

Use of alcohol, cigarettes, cannabis and other psychoactive substances by young Europeans has increased since the 1990s, in a variety of drug-using repertoires (EMCDDA, 2008a). School population surveys invariably show that alcohol consumption and cigarette smoking are far more prevalent than the use of illicit drugs. They also confirm that cannabis is the most commonly used illicit drug, with prevalence estimates generally reaching much higher levels than those for other substances such as ecstasy, amphetamine, cocaine, heroin, LSD and hallucinogenic mushrooms.

Intensive patterns of drug use, with the possible exception of tobacco smoking, usually remain limited among adolescents. However, the use of any psychoactive substance in this age group is of concern as the brain and other organs are still developing during adolescence, and exposure to toxic substances may cause damage, though it might only appear later in life. In addition, early initiation during adolescence has been associated with higher probability of drug use later in life and greater difficulties in reducing or ceasing drug use (von Sydow et al., 2002). Polydrug use among adolescents, defined as the use of at least two different psychoactive substances at a young age, could be considered an indirect indicator for early initiation. Furthermore, the use of illicit substances that are uncommon at this age — depending on the local context, these might be cannabis or other drugs such as cocaine — could also reflect higher levels of risk behaviours, social exclusion or deviance among adolescents.

Individual data from surveys carried out in 2003 by the European school survey project on alcohol and other drugs (ESPAD) were used to examine the characteristics of polydrug use among over 70 000 15 to 16-year-old students from 22 European countries. In order to attain sufficiently large samples for statistical analysis, while also allowing exploration of differences in polydrug use patterns in different contexts, the countries were divided into three distinct groups based on their prevalence levels of substance use during the last 30 days (last month use). The United Kingdom was assigned to the high-prevalence group. The proportion of polydrug users was nearly 40% in the high-prevalence country group, 36% in the medium-prevalence country group and 22.5% in the low-prevalence group.

Polydrug use among young adults

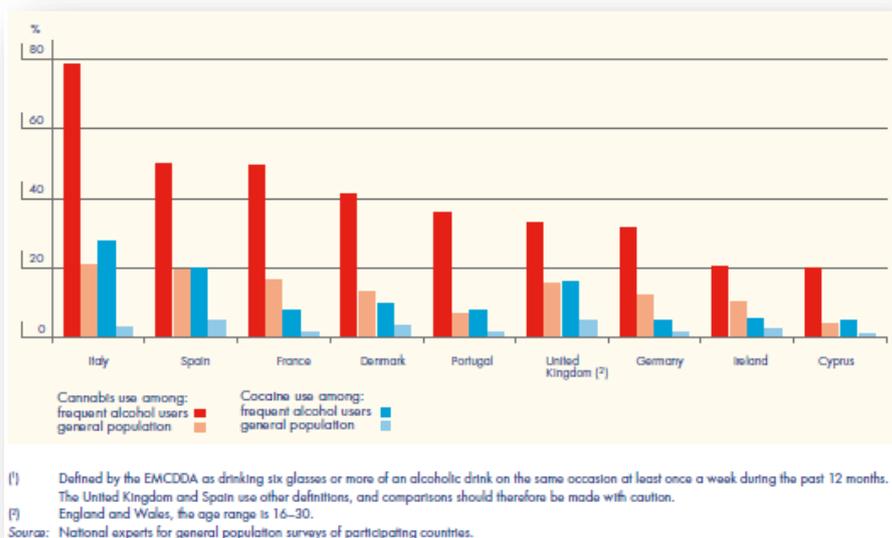
While polydrug use among adolescents can be an indicator of early initiation, risk behaviours or deviance, polydrug use among young adults can be symptomatic of more established patterns of multiple substance use, potentially carrying long-term health problems and acute risk during leisure time. Data on young adults (15–34 years) has been drawn from general population surveys conducted between 2005 and 2008 in nine EU Member States.

Alcohol use and cigarette smoking, followed by cannabis use, were the most prevalent forms of substance use consistently reported by young adults in all countries. However, there were wide variations among the nine reporting countries: the prevalence of cannabis use in the last year ranged from 3.6 % to 20.9 % and last year cocaine use ranged from 0.9 % to 5.1 %.

Among young adults (aged 15 to 34), frequent or heavy alcohol users were, in general, between two and six times more likely to report the use of cannabis compared to the general population and between two and nine times more likely to use cocaine. The strongest associations between heavy alcohol and illicit drug use were found in the countries with the lowest prevalence of heavy alcohol use (Cyprus, France, Italy, Portugal), and the weakest associations in those countries where frequent or heavy alcohol use is more widespread, such as Ireland and the United Kingdom (England and Wales).

Most cannabis users did not report the use of other illicit drugs, but they were nevertheless more likely to do so than the general population. The prevalence of last year use of other illicit drugs among cannabis users varied between 4% (Italy) and 35% (Cyprus) for ecstasy; between 1% (France) and 17% (Denmark) for amphetamines; and between 6% (France) and more than 20% (Cyprus, Ireland, Spain and the United Kingdom) for cocaine. Overall, cannabis users were between 4 and 25 times more likely to report the use of cocaine than were the general population.

Figure 18: Frequent or heavy alcohol users — use of cannabis and cocaine during the last 12 months compared to the general population of 15- to 34-year-olds



Polydrug use and its health consequences among problem drug users

Problem drug users, those practising the more intensive and damaging forms of drug use, often suffer from underlying health problems, which can increase their susceptibility to the harmful effects of combining drugs. Furthermore, some of the drug combinations commonly taken by problem drug users are associated with particularly elevated risks. These risks and health consequences are examined below, with particular attention to clients in opioid substitution treatment, among whom polydrug use levels are very high, and are connected with severe adverse health and psychosocial consequences.

Acute health problems and drug-induced deaths related to polydrug use

Interactions between different drugs consumed close together in time can lead to increased toxicity. The effects of certain psychoactive substances can also lead to increased risk behaviour with another substance. For instance, alcohol intoxication can reduce the capacity to judge the amount of opioids consumed or reduce awareness of the loss of tolerance to opioids that is likely to occur after discharge from treatment or release from prison. The co-use of several substances can also increase the risk of negative outcomes, such as accidents or injuries. Research has also shown that the added effects of multiple substance use can increase considerably the risk of road accidents, even with relatively low levels of intoxication (EMCDDA, 2007).

Hospital emergency services report that polydrug intoxications, with alcohol playing a key role, represent a significant proportion of medical emergencies (Sopenã et al., 2008). Cardiologists also report that cocaine users typically consume other toxic substances (including tobacco), resulting in greater diagnostic difficulties. It is suggested that cocaine use be considered when young adults present with chest pain (Guiraudet et al., 2001).

The true numbers of drug-induced deaths in Europe, as well as the extent to which these are caused by the consumption of more than one substance, is likely to be underestimated for a number of reasons. Therefore, a pilot study was carried out to explore the feasibility of collecting further information on the substances involved in the drug-induced deaths reported to the EMCDDA, drawing on general and special mortality registries. Nine countries reported more than 6 900 deaths (two-thirds of which were in the United Kingdom) that had occurred between 2002 and 2005. The reporting countries generally used the sources of information and case definitions recommended by the EMCDDA. The substances searched for and reported included opioids, cocaine, amphetamines, hallucinogens, cannabis, volatile substances, psychoactive medicines and alcohol. Some countries also reported that certain substances were less likely to be searched for or reported (e.g. cannabis). The results of this feasibility study are in line with the data collected through the EMCDDA drug-related death indicator and show that the vast majority of reported drug-induced deaths are related to opioids. At least one opioid was found in the post mortem toxicology of three-quarter of all cases (77 %), followed by cocaine which was found in one-fifth of cases (21 %), and amphetamines (7 %).

In Blackpool, as at 31/3/2013, 63% (n=771) of those adults in treatment reported the use of a second drug, whilst 30% (n=363) reported the use of a third drug.

vii. Dual Diagnosis / Comorbidity

There are many different terms used to describe the combination of, and association between, substance misuse and mental illness, with the most commonly used being 'dual diagnosis' and 'comorbidity'. These terms reflect the coexistence of substance use, misuse, harmful use or addiction, and psychological or psychiatric problems. Two or more substance disorder or psychiatric conditions may be present at the same time, or may occur at different times. There may also be physical illnesses that further complicate the picture, and the social manifestations may add another level of complexity.

The majority of the research on dual diagnosis has been undertaken in the United States, but there is increasing interest across Europe, including the UK. However, differences in the health and social care provisions in each country mean that not all of these findings are applicable to a UK context. It should also be noted that medical research predominates in dual diagnosis and very little research has been undertaken from a social work or social care perspective. Nevertheless, generalisation from research into mental health issues

might suggest that social isolation, stigmatisation and social exclusion are likely to be common experiences, as well as generally poor provision for some groups of people from ethnic minorities.

Research shows that substance use, intoxication, harmful use, withdrawal and dependence may lead to or exacerbate psychiatric or psychological symptoms or syndromes. Conversely, psychological morbidity and psychiatric disorder may lead to substance use, harmful use and dependence (addiction). The most common associations for substance misuse are with depression, anxiety and schizophrenia, but eating, post-traumatic stress, attention deficit, hyperactivity and memory disorders also occur. Alcohol problems, for example, are often seen with bipolar disorders, schizophrenia, and personality disorders, while concurrent use of other illicit substances is well recognized in opiate dependence. Cocaine users, too, who may supplement their use with alcohol, may also have affective disorders and personality disorders.

In prisoners in England and Wales, severe dependence on cannabis or stimulants, such as amphetamines or cocaine, was associated with an increased risk of psychosis. Significant proportions of those being treated as inpatients or in the community for severe mental illness have substance misuse problems, and this has treatment implications that are not always satisfactorily addressed. The number of admissions to NHS hospitals with a primary or secondary diagnosis of drug-related mental health or behavioural disorder has risen from 19,018 episodes in 1996/97 to 38,170 in 2006/07.

Co-existing mental health and substance problems are very common in health and social care practice. In a study on primary care in the UK during 1993-1998 the prevalence of co-existing drug and psychiatric conditions increased by 62% in England and Wales, with the rates of drug problems and psychoses, schizophrenia, and paranoia increasing by 147%, 128% and 144%, respectively. In 1998, therefore, a typical general practice might have encountered eleven cases of comorbidity. An examination of screening rates for a diverse range of services showed substantial differences between community mental health teams (37%), inpatient mental health (56%), forensic (62%), substance misuse (93%) and primary care services (24%).

In Blackpool, for the period April 2012 to March 2013, 23% (n=87) of the individuals starting a new treatment journey had been recorded as receiving care from mental health services for reasons other than substance misuse.

ix. Hospital Admissions (Drug-Related)

In England (unless otherwise stated), in 2012/13:

4. There were 6,549 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder. This is a 5% (322) increase from 2011/12. However, overall, between 2002/03 and 2012/13, admissions have decreased by 15% (1,142) from 7,691 to 6,549.
5. Nearly three times as many males were admitted to hospital with a primary diagnosis of drug-related mental health and behavioural disorders than females (4,823 and 1,726 respectively). More people aged 25-34 were admitted than any other age group, accounting for about a third (2,185 out of 6,549) of all such admissions.
6. There were 61,142 admissions with a primary or secondary diagnosis of drug related mental health and behaviour disorders. This is a 6% (3,290) increase from 2011/12. Figures have continued to increase year on year and are now almost twice as high as they were ten years ago when they were 31,490 in 2002/03.

7. There were 12,238 admissions to hospital with a primary diagnosis of poisoning by illicit drugs. There has been a long term increase of 75% (5,227) since 2002/03 when there were 7,011 such admissions.
8. More males were admitted to hospital with a primary diagnosis of poisoning by illicit drugs than females (6,414 compared to 5,824). Adults in the 16-24 age group accounted for the highest number of admissions (2,883) and those in the 65-74 age group reported the lowest number (415).

In Blackpool, in 2010/11:

- a. There were 69 hospital admissions where there was a primary diagnosis of drug related mental health and behavioural disorders.
- b. There were 545 hospital admissions where there was a primary or secondary diagnosis of drug related mental health and behavioural disorders.
- c. There were 82 hospital admissions where there was a primary diagnosis of poisoning by drugs.

x. Families in Need

a. Children and Families Affected

Information obtained from the National Drug Treatment Monitoring System (NDTMS) indicate that there were 201 individuals in treatment in Blackpool with children, which was 54% of those starting treatment during 2012. This includes 15 (31%) of those starting treatment at the Hub (Young Peoples treatment service).

b. Accommodation Need

The housing situation at presentation for treatment was reported for 358 clients in Blackpool in 2012/13. Of these, 42 (12%) reported an urgent housing problem (where they have no fixed abode), while a further 50 (14%) reported a housing problem (such as staying with friends or family as a short term guest or residing at a short term hostel). 266 (74%) reported no housing problems. These percentages are very similar to those seen for England (9%, 15% and 74% respectively).

Table 10: Housing situation of new treatment journeys – England & Blackpool 2012/13

Housing situation	England		Blackpool	
	n	%	n	%
Urgent problem	6407	9%	42	12%
Housing problem	9995	15%	50	14%
No problem	50156	74%	266	74%
Other	1254	2%	0	0%
TOTAL	67812	100%	358	100%
Not Stated/Missing	1435		-	-
Total incl. missing	69247		-	-

Source: NDTMS

xii. Drugs and Community Safety

- ***Offender Drug Use***

Findings from the Prisoner and Community Penalties Criminality Surveys (Budd et al. 2005) show that drug use among offenders in England and Wales was far higher than among the general population, even after controlling for age. 73% of prisoners said they had used at least one of the 13 drugs asked about in the last 12 months. Although cannabis was most common – used by 64%; just under a half (47%) reported using heroin, crack or cocaine. Those serving a community sentence were somewhat less likely to say they had used drugs, though still around three in ten had used heroin, crack or cocaine.

Twenty-nine per cent of all male prisoners reported using heroin on at least a weekly basis in the 12 months before prison. The figures for cocaine and crack use were 18% and 21% respectively. Frequent use of these drugs was lower among those serving a community sentence.

Those who were young, white and single were more likely to say they had used heroin, crack or cocaine. Use of these drugs was also associated with social disadvantage. Those who had poor educational attainment, were unemployed, lacked stable accommodation and had experienced time in care as a child were particularly likely to have used these substances.

Just over a half of male prisoners who reported using drugs in the previous 12 months said they had experienced problems staying off drugs before they came into prison. Drug use was also problematic for a significant proportion of drug users serving a community sentence (43% of males; 39% of females).

Drug use itself was also strongly associated with offending, with offending increasing with more problematic patterns of drug use. Over nine in ten prisoners who said they had used heroin, crack or cocaine also reported committing an offence covered by the survey, compared with just 37% of those who had not used any drugs. A similar pattern is evident for those serving community sentences.

Although the relationship between drug use and offending is complex, for some offenders their drug use clearly contributes to their offending behaviour and is a barrier to them desisting:

- i. Over a half (55%) of drug-using prisoners said they had committed offences related to their drug use.
- ii. Almost four in ten drug users serving community sentences (38% for both males and females) had done so.
- iii. Those using heroin, crack or cocaine were particularly likely to say they had committed offences due to their drug use, usually to help fund a drug habit.

89% of arrestees who said that they had committed one or more acquisitive crimes and that they had used heroin *and* cocaine *and* crack in the last 12 months acknowledged a link between their drug use and offending behaviour (Bennet & Holloway, 2004).

Females were as likely to say they had used the most harmful drugs as their male peers, though were more likely to be receiving or wanting to receive treatment for their drug problems. The factors associated with increased participation in offending and drug use for female offenders were on the whole the same as for male offenders.

Table 11: Source of criminal justice referrals into drug treatment: Blackpool 2012-13

Referral Source	n	%
Test on arrest (programme ceased 31/3/2013)	385	43
HM Prisons (Preston/Kirkham/Haverigg/Styal)	216	24
Voluntary	165	18
Probation	77	9
Drug Rehabilitation Requirement	42	5
Police	7	1
Total	892	100

Source: Renaissance at Drugline-Lancashire

- ***Drug Related Offending***

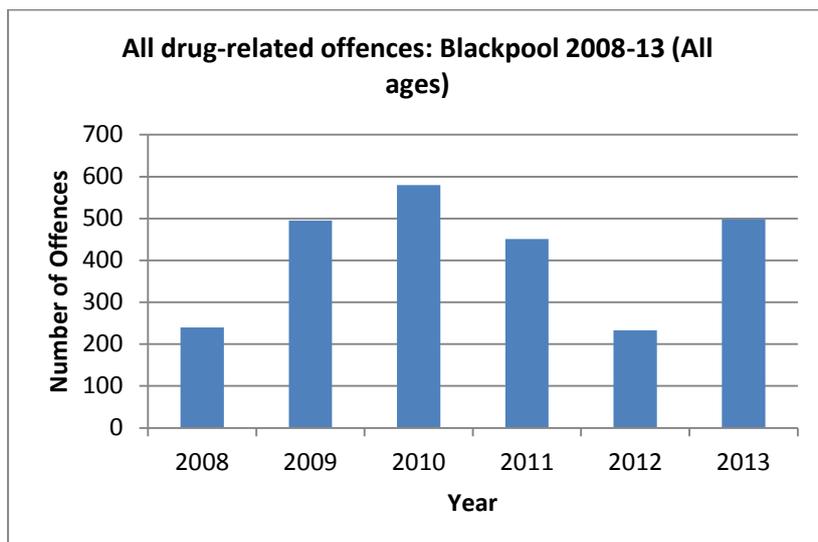
Over the past 10-15 years, UK drug strategies have increasingly focused on providing treatment and support services for drug-dependent offenders – who commit a disproportionate number of acquisitive crimes (e.g. shoplifting and burglary) – as a way of reducing overall crime levels (UKDPC, 2008). An independent review of the published evidence from leading researchers at the Institute for Criminal Policy Research (ICPR), King’s College London, found that:

- a. At least 1 in 8 arrestees in England and Wales are estimated to be problem heroin and/or crack users, compared with 1 in 100 of the general population
- b. 81% of arrestees who used heroin and/or crack at least once a week said they committed an acquisitive crime in the previous 12 months, compared with 30% of other arrestees
 - a. 31% reported an average of at least one crime a day, compared with 3% of other arrestees

There is strong evidence that problematic use of some drugs, notably heroin and crack, can amplify offending behaviour, and there is a particularly strong association with acquisitive crime, such as shoplifting and burglary. However, for most offenders who use drugs, whose drug use is less extensive, there is no direct causal link between drugs and crime. For example, most are not committing crimes to pay for their drugs.

Drug-related offences committed in Blackpool increased 107% between 2008 and 2013, from 240 to 498 offences (Figure 18). However, there was a peak of 580 offences in 2010. There was a sharp drop in the number of offences committed in 2012 (n=233) and further investigation may be required to ascertain the reason for this.

Figure 19: All drug-related offences: Blackpool 2008-12 (All ages)



Source: MADE

- **Domestic Violence and Abuse**

Domestic abuse is a term that describes intentional, on-going, controlling and coercive behaviours by one person, using emotional, financial, physical and sexual violence, stalking and harassment, to ensure power and control over another, with who they have, or have had, an intimate or family relationship.

Although national research shows that the incidence of domestic abuse varies only marginally when analysed by geography, class, age, ability, sexuality, ethnicity and nationality, such issues do affect risk and the severity of violence, and the experience of survivors from these groups is compounded by additional barriers to seeking help. There are inequalities which can be seen when looking at 'reported' domestic abuse in the county.

Alcohol and drug misuse

Victims of domestic abuse may misuse alcohol and other substances as a way of coping with their situation. 57% of the 122 attendees at Preston and Chorley accident and emergency departments between January 2011 and March 2012 who were assaulted in the home and answered a survey about drinking alcohol in the 3 hours previous to the incident, said that they had been drinking.

The national charity Co-ordinated Action Against Domestic Abuse (CAADA), using evidence gathered directly from 2653 victims of domestic abuse in the year to March 2012, found that 18% (n=481) reported drugs or alcohol misuse (Table 10).

Table 12: Complex needs identified at intake

	Yes		No		Missing		Total
	n	%	n	%	n	%	n
Drugs misuse	172	6	2398	90	83	3	2653
Alcohol misuse	309	12	2265	85	79	3	2653
Mental health issues	832	31	1733	65	88	3	2653
Threatened or attempted suicide	500	19	1966	74	187	7	2653
Self harm	422	16	1986	75	245	9	2653
Financial problems	719	27	1792	68	142	5	2653
Requiring benefits advice	491	19	207	8	21	1	719

Source: CAADA, 2012

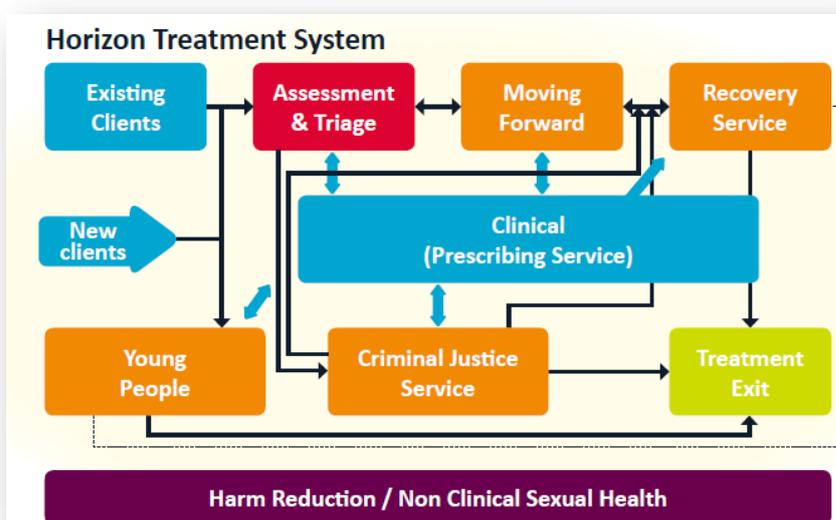
xiii. Service overview

- **Description**

The current service provision of Drug and Alcohol Treatment Services for Blackpool operates as a consortium of providers under the branding of “Horizon”. The providers involved in the Consortium are:-

- Lancashire Care NHS Foundation Trust (Prescribing Service)
- ADS
- Addaction
- TTP Communities
- Renaissance – Drugline Lancashire
- The Hub (Blackpool Council Provider)
- Fylde Coast Medical Services (GP provision for Criminal Justice)

- **Treatment Journey**



The key focus of Horizon is to support clients in achieving recovery. It is important to note that recovery is what an individual wishes to attain in order for them to fully integrate within the Community. The treatment service is there to help and support clients resolve their housing issues, employment, training, educational needs and to be able to support their family or community.

In line with the Public Health Framework the key aims of the service are:-

1. To reduce the destructive impact of drug and alcohol misuse to those misusing drugs and alcohol, their families and the communities within which they live
2. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, poor sexual health, drugs and alcohol
3. Reducing the burden of disease and disability in life by focusing on preventing and recovering from conditions with the greatest impact, including dementia, anxiety, depression and drug and alcohol dependency.

• **Profile of Service Users**

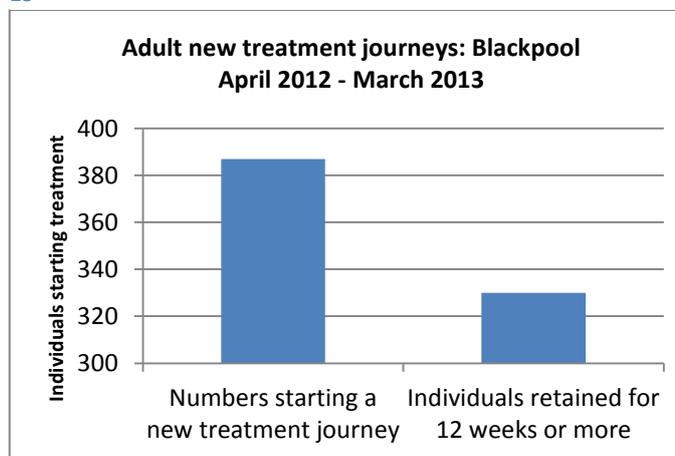
In 2012/13 the estimated number of opiate and/or crack users (OCU) and injectors is detailed below for Blackpool, along with a comparison with the National averages. Blackpool has the 4th highest prevalence rate in the country and this table demonstrates this significant problem.

Table 13: Prevalence estimates (aged 15-64yrs): Local and national rates

Prevalence Estimates (aged 15 – 64)	Local Number	Local Rate per 1000 population	National Rate Per 1000 population
OCU	1,946	21.89	8.67
Opiate	1,802	20.27	7.59
Crack	721	8.11	4.95
Injecting	958	10.77	2.71

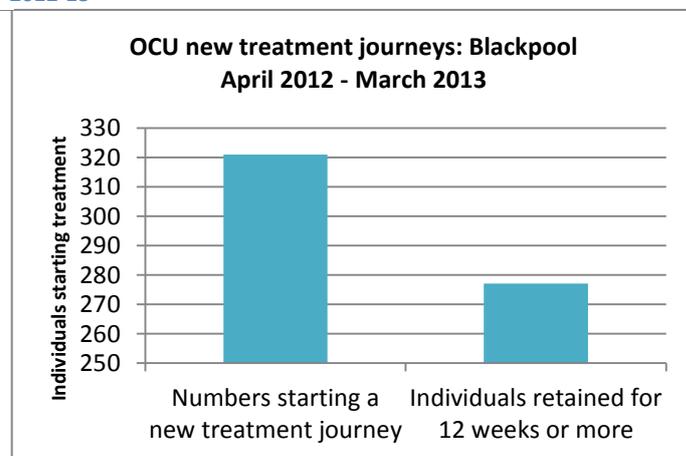
Source: Public Health England (2013): Alcohol and Drugs JSNA support pack

Figure 21: Adult new treatment journey numbers: Blackpool 2012-13



Source: NDTMS

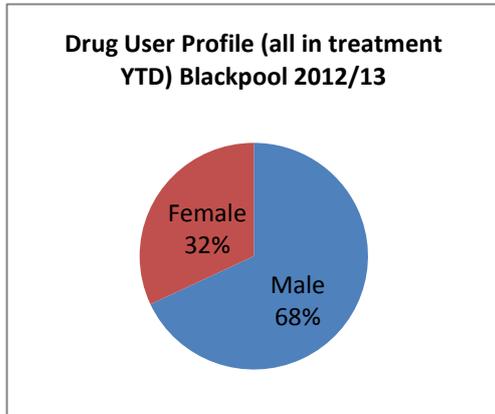
Figure 20: Adult OCU new treatment journey numbers: Blackpool 2012-13



Source: NDTMS

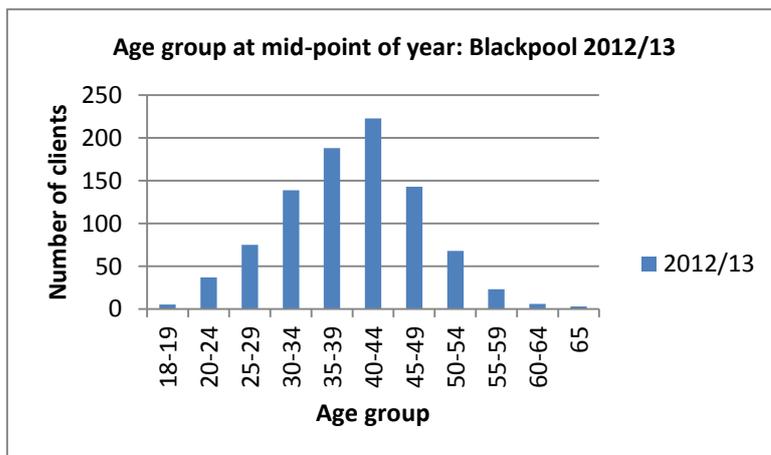
There are a higher number of males (68%) than females (32%) in treatment services in Blackpool. As can be seen from the graph below (Fig. 21), a large number of clients fall into the 30-50 age group, mirroring the national ageing drug-using population.

Figure 22: Adult treatment group gender profile: Blackpool 2012-13



Source: NDTMS

Figure 23: Age group profile: Blackpool 2012-13

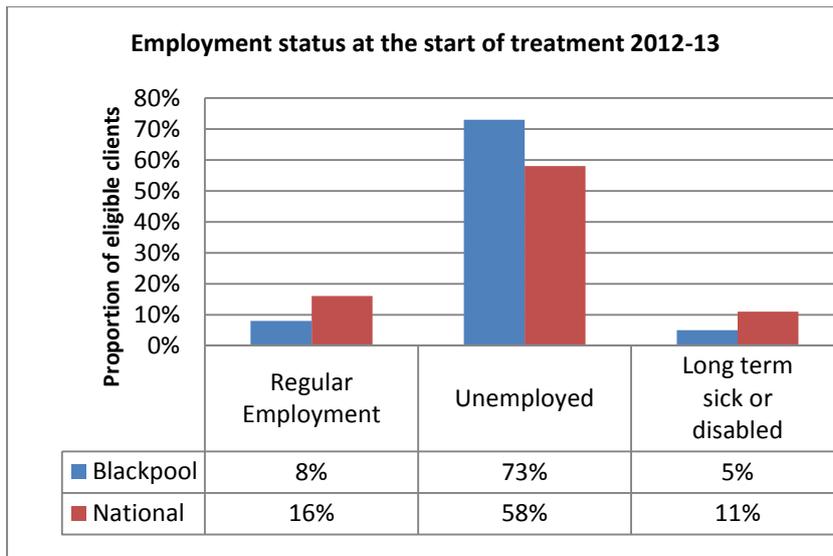


Source: NDTMS

The data below shows the employment status of people starting treatment in Blackpool in 2012-13. The large majority (73%) were unemployed, which is higher than the England average of 58%.

Being in work or undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training. However, the majority of people in drug and alcohol treatment will require significant support to address their education, training and employment needs and to get them job ready.

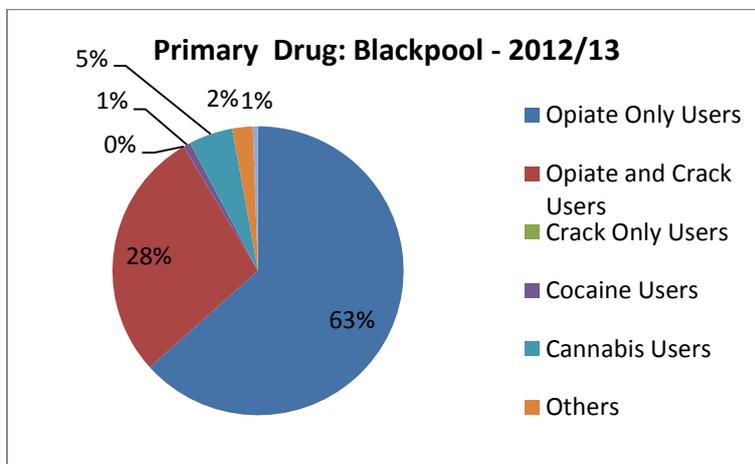
Figure 24: Employment status at start of treatment: Blackpool 2012-13



Source: NDTMS

Opiates were the most prevalent (63%) primary drug for those in treatment in 2012/13. Opiates and/or crack cocaine had previously been used by 91% of those in treatment.

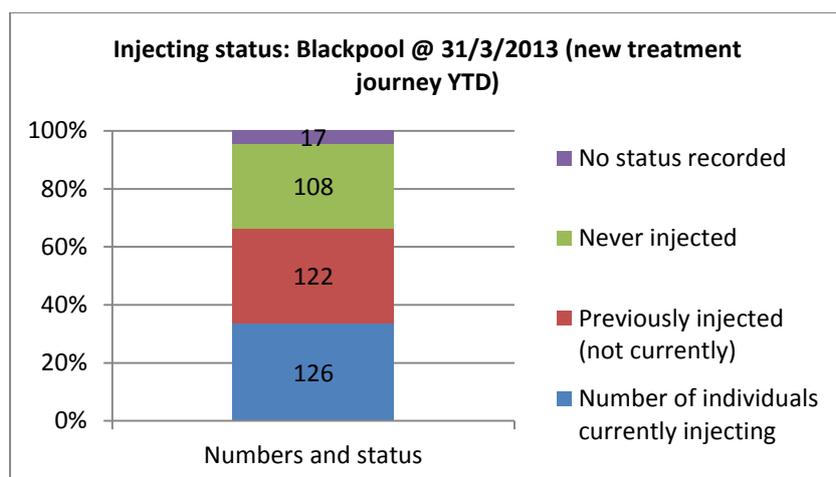
Figure 25: Primary drug of use: Blackpool 2012-13



Source: NDTMS

- 35% of clients starting a new treatment journey during the year ending 31/3/2013 were currently injecting.
- 34% had previously injected (but not currently)
- 30% of clients had never injected.

Figure 26: Injecting status: Blackpool as at March 2013



Source: NDTMS

- Referrals**

Table 14: Source of referral into drug treatment, new presentations into treatment: Blackpool 2012-13

Referral Source	Blackpool		England
	n	%	%
Self	184	74	42
Other	34	14	43
GP	12	5	7
Community Mental Health Team	9	3	1
Social Services	9	3	1
Homeless Team	*		0
Probation	*		5
Total	248	100	100

*Due to small numbers, these have been included in the 'Other' category.

Source: Renaissance at Drugline-Lancashire

Approximately three-quarters (74%) of new entrants to the treatment system in 2012/13 were self-referrals. This is significantly higher than the England average (42%) for the same period.

Young People

[See separate section for 'Children and Young People'.](#)

- Predicted vs Actual Use (Unmet Need)**

Estimated prevalence figures for problem drug use in Blackpool indicate a drug using 15 – 64 year old population of 3481 in 2010/11 (Hay, Santos & Millar, 2013). This compares to 1107 (31.8%) recorded as being in effective treatment between 1/1/2012 and 31/12/2012. This would indicate that there were a potential 2374 problem drug users in Blackpool who were not in treatment during that period.

- **Exits and Transfers**

Table 12 shows the reasons for clients exiting treatment in 2012-13 for England. There were 61,899 clients aged 18 and over who left treatment during the year and were not in treatment on 31st March 2013. Of these, 29,025 (47%) were discharged as Treatment Completed, defined as those completing treatment free of their drug of dependency and not using either heroin or crack cocaine. On average (mean), clients who completed treatment did so after 543 days (just less than 18 months). A further 8,019 (13%) were transferred for further treatment within the community, while 6,602 (11%) were transferred into appropriate treatment while in custody.

Table 15: Treatment exit reasons for individuals not retained in treatment in Blackpool and England on 31/03/ 2013

Treatment exit reason	Blackpool		England	
	n	%	n	%
Treatment completed - drug-free	105	26	21,138	34
Treatment completed - occasional user (not heroin or crack)	44	11	7,887	13
Treatment completed subtotal	149	37	29,025	47
Transferred - not in custody	60	15	8,019	13
Transferred - in custody	48	12	6,602	11
Incomplete - dropped out/left	72	18	14,562	24
Incomplete - retained in custody/prison	3	1	792	1
Incomplete - treatment commencement declined by client	18	5	1,117	2
Incomplete - treatment withdrawn by provider	15	4	578	1
Incomplete - client died	8	2	1,204	2
Transferred to another partnership	24	6		
Total individuals exited	397	100	61,899	100

Source: NDTMS

The above figures show that 26% of Blackpool clients exited treatment drug free, compared to 34% for England. 23% of Blackpool clients dropped out of, or didn't commence treatment, compared to 24% for England.

- **Length of Treatment**

Table 16 gives a breakdown of clients receiving prescribing treatment in England by the length of time that they have been receiving this intervention. 37,326 (25%) had been receiving prescribing for five or more years, while 50,104 (34%) had been receiving prescribing for less than 12 months.

Table 16: Length of time in prescribing for clients in continuous prescribing treatment in England 2012-13

	n	%
Less than 12 months	50,104	34
1 to 2 Years	21,375	14
2 to 3 Years	15,823	11
3 to 4 Years	12,811	8
4 to 5 Years	11,184	8
5+ years	37,326	25
Total	148,423	100

Source: NDTMS

Table 17: Time in treatment in Blackpool as at Sept 2013.

Proportion of clients still in treatment in years			Under 2 years	Between 2 and 4 years	Between 4 and 6 years	6 years and over	Average (years)
Opiate	(%)		43.3%	17.5%	13.3%	25.9%	4.3
Non opiate	(%)		90.0%	10.0%	0.0%	0.0%	0.7

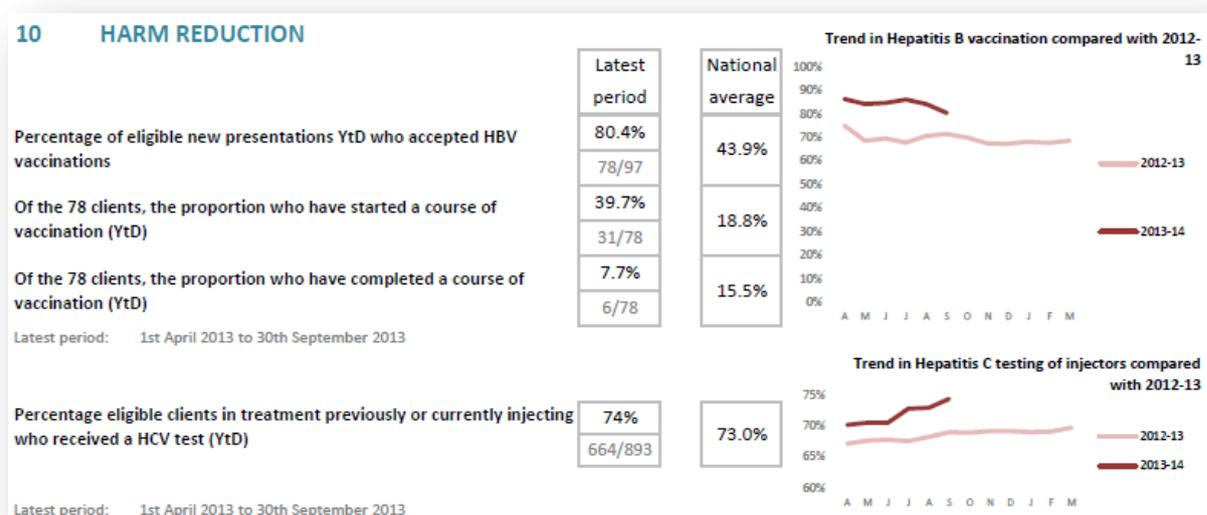
Source: NDTMS

Figures obtained from NDTMS for Blackpool show that 43.3% of opiate users had been in treatment up to two years, compared to 48% for England. Percentages for 2-4 years for Blackpool are similar to those for England (17.5% and 19% respectively). Figures for 5+ years are also similar, at 25.9% and 25% for Blackpool and England respectively.

- Harm Reduction**

During 2012/13, 68% of eligible new entrants accepted Hepatitis B vaccination in Blackpool, compared to 47% nationally. This was an increase from 2011/12. However, only 14% finished the course of treatment. 69% of eligible new entrants to the treatment system in Blackpool, previously or currently injecting, received a Hepatitis C test in 2012/13. This compared to 72.5% nationally.

Figure 27: Hepatitis B and C vaccinations: Blackpool and National 2012-13



Source: DOMES Executive Summary Q2 2013/14.

Heroin Overdose

Ambulance Pickups

One of the best indications of where heroin overdoses occur is ambulance pickups (Figure 26) as this gives the actual location where the event occurred. For the purposes of this report, an ambulance pickup for a heroin

overdose has been defined as a pickup where “heroin” and “overdose” or “o/d” are mentioned in the notes. It should be noted that this might include suspected overdoses which were not actually overdoses.

During the period 2007 to 2010, multiple ambulance pick-ups for suspected heroin overdoses are shown in the map below (Figure 26). The majority are clustered around the centre of the town, as may be expected due to those areas being some of the most deprived wards in Blackpool.

- ***Criminal Justice***

Horizon has a separate ‘Criminal Justice and Complex Clients’ service, which provides the route of treatment for individuals who have been identified through the criminal justice system and drug and alcohol use is a significant factor in their criminal activity. This service is for all drug and alcohol users aged 18 years and over.

For individuals aged 18-24 years, once the criminal justice team have completed their work relating to offending, they are moved onto ‘The Hub’ if they still have a treatment need. If an individual is already open to The Hub when they offend, they are retained by The Hub whilst they are in the community.

As at 7/3/2014 Lancashire Probation Service:

- supervised 193 18-24 year old Blackpool residents in the community.
- 149 (77%) of these individuals had been assessed as having a substance misuse problem. Of these:
- 62 had identified drug problems
- 84 had some level of problematic alcohol use (these figures include those with both alcohol and drug issues)

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