Substance Misuse in Norfolk

By Claire Gummerson, Research and Information Officer for Norfolk Drug and Alcohol Action Team (DAAT).
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Substance Misuse in Norfolk

Executive Summary
Introduction

Substance misuse is defined as intoxication by, or regular excessive consumption of and/or dependence on, psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol).\(^1\)

The Norfolk Drug and Alcohol Partnership (N-DAP) leads on the implementation of national drug and alcohol strategies across Norfolk, and with its partner agencies, commissions and oversees the delivery of substance misuse recovery services. In order to help support this N-DAP conducts a yearly needs assessment to ensure that the necessary range and capacity of services is available and accessible to substance misusers and their families in Norfolk, whether they are currently receiving support or not. The needs assessment also helps the partnership determine its strategic priorities and plan action.

This needs assessment aims to:
- Identify the substance misuse related needs of the people of Norfolk
- To support the commissioning of services
- Inform the development of priorities for N-DAP
- Aid the development of a N-DAP performance framework

This document is designed to both assess the needs of substance misusers and to highlight the impacts of drugs and alcohol on the people of Norfolk, with an aim to illustrating the benefits to partner agencies of tackling substance misuse together. As well as health and criminal justice there are sections looking at the impacts of substance misuse on social care and the fire and rescue service.

In the current financial climate it is vital that all agencies recognise the benefits to their service of identifying people with substance misuse problems, and understanding how to signpost or refer them to support. It is only through partnership working that we can tackle substance misuse, address the associated stigma and build a recovery community that supports people to gain freedom from their dependence on drugs and alcohol.

This year the substance misuse needs of specific groups have been considered in detail, with the needs assessment following a life course approach starting with looking at substance misuse in pregnancy, parental substance misuse and the needs of the family and friends of those who misuse substances. This is followed by a section on young people in Norfolk and their substance misuse related needs (including education and prevention work). The next section focuses on working age adults and trends in drug and alcohol use, physical and mental health, criminal justice impacts and related support needs, including employment and housing. The specialist treatment provided to adult substance misusers in Norfolk is examined in detail including analysis of the characteristics of long-term opiate using clients and how treatment differs for alcohol and other drug clients. Finally there is a section on the substance misuse needs of older people, in particular alcohol, prescription drugs and a new generation of older opiate clients.

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Executive Summary

Section 1: Early Years and Family and Friends of People who Misuse Substances

Substance misuse can have significant effects on the people around the individual experiencing drug and alcohol problems. This includes both children and other dependents and adult friends and family.

Pregnancy and substance misuse
A small proportion of women admit to being moderate or heavy drinkers during pregnancy (8%), which suggests at least 800 pregnant women requiring at least some sort of brief intervention around alcohol in Norfolk each year. It is estimated that at least nine children are born every year in the county with Foetal Alcohol Syndrome (and the true figure is likely to be higher due to difficulties with diagnosis). Between 20 and 30 women are recorded as being pregnant when starting drug and alcohol treatment each year in Norfolk.

The National Alcohol Strategy states that there is a need to raise awareness amongst women who are pregnant or trying to conceive that they should avoid alcohol, including increasing the awareness amongst health professionals. Consideration needs to be given as to how this can be supported in Norfolk.

Children affected by parental substance misuse
Parental problem drug and alcohol use can, and often does, compromise children’s health and development. Just over half of adults in drug and alcohol treatment are parents to children aged under 18 (22% having a child living with them and 36% with a child living elsewhere). One impact of parental substance misuse on young people is that it can result in them caring for the parent and/or other family members. Overall 8% of children (5-15 years old) are estimated to be young carers, and 7% of young carers care because of parental substance misuse – this is around 500 people in Norfolk.

Social workers estimate that on average around 50% of the clients they worked with had issues relating to drug and alcohol use. In Norfolk 35% of families on FIP have substance misuse issues. Early intervention projects are currently under review as part of the ‘Troubled Families’ agenda.

Adult family and friends affected by someone else’s substance misuse
Having a substance misuse problem can impact negatively on the people around that person – emotionally, financially and physically. 3.5% of the population are estimated to be dependent on drugs and 6% on alcohol, and therefore a significant number of people in Norfolk are being affected by the substance misuse of their friends or families. The value of the care and support provided to and Opiate and/or Crack User (OCU) by family members is estimated to be £3,935 per family member per annum and therefore, the total annual saving to statutory services for Norfolk is estimated to be about £17m.

Services for those affected by someone else’s substance misuse
Some specialist substance misuse services do offer support for people affected by the substance misuse of another. There is a gap for young people with no dedicated services for children below the age of eleven affected by parental substance misuse.

A public consultation carried out at the end of 2012 revealed a need for dedicated, publically funded service for the family and friends of those with substance misuse problems, with increased geographical equity of provision, meaning better services for those in rural areas. Everyone needs the option of individual support – but some people will also want to work in groups, and currently there are fewer groups than individual support available. Informal ad hoc support is needed, with an emphasis on ‘out of hours’ peer support.
Stigma needs to be addressed as it is a barrier to accessing help and there is an opportunity for a service of this nature to raise the profile of this issue and therefore begin to reduce stigma. Any dedicated ‘affected others’ service need to have very close links with drug and alcohol treatment services to ensure that access to treatment is made as easy as possible, and joint sessions need to be available so that affected others can find out about the treatment their friend or family member is receiving (as appropriate). Proper promotion, awareness raising, training and investment in promotional materials is key to enabling other professionals to make referrals, and to allow people to self-refer.

The challenge is to commission a service (or services) that meet the needs of people of all ages affected by someone else’s substance misuse in a rapidly changing landscape and in the face of ever increasing budget constraints. While specialist services are the ideal, it may be that people can be well supported by specialist workers within other mainstream services.

Section 2: Young People and Substance Misuse

Drug and alcohol use by young people

Drug and alcohol use by young people in Norfolk is similar to the national average, although the number of young people trying smoking tobacco and cannabis is slightly higher than the average there are similar (low) rates of regular heavy use.

Nitrous oxide (also known as laughing gas) is the fourth most commonly used substance (after alcohol, tobacco and cannabis). Despite use being common, nitrous oxide came high up the list of substances young people did not know much about – suggesting there is a need for education about this drug. Furthermore over half of young people think muscle building steroids are safe if used properly, and again education and harm reduction advice is needed.

One in ten of a sample of Norfolk 12-18 year olds reported drinking more than once a week. For those aged 14 and under 35% reported being ‘really drunk’ at least once, and therefore this clearly represents a group in need of interventions including advice and information. Alcohol related hospital admissions of under 18s continue to fall across the county, but this masks increases in the Great Yarmouth and King’s Lynn & West Norfolk districts.

Groups of young people vulnerable to substance misuse

Some young people face increased risks of developing problems with drugs or alcohol. 55 young people were excluded from school last year for drug and alcohol-related reasons. The number of young people that are Not in Employment, Education or Training (NEET) is rising and young NEET people are more likely to experience problems with substance misuse. Young people seeking supported accommodation have complex and multiple needs and for a significant proportion drugs and alcohol are one of those needs. There are fewer Looked After Children in substance misuse treatment in Norfolk than would be expected. Children’s Services need to work with young people’s substance misuse services to ensure accurate collection of data around the substance misuse needs of looked after children, ensuring effective referral pathways and continue to monitor the numbers in treatment.

Around 600 young people were taken into custody over 2011/12 who were displaying drug or alcohol-related needs. This is clearly a vulnerable group and it is not clear from the available data how their needs are being met. The provision of custody outreach is being reviewed as part of the transfer to the new adult substance misuse treatment and support system, and as such there may be an opportunity to review provision in custody for young people.

Drug and alcohol services for young people in Norfolk

There were 113 formal drug and alcohol education sessions carried out by N-DAP commissioned services in schools in the Norfolk area to a total of 11,170 young people (12% of school children). Given the changes to the education system it is a pertinent time to review
the provision of drug and alcohol education in Norfolk, and consider ways to support access to high quality drug and alcohol education. There are a number of evidence-based educational programmes which could be promoted to schools to ensure access to effective education to support prevention of drug and alcohol problems in the future.

No young people were transferred from young people’s specialist substance misuse treatment to adult services in 2011/12 – While this may be appropriate, treatment providers have a responsibility to ensure adequate transition arrangements are in place across the partnership between adult and young people’s services, and this requires continued monitoring.

In 2011/12 there were 87 young people living in Norfolk who received targeted advice and information on a one-to-one basis. A further 173 received structured drug and/or alcohol treatment, which is 1.8 per 1,000 young people in Norfolk. A benefit of £4.66-£8.38 for every £1 spent on young people’s drug and alcohol treatment.

**Conclusion to young people’s section**

The importance of education, prevention and early intervention in universal settings cannot be underestimated, and yet not enough is known about provision to be confident that all young people are receiving the required information in Norfolk.

Very few young people develop dependency on drugs and alcohol. Those who use drugs and/or alcohol problematically are likely to be vulnerable, experiencing a range of problems, of which substance misuse is just one. It is crucial that services aimed at these groups of young people have the skills to identify potential substance misusers, to ask questions about substance misuse, provide brief advice and education and to refer young people to targeted and specialist substance misuse services where need is identified. The wider needs of young people must be addressed so that problematic use does not become entrenched. It is only through multi-agency working and shared responsibility that positive outcomes can be achieved for the young people of Norfolk.

**Section 3: Working Age Adults and Substance Misuse**

**Drug use by adults**

Cannabis is the most commonly used drug by adults in the UK (6.9% of adults used in the last year). Fewer younger people are using heroin, and the population in treatment for heroin problems is getting older. ‘Party drugs’ like cocaine and ecstasy remain popular - 3% of the adult population admit to using class A drugs in the last year. ‘Legal highs’ pose dangers to users because new substances are rapidly appearing on the market; young people seem willing to try ‘mystery powders’ and more hardened drug users (who were previously using heroin and crack cocaine) are also taking these substances in a possible response to the falling purity of other drugs. 30% of those in drug treatment also cite a ‘prescription only’ or ‘over the counter’ drug as one of their problem substances. Monitoring the prescription, abuse and withdrawal from certain prescription drugs has implications for primary healthcare, both in terms of practice and budgets.

**Alcohol use by adults**

A sixth of the population (15% aged over 16) in Norfolk abstain from alcohol altogether, 4% of the population are ‘higher risk drinkers’ and 0.1% have a severe dependence on alcohol. The prevalence of binge drinking is much higher in Norwich than other parts of the county. National trend data suggests the rate of binge drinking is dropping among all groups with the exception of young women.
Substance Misuse and Health

Hospital admissions
The rate of alcohol-related hospital admissions in Norfolk continues to rise year-on-year. There was a 10% increase in alcohol-related hospital admissions in Norfolk last year, compared to only an 8% increase nationally. Overall it is estimated that alcohol-related hospital admissions cost Norfolk £43.1m in 2011/12, this equates to £60 per adult in Norfolk (compared to £62 on average nationally). The 55-74 age group are responsible for the most alcohol-related hospital inpatient admissions.

Drug-related hospital admissions (including poisonings and mental health related hospital episodes) are not as numerous as alcohol-related ones but also continue to rise year-on-year. When population sizes are taken into account the rate for Great Yarmouth and Waveney is higher than that of the rest of Norfolk.

The continued increase in drug and alcohol-related hospital admissions needs to be a priority area for action and strategic development with the aim of reversing the upward trend.

Blood Borne Viruses (BBV)
Blood borne viruses and injecting continue to be an issue in Norfolk with the prevalence of injecting among new drug clients rising slightly over the last year, and the amount of needles distributed through needle exchanges in Norfolk rose by 19%. N-DAP should consider commissioning a full investigation into why demand for needle exchange has increased across the county in the face of a reported drop in heroin use.

Of the people in drug treatment, 88% have had a Hep C test (no improvement on last year), and the proportion accepting Hep B vaccinations in Norfolk has fallen; therefore the promotion of important harm reduction interventions must therefore remain a priority for specialist treatment agencies, and those in wider healthcare who come into contact with people who inject drugs.

Mental health
One fifth (17%) of clients in drug and alcohol treatment in Norfolk are also receiving mental health services (724 people). Dual diagnoses is far more common among women in treatment, with 21% of female clients also receiving mental health services, compared to only 15% of male clients. 44% of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year. This is 6,500 people in Norfolk. The identification of substance misuse issues should become a core part of mental health assessments across the county and effective care pathways and joint working arrangements with substance misuse services need to be developed and implemented.

Alcohol-related deaths
The rate of alcohol specific deaths in Norfolk is below the national average, but above the regional average. There are three times as many alcohol-specific deaths of males as of females. The general trend for both alcohol specific deaths and alcohol attributable deaths in Norfolk is either stable, or experiencing a small reduction over the last five years of data, although this masks rises in some Norfolk districts. Rates of alcohol specific and alcohol-attributable deaths fluctuate dramatically across the county and are highest in Great Yarmouth and Norwich districts. For females, most districts saw a rise in alcohol attributable mortality over the last year, but reductions in the rate for Great Yarmouth mean the average for Norfolk was a small reduction overall.

Drug-related deaths
Norfolk has the third highest rate of drug-related deaths of the 10 DAAT areas in the Eastern region. Opiates were implicated in the deaths of 80% of accidental overdoses. However,
there is a downwards trend in drug-related deaths with accidental overdoses appearing to be becoming less frequent in Norfolk.

**Drug and alcohol treatment service user deaths**

Over 2011/12 (February 2011 – March 2012) the deaths of 40 drug and alcohol treatment services users were reported. Nine service users died from accidental drug overdoses. Methadone has been directly implicated in seven of these cases; three of these were being prescribed to by Norfolk treatment providers and thorough investigations have been conducted into the circumstances surrounding these deaths. Root cause analysis investigations suggest a number of actions including reviewing risk assessments and adjusting clinical interventions in accordance with changing attendance. The four deaths relating to non-prescribed methadone provides evidence of the trade of illicit methadone in Norfolk that is worthy of further investigation.

**Substance Misuse and Wider Impacts**

**Adult social care and substance misuse**

There were 193 people in Norfolk who received adult social care services over 2011/12 where substance misuse was identified as one of their care needs. This is less than 1% of adult social service users – lower than the 9% indicated by national prevalence estimates. More can be done to clarify the role of adult social workers and social care staff in terms of substance misuse, and also to improve data collection and promote access to training.

**Employment and substance misuse**

The 2010 Drug Strategy highlighted the importance of employment in supporting recovery and this is now one of the key priorities for drug and alcohol partnerships. Addressing substance misuse in the workforce can have significant cost savings for employers. N-DAP can do more to support employers to develop substance misuse policies, raise awareness of treatment and support options and reduce stigma.

Long-term unemployment is linked to substance misuse. Only 26% of alcohol clients and 14% of opiate and crack users in treatment are in paid employment. People with a severe drug and alcohol dependency are a group that are vulnerable to the impact of changes to the disability benefit system. Greater joint working between specialist substance misuse treatment providers and employment support advisors could improve employment opportunities for people affected by substance misuse – such as reviewing referral arrangements, treatment workers being based in employment support offices and dedicated specialist work programmes.

**Housing and substance misuse**

Appropriate housing and related support are critical factors in supporting recovery. A fifth (20%) of people receiving structured drug and alcohol treatment in 2011/12, were experiencing housing problems when they commenced treatment (i.e. being in unstable temporary accommodation, sofa surfing or being of No Fixed Abode [NFA]). There is an identified need for greater provision of designated supported housing for people with substance misuse issues in Norfolk in order to ensure that people can be matched to the right type of accommodation for their stage in the recovery journey (in particular, a need for abstinence based supported housing). Access to outpatient (home) detoxifications for those living in the supported housing sector should also be improved.

**Fire and substance misuse**

There were 479 accidental dwelling fires in Norfolk in 2011/12, research suggests 17% of dwelling fires are linked to alcohol, and this equates to 81 fires in Norfolk. N-DAP could work with relevant NCC departments to give staff the appropriate skills and confidence to add substance misuse to fire risk assessments.
Road safety and substance misuse
Norfolk has a higher rate of people dying from land transport accidents due to alcohol than the regional or national average. Large and mainly rural districts such as King’s Lynn and West Norfolk have the highest rates of land transport accidents, which may be linked to limited public transport options therefore a higher incidence of drink-driving. Options for addressing the high rate of deaths cause by alcohol-related transport accidents should be explored by key partners including Norfolk Constabulary and Norfolk County Council Environment, Transport and Development Team.

Black, Minority and Ethnic (BME) groups and substance misuse
The largest minority group in Norfolk is ‘white other’, which is largely made up of Central and Eastern European (CEE) economic migrants (3.1% of the population). This is also the minority group most frequently seen in treatment making up 3.6% of those seeking help for drug and alcohol problems, and therefore is proportionately represented in treatment. As many of the ‘white other’ group are recent migrants to the UK language can be an issue, and this can be a barrier to accessing treatment as well as having financial implications for the partnership.

The proportion of Gypsy and Travelers in treatment is not known, but this is a socially excluded group, and socially excluded people are generally more vulnerable to substance use; this coupled with this reluctance to access mainstream services suggests there may be an unmet substance misuse need for this Gypsies and Travellers in Norfolk. Consultation and service provision should occur through existing Gypsy and Traveller support networks.

Crime and Antisocial Behaviour and Substance Misuse
One third of violent crimes reported in Norfolk are linked to alcohol (32%). There are clear objectives in the National Alcohol Strategy relating to the development of a coordinated approach to licensing. Partners need to fully consider this to ensure county and locality approaches take account of these objectives.

Furthermore in 2011/12:
- 46% of people taken into custody were thought to be under the influence of either alcohol or drugs
- Between a third and two thirds of acquisitive crime is related to substance misuse. In Norfolk this is 6,500 – 13,000 crimes a year.
- Most offenders (86%) on the Norfolk 180° scheme have drug and/or alcohol problems.

Effective and successful treatment reduces reoffending by around 60%. The Norfolk adult substance misuse treatment and support system which will be provided by Norfolk Recovery Partnership (NRP) from April 2013 will work with offenders in custody, the courts, prisons and those on probation.

Drug and Alcohol Services in Norfolk (Adults)

Brief interventions
There is good evidence that brief interventions can be effective in reducing substance misuse. Focus has primarily been on delivering these in primary health care settings – but there is a potential to create the knowledge and skills amongst a wide range of front line workers to deliver brief interventions.

Drug and alcohol treatment and support services for adults in Norfolk
A new provider will take over the running of the adult substance misuse treatment and support system in Norfolk from April 2013 (a partnership of three current providers called
Norfolk Recovery Partnership [NRP]). This will be accessed through a Single Assessment and Coordination System (SACS). NRP will provide structured treatment and non-structured support including advice and information, needle exchange, and access to BBV interventions – supporting people at all levels of the recovery journey.

Over the last year (2011/12) 4,368 adults received structured drug and alcohol treatment in Norfolk. Around half of these were treated for problems with opiates and crack (51%), 42% for alcohol problems and 7% of problems with other drugs. The rates of clients in treatment is correlated with deprivation – with the more deprived areas of the county having more people displaying drug and alcohol treatment needs. This is particularly true of people with opiate and crack problems, with levels of people with alcohol problems fluctuating less.

**Opiate and Crack User (OCU) Clients**
A significant proportion of OCU in treatment have been there been there for a long time - just over a third of Norfolk OCU clients have been in treatment for more than four years and 21% have been in treatment for more than six years. The proportion of OCU clients who successfully complete treatment in Norfolk has dropped each month between April 2012 and October 2012.

A general review of how shared care is provided in the county is needed (i.e. receiving drug treatment in a shared package of care from a GP and a specialist substance misuse treatment agency). This review should include exactly what shared care GPs are contracted to do, and how these contracts can be managed in the future to ensure that people are supported to move through treatment appropriately.

It is essential that recovery capital is assessed when a client enters treatment and that care planning includes actions to increase recovery capital accordingly. This emphasises a need for treatment service to build strong links with partner agencies to ensure that client needs are met in terms of their health, housing and employment and to help clients to build social networks that support their recovery goals.

Best practice is to provide clients with a menu of treatment and support services with a planned approach to phasing a layering of treatment. This includes appropriate access to psychosocial therapies. The new adult substance misuse treatment and support system in Norfolk needs to ensure that it reflects this new guidance.

**Alcohol clients**
Treatment for this group is characterised by much shorter spells in specialist treatment, a greater rate of successful completion, and generally higher recovery capital than OCU clients. There is a more even gender split among alcohol clients, with 61% male compared to 71% of OCU. Alcohol clients are also generally older than drug clients - 6% of alcohol clients are aged over 65.

**Other drug clients**
The most common primary problem substance among this group is cannabis (50% of other drug clients); this is followed by cocaine, amphetamine and ketamine. While this represents a small proportion of those in treatment at the moment - given the changing patterns of drug use we may expect this group to expand in the future.

Alcohol clients and other drug clients generally have a higher recovery capital when they commence treatment than OCU (especially in terms of housing and jobs) but this does not mean that their treatment outcomes cannot be improved by recovery-focused care planning which aims to increase recovery capital, especially in terms of developing social networks that support a client’s recovery goals.
Residential treatments
Current planned inpatient detoxification takes place in six block booked beds allocated between psychiatric wards - All evidence suggests that such an environment is not appropriate and consideration of future options is underway.

There are already a number of valuable resources that offer Tier Four treatment in Norfolk but there is a lack of a strategic plan that provides a framework and pathways for the commissioning and delivery of Tier Four treatment, which links it with wider community based resources.

Mutual aid
There is a strong evidence base that mutual aid groups support recovery. There are limited mutual aid options in Norfolk, especially for those living in rural communities. N-DAP has a role to play in stimulating a range of different forms of peer-led support and encouraging specialist treatment services to link their clients into this.

Prisons
Around two thirds (63%) of sentenced male prisoners and 39% of sentenced female prisoners admit to hazardous drinking prior to entering prison, with half of these having a severe alcohol dependency, and up to 55% of people entering prison being problematic drug users. There are three prisons in Norfolk: HMP Norwich, HMP Wayland and HMP Bure.

HMP Bure has a lower proportion of opiate using prisoners in treatment than is usually seen, but still has a significant number of prisoners needing treatment for their problems with alcohol and other drugs. Therefore there is more emphasis on non-clinical services (psychosocial) than on clinical services at this prison.

HMP Norwich predominately serves the courts of Norfolk and Suffolk, this means the majority of prisoners are on short-term sentences. High turn-over of prisoners means a significant numbers of assessments, providing short-term interventions, and ensuring care coordination between treatment in prison and local treatment services. The new adult substance misuse treatment and support system in Norfolk offers particular opportunities to join up prison and community services, including a programme where by prisoners are met by an NRP Key Workers on release.

Over a quarter of new receptions at HMP Wayland commence substance misuse treatment. This prison has a higher proportion of inmates on longer sentences, and therefore there are more opportunities carry out meaningful care planned treatment to address substance misuse. However, nine out of ten clients receiving treatment at HMP Wayland do not originate from Norfolk or Suffolk and therefore this represents a greater challenge to ensuring appropriate transfer to services in the community on release.

The cost effectiveness of drug treatment
For every £1 spent on the local adult substance misuse treatment and support system £4.54 is gained in total benefits in terms of savings for criminal justice and health agencies.

Conclusion to working-age adult’s section
A wide range of treatment options and integrated support from the full range of partnership agencies is needed to in order to fully support the recovery of adults affected by drug and alcohol misuse in Norfolk.
Section 4: Older People and Substance Misuse

Older people are a significant population in Norfolk and alcohol consumption among older age groups appears to be increasing. The negative effects of alcohol become more damaging as people move into older age.

Benzodiazepines and other hypnotics are more commonly prescribed to older people than other groups, with significant health implications. There is a potential need for further investigation into the prescribing of hypnotics, given that these drugs are open to abuse, and that current NHS guidance advises against long-term prescriptions of these drugs, highlighting the negative effects for older people in particular. There is also a cohort of older people who are long-term serious drug users who require specific services.

Older people may not feel traditional drug and alcohol services are appropriate to them. Substance misuse of older people has particular significance for adult social care and those providing residential services. It is not necessarily essential that substance misuse related outreach work with older substance users is carried out by specialist staff, all people providing support and care to older people should be given the appropriate skills based training to discuss alcohol and drug consumption with their service users, provide brief interventions and know how to signpost into treatment if appropriate.

Section 5: Conclusion

It has been demonstrated that people who have substance misuse problems usually have other needs, which may include health, housing, employment or all of the above. Preventing problems becoming serious and promoting successful recovery are built on a foundation addressing these wider needs. This is true for young people, working age adults and older people. Substance misuse support services cannot provide a ‘one stop shop’ and need to utilise other specialist services.

Most support services in Norfolk also work with some people with substance misuse problems. All agencies should recognise the benefits for their clients, and therefore their service, to identifying substance misuse and ensuring people receive help and support. A major recurring theme throughout the document is the need to ensure that all professionals that come into contact with people with substance misuse problems feel confident in having a conversation with that person about their substance use, and know how to at least signpost them towards help and support.

This needs assessment also shows developments are necessary for the substance misuse treatment and support system itself to provide the best service to support people with drug and alcohol problems. This includes reviewing the way services are provided to the friends and families of people with substance misuse problems, reviewing drug and alcohol education in schools, increasing access to mutual aid peer-led recovery support, improving access to Tier Four residential treatments and improving joint working so that people are supported to return to work and live in stable accommodation. People in treatment should be offered person-centred recovery-focused care which successfully engages them in treatment, but also offers them the best chance of moving on from that treatment.

The key findings and opportunities identified in this needs assessment will be considered by the N-DAP Board, the DAAT team and the wider partnership to inform the development of ongoing strategy and action plans with a view to ensuring that all the people of Norfolk, young and old, are supported to live lives free from dependency on drugs and alcohol. N-DAP will continue to work towards the overarching goal of preventing and reducing drug and alcohol related harms, to individuals, families and communities in Norfolk.
Substance Misuse in Norfolk

Section 1: Friends and Families of People with Substance Misuse Problems
Introduction

Drug and alcohol problems can have significant effects on the people around the individual experiencing problems. This includes both children and other dependents and adult friends and family.

Relevant groups affected by substance misuse

- Children of parents/carers who misuse substances
- Adult friends and family members of people who use misuse substances
- Adults and young people who take on caring responsibilities because of someone else’s misuse of substances
- Other services working with children and families, particularly children’s social services

Substance Misuse during Pregnancy

Key findings

- 8% of women admitting to being moderate or heavy drinkers during pregnancy, this suggests at least 800 pregnant women requiring at least some sort of brief intervention around alcohol in Norfolk each year.
- It is estimated that at least nine children are born every year in the county with Foetal Alcohol Syndrome (and the true figure is likely to be higher due to difficulties with diagnosis).
- Between 20 and 30 women are recorded as being pregnant when starting drug and alcohol treatment each year in Norfolk.

There is little dispute that excessive parental drinking or drug use negatively affects the unborn child, however there is some disagreement over the degree and nature of these impacts. The effects are based on three inter-related factors: the pharmacological make-up of the drug, the gestation of pregnancy, and the route/amount/duration of drug use. The foetus is more susceptible during the first 4-12 weeks of gestation; drugs taken later generally affect growth or cause neonatal addiction. The effects of cocaine and heroin are particularly damaging because they may cause placental detachment, still birth, premature birth and low birth weight. Babies can also be susceptible to transmission of blood borne viruses that are more prevalent among injecting drug users, such as HIV and Hepatitis C.

Foetal alcohol spectrum disorder (FASD) is the umbrella term for a range of preventable alcohol-related birth defects. Foetal Alcohol Syndrome (FAS) is the most clinically recognisable form of FASD. Children with FAS have distinct facial features, and other symptoms include: hearing and ear problems, weak immune system, epilepsy, cerebral palsy and other muscular problems, liver damage and kidney and heart defects.

It can be difficult to gauge the impact of maternal drug use on the unborn child; two complicating factors are the combination of substance taken, and the pattern of drug and alcohol use. For example, women who use heroin regularly are more likely to use tobacco, cannabis, stimulants and tranquillisers. Moreover, the quantity and pattern of alcohol or drug use can fluctuate from day to day. Use of alcohol alone is more common and therefore more is known about FAS. The majority of people with FAS suffer with behaviour problems and 25 – 30% of people with FAS have an intellectual disability. Whilst FAS is not a common

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3 Ibid.
condition, it is nevertheless regarded as the leading known cause of non-genetic intellectual disability in the Western world.\(^5\)

Prevalence of FAS difficult to estimate due to difficulties in making the diagnosis very early in the child’s life as it is under recognised and symptoms can be labelled as other disorders (including ADHD and Conduct Disorder). Reported rates vary between 0.05 - 2 newborns per 1000 of total live births. FAS is diagnosed on a spectrum (in this sense it can be likened to autism) from a mild but still significant impairment of behaviour, to severe presentation of the full condition. The full disorder of foetal alcohol syndrome is thought to have a prevalence of around 1 in 1,000 births.\(^6\) In 2010 there were 9,259 live births in Norfolk, therefore we can estimate that at least 9-10 children are born every year in the county with this condition (and the true figure is likely to be higher due to difficulties with diagnosis).\(^7\)

A recent large-scale epidemiological study (18,553 English households) examined the associations between drinking during pregnancy and while almost two-thirds (63%) of mothers reported abstinence during pregnancy, and 29% were classified as light, 6% as moderate and 2% as heavy/binge drinkers (i.e. 7 or more units per week or 6 or more units per occasion).\(^8\) We can use the number of live births to conservatively estimate there are around 10,000 pregnancies each year in Norfolk and with 8% of women admitting to being moderate or heavy drinkers during pregnancy, this suggests at least 800 pregnant women requiring at least some sort of brief intervention around alcohol each year.

Between 20 and 30 women are recorded as being pregnant when starting drug and alcohol treatment each year in Norfolk. It is not possible to say how many others became pregnant during their treatment as this is only recorded at initial assessment. Under the ‘Norfolk Safeguarding Children’s Board multi-agency pre birth protocol’ drug and alcohol treatment professionals in Norfolk have a responsibility to work in partnership to contribute to assessments undertaken by Children’s Services where there is an identified risk to a child or unborn baby.\(^9\)

Problems associated with drugs and alcohol can to some extent be ameliorated by early antenatal care, however many pregnant drug users do not come into antenatal care until later as drugs such as heroin often interfere with menstruation and others may fear involvement of social services. It is crucial that frontline workers, such as midwives, are given sufficient training to identify, challenge and support mothers with substance misuse issues. Those training to be midwives at the University of East Anglia cover the topic of substance misuse in several ways included dedicated learning sessions, talks from substance misuse workers and spending the minimum of one day shadowing a substance misuse worker. A recent Dutch study also highlighted the need to consider how messages about drinking during pregnancy are communicated to the partners of pregnant women, and their role in supporting the mother to be abstinent from dangerous drinking whilst pregnant.\(^10\)

Despite the above, it should be noted that while there is general agreement that alcohol and drug use can increase risk, it is also probable that most mothers who use alcohol and drugs will give birth to healthy, normal children who suffer no long-term effects.\(^11\) Early intervention and multi-agency working is key to providing services for pregnant women who misuse substances and their children.

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Children Affected by Parental Substance Misuse

**Key findings**
- 58% of adults in drug and alcohol treatment are parents to children aged under 18 (22% having a child living with them and 36% with a child living elsewhere).
- 8% of children (5-15 years old) are young carers, and 7% of young carers care because of parental substance misuse – this is around 510 people in Norfolk.

While it is not always the case, substance misuse can have a negative affect on an individual’s ability to parent effectively. A wealth of research has looked at the impact of problematic drug use on the children of drug users, and suggests that parental problem drug use can and often does compromise children’s health and development at every stage from conception onwards. The child may be exposed to many sustained or intermittent hazards as a result of parental problem substance use; these include poverty, physical and emotional abuse or neglect, inadequate accommodation and toxic substances in the home. Children living with parental alcoholism face a range of increased risks in their lives including the likelihood of being in trouble with the police and experiencing difficulties in school. Also they are far more likely to develop alcohol issues themselves.

It is estimated that of the 250,000 young people (0-19 years old) in the UK 2-3% are affected by parental drug use and 6% are living with dependant drinkers. This equates to around 12,000 children (0-19 years old) in Norfolk. Parental substance misuse does not just impact on the children in the family. Survey data suggests that 46% of grandparents and other kinship carers say that parental substance misuse was one of the reasons they were caring for those children.

Of the 4,375 people who had structured drug and alcohol treatment in Norfolk in 2011/12, 58% were parents of children under the age of 18 (2,552 people in structured treatment), with 22% having a child living with them (958 people) and 36% with a child either living with their partner, friends, family, or in care (1,554 people). In total around 1,900 children were recorded as living with adults in substance misuse treatment in Norfolk. This is not the full extent of children living with parental substance misuse in Norfolk as it does not take into account parents who are not receiving structured treatment from substance misuse services, and these may represent a more vulnerable group of children.

**Young Carers**
One impact of parental substance misuse on young people is that it can result in them caring for the parent and/or other family members. Estimates suggest that 1.4% of children (5-15

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13 Ibid.
years old) are young carers, this equates to 1,230 young carers in Norfolk. A robust survey of young people accessing services for young carers in 2004 found that around 7% were caring because of parental substance misuse. These prevalence estimates are supported by local data from Norfolk Young Carer’s Project run by Crossroads Care East Anglia who report working with 1,400 young carers since the project began, with 43 young people recorded as caring because of drug misuse (3%) and 111 because of alcohol misuse (8%). We can therefore calculate that there are 86 young carers because of parental substance misuse in Norfolk.

However, the figures from the census are thought to be an under-representation of young carers due to fear and stigma of being identified. A survey of over 4,000 school children in 2010 found that one in twelve are carers (8%). Using this we can calculate that there are 7,307 young carers in Norfolk and 511 of these are caring as a result of their parents misuse drugs and alcohol. Therefore we can estimate that there are between 80 and 510 young carers in Norfolk that are caring because of parental substance misuse.

Recommendation
The breadth of the estimate of young carers who are caring because of parental substance misuses suggests that further investigation is needed to get a better picture of the scale of the issue in Norfolk.

Adult Family and Friends Affected by Someone Else’s Substance Misuse

Key findings
- Having a substance misuse problem can impact negatively on the friends and family around that person – emotionally, financially and physically.
- 3.5% of the population are estimated to be dependent on drugs and 6% on alcohol and therefore a significant number of people in Norfolk are being affected by the substance misuse of another
- The value of the care and support provided to OCU by family members is estimated to be £3,935 per family member per annum and therefore, the total annual saving to statutory services for Norfolk is estimated to be about £17,314,000

It can be extremely stressful to witness a loved one experiencing problems with drug and alcohol. This can affect spouses, partners, parents, grandparents, adult children and siblings, who will often suffer a wide range of negative consequences – including emotional, financial and physical impacts. This group are frequently an unrecognised, unappreciated and unpaid resource providing economic and other forms of support to their substance using relatives. The shame and stigma they often feel can lead to isolation and make them reluctant to seek help. Families can play an important role within a person’s drug using career, especially in the achievement and maintenance of recovery, both within and outside drug treatment.

For every person experiencing problems with their substance misuse it is likely that this is affecting the others around them. This will include friends, parents, partners and children of people who misuse substances. Friends and families need to be supported in their own right, and also given the necessary skills and support to assist the recovery of the person with the substance misuse problems.

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The prevalence of drug dependence in England is estimated to be 3.4% of the population (approximately 18,000 people in Norfolk). Most dependence is on cannabis only (2.5% or 13,300 people in Norfolk), rather than on other drugs (0.9% or 4,800 people). The University of Glasgow estimated that 8.2 people per 1,000 of Norfolk’s adult population are users of opiate and/or crack cocaine (OCU), which equates to 4,421 people in Norfolk. It is estimated that 5.4% of the population in England is mildly dependent on alcohol (29,000 people in Norfolk), 0.4% of the population are moderately dependent (2,100 people in Norfolk) and 0.1% severely dependent on alcohol (500 people in Norfolk). These statistics give some indication of the significant number of people experiencing problems with substance misuse in Norfolk – that in turn will impact on their friends and family members.

Supporting someone experiencing problems with substances will have financial impacts on the individual; the following figures are based on research by the UK Drug Policy Commission:

- The average annual financial cost per affected family member/carer was estimated to be £9,741 (2008 prices).
- The average excess healthcare cost for families of drug users was estimated to be £450 per family member per annum.
- On the basis that there are approximately 4,400 opiate and crack users in Norfolk and that each one has at least one affected friend or family member - This equates to an estimated overall total cost of about £44,840,400.

Some people will be caring for a friend or relative with drug or alcohol problems, or taking on their caring responsibilities. Again these figures are estimated by the UK Drug Policy Commission:

- The value of the care and support provided to OCU by family members is estimated to be £3,935 per family member per annum.
- Therefore, the total annual saving to statutory services for Norfolk is estimated to be about £17,314,000.

Services for People Affected by Someone Else’s Substance Misuse

**Key findings**

- Some specialist substance misuse services do offer support for people affected by the substance misuse of another.
- There is a gap for young people with no dedicated services for children below the age of eleven affected by parental substance misuse.
- One-to-one advice, information and counselling is the service most requested, but groups do also operate, including peer led mutual-aid groups.
- Stigma may impede people supporting people with substance misuse problems from accessing mainstream services.

**Young People**

Under18 provides one-to-one support to young people (aged 11 to 18) affected by someone else’s substance misuse (usually their parent or carer). In the two years between April 2010 and April 2012 78 young people have received individual psychosocial support from Under18. While young carer groups available, one to one support provided by Under18 is

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24 The National Treatment Agency (NTA) calculates this using the ONS mid-year population estimate for Norfolk (853,400) and estimates problematic drug use of the section of the population aged 16-64 (537,700).


unique and Children’s Services and other agencies are still referring affected others regularly.

NORCAS is funded by Children In Need to run a two year project providing twelve week group work programmes for young people caring for parents with substance misuse issues. The ‘Too Much Too Young’ project has been running for one year now with one group based in Norwich and one in Great Yarmouth employing two full-time workers, one in each location. There are around twelve young people in a group and are receiving referrals from a range of agencies including adult substance misuse agencies, and young carers groups. The service is designed to compliment rather than duplicate the work of Under 18 and refer people to Under18 if they feel they will benefit from one-to-one counselling.

Recommendation
There are no dedicated services for younger children (eleven and below) who are affected by parental substance misuse. There is some anecdotal evidence of Early Years projects and children’s centres supporting children aged five and under, but it is less clear what is available for children aged between six and eleven. Consideration needs to be given as to how support for children within this age group is developed and implemented across the county.

Adults
Many of the substance misuse agencies in Norfolk also work with people affected by someone else’s substance use. Some only offer these services to friends and families of their substance misuse clients, while others offer services more widely. These services usually take the form of providing informal support and advice and signposting to peer support groups.

One specialist substance misuse agency has a dedicated Carer’s worker who is funded for one day a week; operates only in the Norwich and Great Yarmouth areas and has an active caseload of around 40 people per quarter. They also support a monthly support group (attended by around seven people). This service also has a part-time Carers worker (ten hours per week) operating in the Thetford area, supporting clients on a one-to-one basis with an active caseload of around 15 families and providing a monthly group (usually attended by around five people).

West Norfolk Carers has a dedicated Substance Misuse Family Support worker who has a caseload of around 50 families that are affected by the substance misuse of another and are currently in receipt of some level of carers support in West Norfolk.

The UK Drug Policy Commission has carried out a large project reviewing provision of services for friends and families affected by substance misuse. They conclude that “Whilst there is increased recognition of family needs and the fact that drug problems lead to harm not only to the user but also to close adult family members, there appears to be yet a lack of translation of this recognition into the development of comprehensive services.” They also found that “Evidence based approaches were the exception rather than the rule”.

National research has identified a range of types of services and interventions needed to support families including:

- Advice and information provided through non-specialist settings, such as NHS Direct, Carers Direct or third sector carers services, which can provide direction towards sources of help.

27 For detail of the whole UKDPC project see http://www.ukdpc.org.uk/publication/supporting-supporters-families-drug-misusers-policy-briefing/ [accessed 09 October 2012]
- Dedicated family and carer support services providing help and support to family members in their own right; for example, peer support groups, specialist support groups and services, help from mainstream carers organisations, and GPs.
- Proper assessment of family relationships at the point when a drug user enters a treatment programme.
- Providing support and recognising the contribution of family members within treatment programmes for drug users, including residential recovery programmes. This could typically include the provision of information and education about drug misuse, the identification of sources of stress, handling relapses and the promotion of coping skills.
- For some people there will be a need for more intensive and specialist support, provided through such interventions as intensive family-based therapy, Behavioural Couples Therapy, Multidimensional Family Therapy and social network approaches.\textsuperscript{29}

The dedicated support workers for people affected by someone else’s substance misuse in Norfolk report the main functions of their role are:

- Delivering 1:1 sessions in a range of settings (home visits, neutral territory, office based). Providing emotional support and covering topics such as:
  - Understanding characteristics of different substances and the behaviours they illicit.
  - How supporting someone with substance use problems makes the carer feel and practical actions that they can take.
  - Additional needs in terms of maintaining the welfare of the carer. These could be related to personal grooming, or practical needs to deal with an issue in the home.
- Conducting assessments to ascertain the length of intervention required, establishing outcome based criteria to guide future interventions, formulate action plan and establish a framework in which to monitor impact and progress. These plans are reviewed and altered as appropriate.
- Facilitating specialist group sessions/support groups
- Carrying out Carers Assessments to facilitate access to further support

These specialist workers report that it is one-to-one contact is the main thrust of their work, giving general advice and support, information on drug and alcohol issues, brief intervention and counselling. There is reportedly a growing demand for the Carer’s Service, particularly in rural areas, which has resulted in people increasingly being supported remotely over the telephone rather than home visits.

**Financial support**

People who misuse substances can place financial pressure on the family, money may be spent on drugs and alcohol and the basic needs of family go left unmet. There is some financial support available for affected others in Norfolk through the services described above. The specialist substance misuse agency offers financial support in the form of the ‘Carer’s Grant’ for activities such as respite breaks, family days out and some provision of basic home equipment which the client is unable to afford. West Norfolk carers also provide some financial support and gave similar examples including one occasion where the direct payment funding was used to buy a safe for someone to store money from their partner to ensure there was money available for basic needs such as food and clothing for the family.

**Mutual Aid**

Al-Anon is an international organisation which runs peer led mutual aid groups for anyone whose life is, or has been, affected by alcohol. There are eleven Al-Anon meetings each week across Norfolk, with at least one being held in each district of the county. Families Anonymous is a similar organisation that offers support for the friends and families of people.

\textsuperscript{29} UKDPC (2009) *Supporting the Supporters: Families of drug misusers*. UK Drug Policy Commission
with drug problems. There are two Families Anonymous groups in Norfolk, both in the Norwich area.

The impact of stigma

Significant stigma exists around substance misuse, and this can prevent people from accessing services. Research has shown that people stigmatise not only the person with substance misuse problems but also, by association, their family members. One study found that 23% of people believe that most people would not become dependent on drugs if they had good parents; furthermore one in three people agreed that parents would be foolish to let their children play with the children of a person with a history of drug dependence. Therefore in addition to the stresses caused by supporting someone through their substance misuse problems, families of substance misusers must also cope with the stigma and shame associated with drug use.30

While there are services available to both young and adult carers in Norfolk, the stigma associated with substance misuse can act as a barrier to these people accessing these services. One of the key aspects of carers support is people having someone to talk to who understands their situation. It may be that the specialist situation of substance misuse requires specialist services. In order to fully support people affected by someone else’s substance misuse the optimum model would be a specialised service to work alongside generic carers support services in Norfolk. However, if this is not feasible and these needs are to be met in mainstream services, then specialist substance misuse/family and friends workers could mitigate against some of the impacts of stigma.

Training

Training for mainstream or tier one workers in drugs and alcohol will help address stigma and increase referrals to support services. Services such as social services, schools, health staff and domestic violence teams need to be able to identify and respond to the needs of family members of people with substance misuse problems.

Other Relevant Services:

Mainstream carer’s services

There are a range of dedicated services for carers around Norfolk, for example: Norfolk Carers Support which provide Carer Support Group Meetings, Carers Café's, one to one support at local libraries and carers appointments held in GP Surgeries; and Cross Roads Care who provide support in the home, day care and clubs, support for people at the end of life and for young carers. In order to access this support the individual must recognise themselves as a carer.

Norfolk Children’s Social Services and substance misuse

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<th>Key findings</th>
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<td>Social workers estimate that on average around 50% of the clients they worked with had issues relating to drug and alcohol use.</td>
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<td>In Norfolk 35% of families on FIP have substance misuse issues.</td>
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The impact of substance misuse on the family has important implications for Children and Family Services. Findings of a national survey of social workers found that they believed that on average around 50% of the clients they worked with had issues relating to drug and alcohol use.31 Local research has demonstrated that there are some areas of extremely good practice where social workers and drug and alcohol workers are working closely together and

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sharing information. However, participants in the study stressed that this was not the case in all areas and that good practice rested more on effective personal relationships rather than formal procedures.\textsuperscript{32} There is clearly a role for statutory and other supports services in identifying families affected by substance misuse, supporting their engagement to substance misuse services and referring into specialist treatment services. The numbers of formal referrals from social services are very low although they reportedly are frequently ‘signposting’ people into treatment.

There is a Norfolk Safeguarding Children Board protocol that outlines the working practices for anyone working with parents who have substance misuse problems (NSCB Protocol 10).\textsuperscript{33} A review of the implementation of this protocol was carried out in 2010 which found that there was good awareness among adult substance misuse workers to consider the potential impacts of a client’s substance use on their children; 81% of adult substance misuse workers had been trained in safeguarding children and just over half (56%) had made a safeguarding referral to Norfolk Children’s Services.\textsuperscript{34}

Given the proportion of clients who are parents, the links between substance misuse and safeguarding, and the responsibilities placed on substance misuse agencies in terms of their key role in protecting children, clearly has implications for service provision. Many agencies have dedicated safeguarding leads but all Key Workers and some other staff will be expected to spend a proportion of their time on child protection work.

Since the review of Protocol 10, the protocol has been updated, made easier to follow and flow diagrams designed for easy reference, this is in the process of being ratified by the NSCB. A safeguarding page has also been added to the N-DAP website with useful links aimed at professionals with safeguarding concerns.

Early intervention and prevention – Family focused projects

The 2010 Drugs Strategy asserts that family-focused interventions have the best evidence of preventing substance misuse amongst young people. These have led to significant reductions in risks associated with substance misuse, mental ill health and child protection and have led to reductions in anti-social behaviour, crime, truanting and domestic violence.\textsuperscript{35} There is a strong body of evidence that suggests an intergenerational model of substance misuse, for some young people growing up in a family where people misuse substances can increase their chance of using substances themselves.\textsuperscript{36} 40% of clients in specialist substance misuse treatment with the Under18 declared at assessment that someone in their family has problems with substance misuse.

Intensive family interventions in Norfolk (formerly known as Family Intervention Projects or FIPs) work with the most challenging families and tackle issues such as anti-social behaviour, youth crime, inter-generational disadvantage and worklessness in families. In Norfolk 35% of families on FIP have substance misuse issues, which is in line with the national average. Nationally half of family intervention families who were reported substance misuse issues at the ‘support plan’ stage achieved a successful outcome (i.e. they no longer had this problem when they left).\textsuperscript{37}

The future of FIP and other similar projects in Norfolk is linked to the Early Intervention Programme, Troubled Families project and Locality Team Model projects.

\textsuperscript{32} N-DAP (2010) Parental Substance Misuse in Norfolk: How effectively has NSCB safeguarding Protocol 10 been implemented? Available from the resources section of the N-DAP website www.ndap.org
\textsuperscript{33} Norfolk Safeguarding Children Board (NSCB) (2009) Protocol 10: Substance Misuse
\textsuperscript{34} N-DAP (2010) Parental Substance Misuse in Norfolk: How effectively has NSCB safeguarding Protocol 10 been implemented? Available from the resources section of the N-DAP website www.ndap.org
Results of the Public Consultation

Key findings

- There is a need for dedicated, publically funded services for the family and friends of those with substance misuse problems, with increased geographical equity of provision - meaning better services for those in rural areas.
- Everyone needs the option of individual support – but some people will also want to work in groups, and currently there are fewer groups than individual support.
- Informal ad hoc support is needed – out of hours peer support especially.
- Stigma needs to be addressed as it is a barrier to accessing help and there is an opportunity for this service to raise the profile of this issue and therefore begin to reduce stigma.
- Any dedicated ‘affected others’ service needs to have very close links with drug and alcohol treatment services to ensure that access to treatment is made as easy as possible, and joint sessions are available and that affected others can find out about the treatment their friend or family member is receiving (as appropriate).
- Proper promotion, awareness raising, training and investment in promotional materials is key to enabling other professionals to make referrals, and to allow people to self-refer.

In order to support the review of services for the family and friends of people who have substance misuse problems, a number of consultation activities were carried out:

- A workshop held with 19 professionals from across the partnership (13th November 2012). The output from this session is available on the N-DAP website.
- A survey aimed at the general public regarding families and friends that are affected by the substance misuse.
- A survey aimed at professional colleagues who come into contact with families and friends who are affected by someone else’s substance misuse.
- The gathering of case studies which demonstrate the more detailed impact on families and friends that are affected by the substance misuse of another.

The survey of the general public

Overall 145 people responded to an online survey regarding people affected by someone else’s substance misuse. The survey was promoted via the N-DAP website, the NCC website and was sent directly to Your Voice members. Drug and alcohol treatment agencies were also asked to promote the survey (along with other partner agencies) and the option to complete the survey on paper was available.

If people had not been personally affected by someone else’s substance misuse they were asked “Where would you go for help if you were concerned about a friend or family member’s use of drugs or alcohol”. More people said that they would go to their GP than any other source of help (63% said GP), and other popular answers were the internet (49%), drug and alcohol treatment services (45%), telephone helplines (35%) and peer support groups (34%). A large proportion would also go to informal sources of support such as friends and family (see figure 1).
These results highlight the importance of GPs as a ‘first point of call’. Also very few people said they would go to a carer’s service, supporting the view that people do not make the link between supporting someone with substance misuse problems and being a carer.

People affected by substance misuse of another, but not accessing help

The rest of the survey respondents were divided into two groups: those that had been affected by someone else’s substance misuse and received support, and those that had not received support.

Of the 68 people who had been affected by someone else’s substance misuse, three quarters (76%) had not had any support to help them deal with the effects of their friend or family member’s use of drugs and alcohol. Just over half stated that they had not received help because this did not know what was available. A third felt they did not need help (35%) and a quarter said that they “Don’t believe anyone can help me”.

When asked about what sort of help they would find useful, the most popular response was “Advice about how to get help for the person with drug and alcohol problems”, (55% said this would be ‘very useful’). This was followed by “Advice about what you can do when they are getting help”. People were less sure about how useful “Information about drugs and alcohol” would be to them and “Sessions where you can speak to others in the same situation”. “Help making contact with other agencies (housing, social services etc.)” seemed more specialised with only 37% saying it would be very useful. Finally people were most likely to say “Sessions where you can both talk to someone together” “Might be useful” (40%), with 10% saying this would not be useful at all. So it seems that for those who had not accessed any help, it is information about what services are available, how to motivate them to access that support or treatment, and what their role might be when that person is getting professional help is most important.
When asked about what help they needed to support them personally the top answer was “Someone to listen/ individual counselling” (44% thought this would be very useful). Other popular responses were “Speaking to others in the same situation” and “Information about how to maintain your well being”. People were divided over whether “time away from your caring responsibilities” would help with 31% saying it would be very useful, and 31% also saying it would not help them at all. 41% felt the “Formal assessment to see whether you are able to claim benefits” would not be useful to them at all and 36% did not feel “Help explaining your situation to other organisations” would be useful.

So as might be expected the key thing people need is someone to listen and provide counselling advice. Overwhelmingly people felt that they would like to receive help face-to-face (85%). The internet was a more popular source of help than the telephone or leaflets (60% would like to receive help online as opposed to 33% on the telephone or leaflets). However, this result may have been influenced by it being mainly an online survey and therefore completed by people who are happy using the internet.

**People affected by substance misuse of another, and accessing help**

The respondents that were affected by someone else’s substance misuse and had received help were asked where they had got it from; the three most popular places were their GP, a drug and alcohol treatment service and peer support groups such as AlFam and AlAnon. This again highlights the important role GPs have as a first point of contact, and how it will be essential that they are made aware of any new service, and how to refer people to it. Several respondents had received help from carer’s services.

The most common type of support received was “Information about drugs and alcohol” (70% had received this) and “Sessions where you can speak to others in the same situation” (64% had received). Most of the respondents had had someone to listen to them or counselling (75%) and “Information on maintaining their well being” (67%). Very few had received respite or help explaining the situation to other organisations, none reporting having had a formal assessment to see whether they were eligible for carer’s benefits.

**Other comments**

People were also asked for their general comments on the issue. A recurring theme from this was a need for informal support on an ad hoc basis. Some people phrased this as “A safe place to go when in need of support” or even when they are in fear of violence. Others suggested a telephone support group as a spin off of a physical peer support group. It was also noted that peer support group like AlAnon were useful for some people, but the 12-step approach does not suit everyone and other types of peer support should be made available.

Alternative therapies to support the well being of those affected and tips to manage stress were suggested to be important; as are alternative activities and respite. Several people felt support was needed for the affected other to gain a sense of detachment from the user – this seemed to be particularly important to those supporting their adult children who had substance misuse problems. Others raised the issue that all support needs to be flexible and tailored to the affected other and their relationship to the person with substance misuse problems – for example the child of someone with alcohol problems will need different support to their spouse or partner.

Several respondents highlighted the importance of joint counselling between the person with substance misuse problems and their affected other, particularly as a way of helping the user understand the impact of their substance misuse and this being a motivating factor to get treatment. People generally felt that techniques and tips to motivate someone into treatment were useful. It was also noted that the person affected by someone else’s substance use would benefit from information about how to help other family members who are also affected, as well as the user.
More than one person noted that practical support in terms of getting help with benefits and dealing with financial problems and housing services was needed, as well as general information about drugs and alcohol. Finally the importance of adequate promotion of these services was raised many times, with a number of people commenting that they did not know that there was any support available for people in their situation.

Survey of professionals involved in substance misuse, service for carers and other relevant services

Alongside the survey for the general public and those that had been affected by substance misuse, there was a survey aimed at people working in relevant professions, who come across affected others in their work. There were 40 responses overall from people working in all areas of Norfolk. Two thirds worked with children and young people, 13% with adults and 22% with both. There were respondents from criminal justice agencies, social services, drug and alcohol services, education, health and voluntary sector organisations.

Respondents were given a list of possible services that may be of help to people affected by someone else’s substance misuse. No-one answered “not useful at all” to any of the options (see figure 2).

The service that the most people agreed would be “Very useful” were “Opportunities to take a break from looking after someone” or in other words, respite from caring. “Access to emergency support” was also rated highly, as was “Help to make contact with other agencies”. People were more divided on how useful group sessions aimed at the affected others well being would be, and group sessions to help people support the person with substance misuse problems. People were more likely to say that they thought individual counselling was “Very useful” rather than group work.
Respondents were then asked whether the services outlined above were available in their area. For six of the nine services, “Don’t know” was the most common response and therefore what came out most clearly was that people were not sure whether these sort of services existed or not. So again, adequate promotion of any new services is essential.

People were most likely to say “Help to make contact with other agencies” existed in their area (56%), followed by “Individual counselling to help someone support someone with drug and alcohol problems” (50%) and “Individual counselling to take care of the affected other’s own well being” (47%). People were least likely to say that “Opportunities to take a break from looking after someone” and “access to emergency support” were available. There was general consensus that individual counselling is more available than group work, and therefore this represents more of a gap. At least three respondents did say that each service does exist in their area – so each of these interventions already exists somewhere in the county in some form.

It was highlighted in the comments for this section of the survey that some of these services are available purely because certain voluntary sector agencies go above and beyond what they are funded to do and therefore there needed to be secure funding for these services. Others pointed out that while these might be available in the urban parts of their area, provision in more rural parts of Norfolk was lacking.

When asked about gaps in services for young people affected by the substance misuse of others some people reiterated that there was not a dedicated, publically funded service and therefore there was no security around what already exists. Others mentioned the lack of provision in rural areas and generally a need for wider coverage of what already exists. Overwhelmingly though the response was that people were not aware of what was provided for young people and therefore raising awareness of services is needed – people also highlighted that this needs to be particularly promoted in schools and directly to young people so that they know how to access help directly.

When asked about gaps in services for adults affected by someone else’s substance misuse people generally felt that all the relevant services were out there, but that provision was patchy and that adequate provision was needed across the whole county. It was mentioned that there were not enough opportunities for people to get together in groups in the county, and that while some services existed for spouses/partners, there was not enough for other affected others. Also one person felt that services were particularly lacking where the person with the substance misuse problems also had a dual diagnosis of mental health problems, and there was not enough join up between mental health and substance misuse agencies.

The need for confidentiality was also raised as an important point, as some people accessing services may not want the person whose substance misuse they are concerned about to know that they are accessing help. The stigma associated with substance misuse may also be a barrier to people getting help so it is essential people know that they can access services confidentially, but also that this service aims to raise awareness to address stigma directly.

When asked “Is there anything that could help you to deliver more effective support to people who are affected by someone else’s substance misuse” the respondents almost unanimously answered that they needed clear information about what was available in their part of the county, and how to refer/signpost people so that they can access help. Leaflets that they can hand out to people was suggested and also posters to raise general awareness about services would also help address stigma by normalising the issue. Others felt that they would like more training. Finally people highlighted the importance of providing a flexible, non-time limited support service to meet the varied needs of the varied people experiencing these problems.
So overall the key elements of a service to support adults affected by the substance misuse of their friends and families is better knowledge, self help and support and coordination of existing services.

**Recommendation**

The key findings of the Family and Friends consultation need to be reviewed to ensuring that plans are put in place to meet the identified needs.

The challenge for commissions is to commission a service (or services) to meet the needs of people of all ages affected by someone else’s substance misuse in a rapidly changing landscape in terms of wider services for children, families and carers, and in the face of ever increasing budget constraints. While specialist services are the optimum, it may be that people can be well supported by specialist workers within other mainstream services.

**Conclusion to Family and Friends Section**

Substance misuse does not only affect the individual but will impact on their children, parents, partner, wider family and friends. People can be extremely negatively affected by the substance misuse of another person – emotionally, practically and financially. These people’s lives can be significantly improved by the provision of advice, support, someone to talk to, and by practical things such as financial support and basic first aid information. Some people – ranging from young children to grandparents – may take on a caring role because of someone else’s substance misuse, and as such require the same services as any other carers but with specialist knowledge and understanding of the impacts of substance misuse.

The question of whether these people need dedicated services, or whether they are able to get what they need from more general family, carer’s or substance misuse services is difficult to answer, especially given the state of flux these services find themselves in at the moment in Norfolk. The stigma surrounding substance misuse should not be forgotten in these considerations, as it can provide a really significant barrier to people accessing services. While specialist services are the optimum, it may be that people can be well supported by specialist workers within other mainstream services.
Substance Misuse in Norfolk

Section 2: Young People
Introduction
The majority of young people do not use drugs and most of those that do, are not dependent on them. However, drug or alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life.

*Note: unless otherwise specified 'Young People' relates to those under the age of 18.*

**Drug and Alcohol Use by Young People**

**Key findings**

- Drug and alcohol use by young people in Norfolk is similar to the national average, although the number of young people trying smoking tobacco and cannabis is slightly higher than the national average. There are similar rates of regular heavy use.
- Nitrous oxide (also known as laughing gas) is the fourth most commonly used substance (after alcohol, tobacco and cannabis).
- Over half think muscle building steroids are safe if used properly.
- One in ten of a sample of Norfolk 12-18 year olds reported drinking more than once a week. For those aged 14 and under in Norfolk 35% reported being ‘really drunk’ at least once, and therefore this clearly represents a group in need of interventions including advice and information
- Alcohol related hospital admissions of under 18 year olds continue to fall but this masks increases in the Great Yarmouth and King’s Lynn & West Norfolk districts.

DAAT officers in conjunction with the Matthew Project conducted a survey in February 2012 of just over 1,000 young people aged between 12 and 18 (although most were 15 or 16 [70%]). In general levels of substance use were found to be the same as what you would expect by looking at national averages, with alcohol being the most commonly used substance, followed by tobacco and then cannabis. This also fits with what is known about young people who are receiving specialist drug and alcohol treatment in Norfolk; 80% are being treated for problems with either alcohol or with cannabis or both.

The survey found that:

<table>
<thead>
<tr>
<th></th>
<th>National Average</th>
<th>Norfolk average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have experienced being drunk at least once</td>
<td>80%</td>
<td>51%</td>
</tr>
<tr>
<td>Drinking every day or every week</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have tried smoking tobacco</td>
<td>35%</td>
<td>37%</td>
</tr>
<tr>
<td>Smoking every day or every week</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Drug Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tried cannabis</td>
<td>12%</td>
<td>19%</td>
</tr>
<tr>
<td>Tried Class A</td>
<td>3%</td>
<td>5%</td>
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</tbody>
</table>

Results showed that rates of young people trying smoking tobacco and cannabis were slightly higher than the national average, but there were similar rates of regular heavy use. So while more young people in Norfolk might experiment with substances than average, this

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40 N-DAP (2012) Young People in Norfolk, Drugs and Alcohol: Survey 2012. All Norfolk data in this section is taken from this survey, the full report is available from the resources section of the N-DAP website [www.ndap.org](http://www.ndap.org)
is not translating into more young people than average smoking tobacco and cannabis heavily.

**Drugs and Young People – Prevalence and trends**

Some of the most interesting findings were around use of the more unusual substances; the most commonly used substance after alcohol, tobacco and cannabis was nitrous oxide (also known as laughing gas), which 5% of young people have tried. This made it by far the most commonly used legal high. It might be expected that the substances most commonly used by young people are the ones that are most well known amongst them, but this is not the case. Nitrous oxide is the second least well known substance after barbiturates, (with one in three respondents saying they have never heard of it) but the fourth most frequently used. This suggests that while it is one of the more well used drugs, it may be one that young people have received little advice and information about, and therefore it would be worth addressing how nitrous oxide is covered in drug education in Norfolk.

Use of ketamine (medically used as an anaesthetic on both humans and animals and is a Class C controlled drug) is as common as use of ecstasy or amphetamines (around 3%). Use in Norfolk is also higher than the national average (3% in Norfolk, 0.6% nationally). The number of young people (18 and under) reporting ketamine use when entering treatment has remained steady for the past four years at 3-4%.

Similar levels had used muscle building steroids as have used class A drugs like ecstasy (3%); which is well above the national average of 0.5%. Most surprisingly steroids came second (after alcohol) in the list of drugs young people thought were ‘safe if used properly’, with over half of young people surveyed (52%) saying steroids can be safe. Steroid use among young people can be particularly dangerous as their bodies are still developing and unnatural hormone changes can be very damaging. This reported level of use coupled with the common perception that steroids are “safe if used properly” suggests there is a need to provide advice and information to young people about steroids and other performance/image enhancing drugs. The Matthew Project Under18 service have planned a training session with all of their staff on steroids in Autumn 2012, and where appropriate drug education sessions carried out in schools and other youth settings will be expanded to include information about these drugs.

**Alcohol and Young People – Prevalence and trends**

When asked about alcohol use in the last month a third (35%) of young people in Norfolk had not drunk at all but the majority of respondents had drunk once or twice (38%), 18% had drunk three to five times, 7% had drunk more than six times and 2% reported drinking every day. So this means nearly 10% of a sample of 12-18 year olds reported drinking more than once a week.

Young people were asked if they had ever drunk “so much alcohol that they were really drunk”; almost half said ‘Never’ (48%), 15% said ‘Yes once’, 17% said ‘Yes – two or three times’, 11% said ‘Yes four to ten times’ and 9% said they had been drunk more than ten times (see figure 3).

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The Norfolk figures compare favourably with a national study carried out by the Joseph Rowntree Foundation (JRF) in 2009. This study found that 80% of Year 11 pupils (aged 15-16) reported having been drunk at least once, whereas in Norfolk this proportion is only 65%.43

Between 2008/09 and 2010/11 there were 161 alcohol related hospital admissions of under 18 year olds in Norfolk. This gives a rate of 33 per 100,000 of under 18s; this rate has dropped over the last few years and is statistically significantly lower than the average rate for England (56 per 100,000 young people) (see figure 4). However two districts in Norfolk have seen this rate increase over the last two years (Great Yarmouth and King’s Lynn & West Norfolk).

Department of Health guidance sets out the risks associated with early onset drinking of alcohol (physical harm, increased risk of developing alcohol problems in the future and engage in other risky behaviour) and advises that young people who choose to drink should

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not do so until at least the age of 15.\textsuperscript{44} For those aged 14 and under in Norfolk 35\% reported being ‘really drunk’ at least once, and therefore this clearly represents a group in need of interventions including advice and information.

![Number of times young people have experienced being drunk by age](image)

*Figure 5*

Figure 5 shows there is a leap between those aged 14 saying they had been drunk more than four times (7\%) and those aged 15 saying this (26\%). The survey also showed that those who had tried substances most commonly tried them at age 14, and therefore this provides a good evidence base for ensuring that children of that age and slightly younger are getting good quality substance misuse education. This education should cover drug use as well as smoking and drinking.

*For a full analysis of the survey results please see the Research and Reports section of the N-DAP website.*

**Groups of Young People Vulnerable to Substance Misuse**

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**Key findings**

- 55 young people were excluded from school last year for drug and alcohol-related reasons.
- The number of young people that are NEET is rising and young NEET people are more likely to experience problems with substance misuse.
- Young people seeking supported accommodation have complex and multiple needs and for a significant proportion drugs and alcohol are one of those needs.
- There are fewer Looked After Children in substance misuse treatment in Norfolk than would be expected.

Some young people face increased risks of developing problems with drugs or alcohol. Vulnerable groups include those who are truanting or excluded from school, looked after children, young offenders and those at risk of involvement in crime and anti-social behaviour, those with mental ill health, and those whose parents misuse drugs or alcohol. Local and national research shows that levels of substance misuse are higher among young people who belong to vulnerable groups; one study found 24\% of vulnerable young people reported

\textsuperscript{44} DoH (2009) *Guidance on the Consumption of Alcohol by Children and Young People.*

using illicit drugs frequently during the preceding 12 months, compared with 5% of their less vulnerable peers.\textsuperscript{45,46}

**Exclusion from School**

Findings from a large scale national survey found that those who had truanted or been excluded from school were more likely than other pupils to take drugs at least once a month, and were also more likely to have taken a Class A drug in the last year.\textsuperscript{47} In 2010/11 130 children were permanently excluded from Norfolk schools, of these less than five children where permanently excluded because of drug or alcohol related reasons. 4,910 secondary school students were given fixed period exclusions in 2010/11, 55 of these were excluded for drug and alcohol-related reasons. This is 1% of all fixed period exclusions, lower than the regional average of 3%. So, while drug and alcohol issues are cause for exclusions from school in Norfolk, they represent a small proportion. The most common reason for permanent exclusion in ‘persistent disruptive behaviour’ and for fixed period exclusion is ‘verbal abuse/threatening behaviour against an adult’.\textsuperscript{48} It is not possible to say how many of these children also have drug and alcohol problems. Given that at least 55 pupils were excluded from school for reasons associated with drugs and alcohol, some of these permanently, it seems that these young people are displaying a need for drug and alcohol interventions. It is not possible to ascertain from available data whether the needs of these young people are being addressed.

**Young People Not in Education Employment or Training (NEET)**

At the end of February 2012 6.4% of young people in Norfolk were NEET (1,700 people), which is slightly above the national average of 6%. The overall percentage of young people that are NEET is increasing, as is the length of time young people are remaining NEET. Rates are highest in Norwich district (10.7%) and lowest in Broadland district (4.6%).\textsuperscript{49}

Analysis of national connexions data by the Audit Commission found that 2% of all NEET and 4% of those NEET for six months or more had disclosed substance misuse issues. They concluded that having an issue with substance misuse makes a young person 2.1 times more likely to be NEET for six months or more.\textsuperscript{50} Of those who received specialist drug and alcohol treatment in Norfolk over the last year, 21% were NEET (28 young people). This is an increase from 16% last year, and is higher than the national average of 19%.\textsuperscript{51} However the relationship between these two factors is not straightforward as being NEET can be both a cause and a consequence of substance misuse.

Given the changes to wider young people’s services and the increase in the proportion of young people presenting to treatment as NEET, there may be implications for treatment in terms of numbers in need and the long-term outcomes for these clients, and N-DAP should continue to monitor the prevalence of NEET in the treatment system.

**Young people in supported housing**

Between 2008 and 2010, 471 young people (16-18) were housed in supported accommodation in Norfolk, of these 10% (47 people) had drug and/or alcohol misuse as a primary, secondary or tertiary reason for needing this support. For only ten young people substance misuse was the primary reason for being in supported housing, however, these


\textsuperscript{50} Audit Commission (2010) Against the Odds: re-engaging Young People in education, Employment or Training. HM Government

\textsuperscript{51} NDTMS (2012) Drug and Alcohol Treatment data for 2011/12. National Treatment Agency
issues were more commonly recorded as a secondary or tertiary reason and combined with other issues. The most commonly recorded issue was ‘generic homelessness’ and others included offending, mental health problems, being a teenage parent, and having learning difficulties. This demonstrates that young people seeking supported accommodation have complex and multiple needs and for a significant proportion drugs and alcohol are one of those needs.

Norfolk has a lower proportion of young people in specialist drug and alcohol treatment that are Looked After Children (LAC) than is usually seen nationally and in our close statistical neighbours (Lincolnshire and Merton). Only 9% of referrals into specialist treatment come from Children and Family Services (ten young people last year) compared to 12% nationally. It may be that more needs to be done to ensure that appropriate assessments and referrals are being made (see figure 6).

![Figure 6](image)

Only 6% (11 clients) described themselves as NFA or living in unsettled accommodation when they began treatment. Given the well established link between housing problems and substance misuse, the numbers of NFA are lower than might be expected. No YP housing providers made a referral of a young person into specialist treatment in 2011/12, and on average nationally this makes up 2% of referrals. Whether this represents unmet need in terms of engaging with those in hostels or temporary accommodation is unknown, and should be investigated further.

**Looked After Children**

In the year ending of March 2012 there were 1,010 Looked After Children (LAC) in Norfolk, and 531 children subject to a Child Protection Plan. Findings from Department for Education analysis of outcomes for children who have been continuously looked after by a Local Authority for at least 12 months as at 31 March 2010 in England suggest that 4.3% were identified as having a substance misuse problem during the year. The regional average is 4.7% but the Norfolk percentage is just 1.8% (680 children looked after for at least twelve months - ten recorded as having a substance misuse problem). So either Norfolk has far fewer substance misuse problems among its Looked After Children, or there is an issue with the way this information is recorded. A recent national study looking at substance misuse and social care practice concluded that both adults and children’s social care appear to

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collect little, if any, routine data on substance use by their service users. The authors of this study highlight the strategic importance of such data, in order to provide a base for arguments for service development.\(^{55}\) Robust identification of substance misuse is crucial in all groups of young people, but takes on a particular importance for vulnerable groups such as looked after children. LAC young people should have an annual health check, which provides an opportunity to revisit the topic of substance misuse.

It is also worth noting that of the ten LAC identified as having a substance misuse problem over the last year in Norfolk; all ten were recorded as refusing the offer of a substance misuse intervention. Nationally 56% of LAC with substance misuse problems are recorded as accepting an intervention. Again it should be established what the reasons for this were, whether they were already receiving an intervention, or whether this is a data recording issue, or whether there is a problem with the way an intervention is offered, and/or the assessment/referral systems. There may be issues over on what is being asked, how it is answered, how this information is captured and how it is then acted upon.

If there are approximately 1,010 LAC in Norfolk and nationally 4.3% are identified as having a substance misuse issue this would mean we could expect around 43 LAC in treatment or receiving support, instead there were 17 in 2011/12. The ‘Being Healthy Outcomes Group’ is currently looking at how to better join up the work of health teams and social work teams to improve provision for LAC. Consultation with the In Care Council (ICC) in 2010 revealed a perception that action taken by social workers to identify and intervene in substance misuse issues in young people in care was widely variable, with some not asking the right questions, some doing too little to help and others taking an overbearing and accusatory approach to substance misuse.

A social worker from Norfolk Children’s Services has been seconded to work within the Under18 service. Staff report this has facilitated and strengthened links with Children’s Services; this worker has access to Care First (the Children’s Services computer system), enabling quick identification of those working with the young people at risk. Staff report that their knowledge and influence have resulted in quicker responses and better cooperation with Children’s Services teams. Only 9% of referrals into specialist treatment come from Children and Family Services (ten young people in 2011/12) compared to 12% nationally. Recent national research carried out with social workers (both adult’s and children’s) found that in spite of some groups of practitioners having significant numbers of people on their caseloads with alcohol and drug problems the number of referrals to specialist services was quite low. This may be explained by the service user already being engaged with treatment or simply refusing to accept a referral.\(^{56}\) The DAAT will continue to monitor levels of referrals from social care and Under18 need to work to raise awareness of substance misuse services.

**Recommendation**

Children’s Social Services should put in place clear processes for the accurate collection of data about the substance misuse needs of looked after children, and continue to build effective referral pathways to appropriate services. The ‘Corporate Parenting Being Healthy Outcomes’ group may be the appropriate mechanism to take this forward as they are reviewing working practices between health and social care.

**Young people with Mental Health Problems**

Figures from the 2010 CAMHS Needs Assessment suggest that there are 14,500 young people in Norfolk with a diagnosable mental health problem (8% of young people). CAMHS identified that young people with substance misuse problems as a group at greater risk of having mental health problems.\(^{57}\) There was clearly an overlap between the CAMHS and the


\(^{56}\) *Ibid.*

\(^{57}\) *Ibid.*
N-DAP client groups, as a result research was commissioned to investigate the effectiveness of joint planning processes and practice and evaluates what practice can lead to the effective delivery of desired outcomes.

Although the study found good examples of joint working between mental health and substance misuse agencies it was found that substance misuse was rarely part of joint planning. While most workers advocate multi-agency working, there were frequent examples of supporting the wider needs of a child or young person in-house. Although this was often appropriate, it sometimes reduces positive outcomes for the child or young person who might have benefited from multi-agency working. The reasons for this that were given included waiting lists, risk of disengagement, unawareness or non-availability of another service. One of the relevant recommendations from the report for substance misuse services is an increased understanding of mental health needs. The Under18 service has trained mental health nurses within the service who other workers can consult when mental health issues require formal assessments. The training needs of other staff members in this area should be assessed.58

**Substance Misuse-Related Crime**

In 2011/12 there were 103 young people (aged 17 or under) in Norfolk who were known to be offenders of alcohol-related crimes against the person (including violence, sexual assault and robbery). A third of these were female, which is an unusually high proportion when compared to other age groups. There were a further 17 violent offences linked to drugs where the known offender was under the age of 18 across Norfolk.

In 2011/12 there were 596 people aged 17 or under that were taken into custody in Norfolk who either disclosed misusing substances at the time of their arrest, or were believed to be under the influence by custody staff, this is around 10% of all young people taken into custody, and represents no change from last year.

There is an enhanced arrest referral scheme in Norfolk run by ‘The Matthew Project – Community Justice Team – Custody and Case Management’ (CCM). Workers undertake assessments within police investigation centres (PICs) and courts across the county; they also make referrals to treatment agencies, provide one-to-one interventions, support and case management. This programme is aimed at priority offenders using class A drugs, and as such does not usually deal with those aged under 18. Despite this young people are occasionally seen by CCM, the protocol is that if the young person is involved with the NYOT their Key Worker is informed; if they are not, then brief information and advice may be given, and if necessary the CCM workers refers the young person to Under18. The CCM team at Matthew Project reported seeing nine young people in custody over 2011/12.

**Recommendation**

Young people who are taken into custody displaying a drug or alcohol-related need are clearly an extremely vulnerable group and it is not clear from the available data how their needs are being met. The provision of custody outreach is being reviewed as part of the transfer to the new adult substance misuse treatment and support system, and as such there may be an opportunity to review provision in custody for young people.

**Risk/Harm Profile of Young People**

The NTA has identified ten factors that increase a young person’s risk of becoming dependant on substances (see graph below). They have used these factors to profile each

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58 Magilton, S. (2010) *Effectiveness of mental health and/or substance misuse related joint planning processes and practice* [report available on request form Jonathan Stanley, CAMHS Strategic Commissioner, jonathan.stanley@norfolk.gov.uk]
DAAT in terms of how many young people in treatment display these vulnerabilities (if a young person displays risk factors they are given a score of one for each they are recorded to have). Norfolk can be compared to other areas with a similar score on the Child Wellbeing Index, the two most similar are Lincolnshire and Merton (in Greater London). Figure 7 shows that in general there are a greater proportion of young people in substance misuse treatment in Norfolk with higher scores on the Risk/Harm profile than the national average. Only 47% of young people have a score of 0-2 compared to the national average of 57%. Norfolk has more young people displaying a risk score of 3 than is usually seen:

![Overview of Risk/Harm Profile 2011-12](image_url)

**Figure 7**

In general the risk profile for Norfolk is similar to the National picture in that early onset (using primary problem substance aged 15 or under), poly drug use (using more than one substance) and offending are the most commonly observed risk factors, although Norfolk has more poly drug users (63% of new clients this year displayed this characteristic, compared to 57% nationally), and more young people offending (see figure 8):

![Risk/Harm Profile of Drug and Alcohol Treatment Clients](image_url)

**Figure 8**
Overall the risk/harm profile for 2010-11 has stayed relatively similar to 2010/11, although there is a slightly higher proportion disclosing poly drug use.

**Drug and Alcohol Services for Young People in Norfolk**

**Key findings**
- 113 formal drug and alcohol education sessions were carried out by DAAT commissioned services in schools in the Norfolk area to a total of 11,170 young people (12% of school children).
- It is not known what substance misuse education the other 88% of school children received. Given the proliferation of academies and free schools it is a good time to review provision of drug and alcohol education and prevention work across the county.
- In 2011/12 there were 87 young people living in Norfolk who received targeted advice and information on a one-to-one basis. A further 173 received structured drug and/or alcohol treatment, which is 1.8 per 1,000 young people in Norfolk.

N-DAP commissions The Matthew Project Under18 (Under18) to provide universal, targeted and specialist substance misuse interventions to young people across Norfolk. Delivery of the service commenced in October 2009 and the contract runs until September 2014. Under18 provides consultancy and support for universal services, substance misuse education (formal and informal) and prevention in universal and targeted settings, advice and information, outreach, psychosocial interventions, community prescribing, specialist harm reduction, family intervention services and access to residential substance misuse treatment. The service is delivered in partnership with Norfolk and Suffolk Foundation Trust Alcohol and Drug Service (TADS) and Norfolk Children’s Services. The service employs the equivalent of around 18 full-time posts, including young people’s substance misuse workers and counsellors, specialist substance misuse nurses and a consultant psychiatrist from the Trust Alcohol and Drug Service (now part of the Norfolk Recovery Partnership) and an advanced social work practitioner from Norfolk Children’s Service. Under18 has bases in Great Yarmouth, King’s Lynn and Norwich; and carries out much of its work on an outreach basis.

N-DAP also provides funding to the Norfolk Youth Offending Term (NYOT) to provide targeted brief interventions and structured care planned treatment to young people engaged with the team who display drug and alcohol needs.

**Prevention Work in Schools and Outreach to Young People**

Drug Education is a discretionary subject (with some minimum statutory content contained in the Science Order of the National Curriculum) usually delivered as part of a PSHE/Citizenship Education programme. Under18 is commissioned by Norfolk Drug and Alcohol Partnership (N-DAP) to provide drug and alcohol advice, information and education to young people in a range of settings, which includes offering lessons and assemblies to NCC schools free of charge. Between April 2011 and April 2012 Under18 provided 113 formal education sessions in schools in the Norfolk area to a total of 11,170 young people. 62 sessions were in high schools, 30 in primary and junior schools and 21 in other education establishments.
The map above (figure 9) demonstrates that there are a number of secondary schools that did not use the Matthew Projects Services last year. The 2011 School Census showed 94,392 school-aged children in Norfolk, 55,319 in primary education and 39,073 people in secondary education; therefore we can say at least 12% received substance misuse education from Under18. However, it is not possible to say what other drug and alcohol educations schools might have provided in-house.

As of October 2012 there are now 22 high schools and eight primary/junior schools that are academies. There is also a free school in Norwich and two further free schools proposed. The introduction of academies and free schools is relevant to the provision of universal drug and alcohol interventions as they are not covered by the contract N-DAP has with Under18 to provide services in schools. In the past the Matthew Project Youth Team has provided services to non-statutory funded schools in Norfolk. Under18 have now been approached directly by academies to provide services and have developed a charging structure accordingly.

N-DAP has a responsibility to young people in Norfolk in supporting them with needs relating to substance misuse regardless of their place of education. The partnership must ensure awareness of Under18 is raised in all schools so that young people know how to get access to the service in order to address their needs. Universal education is an important referral source for young people needing specialist treatment; overall in 2011/12 19% of referrals come from education. Care must be taken to ensure that school sessions are directed towards the most high risk groups and given the recent changes there may be a need to revisit this process.
Under18 also carry out other prevention activities in the form of informal education and outreach, they report engaging with a further 3,830 young people in Norfolk in 183 other sessions of informal education and outreach. Under18 operates a ‘Voicebox’ caravan, which is a mobile outreach tool that is used as part of the school sessions and can also be used as for drop-ins other community settings.

The outreach work of Under18 represents an important response to youth antisocial behaviour in the county. In 2011/12 there were 598 reports of antisocial behaviour to the police recorded as involving young people and alcohol or drugs, this is 9% of all substance misuse related antisocial behaviour. The majority of reports are in the warmer months between April and October where young people are more likely to congregate outside. Although this can be a concern for residents, it can provide an opportunity to engage with these young people. Local Police Safer Neighbourhood Teams often liaise with Under18 service and the Matthew Project Youth team to arrange visits to areas where there have been complaints, to engage with young people and act as an inhibitor to crime and anti-social behaviour.

NORCAS is a local charity that also provides substance misuse services to young people in the county (although not commissioned by N-DAP); this includes outreach on the streets of Great Yarmouth and into the James Paget Hospital.

**Young People Receiving Structured Drug and Alcohol Services as Individuals**

Under18 and NYOT also work with young people on a one-to-one basis to address their substance use, this can either be on the basis of ad hoc targeted sessions or a more structured, specialist basis. In 2011/12 there were 87 young people living in Norfolk who received targeted advice and information on a one-to-one basis. A further 173 received structured drug and/or alcohol treatment, which is 1.8 per 1,000 young people in Norfolk (see figure 10).

![Rate of Young People in Structured Drug and Alcohol Treatment per 1,000 of the population (2011/12)](image-url)

*Figure 10*
Two thirds (67%) stated that cannabis was their primary problem substance and 27% say alcohol. Of the remaining clients less than five were using opiates and/or crack. There have been less than five opiate and/or crack users in treatment in Norfolk so far in 2012/13.

In general the young people’s structured treatment services in Norfolk are performing very well against their targets:

- No young person has waited more than three weeks to commence treatment
- All have a care plan within two weeks of starting treatment
- All are offered Hepatitis B vaccinations

Young people were referred from a range of sources with particularly positive increases in referrals from Universal Education, Targeted Youth Support, Outreach, Children Looked After, and Children & Family Services in quarter 4 of 2011/12. However, there were still no referrals from YP Housing Providers (these make up 2% of referrals nationally).

Four out of five (80%) of the young people who left treatment did so in a care planned way (i.e. did not just drop out of treatment). No young person was transferred from treatment with young people’s specialist substance misuse agencies to adult treatment agencies. The treatment providers report that this is because has been no young people who require services beyond their 18th birthday.

Recommendations
While it may be the case that no young people need to be transferred from young people to adult services treatment providers have a responsibility to ensure adequate transition arrangements are in place across the partnership between adult and young people’s services, and this requires continued monitoring.

A Cost Benefit Analysis of Young People’s Drug and Alcohol Treatment

Key findings
- A benefit of £4.66-£8.38 for every £1 spent on young people’s drug and alcohol treatment

A detailed cost-benefit analysis of young people’s drug and alcohol treatment in England was published in 2011. This analysis weighed the costs of treatment with the immediate and long-term benefits treatment has for young people. Substance misuse by young people imposes a range of immediate burdens on society in terms of the cost of crime committed by young people misusing drugs, the NHS costs associated with treatment of drug and alcohol-related conditions affecting young people, and the cost of drug and alcohol related deaths for young people. They also took into account the long-term cost imposed on society if these young people went on to become adult problematic drug users, including crime, health, and employment benefits. Given that substance misuse treatment is shown to reduce substance misuse, reduce offending and improve educational and employment opportunities for young people, the study concluded that the immediate and long-term benefits of specialist substance misuse treatment are likely to significantly outweigh the cost of providing this treatment. In particular, they estimated a benefit of £4.66-£8.38 for every £1 spent on young people’s drug and alcohol treatment. In fact they concluded that the number of those who are likely to develop substance misuse problems as adults would just need to be reduced by 3% - 6% for the long-term benefits to offset the cost of treatment. Furthermore, these estimates were based on a conservative set of assumptions and therefore the report concluded that the benefit of specialist drug and alcohol treatment for young people may be larger than reported.59

59 Department for Education (2011) Specialist Drug and Alcohol Services for Young People – A Cost Benefit Analysis. HM Government
Conclusion to Young People’s Section

This needs assessment shows that while the prevalence of some substance misuse is falling among some young people, trends in drug use are changing and this presents new harms and challenges for the partnership. All young people are entitled to education and advice to prevent them from using substance in the first place, or to prevent that use to become harmful. The importance of education, prevention and early intervention in universal settings cannot be underestimated, and yet not enough is known about provision to be confident that all young people are receiving the required information in Norfolk.

Very few young people develop dependency on drugs and alcohol, but there is a significant group of young people who require more targeted brief interventions and structured specialist treatment including counselling and prescribing.

Those who use drugs and/or alcohol problematically are likely to be vulnerable, experiencing a range of problems, of which substance misuse is one. Vulnerable groups include those with mental health issues, those engaged in risky sexual behaviour, NEET, LAC, and those involved in anti-social behaviour and crime. It is crucial that services aimed at these groups of young people have the skills to identify potential substance misusers, to ask questions about substance misuse, provide brief advice and education and to refer young people to treatment services where need is identified. This means that the commissioning and delivery of specialist drug/alcohol interventions for young people should take place within wider children and young people’s planning rather than in a drug/alcohol specific silo. The wider needs of young people must be addressed so that problematic use does not become entrenched. It is only through multi-agency working and shared responsibility that more positive outcomes can be achieved for the young people of Norfolk.
Substance Misuse in Norfolk

Section 3: Working Age Adults
Chapter 1: Drug and Alcohol Use by Adults

Drugs and Working Age Adults – Prevalence and trends

Key findings

- Cannabis is the most commonly used drug by adults in the UK (6.9% of adults used in the last year).
- Fewer young people are using heroin, and the population in treatment for heroin problems is getting older.
- ‘Party drugs’ like cocaine and ecstasy remain popular - 3% of the adult population admit to using class A drugs in the last year.
- ‘Legal highs’ pose dangers to users because new substances are rapidly appearing on the market, young people seem willing to try ‘mystery powders’ and more hardened drug users (who were previously using heroin and crack cocaine) are taking these substances in a response to the falling purity of other drugs.
- 30% of those in drug treatment also cite a prescription only or over the counter drug as one of their problem substances. Monitoring the prescription, abuse and withdrawal from certain prescription drugs has implications for primary healthcare, both in terms of practice and budgets.

Given the stigma associated with substance misuse and the illegal nature of some drugs it is difficult to accurately estimate the scale of prevalence of use and dependence in Norfolk. Statistics from the Crime Survey for England and Wales show that 3% of the population aged 16-59 admit to using class A drugs in the last year, and this rate has remained largely unchanged for the last 15 years. Cannabis is the most commonly used drug in the UK (6.9% of 16-59 year olds used in the last year), followed by powder cocaine (2.2%).

There have been no new prevalence estimates of drug dependence over the previous year, and therefore the following figures represent no change from last year’s needs assessment. The prevalence of drug dependence in England is estimated to be 3.4% of the population (approximately 17,950 people in Norfolk). Drug dependency is defined as a cluster of behaviours such as: a sense of need or dependence, impaired capacity to control substance-taking behaviour and persistent use despite evidence of harm. Most dependence is on cannabis only (2.5% or 13,200 people in Norfolk), rather than on other drugs (0.9% or 4,750 people). Symptoms of drug dependence were most commonly reported by adults aged between 16 and 24 (13.3% of men and 7.0% of women in this age group), prevalence decreases with age, except for the 55-64 age group (almost exclusively cannabis dependence) and all types of drug dependency are more common among males than females (4.5% of men and 2.3% of women).

While many people use illegal drugs, only a few will ever become dependent on them. Of the three million or so people who use drugs in England, only around 300,000 use the most problematic drugs: heroin and crack, and over half of these people are in treatment. The most recently available estimates suggest 7.7 people per 1,000 of Norfolk’s adult population are Opiate and/or Crack cocaine Users (OCU), which equates to 4,201 people in Norfolk. The Norfolk rate is higher than the regional average of 6.3 but slightly lower than the national average of 8.7 (however, because of the wide confidence interval on the Norfolk estimate, this difference can not be considered statistically significant).

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63 Estimates provided by the National Treatment Agency – See National and Regional Estimates of the Prevalence of Opiate and/or Crack Cocaine Use 2010/11. For more detail: http://www.nta.nhs.uk/facts-prevalence.aspx
Opiates and crack

Nationally the popularity of heroin appears to be dropping and the existing population of OCU is getting older. One theory is that the drug is less attractive to younger adults as they have seen the damage it can cause.\textsuperscript{64} Evidence of this trend has been seen among the people seeking help for drug problems in Norfolk, only 32% of OCU in treatment are aged between 25 and 35 in 2011/12 compared to a peak of 40% in 2009/10. 20% are now aged between 45 and 54, compared to only 13% just three years ago (see figure 11).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure11.png}
\caption{Age of Opiate and Crack Users in Treatment in Norfolk}
\end{figure}

However, this does not mean that younger people are not using drugs, and that this drug use in not causing problems.

Club/Party drugs

Use of ‘club’ or ‘party’ drugs remains popular amongst drug users. These substances include stimulants like MDMA (or ecstasy), cocaine, and other drugs like ketamine and legal highs. The 2012 Global Drugs Survey collected data from 15,500 drug users worldwide (online survey promoted through the Guardian newspaper and Mixmag magazine).\textsuperscript{65} The drugs most likely to be used by respondents were overwhelmingly alcohol and tobacco, with 92% of respondents saying they had drunk alcohol in the last month, 53% had taken cannabis, 34% MDMA and 22% cocaine.\textsuperscript{66}

A recent report by the National Drug Treatment Agency noted that the use of these drugs is not translating into significant numbers coming into treatment. Only 7% of those in drug and alcohol treatment in Norfolk are being treated for drugs other then opiate, crack or heroin. Of these the most significant group has cannabis as their primary problem substance (50%). This is followed by cocaine (16% of those in treatment) amphetamines (11%), ketamine (7%), benzodiazepines (5%), and other prescription drugs (5%). Use of ketamine (a powerful hallucinogenic anaesthetic), has risen in recent years, although now seems to be stabilising.\textsuperscript{67} In Norfolk people accessing help for ketamine use has risen steadily year-on-year for under five clients in 2004/05 to 74 clients in the last year (although this remains less than 1% of clients overall).

\textsuperscript{64} NTA (2012) Drug Treatment 2012: Progress made, challenges ahead. National Treatment Agency
\textsuperscript{65} Given the methodology this may not be representative of the population at large, however, with such a large sample size (7,700 from the UK, which is three times bigger than the current drug users captured in the latest Crime Survey of England and Wales) it can provide a valuable insight into what drugs are taken by the wider drug using population, as opposed to just those in drug treatment.
New psychoactive substances

The most obvious drug trend of recent years is the rise in popularity of new psychoactive substances or ‘legal highs’. This is a fast moving area with almost 50 new psychoactive substances reported to the EU early warning system in 2012.\textsuperscript{68} Little is known about the potential harms of many of these substances and law enforcement agencies and governments have a difficult job to keep legislation up to date. The line between the illegal and legal drug market is becoming more blurred with many legal brands containing the (now illegal) mephedrone. Now more than ever, it is increasingly hard for drug users to know whether the white powder they are buying from the internet, or from street dealers, is against the law or how many different substances have been combined to make it. This poses both dangers to the user and significant challenges for law enforcement agencies. The Global Drug Survey found 15% of respondents say they have taken an unknown white powder in the past 12 months, a third admitting it was supplied by someone they did not trust. Younger drug users are much more likely to take risks with unknown substances; a fifth of all respondents aged 18-25 said they had taken “mystery powders”. There is therefore clearly a need to consider how harm reduction messages can be communicated to this group.

Furthermore there is evidence nationally of more hardened drug users using - and even injecting - legal highs (particularly the now illegal mephedrone) in a response to falling purity of other drugs.\textsuperscript{69} There is limited anecdotal evidence of this in Norfolk but people have started to seek treatment for problems experienced with new psychoactive substances; although in 2011/12 this was less than five adults in treatment with a legal high as a primary problem substance (data is recorded of up to three problem substances - a further five adults have a new psychoactive substance listed as one of their other two problem substances). There is a need to ensure that frontline workers have sufficient support to provide an effective response to people displaying these changing patterns of drug use, and that their knowledge and skills are kept up to date.

Prescription drugs

Another group of drugs that are increasingly cited as a problem by people receiving substance misuse treatment in Norfolk are ‘Prescription only medications and over-the-counter’ drugs (POM/OTC). We know that over 2011/12 there were 740 people who received treatment for problems with POM/OTC drugs; which is almost a third of drug clients (29%) and gives Norfolk the 12\textsuperscript{th} highest proportion of the 149 DAATs in the country (just below Cumbria, which is another area in our cluster of similar DAATs). The other DAATs in the region that comes close to this rate are Suffolk with 21% and Southend-on-Sea with 20%.

Use of prescription drugs is also significant among the wider drug using population; the Global Drug Survey found that about a third of the 7,700 people from the UK who revealed their illegal drug use also took benzodiazepines such as temazepam in the last year and 7.2% taking the newer “z-drugs” – zopiclone and zolpidem. A quarter of responders had taken prescription opioid painkillers and 9% had taken other prescription painkillers, while most said they took them for pain relief, 24% said they took them to get to sleep and 18% said they took them for mood-changing purposes.

Use of drugs such as benzodiazepines and opiate based painkillers is of concern because these drugs can be highly addictive, and are regularly linked to drug related deaths.\textsuperscript{70} Research suggests that these drugs are most frequently obtained from GPs (and not bought illicitly as may be expected). A survey carried out by the Family Doctor’s Association of 200 of their members found that 52% of GPs were worried about prescription drug abuse in their area. Eight out of 10 said they were aware of prescribing to people who they thought were

\textsuperscript{68} EMCCDA (2012) Annual Report 2012. European Monitoring Centre for Drugs and Drug Addiction
\textsuperscript{69} Daly, M. (2012) 2012 Street Drugs Trend Survey. Drugscope
\textsuperscript{70} See the Drug Related Death section for more information.
addicted and half were aware of occasions when prescriptions had been sold on.\textsuperscript{71} If these drugs are being requested/prescribed/used inappropriately this clearly has both practice and cost implications for the NHS. Furthermore as these substances are often physically addictive any withdrawal should be clinically managed, and therefore there are again implications for service demand and funding.\textsuperscript{72}

Given the changing trends in drug use it is crucial that the support and treatment services are able to meet the wide range of needs associated with the changing pattern of drug use and dependency. This includes supporting the chronic, aging, opiate and crack users, the younger club drug user, and all combinations in between. Flexible, person-centered recovery-focused services are needed with interventions ranging from brief harm reduction advice sessions, to long-term packages of care including substitute prescribing and psychosocial counseling. All services should be working towards the ultimate goal of helping people to live a life free from dependency on alcohol and drugs.

### Alcohol and Working Age Adults – Prevalence and Trends

<table>
<thead>
<tr>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A sixth of the population (15% aged over 16) in Norfolk abstain from alcohol altogether</td>
</tr>
<tr>
<td>• 4% of the population are ‘higher risk drinkers’</td>
</tr>
<tr>
<td>• 0.1% have a severe dependence on alcohol</td>
</tr>
<tr>
<td>• The prevalence of binge drinking is much higher in Norwich than other parts of the county.</td>
</tr>
<tr>
<td>• The rate of binge drinking is dropping among all groups with the exception of young women.</td>
</tr>
</tbody>
</table>

A sixth of the population (15% aged over 16) in Norfolk abstain from alcohol altogether. Of the 75% who drink some times - 4% are estimated to be ‘higher risk drinkers’ (males drinking more than 50 units a week and 35 for females). These figures are in line with national averages.

\textsuperscript{71} The Global Drug Survey (2012) \url{http://www.guardian.co.uk/society/guardian-mixmag-drug-survey}

\textsuperscript{72} RCGP (2013) \textit{Addiction to medicines consensus statement.} \url{http://www.rcgp.org.uk/news/2013/january/~/media/Files/News/RCGP-Addiction-to-Medicine-consensus-statement.ashx}
The following statistics are taken from a number of government datasets combined by Alcohol Concern.\textsuperscript{73}

<table>
<thead>
<tr>
<th></th>
<th>Number in Norfolk</th>
<th>Estimated local healthcare costs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abstainers</strong></td>
<td>76,150 (15% of people)</td>
<td></td>
</tr>
<tr>
<td><strong>Higher risk drinkers</strong></td>
<td>21,803 (4% of drinkers)</td>
<td>£6.8m per year</td>
</tr>
<tr>
<td>Drink at a very heavy level which significantly increases the risk of damaging their health and may have already caused some harm to their health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Increasing risk drinkers</strong></td>
<td>89,368 (14% of drinkers)</td>
<td>£28m per year</td>
</tr>
<tr>
<td>Drink above the recommended levels which increases the risk of damaging their health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lower risk drinkers</strong></td>
<td>508,569 (82% of drinkers)</td>
<td>£8.2m per year</td>
</tr>
<tr>
<td>Drink within the recommended alcohol guidelines.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

‘Binge drinking’ as a particularly risky pattern of drinking as binge drinkers tend to drink with the intention of getting drunk, and are at risk from accidents, assault and alcohol poisoning; and are also most likely to be aged under 25.\textsuperscript{74} Norwich district has a significantly higher rate of binge drinkers than usually seen, 24% binge drink, compared to 17% in Norfolk on average.\textsuperscript{75} (See figure 12)

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{binge_drinking_graph.png}
\caption{Synthetic estimate of the percentage of the population aged 16 years and over who report engaging in binge drinking (2007-2008)}
\end{figure}

Although binge drinking has been reported as an increasing trend in recent years, this may have peaked as the annual NHS Health Survey found that 20% of respondents met the

\textsuperscript{73} Alcohol Concern (2012) Alcohol Harm Map for Norfolk. \url{http://www.alcoholconcern.org.uk/campaign/alcohol-harm-map} (accessed 12 October 2012)

\textsuperscript{74} Binge drinking is defined as the proportion of adult men who drank 8 or more units of alcohol on the heaviest drinking day in the previous seven days at time of survey and adult women who drank 6 or more units.

criteria for binge drinking in the previous week in 2007, and this fell to 17% in 2011.\(^{76}\) Men aged between 24 and 34 are most likely to binge drink (28% did in the last week) followed by men aged 16-24 (25%). These are also the age groups of women most likely to binge drink, although for women the 16-24 age group is worse (24%) than the 24-34 (19%). While there has been a significant drop in binge drinking by males aged 16-24 in recent years, and a general decline across the population, the rate for young women has risen over the last year (see figure 13).

Men aged between 24 and 34 are most likely to binge drink (28% did in the last week) followed by men aged 16-24 (25%). These are also the age groups of women most likely to binge drink, although for women the 16-24 age group is worse (24%) than the 24-34 (19%). While there has been a significant drop in binge drinking by males aged 16-24 in recent years, and a general decline across the population, the rate for young women has risen over the last year (see figure 13).

![Percentage of Young Adults Reporting Binge Drinking by Age and Sex](image)

**Figure 13**

**Prevalence of alcohol dependency**

A subset of harmful drinkers will meet the diagnostic criteria for ‘alcohol dependence’. The definition of ‘dependence’ on alcohol is the same as that for drugs (see above) and therefore includes behaviours such as a sense of need or dependence, impaired capacity to control substance-taking behaviour and persistent use despite evidence of harm.

There have been no new prevalence estimates of alcohol dependence over the previous year and therefore the following figures represent no change from last year’s needs assessment. It is estimated that 5.4% of the population in England is mildly dependent on alcohol (equating to 31,000 people in Norfolk), 0.4% of the population are moderately dependent (2,300 people) and 0.1% severely dependent on alcohol (580 people).\(^{77}\)

Prevalence is higher among men than women (any dependence – 8.7% of men and 3.3% of women). The highest rate of moderate dependence for males in for those aged 25-34 (1.8% of men) and for women it is the younger group of those aged 16-24 (0.3% of women). This echoes the findings from the binge drinking data cited above. In terms of severe dependence the highest rates for men are among people aged 35-44 (0.2% of men) and for women it is the older group of 45-54 year olds (0.2% of women). People from ethnic minorities were found to be less likely to be alcohol dependent than white people, this was true for both men and women. There was no significant relationship identified between alcohol dependency and income.\(^{78}\)

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\(^{78}\) *Ibid.*
Chapter 2: Substance Misuse and Health

Alcohol-Related Hospital Admissions

Key findings

- The rate of alcohol-related hospital admissions in Norfolk continues to rise year-on-year. There was a 10% increase alcohol related hospital admissions in Norfolk last year, compared to only an 8% increase nationally.
- Overall it is estimated that alcohol-related hospital admissions cost Norfolk £43.1m in 2011/12, this equates to £60 per adult in Norfolk (compared to £62 on average nationally).
- The 55-74 age group are responsible for the most alcohol related hospital inpatient admissions.

The physical harm related to alcohol is a consequence of its toxic and dependence-producing properties. Most organs in the body can be affected by the toxic effects of alcohol, resulting in more than 60 different diseases. The risks of developing these diseases are related to the amount of alcohol consumed over time, with different diseases having different levels of risk. Alcohol is rapidly absorbed in the gut and reaches the brain soon after drinking. This quickly leads to changes in coordination that increase the risk of accidents and injuries, particularly when driving a vehicle or operating machinery. The physical harm related to alcohol has been increasing in the UK in the past three decades, and this has had significant implications for health services.\(^{79}\)

There were 105,565 alcohol-related admissions in Norfolk in 2010/11,\(^{80}\) including:

<table>
<thead>
<tr>
<th>Number in Norfolk</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E (accident &amp; emergency) admissions</td>
<td>61,297</td>
</tr>
<tr>
<td>Inpatient admissions</td>
<td>20,465</td>
</tr>
<tr>
<td>Outpatient admissions</td>
<td>23,803</td>
</tr>
</tbody>
</table>

The rate of alcohol-related hospital admissions in Norfolk continues to rise year-on-year. Norfolk remains slightly above average for the eastern region, but statistically significantly below the national average (see figure 14). There was a 10% increase alcohol related hospital admissions in Norfolk last year, compared to only an 8% increase nationally.\(^{81}\)

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The rates of alcohol-related hospital admissions are not spread evenly across the county. Rates are highest in King’s Lynn and West Norfolk (KL&WN) district followed by Great Yarmouth, and both of these districts are significantly above the national average for hospital admissions for alcohol-attributable conditions. These are followed by the Norwich district and then Breckland. North Norfolk has the worst rate of the other more rural, affluent areas of the county, above Broadland and South Norfolk (see figure 15).\footnote{NWPHO (2012) \textit{Local Alcohol Profiles England}. North West Public Health Observatory on behalf of Public Health Observatories in England: \url{http://www.lape.org.uk/}}
Overall it is estimated that alcohol-related hospital admissions cost Norfolk £43.1m in 2011/12, this equates to £60 per adult in Norfolk (compared to £62 on average nationally). The Inpatient Admissions can be broken down as follows:

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number in Norfolk</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12,721</td>
<td>£20.1m</td>
</tr>
<tr>
<td>Female</td>
<td>7,744</td>
<td>£11.3m</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Number in Norfolk</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24 year olds</td>
<td>678</td>
<td>£0.8m</td>
</tr>
<tr>
<td>25-54 year olds</td>
<td>4,946</td>
<td>£7m</td>
</tr>
<tr>
<td>55-74 year olds</td>
<td>8,356</td>
<td>£13.5m</td>
</tr>
<tr>
<td>75+ year olds</td>
<td>6,486</td>
<td>£10.2m</td>
</tr>
</tbody>
</table>

It is worth noting from the table above that 55-74 year olds are the group that have the most alcohol related inpatient admissions, this may come as a surprise given that alcohol related harms are usually linked to young people (particularly A&E visits), but it is chronic long-term conditions that manifest in middle to older age that are actually causing the major impacts on the NHS.

**Key findings**

- Drug related hospital admissions (including poisonings and mental health related hospital episodes) are not as numerous as alcohol-related ones but also continue to rise year-on-year.
- When population sizes are taken into account the rate for Great Yarmouth and Waveney is higher than that for the rest of Norfolk.

Individuals who take illicit drugs face potential health risks as these drugs are not controlled or supervised by medical professionals. Illicit drug users are at risk of being poisoned by drugs and overdosing which can lead to a fatality. As well as these health risks, drugs can become addictive and lead to long-term damage to the body. Drug-related hospital admissions are not quite as numerous as alcohol-related ones, but nevertheless represent preventable admissions that continue to be a drain on NHS resources. Like alcohol-related hospital admissions they continue to rise year-on-year.

In 2011/12 there were 544 admissions to hospital in Norfolk where there was a primary or secondary diagnosis of drug-related mental health and behavioural disorders (see figure 16).\(^{33}\)

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\(^{33}\) In this context “Norfolk” refers to the now obsolete PCT area, which is almost the same as the county area, but excludes the Great Yarmouth district. Data on Great Yarmouth is covered by data referring to the old “Great Yarmouth and Waveney PCT” area.
The figure in Norfolk has risen by a fifth since last year (544 admissions in 2010/11, 19% increase), which is a 40% rise since 2008/09 (389 admissions). The number of admissions in Great Yarmouth and Waveney has risen by a quarter (25%) from 165 last year to 207 this year, which is a 77% increase since 2008/09 (an increase of 90 admissions in the year). This is against a national trend of a reduction in drug related hospital admissions, falling by 7% since last year. Reasons for this need to be thoroughly investigated, including the possibility that changes to data recording practices have had an influence.

This means that for Norfolk there are 115 admissions per 100,000 of the working age population (16-64) each year which is just above our regional average, but is lower than the figure for Great Yarmouth and Waveney of 159 admissions per 100,000 working age people (the third highest of the 13 old PCT areas in the region – see figure 17).

Furthermore, there were 145 hospital admissions where there was a primary diagnosis of poisoning by drugs in Norfolk area in 2011/12 and 47 in Great Yarmouth and Waveney. This means that in Norfolk there were 31 admissions per 100,000 of the working age population (16-64), slightly higher than the regional average of 28, but lower than the figure for Great

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Yarmouth - 36 per 100,000 (the second highest in the region). This represents a 16% increase for Norfolk, which is unusual as the number has stayed stable at around 125 a year for the last three years (see figure 18).

![Hospital admissions with a primary diagnosis of poisoning by drugs](image)

The drugs involved in these poisonings are not identifiable from the data currently available, but it may be possible to investigate this further by looking at local hospital episode data.

Overall, with both indicators, when numbers of admissions are considered in relation to population size, the rates in Great Yarmouth and Waveney are higher than those in Norfolk, and both areas remain above average for the region.\(^{85}\)

Use of certain substances can lead to a number of other conditions that are not included in these figures, for example drug use can lead to vulnerability to various viral infections, such as hepatitis C and bacterial infections and other cardiac problems; therefore, the results presented based on these particular diagnostic codes may underestimate the burden that drug use has on secondary care.\(^{86}\)

**Recommendation**

The continued increase in drug and alcohol related hospital admissions needs to be a priority area for action and strategic development with the aim of reversing the upward trend. Particular attention should be paid to priority groups including young people with a view to preventing future harm and 55-74 year olds who account for the greatest number of alcohol-related hospital admissions.


\(^{86}\) Association of Public Health Authorities (2009) *Indications of Public Health in the English Regions: 10 Drug Use*
Blood Borne Viruses (BBV)

Key findings
- 88% of drug client have had a Hep C test (no improvement on last year), and the proportion accepting Hep B vaccinations in Norfolk has fallen.
- The prevalence of injecting among new drug clients has risen slightly from last year.
- The amount of needles distributed through needle exchanges in Norfolk has risen 19% when compared to last year.

A Blood Borne Virus (BBV) is transmitted when blood from an infected person gets into the bloodstream of another. It has been shown that People Who Inject Drugs (PWID) are at increased risk from BBVs due to the dangers associated with injecting including sharing needles and injecting paraphernalia, frequency of injection, repeated injecting with used needles and inadequate cleaning of injecting paraphernalia.  

Hepatitis C (Hep C):
The Health Protection Agency (HPA) report that 45% of PWID in contact with drug treatment services in England tested positive for the Hep C virus. Of the people in drug treatment over 2011/12, 1,975 clients have previously, or are currently injecting. This would suggest that approximately 890 PWID in treatment in Norfolk have Hep C.

All substance misuse agencies are required to offer clients who are currently injecting, or have previously injected a Hep C test. Overall of those in treatment who have a history of injecting, 1,599 clients or 88% have had a Hep C test. This only represents a 1% increase compared to last year, meaning progress has slowed in this area of performance. The promotion of this important harm reduction intervention must therefore remain a priority for specialist treatment agencies, and those coming into contact with PWID in wider healthcare.

Hepatitis B (Hep B):
The HPA found that nationally, the transmission of Hep B has declined in recent years and the proportion ‘ever infected’ has fallen from 28% in 2000 to 16% in 2011. They attribute this to the increase in uptake of vaccinations. All drug clients (regardless of injecting history), should be offered a Hep B vaccination when starting treatment and of the 799 drug clients that started a new treatment journey in 2011/12 96% were recorded as being offered a Hepatitis B vaccination. 30% (240 people) were recorded as accepting the vaccination; 44% refused (350 people) and 18% were already immunised (146). This represents a change from last year where more people accepted the vaccination, and the number recorded as ‘already immunised’ has not increased sufficiently to account for this shift. The way this intervention is offered may need to be reviewed in light of this trend.

HIV:
The HPA estimates that around 1.2% of current or former injecting drug users have HIV. Out of the 2011/12 drug and alcohol treatment population in Norfolk 1,975 clients have previously or are currently injecting which would suggest that approximately 30 PWID in treatment in Norfolk are HIV positive. Although HIV is discussed during the assessment on entry to treatment in Norfolk, information about HIV is not returned to NDTMS and therefore prevalence data is not available. In order to enable the DAAT to have a clear picture of the prevalence of HIV in the future, this data will collected systematically from April 2013.

90 Ibid.
**Bacterial infections**

People who inject drugs are also susceptible to injecting site infections and the HPA found that these remain common nationally, with 28% of PWID participating in their study in 2011 reporting an abscess, sore or open wound at an injecting site during the preceding year.\(^9\) Infections seen nationally include meticillin-resistant *Staphylococcus aureus* and group A streptococcal infections, wound botulism and tetanus.

**Prevalence of injecting among drug users and use of needle exchange schemes (NEX)**

Just over a quarter of those starting drug treatment in Norfolk in the last year reported they were currently injecting (28%, 226 people); a third had previously injected (33%, 262 people) and 38% had never injected (306). The NTA report a decline in prevalence of injecting among the drug using population nationally and the HPA demonstrate the amount of PWIDs sharing needles has declined from 31% in 2000 to 16% in 2011.\(^91\)\(^92\) The percentage ‘currently injecting’ in Norfolk has decreased year-on-year from 51% 2005/06, but this trend appears to have now stabilised and the most recent figure represents a small rise on the year before (26% in 2010/11 – see figure 19).

![The prevalence of injecting among new drug clients in Norfolk](image)

**Figure 19**

Given the continued prevalence of injecting, sharing and BBVs - needle exchange continues to represent a vital harm reduction intervention. Needle exchange in Norfolk operates through 81 out of 156 pharmacies (52%). Demand for needles appears to be highest in Norwich CCG area, followed by the West of the county (see figure 20).

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Between April and September 2012 a total of 31,217 packs and equivalents were distributed at an average of 5,202 per month. The majority are distributed through pharmacies (84%) and the remainder through specialist drug and alcohol treatment agencies.

This level of distribution represents an increase of 19% over the same period in 2011 and the first increase in distribution over this period since 2006. Set against a backdrop of a fall in new opiate clients in both adult and young people’s services this increase is unexpected. Overall the relative percentages of needle sizes issued as well as outlet types are broadly similar indicating that the increased demand is for all sizes and through all outlet types.

There are a number of explanations for this trend; firstly it may be that a shrinking pool of injecting drug users means better awareness of the needle exchange services and therefore increased use of the service. Only 10% of PWID starting treatment in 2011/12 admitted to sharing needles, compared to 16% last year.

Secondly there may be an increase of people injecting performance and image enhancing drugs (PIEDs). Anecdotally the number of people accessing needle exchange for needles to inject these drugs is increasing. However, nature of PIED injecting is that significantly fewer needles are required to complete a ‘cycle’ compared to maintaining an injecting heroin dependency. Therefore the 49,890 additional needles distributed would represent a considerable number of new PIED injectors.94

A further explanation would be individuals injecting new psychoactive substances (legal highs). Other areas of the country have reported an increasing problem of people injecting drugs such as mephedrone, although while there have been occasional reports of Norfolk drug treatment users engaging in these practices, there have been nothing on the scale that would be required to explain this trend.95

Finally there may be an increase in people injecting heroin. However, this does not reflect nationally and locally observed trends which show fewer and fewer people using heroin, especially in younger age groups. It could be explained by the relapse of individuals who ceased using heroin during the shortage of late 2010 and early 2011, but unfortunately it is not possible to quantify or confirm this theory with available data. N-DAP will continue to

94 All information on Needle Exchange provided by Paul Brierley Needle Exchange and Supervised Consumption Co-ordinator for Norfolk
95 Daly, M. (2012) 2012 Street Drugs Trend Survey. Drugscope
monitor the use of needle exchange in Norfolk to determine whether this becomes a long-term trend and will continue to explore all possible reasons for it.

**Recommendations**

12% of clients with an injecting history do not have a Hep C test recorded and the promotion of this important harm reduction intervention must therefore remain a priority for specialist treatment agencies, and those coming into contact with PWID in wider healthcare.

N-DAP should consider commissioning a full investigation into why demand for needle exchange has increased across the county in the face of a reported drop in heroin use.

The scheme also continues to oversee the use of public sharps bins as a harm reduction measure to reduce the incidence of inappropriately discarded injecting equipment. Waste collection for used equipment is available at 100% of outlets. 12,787 litres of waste (returned used injecting equipment) was collected from all NEX outlets for disposal over 2011/12.

**Mental Health (Dual Diagnosis)**

**Key findings**

- 17% of clients in drug and alcohol treatment in Norfolk are also receiving mental health services (724 people). Dual diagnoses is far more common among women in treatment, with 21% of female clients also receiving mental health services, compared to only 15% of male clients.
- 44% of mental health service users either reported drug use or were assessed to have used alcohol at hazardous or harmful levels in the past year. This is 6,500 people in Norfolk.
- Many third sector organisations that help people with their mental health also work with people with substance misuse problems and there are opportunities to improve the care of people with a dual diagnosis through closer working relationships between providers.

The nature of the relationship between mental health problems and substance misuse is complex. In many areas a significant proportion of people with severe mental health problems misuse substances, whether as “self-medication”, episodically or continuously. Equally, many people who require help with substance misuse suffer from a common mental health problem such as depression or anxiety. Substance misuse is usual rather than exceptional amongst people with severe mental health problems and individuals with these dual problems deserve high quality, patient focused, integrated care; and this should be delivered within mental health services.96

The term ‘dual diagnosis’ covers a broad spectrum of mental health and substance misuse problems. One fifth (17%) of those in structured drug and alcohol treatment in 2011/12, were recorded as also receiving care from mental health services for reasons other than substance misuse (724 clients). This figure has not changed when compared to the year before. There are no significant differences between OCU or alcohol clients for this measure but dual diagnoses is far more common among women in treatment, with 21% of female clients also receiving mental health services, compared to only 15% of male clients.

Research suggests that 75% of mental health service users drink alcohol, and 31% use illicit drugs. It is estimated that 17% can be diagnosed as dependant on illicit drugs, 26% are hazardous or harmful drinkers and 9% are dependent on alcohol. Overall 44% of people

receiving mental health services are report harmful use of either alcohol or drugs. It is not possible to say how many of the people who are receiving mental health services in Norfolk also have substance misuse problems because this is not recorded as part of their initial assessment, which means the an opportunity is being missed to both raise the issue with clients to allow for proper screening and referral, and to collect valuable data. In 2011/12 14,800 people accessed NHS specialist mental health treatment in Norfolk, if we use the estimate that 44% of these will also have a substance misuse need, this is 6,500 people.

**Recommendation**
The identification of substance misuse issues should become a core part of mental health assessments across the county and effective care pathways and joint working arrangements with substance misuse services need to be developed and implemented.

In early 2012 Voluntary Norfolk carried out a piece of work with the Norfolk Joint Strategic Needs Assessment (JSNA) team to examining voluntary sector’s contribution to helping those with mental health problems in Norfolk. Of the eleven Third Sector organisations surveyed who support people with their mental health, 54% also said they work with people with substance misuse problems. This highlights that dual diagnosis manifests itself both at high levels of need and those accessing non-specialist support. This study found “there is a need to recognise that dual diagnosis requires specialist services and shared responsibility through closer working relationships between service providers, rather than being an ‘opportunity to disengage’ which some respondents felt was sometimes the case.”

**Alcohol-Related Deaths**

**Key findings**
- The general trend for both alcohol-specific deaths and alcohol-attributable deaths in Norfolk is either stable, or a small reduction over the last five years of data, although this masks rises in some Norfolk districts.
- The rate of alcohol specific deaths in Norfolk is below the national average, but above the regional average.
- There are three times as many alcohol-specific deaths of males than females
- Rates of alcohol specific and alcohol attributable deaths fluctuate dramatically across the county and are highest in Great Yarmouth and Norwich districts
- For females, most districts saw a rise in alcohol attributable mortality over the last year, but reductions in the rate for Great Yarmouth mean the average for Norfolk was a small reduction overall.

Excessive consumption of alcohol is a major preventable cause of premature mortality in the UK, with alcohol-related deaths accounting for almost 1.5 per cent of all deaths in England and Wales in 2010. “Alcohol specific deaths” are those directly attributable to alcohol including alcohol-related liver disease and alcohol overdose. The overall number of alcohol specific deaths of males in Norfolk was 150 over the two year period 2008/10 (most recently available data). The rate has remained steady over the last five years at 11 per 100,000 of

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98 ONS (2012) Mental Health: Adults accessing NHS specialist mental health services. Available at: http://www.norfolkinsight.org.uk/dataviews/tabular?viewId=143&geoid=15&subsetId= [accessed 07/12/12]
the population (DSR).\textsuperscript{101} This is above the average rate for the region (9 per 100,000) and below the rate of the average for England (13 per 100,000).\textsuperscript{102}

The rate fluctuates drastically across the county (see figure 21).

Rates of male deaths caused specifically by alcohol are highest in Great Yarmouth (23 per 100,000), followed by Norwich (17 per 100,000) and then North Norfolk (13 per 100,000). However, Norwich was the only district that saw a small increase in the number of alcohol specific deaths over the last two two-year periods.\textsuperscript{103}

The overall number of alcohol specific deaths of females is lower than that of males. In Norfolk there were 56 alcohol-specific deaths of females over the two year period 2008/10, a third of the number for men. The rate has remained steady over the last five years at four per 100,000 of the population (DSR). This is in line with the average rate for the region (four per 100,000) and below the average for England (six per 100,000). Again the rates differ across the county and are highest in Great Yarmouth (seven per 100,000).\textsuperscript{104}

Alcohol-attributable or related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some, but not all, cases of the condition; for example certain hypertensive diseases, various cancers and falls. The rate of alcohol-attributable deaths in Norfolk for females has stayed in line with the regional average over the last four years and was 12.6 deaths per 100,000 of the population (DSR). This is well below the national average of 14.7 per 100,000. The rate of alcohol-attributable deaths among men is far higher: 32 per 100,000 in Norfolk (see figure 22).

\textsuperscript{101} DSR refers to ‘Directly Standardised Rate. The observed mortality rates for the population in a certain area will depend to some extent on the ages of the people in that area. Age standardisation facilitates comparisons across geographical areas by controlling for differences in the age structure of local populations.


\textsuperscript{103} bid

\textsuperscript{104} bid
The rate for males dropped slightly over the last year of available data and is now far lower than the peak of 39 per 100,000 (DSR) in 2008. There is generally a small downward trend in the alcohol-attributable mortality of both men and women in Norfolk. For males most areas saw a reduction over the last year apart from King’s Lynn and West Norfolk and South Norfolk. For females, most districts saw a rise, but reductions in the rate for Great Yarmouth mean the average for Norfolk was a small reduction overall (see figure 23).

While the number of alcohol-related deaths is higher in older people, the rate of deaths that are attributed to alcohol is higher among young people, with 27% of all deaths in the 16-24 age group attributed to alcohol consumption, compared to 1.4% among those aged 75 and over. Below the age of 35, alcohol-related deaths were most likely to occur from the acute consequences of alcohol consumption, in particular, intentional self-harm and road traffic accidents. Beyond the age of 35 chronic diseases including alcoholic liver disease, malignant neoplasm of the oesophagus and breast, and hypertensive diseases were the most common causes of alcohol-related deaths.\(^{105}\)

Drug-Related Deaths

**Key findings**
- Norfolk has the third highest rate of drug-related deaths of the ten DAAT areas in the Eastern region.
- Opiates were implicated in the deaths of 80% of accidental overdoses.
- There is a downwards trend in drug-related deaths with accidental overdoses appearing to be becoming less frequent in Norfolk.

Norfolk has the third highest rate of drug-related deaths (DRD) of the ten DAAT areas in the eastern region with 3.6 deaths per 100,000 people (just behind Southend with 5.9 and Peterborough with 5.6). To put this in context this is far lower than some areas of the country, the highest being Brighton and Hove with 23.6, East Lancashire with 14 and North Tyneside with 13. However, ‘standard mortality ratio’ calculations based on actual numbers of deaths compared to numbers predicted show that there continues to be more drug related deaths in Norfolk than would be expected (which is not the case in the majority of areas in the region).

This definition of drug-related deaths includes people who have taken an overdose of drugs with the intention of committing suicide, accidental overdoses of illicit and prescription drugs, and those deaths where intention could not be determined. Using this definition there were 22 drug related deaths in Norfolk in 2010 (slightly less than the 29 seen last year and far lower than the unexplained 2007 peak of 41). Of the Norfolk districts Great Yarmouth has the highest rate of drug related deaths per 100,000 of population (8.6) followed closely by Norwich (7.2) with the rest ranging between 3.3 and 1.0. The Great Yarmouth rate is the highest of all the 47 Local Authority Districts in the eastern region (see figure 24).

Analysis of data recorded on the primary care mortality database suggests that between January 2003 and January 2011 there were 265 deaths in Norfolk linked to drugs (please note this excludes Great Yarmouth). Most of these were recorded as accidental overdoses (74%, 196); one sixth as suicides (14%) and the rest were recorded with an open verdict (12%).

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107 ibid
The vast majority of people who died of an accidental DRD are male (78%), and almost half were aged between 31 and 40 years old (40%). This information continues to fit closely with the principal demographic characteristics of those dying of drug-related deaths identified in national reports.\textsuperscript{109}

Heroin and/or methadone were implicated in the deaths of 80% of accidental overdoses. Of the remaining accidental overdoses: 11% were prescription drugs (mainly antidepressants), 2% were stimulant drugs (cocaine and amphetamine) and in 6% ‘unspecified drugs’ was recorded. In the final 2% it was conditions relating to injecting drugs that were a contributing factor in the death. In just under half of the cases where opiates were implicated, heroin was thought to be the cause of death, but nearly a third were caused by methadone and a small percentage (6% or 10 cases) were not caused by illicit drugs or their substitutes, but by prescription opiate-based painkillers (see figure 25).\textsuperscript{110}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{figure25.png}
\caption{Opiate related deaths in Norfolk 2002-2011}
\end{figure}

Using multiple drugs at the same time (or poly drug use) was a feature in a just over a third of cases (35%), and alcohol was implicated in just under a third of the drug-related deaths in Norfolk. Prescription drugs were recorded alongside other drugs in 12% of cases, and without other illicit drugs in 8% of cases. These included antidepressants, antipsychotics, antihistamines and benzodiazepines.\textsuperscript{111}

Where overdose deaths have been linked to heroin it may be as a result of a strong batch. However, these deaths tend to be fairly spread out and over the last ten years there were only two occasions where three people died from heroin overdose in the same month (last time was August 2007). Norfolk operates a warning system whereby if a strong batch of heroin (or any other drug) is identified by a treatment agency or the police a wide range of partners are informed to pass on the message to users. Generally, accidental overdoses appear to be becoming less frequent in Norfolk (see figure 26).\textsuperscript{112}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{figure26.png}
\caption{Norfolk Extract from Primary Care Mortality Database (Provided by Public Health Information Team in NHS Norfolk and Waveney)}
\end{figure}

\begin{itemize}
\item \textsuperscript{109} Ghodse et al (2010) \textit{Drug Related Deaths in the UK (np-SAD)}, St Georges University.
\item \textsuperscript{110} ibid
\item \textsuperscript{111} ibid
\item \textsuperscript{112} ONS (2012) \textit{Norfolk Extract from Primary Care Mortality Database (Provided by Public Health Information Team in NHS Norfolk and Waveney)}
\end{itemize}
N-DAP works to combat drug-related deaths by ensuring quick access to harm minimisation interventions such as methadone prescription, ensuring strict controls to guarantee correct titration and to limit people using on top (in line with best practice guidance).113 Educational messages around the use of multiple substances, and what to do if you witness and overdose are also important (N-DAP produced poster/leaflets regarding this in 2011). N-DAP also runs training courses in overdose prevention as part of its regular training calendar, this is open to both service users and professionals and trains around 100 people a year. Naloxone is a drug which reverses the effects of opiate overdose and this is now distributed to certain drug users in Norfolk and their significant others.

Drug and Alcohol Treatment Service User Deaths

Key findings
- 2011/12 (February 2011 – March 2012) the deaths of 40 drug and alcohol treatment services users were reported
- Nine service users died from accidental drug overdoses. Methadone has been directly implicated in seven of these cases, Methadone has been directly implicated in seven of these cases; three of these were being prescribed to by Norfolk treatment providers and through investigations have been conducted into the circumstances surrounding these deaths.
- Root cause analysis investigations suggest a number of actions including reviewing risk assessments and adjusting clinical interventions in accordance with changing attendance.

In order to gain more insight into drug and alcohol-related deaths in the county, and to support safe service governance of drug and alcohol treatment services, all services report any deaths of clients to the DAAT. Further investigations have also been made into how the different provider agencies investigate service user deaths and quarterly reports to the N-DAP service governance forum report actions from root cause analysis investigations, so that learning can be shared across the partnership.

Of the course of 2011/12 (February 2011 – March 2012) the deaths of 40 drug and alcohol treatment services users were reported (see figure 27).

![Norfolk Drug and Alcohol Service User Deaths - Cause of death](image)

The majority of deaths of drug and alcohol treatment service users were from long-term conditions relating to their use of alcohol (such as cirrhosis of the liver). Nine died of other long-term conditions (such as heart disease) and there were a variety of other causes of death, but details have been suppressed to protect confidentiality.

The deaths of the nine service users who died from accidental drug overdoses were spread out across the year, with no more than two occurring in any one month. The demographics of the deceased are as followed: all were white males aged between their late 20’s and mid 50’s. All died in their place of residence (mainly rented from the council, one was living in a hostel). Nine of the ten were long-term benefit claimants (in line with the wider OCU treatment population). This information continues to fit closely with the principal demographic characteristics of those dying of drug-related deaths identified in national research: the majority of cases were males (78%), under the age of 45 years (74%), and white (95%). Most deaths (75%) occurred at a private residential address.\[^{114}\]

Of the nine service users who died as a result of a drug overdose, seven were in structured treatment at the time of their deaths, one was receiving low threshold services and one had been in telephone contact with the agency but failed to attend their assessment appointment. Of the seven in structured treatment six were receiving substitute prescribing, with two of them not receiving psychosocial treatment alongside their prescription. Two was reported to have also been involved with mental health services, and one was awaiting an assessment.

All of these nine deaths have been officially classified by the coroner as drug overdoses. Methadone has been directly implicated in seven of these cases, and three of these were being prescribed to by Norfolk treatment providers. Benzodiazapines were directly implicated in two of these deaths, alcohol in one of them and two were simply classified as ‘multiple drug overdose’.

Full RCA investigations have been carried out in four of these cases and two investigations are in progress. Several recommendations have arisen from these investigations including:

- To ensure that all service users have an up-to-date full risk assessment, which is documented and communicated to the appropriate care professionals, meaning risk assessments should be reviewed and updated on a regular basis.
- When a client re-presents to treatment, previous risk assessments should be reviewed to assess whether the risk remains present.
- Consideration should be given as to whether there is requirement to adjust clinical interventions in accordance with changing attendance (specific to methadone). If there should be consistent practice consideration of applying a protocol or including in operational policy.
- Consideration should be given as to whether there is a clinical need to establish prompt follow-up interventions (e.g. telephone contact or another appointment) within a short defined time period following appointments where the service user has expressed suicidal ideation but is assessed as not requiring crisis intervention.

**Recommendations**

- Ensure that RCA recommendations from investigations into the deaths of drug and alcohol treatment service users are fully implemented.
- The four deaths relating to non-prescribed methadone provides evidence of the trade of illicit methadone in Norfolk that is worthy of further investigation.

**Suicide Deaths**

While Norfolk does not have an unusually high rate of suicide (90.8 per 100,000 in Norfolk compared to 100 on average nationally), but nationally and regionally suicide rates are rising.\(^{115}\) Substance misuse increases the risk of suicide attempts and death by suicide.\(^{116}\) Up to 41% of suicides are attributable to alcohol and 23% of people who engage in deliberate self-harm are alcohol dependent.\(^{117,118}\)

**Recommendation**

Several drug and alcohol treatment service users committed suicide last year and given the links between suicide and substance misuse there is a clear link with the county Suicide Strategy that needs to be strengthened.

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\(^{115}\) NEPHO (2012) *Community Mental Health Profile – Norfolk*. North East Public Health Observatory


Chapter 3: Substance Misuse and Other Needs

Adult Social Care and Substance Misuse

Key findings

- 193 people in Norfolk who received adult social care services over 2011/12 where a substance misuse was identified as one of their care needs.
- This is less than 1% of adult social service users – lower than the 9% estimated to have substance misuse needs.
- More can be done to clarify the role of adult social workers and social care staff in terms of substance misuse, and also to improve data collection and promote access to training.

People receiving adult social care services may have problems with drinking or using drugs that can impact on their other care needs or be the primary cause of their condition. International research evidence and practitioner reports suggest that substance misuse problems do exist within social care client groups including people with learning disabilities, physical disabilities, and older people. Such problems add complexity to the health and social care needs that social care professionals endeavour to meet.

Prevalence of substance misuse

Adult social workers estimate that 9% of clients their caseloads are negatively affected by their misuse of substances (one in 10 cases) and a further 4% are believed to be affected by someone else’s substance use. While this may not be a large percentage it does mean that for an average workload in adult social services of 21 cases (the average found in one study), could contain up to three cases with some concerns related to alcohol and/or drug use (two with concerns about someone’s own use, and one with concerns about the use by someone close to the service user).\(^{119}\)

Substance misuse needs can be identified as part of the adult social care assessment. In Norfolk in 2011/12 there were 193 people who received social care services where a substance misuse was identified as one of their care needs; which is less than 1% of all adult social care clients, far below the 9% estimated in the national survey of adult social workers. This may suggest under recording of substance misuse needs among adult social care clients in Norfolk.

Recommendation

The potential under-recording of substance misuse needs amongst adult social care clients requires further investigation and appropriate action to ensure effective data collection is taken.

Types of adult social services client

One in ten of the total adult social services caseload is estimated to have substance misuse needs, and this can be broken down further to reveal 32% of adults with mental health problems, 13% of adults with other needs, 9% of adults with learning disabilities and 5% of older people.\(^{120}\) Given the low numbers of social care clients with substance misuse needs recorded in Norfolk it would not be useful to compare Norfolk data to these caseload proportions, however we can say that of those in Norfolk it was most commonly ‘physical disability, frailty & temporary illness’ needs that were identified alongside substance misuse (43% of those with substance misuse needs), the second largest group had no other needs.

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\(^{119}\) Galvani, S et al (2011) *From the Front Line: Alcohol, Drugs and Social Work Practice – A national study.* Tilda Goldberg Centre

\(^{120}\) ibid
identified (41%), followed by those with mental health needs (15%), and other care needs included: dementia, learning disability, hearing impairment, visual impairment and vulnerable people (see figure 28).

So unlike the estimates from the national survey, it is those social care clients with a physical disability that are most commonly identified with substance misuse needs rather than mental health clients. In some cases the physical illness is a direct result of their substance use, for example infections associated with injecting or liver diseases associated with chronic alcohol use. It may be that social workers feel more comfortable recording these more obvious physical impacts of substance misuse, and less comfortable with recording dual diagnosis of substance misuse amongst adults with mental health problems.

Types of substance misuse

Respondents to the national survey of adult social care staff stated that it was predominantly alcohol problems that were encountered on their caseload, as opposed to drugs (21% of adult social care staff encounter alcohol problems at least weekly, and 10% encounter drugs). This is supported locally by data of those receiving adult social services with identified substance misuse needs – 61% had an alcohol problem, 17% alcohol and drugs, 14% drugs and 8% ‘other’ (which may refer to prescription drug use). This split may be attributable to the social acceptance of alcohol compared with illicit drugs.

The national research found problematic prescription drug use was mentioned most by those working with older people and adults with learning disabilities. As well as concerns about potential overdose of prescription drugs, this study highlighted how being prescribed certain drugs can make a person vulnerable to exploitation by people who want to use those drugs illicitly. A case study was supplied describing an older person with learning disabilities who was targeted for their medications, and because of their disabilities did not realise what was happening. It is not known whether anything of this nature has occurred locally.

The recent consensus statement representing the Department of Health, professional groups, Royal Colleges, specialist services and voluntary organisations about addition to prescribed medicines highlighted the importance of social care as well as health care

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121 Data provided by Norfolk County Council Planning Performance and Partnerships Service
123 ibid
professionals in working to prevent addictions to medicines from occurring, and to support all those suffering dependence and its impact.\textsuperscript{124}

**The role of social care staff in addressing substance misuse**

There is a general consensus that social work and social care staff ought to be in a position to identify substance misuse and be able to provide some information about accessing services at a minimum. One study found that those working with mental health were most likely to say they found it easy to identify problematic substance use, far more than the other groups. Those working with learning disabilities were least likely to even consider asking about alcohol and drugs with their service users, and that there is some suggestion that as a specialism this group is behind others in recognising that their clients may have substance misuse related needs.\textsuperscript{125}

Research shows that some social care staff view their role as offering information, signposting people to specialist services and putting the responsibility to access support into the client’s hands. However, others believe that social care practitioners should be able to make an assessment of the level of need in relation to substance misuse, to have sufficient knowledge and the necessary skills to be able to encourage a person to consider treatment, to then support a person during or after treatment, and to hold a case until a person is ready to change. It may even be feasible for practitioners to provide brief interventions and a use motivational interviewing techniques.\textsuperscript{126} There is a need to establish exactly what is expected of adult social work and social care staff in Norfolk; to clearly define their roles and communicate this to staff, with provision of appropriate training and supervision.

**Training**

Unsurprisingly research shows that the more training a social worker has on substance misuse the more likely they were to ask their service users about it, and to be aware of local services and how to make referrals to them.\textsuperscript{127}

Everyone working or volunteering in Norfolk that may come into contact with people with substance misuse problems are eligible to attend N-DAP training courses free of charge. The N-DAP Training and Workforce Development Coordinator also carries out a number of pieces of work with social work students in Norfolk (Adult and Children’s Services) including two full-day workshops with all social work students at Norwich City College. In addition the DAAT brings together an expert panel every year to help students with their specialist practice unit. Furthermore an agreement has recently been reached to work jointly on providing drug and alcohol awareness workshops on the next newly qualified social workers recall day. Finally, action has recently been taken to provide training to social care staff; for example an in-house briefing session for Leaf Home Care, and supporting lectures at the College Of West Anglia to teach their social care students about Brief Interventions. One of the elements in the 2013 N-DAP training plan is to provide a ‘Alcohol, Drugs and Home Care’ course aimed at increasing home carers’ knowledge and confidence in responding to alcohol and drug related problems among older people.

\textsuperscript{125} Galvani, S et al (2011) From the Front Line: Alcohol, Drugs and Social Work Practice – A national study. Tilda Goldberg Centre
\textsuperscript{126} ibid
\textsuperscript{127} bid
Employment and Substance Misuse

Key findings

- The 2010 Drug Strategy highlighted the importance of employment in supporting recovery and this is now one of the key priorities for drug and alcohol partnerships.
- Addressing substance misuse in the workforce can have significant cost savings for employers.
- N-DAP can do more to support employers to develop substance misuse policies, raise awareness of treatment and support options and reduce stigma.
- Long-term unemployment is linked to substance misuse. Only 26% of alcohol clients and 14% of opiate and crack users in treatment are in paid employment.
- People with a severe drug and alcohol dependency are a group that are vulnerable to the impact of changes to the disability benefit system.

The misuse of drugs and alcohol will affect many parts of a person’s life, including their performance at work and could ultimately result in them losing their job. Substance misuse reduces the productivity of the UK economy by increased sickness absence, inability to work (unemployment and early retirement) and premature deaths among people of working age. It is estimated that up to 17 million working days are lost each year due to the effects of alcohol, and combined, these three factors account for a total alcohol-related output loss to the UK economy of up to £6.4bn (double the cost to the NHS). Further impacts include substance misuse-related accidents or injuries and damaged customer relationships or team morale. Using a modelled calculation, alcohol-related harm costs an average organisation with 200 employees around £37,634 per annum.

While some larger firms will have drug and alcohol policies it is not always something employers know how to deal with, and many do not have a written policy. Government guidance states that a comprehensive approach to helping employees to recognise and reduce substance misuse is likely to positively impact health and well-being. Addressing these issues can therefore result in significant cost savings to employers, individuals and the wider economy, and benefit individuals with substance misuse problems.

Some people experience problems with substance misuse that does not dramatically affect their working life, but work commitments make it difficult for them to attend treatment appointments, or to pick up a prescription on a daily basis. Specialist substance misuse treatment and support needs to be flexible to meet the needs of working people. Just over a quarter of those receiving structured treatment for alcohol problems are in paid employment.

130 ibid
employment when they enter treatment (26%) and a smaller proportion of Opiate and Crack Using (OCU) clients (14%). This demonstrates a need to make sure all services are flexible and available to working clients, such as appointment times outside of office hours. Treatment interventions that can be carried out partly on a ‘distance learning’ basis may be appropriate for this group, such as ‘Breaking Free Online’ which has recently been purchased by N-DAP (to be used in conjunction with traditional face-to-face interventions).

**Recommendation**

- Awareness of substance misuse among employers needs to be raised, and employers should be supported in developing drug and alcohol policies that take into account treatment needs. HR departments should have sufficient skills and understanding of substance misuse in order to support their employees.
- N-DAP communication plans and strategies should include providing information to employers and offering promotional materials so that staff know what to do if they or a colleague are suffering from a substance misuse problem.

**Unemployment**

Unemployment, particularly long-term unemployment is associated with drug and alcohol dependency. The rate of Opiate and Crack Users (OCU) that are unemployed in Norfolk (86%) is higher than the national average of 80%. Overall of those known to have drug and alcohol problems in Norfolk only 20% are in regular employment, and this rate remains unchanged over the last two years. The 2010 Drug Strategy highlighted the importance of employment in supporting recovery and this is now one of the key priorities for drug and alcohol partnerships.

Over half of adults in drug and alcohol treatment in Norfolk are recorded as ‘economically inactive’ (53%), 16% are long-term sick or disabled (a rise from 11% last year), 1% are students and 3% are retired (the employment status of 7% of clients has not been recorded). In August 2011 (most recent figures) there were 1,240 people in Norfolk who were claiming Incapacity Benefits (IB), Serious Disability Allowance (SDA) or Employment Support Allowance whose main medical reason was recorded as alcohol or drug problem. This gives a crude rate of 2.5 per 1,000 of the working age of the population, which is lower than the rate for England (3.9 per 1,000). The rate varies across the county and is above national average in Norwich (5.1 per 1,000 working age people) and in Great Yarmouth (3.9 per 1,000) – see figure 29.

![Image of working age people claiming disability related benefits](http://statistics.dwp.gov.uk/asd/asd1/adhoc_analysis/2012/ib_sda_esa_dla_drug_alcohol_by_la_july2012.xls)

**Figure 29**

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Significant changes are being made to the way the disability benefit system operates. Incapacity Benefit is currently being phased out and being replaced with the Employment and Support Allowance (ESA), alongside a new assessment, the Work Capability Assessment (WCA). ESA replaced Incapacity Benefit (IB) for new clients in October 2008, and between October 2010 and 2014 everyone on IB is being reassessed and either placed on Job Seekers Allowance or ESA (with a few exceptions).

The Department for Work and Pensions (DWP) data shows that for new claimants of these benefits since 2008 just 9% were placed in the Support Group (therefore are entitled to ESA and exempt from mandatory work related activity); and 20% are placed in the Work Related Activity Group (receive ESA and engage in mandatory work-related activity) 31% were deemed fit to work and therefore placed on job seekers allowance and subject to its conditions. The remaining 37% of claims are closed before the assessment is complete. For those with alcohol problems a lower rate are placed in the support group (only 6%) and a higher rate found fit for work (37%). People with substance misuse problems are less likely to be placed in the support group than those with other conditions (see figure 30).

What this demonstrates is that people with a severe drug and alcohol dependency are a group that is vulnerable to the impact of changes to the disability benefit system. Disruption to benefits and the uncertainty and stress caused may have a negative affect on their ability to address their substance misuse problems. Drug and alcohol treatment services report spending an increasing amount of time helping clients to deal with problems with their benefits and to appeal WCA decisions.

This also means that an increasing number of people in treatment are being deemed to be fit for work, and therefore the partnership need to consider how it can further support these people to increase their skills and to move forward into the workplace. There are a number of barriers to work for people in recovery, many drug users also have criminal records and the increasing use of criminal record checks in recruitment creates further disadvantage. In addition to often very low skills and limited exposure to employment, housing can also often pose an additional ‘invisible’ barrier to employment for this group – ‘sofa-surfing’, hostel accommodation etc is a poor platform for obtaining and retaining employment.

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Another barrier to employment for those with substance misuse issues is the reluctance of employers to take on people who have had drug and alcohol problems. Two-thirds of employers who responded to a survey said they would refuse to employ a former heroin or crack cocaine user, even if they were otherwise suitable for the job. This suggests there is a need for action across the partnership to address the views of employers.

**Recommendations**
Improving employer’s knowledge of drug and alcohol services, how to address problems and reducing stigma should help address the problem of employment for those in recovery, and also facilitate signposting into treatment of people with substance misuse issues before those problems escalate to the point that people losing their jobs.

**Working with employment providers**
Recent guidance from the National Treatment Association highlighted best practice in terms of helping people with drug and alcohol problems back into employment. Training of JCP staff is highlighted as important in increasing referrals. Between 2009 and 2011 the DAAT Training and Workforce Development coordinator ran 16 sessions in which around 200 staff were trained in general drug and alcohol awareness, and what services are available in Norfolk (this included JCP, A4e and Shaw Trust staff). No sessions were provided in 2012 and conducting these sessions on an ongoing basis should be considered for future N-DAP Training plans.

One of the aims of this awareness raising was to give employment advisors the necessary confidence to refer clients into treatment; however, only four referrals were received between January and November 2012 (compared to five in 2011). Given the number of people affected by both substance misuse and employment problems, this is extremely low and suggests that the training and support provided has had little impact on the number of referrals for support and treatment. There is a need to develop joint working processes in order to develop a joined up care pathway for people with drug and alcohol problems in Norfolk.

In 2010 three JCP centres in England carried out a trial where treatment agency staff were based in JCP centres two to four times a week to see customers with substance misuse problems. In general the trial was deemed to be a success and resulted in an increase in referrals to the treatment agency. Job centre staff felt more comfortable raising substance misuse with customers knowing that someone from the treatment service was on hand to take over any difficult discussions.

In some areas specific programmes aimed at getting people with substance misuse issues back to work are run by third sector providers, for example the NEXT project that is run by Addaction in some London boroughs. This project brings together both people with drug and alcohol problems and family members/affected others. It runs for 12 weeks with two full days of training each week, with subjects range from setting healthy interpersonal boundaries to career action planning. This is followed by a six-month volunteer placement and coursework, leading to a recognised qualification. Of the 452 trainees since 2005, 90% have completed qualifications and gone on to further education and volunteering. More than half of 2009’s cohort and 31% of graduates since 2008 are now in full-time employment. The project costs around £2,500 for each person.

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138 For more information on the project see: [http://www.addaction.org.uk/page.asp?section=185&sectionTitle=NEXT+project](http://www.addaction.org.uk/page.asp?section=185&sectionTitle=NEXT+project)
It has long been recognised that the absence of secure and stable accommodation can act as a trigger for substance misuse, and can impede an individual’s recovery from their drug and alcohol problems. More than 40% of single homeless people cite drug use as the main reason for homelessness, while two-thirds report increasing problematic substance misuse after becoming homeless. A recent study into Multiple Exclusion Homelessness (MEH) found that 70% of those surveyed had experienced problems with drugs and alcohol. It concluded that first stage in becoming MEH is often substance misuse, with 19 being the median age for a homeless person to commence heavy alcohol and drug use.

In 2011/12 the rate of those considered homeless or in priority housing need in Norfolk is 1.91 per 1,000 households; this is lower than the national average of 2.31 but higher than the comparable figure last year of 1.77. This suggests that housing problems may be increasing in Norfolk, which will have an impact on future services. This rate equates to around 705 households.

If 70% were experiencing a substance misuse issue, this would be at least one person in approximately 495 households.

Appropriate housing and related support are critical factors in supporting recovery. It provides the foundation from which people can enter and continue in education, training or employment and secure housing is a known factor in helping ex-offenders to avoid re-offending. The government recognised the role of housing in supporting recovery in its 2010 Drugs Strategy. It was explicitly stated that recovery required a ‘whole systems’ approach.

### Recommendations

- Greater joint working between specialist substance misuse treatment providers and employment support advisors is needed to improve employment opportunities for people affected by substance misuse.
- Three-way case conference meetings are good practice. It is not known whether this happens in Norfolk. What is required is a full audit of employment support and services in the county for those with drug and alcohol problems, links and referral pathways between organisations and an exploration of what training/support is required to ensure that referral pathways are utilised.
- Explore potential for treatment agency staff to be based in JCP centres two to four times a week.
- Consideration should be given to funding a specialist project aimed at improving the employment opportunities for people with drug and alcohol problems.

### Housing and Substance Misuse

#### Key findings

- Appropriate housing and related support are critical factors in supporting recovery.
- One fifth (20%) of people receiving structured drug and alcohol treatment in 2011/12 were experiencing housing problems when they commenced treatment (i.e. being in unstable temporary accommodation, sofa surfing or being of No Fixed Abode [NFA]).
- There is an identified need for greater provision of designated supported housing for people with substance misuse issues in Norfolk in order to ensure that people can be matched to the right type of accommodation for their stage in the recovery journey (in particular, a need for abstinence-based supported housing).
- Access to outpatient (home) detoxifications for those living in the supported housing sector should also be improved.

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142 NTA (2009) Breaking the Link: The role of drug treatment in tackling crime. The National Treatment Agency
approach’ including housing alongside health, probation, education and wider support services.\textsuperscript{143}

The N-DAP Substance Misuse Housing Pathways Project conducted a detailed assessment of the temporary accommodation provided to people with substance misuse problems in Norfolk. They found that there are 21 supported housing providers in Norfolk covering 72 individual projects and together these projects have just over 1,000 beds. Across Norfolk there are currently five specialist projects for people with drug and alcohol issues and only one is accessible without a specialist referral route or funding stream. Of these, four projects were defined as having a high tolerance to working with people using drugs and alcohol, and this represents 99 beds. The study also recognised the success of ‘Hostel in-reach’ services, which both increase client participation and improve the skills and confidence of hostel workers.\textsuperscript{144}

This study highlighted the importance of matching people to accommodation that was suitable to their stage in their recovery journey (i.e. the need to be in either ‘wet’ or a ‘dry’ housing). They gave examples of a number of cases where this had not happened, particularly in terms of clients undergoing detoxification without abstinent accommodation being available to them post-detox. There is a need for greater provision for designated supported housing for people with substance misuse issues in Norfolk, and recognition of this led to the “Norfolk Housing and Support Strategy for People who Misuse Substances 2011-2013” being developed by Norwich City and Norfolk County Councils in 2011.\textsuperscript{145}

### Recommendations

Support the implementation of the Norfolk Housing and Support Strategy for People who Misuse Substances 2011-2013 including:

- Addressing the lack of abstinence based accommodation
- Improve access to outpatient (home) detoxifications for those living in the supported housing sector.
- Ensure consistent application of relevant policies and practices across the county.

One fifth (20\%) of people receiving structured drug and alcohol treatment in 2011/12, were experiencing housing problems when they commenced treatment (i.e. being in unstable temporary accommodation, sofa surfing or being of No Fixed Abode [NFA]). This represents no change from last year, although the proportion of new drug clients reporting being NFA at treatment start dropped from 12\% in 2010/11 to 10\% in 2011/12. In Norfolk people in treatment for their problems with opiates and crack are significantly more likely to present to treatment with housing problems than people being treated for other drugs (see figure 31).


There have been an number of recent changes to Government housing policy that will impact on people with housing related needs, one example is the Localism Act 2011 which made changes to the way people access social housing, the types of tenancies provided and the new powers for local authorities to discharge the homelessness duty into the private rented sector. The reforms of housing benefit and the introduction of universal credit will also affect people with housing problems, and given that those with substance misuse problems are over represented in this group, these wider policy changes could have a significant impact on people recovering from their problems with drugs and alcohol.\textsuperscript{146}

Fire and Substance Misuse

**Key findings**

- There were 479 accidental dwelling fires in Norfolk in 2011/12, 17\% are believed to be linked to substance misuse, which is 81 fires.

Problematic use of drugs and alcohol is linked to an increased risk of experiencing a fire at home. This is often caused by people drinking alcohol and then falling asleep whilst cooking or smoking. Intoxication can also cause drowsiness and can make people less alert to the signs of fire. It can also heighten feelings of disorientation which compromises someone’s ability to escape, and increasing the risk of being injured in the incidence of a fire.\textsuperscript{147}

Although Norfolk Fire and Rescue Service do not collect data on whether they believe a fire to be linked to substance misuse, research from Scotland suggests that impairment due to suspected alcohol and/or drugs use is a contributory factor in 17\% of fires.\textsuperscript{148} There were 479 accidental dwelling fires in Norfolk in 2011/12;\textsuperscript{149} this suggests there were 81 substance misuse-related fires. According to research carried out by the London Fire Brigade almost one third of fatal fires in Londoner’s homes are alcohol related (there was only one fatality due to accidental fire in a dwelling in Norfolk in 2011/12).\textsuperscript{150}

Norfolk Fire and Rescue Service carry out fire risk assessments in conjunction with Norfolk adult social services. The following case study outlines some of the issues:

\textsuperscript{146} CIH (2012) *The Role of Housing in Drug Recovery: A practice compendium*. Chartered Institute of Housing
\textsuperscript{147} ISA (2010) *Alcohol and Accidents*. Institute of Alcohol Studies
\textsuperscript{149} Data provided by Norfolk Fire and Rescue Service
Mrs B is an older person who lives in her own home. She drinks heavily and smokes cigarettes but denies she does this. She sometimes falls and has on occasion left her dinner to burn. She is able to walk to the shops to purchase alcohol. She smokes in her bedroom. The social care practitioner identified a major risk of fire in her home. Despite everyone’s concerns Mrs B wants to remain living in her own home. She has had several mental capacity assessments that conclude she is able to make this decision. To mitigate the fire risks a referral was made to the assistive technology service and a smoke detector, carbon monoxide detector and heat detector were fitted that are linked to the fire service. Mrs B has a personal alarm although tends not use this when she has been drinking. Carers visit Mrs B several times a day to support her though she sometimes declines their help. The fire service has responded three times to fire alarms. There is ongoing involvement by a multi disciplinary team to try to manage the risks of this situation.¹⁵¹

**Recommendation**

Smoking is identified as a risk factor on fire risk assessments but substance misuse is not. This is likely to be because people feel uncomfortable about raising such a sensitive issue and the associated stigma. It may be that the people carrying out these assessments would benefit from training aimed at giving them the skills and confidence to raise these issues. Consideration should be given to adding substance misuse to the fire risk assessment.

### Road Safety and Substance Misuse

#### Key finding

- Norfolk has a rate of 2.07 per 100,000 people (DSR) dying from land transport accidents due to alcohol; this is higher than the eastern region average of 1.38 DSR per 100,000 and the national average of 1.30 DSR per 100,000.
- Large and mainly rural districts such as King’s Lynn and West Norfolk have the highest rates of land transport accidents, which may be linked to limited public transport options therefore a higher incidence of drink-driving.

It is an offence to 'Drive with excess alcohol' - there is a specific limit on the amount of alcohol allowed in your blood, breath or urine when you are driving, and if you exceed that limit you commit an offence. In 2010 there were 20,500 road accidents resulting in injury the eastern region, and of these 421 drivers were found to have consumed more alcohol than the legal limit. This is 2% of all of those tested, which is in line with the national average.¹⁵² It is also an offence to 'Drive whilst unfit through drink or drugs'. This is determined initially by a police officer carrying out a 'Field Impairment Test' (FIT) (walking in a straight line etc.) followed by a blood test carried out by a doctor. Comparable figures

The number of people killed or seriously injured on Norfolk’s roads has reduced significantly over the long-term, however in the year ending August 2012 there were still 365 people killed or seriously injured in road traffic collisions in Norfolk.¹⁵³ Research conducted in Scotland found that 9% of all road traffic casualties are linked to alcohol consumption, and that this rises markedly amongst pedestrians where nearly a third (31%) of all pedestrian casualties had consumed alcohol.¹⁵⁴ This allows us to estimate that there were 33 deaths or serious injuries cause by road traffic collisions linked to alcohol in Norfolk last year.

¹⁵³ Data from the Norfolk Road Safety Team [http://www.norfolk.gov.uk/Travel_and_transport/Road_safety/index.htm](http://www.norfolk.gov.uk/Travel_and_transport/Road_safety/index.htm)
Norfolk has a rate of 2.07 alcohol-attributable land transport deaths per 100,000 of the population (DSR); this is higher than the regional average of 1.38 per 100,000 and the national average of 1.30 per 100,000 (DSR) (see figure 32). This is the only one of the 23 official indicators of alcohol-related harm where Norfolk is statistically significantly worse than the rest of the country.\textsuperscript{155}

The higher rate in Norfolk may be related to the rural nature of the county, with large and mainly rural areas such as King’s Lynn having the highest rate followed by Breckland and North Norfolk. In rural areas like these where there are limited public transport options there may be a higher incidence of drink-driving, and therefore land transport accidents. In 2010, 709 people were convicted of driving under the influence of drink or drugs in Norfolk.

\textbf{Recommendations}

Options for addressing the high rate of deaths cause by alcohol-related transport accidents should be explored by partners including Norfolk Constabulary and Norfolk County Council Environment, Transport and Development Team.

\textsuperscript{155} NWPHO (2012) \textit{Local Alcohol Profiles England}. North West Public Health Observatory on behalf of Public Health Observatories in England: \url{http://www.lape.org.uk/}
Black, Minority and Ethnic (BME) Groups and Substance Misuse

Key findings

- The largest minority group in Norfolk is ‘white other’, which is largely made up of Central and Eastern European (CEE) economic migrants (3.1% of the population). This is also the minority group most frequently seen in treatment making up 3.6% of those seeking help for drug and alcohol problems, and therefore proportionately represented in treatment.
- As many of the ‘white other’ group are recent migrants to the UK language can be an issue, and this raises challenges for treatment providers as well as financial implications for the partnership.
- The proportion of Gypsies and Travellers in treatment is not known, but given that this group is socially excluded, and that socially excluded people are more vulnerable to substance use, and that this group is less likely to access mainstream services – this may represent an unmet need.

The majority of people in Norfolk are White (96.4%); this can be broken down into the ethnicity groups of 92.4% White British, 3.5% White ‘other’, 0.4% White Irish and 0.1% White Gypsy or Irish Traveler. Of the remaining 3.6% of the population: 1.6% are Asian Indian (including Indian, Pakistani, Bangladeshi and Chinese) 1.1% are of Mixed ethnicity, 0.6% are Black, and 0.2% ‘Other’.

Of those in treatment in 2011/12, 92.7% are identified as being ‘White British’, meaning 7.3% are from other BME groups (no change from last year). On the whole the population in Norfolk matches the proportions of the different ethnic minority groups in treatment, apart from the Asian population who make up 1.6% of people in Norfolk, but only 0.3% of those in treatment. However, estimates of prevalence of substance misuse among the different ethnic groups usually place Asian people as the least likely to have substance misuse issues (Mixed is generally the highest followed by White, and then Black) and therefore this does not necessarily suggest an unmet need (see figure 33).

The Proportion of BME clients in Drug and Alcohol Treatment Compared to the General Population of Norfolk

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Drug and alcohol treatment</th>
<th>General Population of Norfolk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other White</td>
<td>4.0%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Other</td>
<td>1.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.8%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Black</td>
<td>0.7%</td>
<td>0.1%</td>
</tr>
<tr>
<td>White Irish</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>1.6%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Figure 33


Central and East European migrants

The largest group within the ‘Black Minority Ethnic’ (BME) population in Norfolk is those classed as ‘White Other’. It is thought that this group in Norfolk is predominantly made up of young economic migrants from Central and Eastern Europe (CEE).

While there is a large body of literature on the interactions between substance misuse and people from South Asian, Black Caribbean and Black African communities, but very few studies have focused on CEE migrants. People in the UK from CEE backgrounds are more likely to be recent migrants to the UK than more established communities such as Asian or Black minority groups. There is evidence that a small minority of these migrants comes into the UK with pre-existing substance misuse conditions, and others may experience difficulties with employment and/or housing that can cause them to turn to substance misuse. There is also evidence of Eastern European women being trafficked into Norfolk to work as sex workers, and there are established links between sex working and substance misuse.

The ethnicity of drug and alcohol treatment clients can be broken down further by looking at the recorded nationality of clients. In 2011/12, there were people from 36 different nationalities in drug and alcohol treatment (249 people). Most clients were recorded as having a nationality of the UK (4,126 or 94%), the second largest group was from Portugal (83 clients), followed by Lithuania (32 clients), Latvian (26 clients), and Poland (19 clients). Of the clients who did not have a UK nationality just over two thirds (70%) were Opiate and/or Crack users (OCU), 26% alcohol clients and 4% had problems with other drugs, which means that there is a statistically significantly higher percentage who are OCU than among British clients (see figure 34).

Recent migrants to the UK are less likely to speak English and language barriers can make it difficult to access services. This is particularly relevant to drug and alcohol treatment in terms of providing psychosocial interventions and counseling. Substance misuse support services in Norfolk use the INTRAN translation service. In 2010/11 the most frequently interpreted language was Lithuanian, followed by Polish, Russian, Portuguese and Mandarin. Last

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year it was reported that French had become a commonly interpreted language (potentially reflecting the increase in asylum seekers in Norfolk from French speaking African countries) but this has since ceased. As well as causing a potential barrier to treatment, interpretation has a cost implication for the partnership, however, it is not possible to estimate the total costs because NHS services buy their interpretation services directly and not through N-DAP. The non-clinical services in N-DAP, which make-up around a quarter of the structured treatment system, spent at least £8,000 on interpretation in 2011/12.

Recommendations
Given the identified language barriers for BME groups which may impact on access to substance misuse services, consideration should be given to supporting access through the provision of active outreach. This should be carried out by developing joint working approaches with organisations that are already working with these groups.

Gypsies and Travellers
As of June 2012 there were 504 Gypsy and Traveller caravans counted in Norfolk, and therefore this is a significant minority group in the county. Within Gypsy and Traveller communities, drugs are considered to be even more of a taboo subject than in the wider community, leading to reticence to discuss drugs issues, especially with outside agencies or individuals. This is likely to lead to a low level of understanding about drugs, their use, misuse, and services which may be available. Alongside this, a lack of knowledge and awareness about the specific needs of the local Gypsy and Traveller community may mean that local drugs services are not readily available to members of the community, and that information about the services is lacking.

Research shows that substance misuse is more common in circumstances of poverty, discrimination, and socio-economic disadvantage - which is a situation a disproportionate number of Gypsies and Travellers find themselves. One European study found varying degrees of awareness about alcohol abuse among Romani communities, and with respect to drugs, there was markedly less awareness about rates of abuse, let alone access to information about harms or possibilities for treatment. Alcohol misuse has always been known to occur amongst a minority of Gypsy and Traveller populations but anecdotal evidence indicates that, amongst some communities and particularly where families have been housed into run-down housing estates, or unemployment and depression are common, young men are becoming increasingly involved in a culture of alcohol and drug dependency.

Many Gypsy and Traveller communities in Norfolk are located in reasonably rural locations, these populations can be highly changeable, and Gypsies and Travellers themselves may be unable, reticent or uninformed about access to substance misuse services. Whether someone belongs to the Gypsy and Traveller community is not recorded when they enter drug or alcohol treatment, therefore it is not possible to say whether this group is accessing drug and alcohol services. However studies have found substance misuse to be prevalent among the Gypsy and Traveller community. It is not clear whether this group displays more need than the general community, but what is known is that this group is more likely to be socially excluded (in terms of poverty and deprivation) and that socially excluded people are more likely to have substance misuse problems. People with drug and alcohol problems require access to advice, information, brief interventions and structured treatment, and given

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162 CLG (2012) Counts of Gypsy and Traveller Caravans by Authorised and Unauthorised sites. Communities and Local Government
that this group is less likely to access help from mainstream services (like health and education) this may represent an unmet need in the county.\textsuperscript{167}

\begin{center}
\textbf{Recommendations}
It is tradition within Gypsy and Traveller communities to establish a framework of their own for dealing with problems and disseminating information; and therefore this points to a need for outreach work. Many Gypsies and Travellers have expressed anxiety about dealing with outside agencies, especially when in unfamiliar situations and surroundings, and therefore any consultation and service provision should occur through existing Gypsy and Traveller support networks.
\end{center}

\textsuperscript{167} Cemlyn, S. (2009) \textit{Inequalities experienced by Gypsy and Traveller Communities: A review}. Equality and Human Rights Commission
Chapter 4: Crime and Antisocial Behaviour and Substance Misuse

Antisocial Behaviour and Substance Misuse

Key findings
- Antisocial Behaviour (ASB) is one of the biggest policing issues for Norfolk Constabulary.
- Alcohol is a contributory factor in at least 5,000 ASB incidents a year in Norfolk.
- Although only 650 or so ASB incidents a year in Norfolk are explicitly linked to drugs, illicit drug use undermines communities making them vulnerable to ASB. Drug use can have an impact on communities and people’s perceptions of safety.

Antisocial Behaviour (ASB) is one of the biggest policing issues for Norfolk Constabulary. Alcohol is a contributory factor in at least 5,000 ASB incidents a year in Norfolk. This includes reports of street drinking and noise from pubs and clubs. Although only 650 or so ASB incidents a year in Norfolk are explicitly linked to drugs, illicit drug use undermines communities making them vulnerable to ASB. Drug use can have an impact on communities and people’s perceptions of safety.\(^\text{168}\) Data from Norfolk Citizens Panel shows that one in five people in Norfolk describe drug use as occurring at least once a week in their neighbourhood. Data from 2008 shows that 23% of people in Norfolk thought that drug use or drug dealing was a problem in their local area.\(^\text{169}\)

Drug and alcohol related antisocial behaviour is distributed across the county (see figure 35)

\[\text{Figure 35 Alcohol-Related Antisocial Behaviour Incidents in Norfolk (mapped to MSOA areas with district boundaries added for context)}\]


\(^{169}\) Norfolk Constabulary (2010) Strategic Assessment 2010
The main hotspots are in the main urban centres of the county; these are not usually the most densely populated areas, but areas where people congregate in pubs, bars and clubs. Locations that most frequently experience substance misuse related ASB are the centres of King’s Lynn, Norwich and Great Yarmouth.

Reducing antisocial behaviour can only be achieved through effective partnership working, relevant Norfolk organisations include: police, probation and youth offending team, operational partnership teams (who are staffed jointly by the local authority and the police and dedicated to dealing with ASB across the county), licensing and trading standards, schools and youth projects, housing and employment services, and drug and alcohol treatment agencies for adults and young people.

**Crime and Substance Misuse**

**Key Findings**

In 2011/12:

- 46% of people taken into custody were thought to be under the influence of either alcohol or drugs
- One third of violent crimes reported in Norfolk are linked to alcohol.
- One to two thirds of acquisitive crime is related to substance misuse. In Norfolk this is 6,500 – 13,000 crimes a year.
- Most offenders (86%) on the Norfolk 180° scheme have drug and/or alcohol problems.

People with substance misuse problems take up a disproportionate amount of police time. As well as causing antisocial behaviour there is an impact in terms of more serious incidents and crime. Overall over 2011/12 there were 18,500 custody records created in Norfolk custody suites.

- 46% were thought to be under the influence of either alcohol or drugs (8,500 of records).
- 28% admitted to being dependent on a substance (22% on some kind of drug and/or 10% on alcohol).

**Alcohol-related violent crime**

One third of violent crimes reported in Norfolk are linked to alcohol (32%). This rate fluctuates between 21% in Broadland and 37% in Norwich. In 2011/12 (financial year April-March) there were 3,520 alcohol-related crimes recorded in Norfolk. This means that there are 6.8 alcohol related crimes per 1,000 people; the highest rate is in Great Yarmouth (13 per 1,000 people) followed by Norwich (12 per 1,000) (see figure 36).
Importantly, alcohol has a dose responsive relationship with violence, with the acute risks of violence increasing with the amount of alcohol consumed. This suggests that reducing alcohol consumption will reduce violence in the county. National research shows that violence that occurs under the influence of alcohol can also result in more serious injury. This is reflected in local statistics with 37% of serious violent assaults in Norfolk are linked to alcohol (including GBH, ABH, malicious wounding etc.), compared to 28% of less serious assaults (e.g. common assault and battery).

The vast majority of recorded perpetrators of alcohol related crimes in Norfolk are male (as with many crime types). The proportion that are recorded as White European is the same as usually seen in the population of Norfolk, but a disproportionate amount are in the younger age groups - over half of all offenders are in the 16-29 age group.

The method that crimes are recorded as being related to alcohol in Norfolk is for a ‘Believed alcohol’ flag to be attached to the crime record; however this option only applies to violent offences, which means other alcohol-related offences are not flagged. Home Office research shows that 21% of young offenders committing violent offences had taken alcohol at the time, but for the proportion was 34% for vehicle-related thefts and 37% for criminal damage. This therefore represents a notable intelligence gap, and should not be seen as the true extent of alcohol-related crime.

Alcohol related violent crime is not distributed evenly across the county, as the map below demonstrates (figure 37).

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Figure 37 Alcohol-Related Violent Crimes in Norfolk (mapped to MSOA areas with district boundaries added for context)

Generally, alcohol-related violent crime is concentrated in the more densely populated parts of the county, in the towns and larger villages. However, there are areas in the North Norfolk district that show higher levels than might be expected. Again the hotspots are in the centre of King’s Lynn, Norwich and Great Yarmouth.

Licensing and the night time economy

Nationally a fifth of all violent incidents occur in or around drinking premises. In Norfolk the highest concentrations of alcohol-related violent crimes occur in the main Night Time Economy (NTE) areas of Norfolk; and 21% of all alcohol-related violence occurs in the current Norwich Public Order Zones. These are areas where licensed premises and food outlets are concentrated, often with late closing hours. The main NTE areas in Norfolk are Prince of Wales Rd in Norwich (309 crimes in one year - 9% of all the alcohol-related crime in Norfolk happens on Prince of Wales Rd), followed by Marine Parade in Great Yarmouth (113 crimes) and Norfolk Street in King’s Lynn (51 crimes).

Not all violent incidents that result in injury will be reported as a crime. Information is also recorded at the Norfolk and Norwich University hospital of people attending with injuries caused by assault. Although it is not possible to say how many of these incidents are alcohol related, 17% of them are recorded as occurring at licenses premises (or on Prince of Wales Rd).

The peak days for alcohol related crimes are Saturday and Sunday and peak times are between 23:00 and 02:00, with nearly a third of all offences occurring during these three hours. These are obviously the peak times that the night time economy operates, and significant policing resources are aimed at these areas during these times.

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that 48,000 officer hours per year are spent patrolling the Norwich’s NTE alone. The cost of violent crime recorded in the Norfolk NTE over 2011 for the Police alone is estimated at 3.3m (this is £63,461 each week across the county). Figures from Norfolk Constabulary show that between August 2009 and January 2012, there were 1,180 alcohol-related violent crimes, which had a total estimated cost to society of £21.8m. That figure includes the cost to the police, the cost of taking people through the courts, and includes impacts on health services, insurance, fixing damage and victim support services.

Norfolk Constabulary report that last year there was an upward trend was observed in violence linked with the NTE and as a consequence it became a policing priority. Since then a change to the policing model has occurred changing the policing levels within the NTE. As well as this, various other initiatives have occurred which involved the licensing team and partners, to further drive reductions. The Police Reform and Social Responsibility Act 2011 amends the Licensing Act 2003 with the aim of rebalancing it in favour of police and partners. It has paved the way for Late Night Levies and Early Morning Restriction Orders whereby the force can charge for premises that open late. In all likelihood this is behind the agreement for Prince of Wales venues to all close by 4am. Norwich City Council is now considering bringing in an Early Morning Restriction Order to restrict the sale of alcohol to before 3am.

The price and availability of alcohol are increasingly becoming political issues. At a national level the Government’s 2012 Alcohol Strategy set out plans to introduce a minimum price per unit – and these proposals are currently out for consultation. The licensing of premises to sell alcohol is controlled at a local level, and evidence from Norwich City Council suggests from 2005 to 2012 there has been a 40% increase in the number of licenses in the Norwich City Council district and there were a total of 542 licenses in the district in November 2012. The density or accumulation of licensed premises in certain places can be a concern as there is some research evidence to suggest the clustering of licensed premises can increase alcohol related harms.

Norfolk Trading Standards work to enforce legislation restricting the sale of alcohol to minors. Over the last year there have been seven different underage sale operations with 66 visits to shops for alcohol test purchases, and of these there were five sales to minors. Three of these infringements resulted in a fixed penalty notice of £80 being given to the seller and two resulted in a written warning. Trading Standards also investigate the sale of counterfeit alcohol, with only one case reported over the last year.

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177 Licensing Team, Norwich City Council, 2012 – Acquired via Jon Cox Speciality Registrar in Norfolk Public Health
Crime and drugs are inextricably linked. Anyone who sells, buys and uses drugs such as heroin, cocaine and cannabis is breaking the law. The British Crime Survey shows that nationally, 26% of people perceive drugs to be the main cause of crime. The crimes related to drugs fall into three main areas:

1) The first is possession, including for personal use, and supply under the Misuse of Drugs Act. In 2011/12 (financial year April-March) there were 2,149 drug offences recorded in Norfolk. Of these offences 86% relate to possession, 8% to supply and 1% production of controlled substances. Overall 71% relate to the possession of cannabis (1,523 crimes last year). The vast majority of production offences are cultivation of cannabis (164 offences last year) (see figure 38)

![Drug Offences in Norfolk 2011-12](image)

In the year before last there were 146 drug offences on average each month in Norfolk, and in this last year the average has risen to 175. However, as drug crime figures are reliant on

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HM Government
proactive policing rather than offences being reported by the public, this increase could be more a reflection of policing priorities rather than an increase in drug use. Recorded drug crimes are distributed across the county as the map below shows (figure 39):

![Drug Crimes in Norfolk](image)

**Figure 39 Drug Crimes in Norfolk (mapped to MSOA areas with district boundaries added for context)**

The map above shows that the majority of drug crimes are recorded around the main urban centres, but do occur right across the county, with very few areas showing no crime at all.

2) The **second** area of crime relevant to drug use is the violence and intimidation committed by organised criminals fighting for territory in the illicit drug trade. Norfolk Constabulary report that during 2012 almost half of the identified Organised Crime Groups (OCGs) are involved in drug supply. They indicate these groups generally supply heroin and cocaine, with some also supplying cannabis, crack cocaine and amphetamine. Nationally OCGs have been moving into the supply of new psychoactive drugs, therefore there is the potential that this will occur in Norfolk.

Overall 312 violent offences reported in the last year were recorded as being drug-related (3% of all violent offences), 7% of robbery (16 crimes) and 3% of sexual offences (25 crimes). Different drugs have different effects. Some, such as cocaine and other stimulants, can be associated with increased aggression. The links between drugs and violence can be similar to those for alcohol, for example through drug use altering cognitive functioning and affecting care giving practices, and shared risk factors making individuals vulnerable to both violence and drug use. However, violence is also an inherent part of illicit drug markets, which lack legal means of resolving business conflicts. For example, violence can be used in the drug trade to enforce the payment of debts, resolve competition between dealers and punish informants.

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Also, some drugs (including alcohol) can increase risks of victimisation, causing people to put themselves in risky situations and sedative effects putting people at risk of sexual assault.\(^{182}\)

3) The third area is acquisitive crime committed by people whose drug use has become an addiction. The relationship between problem drug use and crime is complex. Even so, evidence indicates that problem drug users are responsible for a large percentage of acquisitive crime, such as shoplifting and burglary. Estimates suggest that between 36-66% of acquisitive crime is committed by people with heroin and or crack cocaine problems.\(^{183}\) There were 19,717 acquisitive crimes recorded in Norfolk in 2011-12, if one to two thirds of these are substance misuse related then this is between 6,500 and 13,000 crimes a year. Some also support their use via low-level dealing or prostitution. Their offending often escalates to keep up with the rising cost of their drug use.

It is estimated that between them, every ten opiate and/or crack users not in treatment in 2010-11 committed: 13 robberies and bag snatchs, 23 burglaries, 21 car-related theft, and more than 380 shoplifting thefts.\(^{184}\) Analysis of local data by Norfolk Constabulary shows that many individuals who are recorded as offenders or suspects of acquisitive offences are also known to be drug users. Police figures show that only 6% of the robberies in Norfolk in 2009/10 were linked to drugs, but more detailed analysis suggests that a quarter of robbery offences were drug-related.

People with drug problems can develop a tolerance through daily compulsive use, which can result in an expensive addiction. For instance, the estimated average value of drugs used by opiate and crack users in the four weeks prior to treatment was £1,300.\(^{185}\) With little income they may resort to crime to pay for their drug use. Drug misusing offenders often describe their lives as a constant search for criminal opportunities. Under drug dependency, their part-time offending becomes a full-time occupation. The activity of these people can have a significant impact on local crime figures. The police often trace mini crime waves back to individual offenders. Their arrest and imprisonment gives communities respite. But few drug misusing offenders commit crimes serious enough to keep them in prison for long, and when their addiction remains untreated they quickly return to offending on release. Drug treatment is designed to reduce people’s need for drugs, which in turn reduces the driving force behind their drug-related offending.\(^{186}\)

### Norfolk Services Aimed at Tackling Substance Misuse-Related Crime and Antisocial Behaviour

**Key findings**
- Effective and successful treatment reduces reoffending by around 60%
- The Norfolk drug and alcohol treatment and support system which will be provided by Norfolk Recovery Partnership from April 2013 will work with offenders in custody, the courts, prisons and on probation.

Norfolk Drug and Alcohol Partnership works with the Community Safety Partnership to reduce the crime and antisocial behaviour harms in Norfolk that are caused by substance misuse. The new adult treatment and support system provided by the Norfolk Recovery

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Partnership (NRP) from April 2013 will work closely with the criminal justice system at a number of levels, including:

- Providing open access support for anyone experiencing problems with drugs and/or alcohol (and prioritising offenders within this system).
- Active in-reach into Norfolk custody suites and courts.
- Working closely with Norfolk and Suffolk Probation Trust to manage offenders.
- Providing treatment and support to those on Drug Rehabilitation Requirements (DRR).
- Providing drug and alcohol treatment and recovery services in prisons.

**Recommendations**
Reporting on Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirements (ATR) could be improved in order to aid effective reporting, provide evidence of the services people are receiving and to monitor outcomes.

There are a number of other services in Norfolk aimed at tackling the dual issue of substance misuse and crime and antisocial behaviour:

**SOS bus**
In response to problems associated with substance misuse and the night time economy, two SOS bus projects have been set up in the county. One operates in Norwich and the other in King’s Lynn.

The Norwich SOS Bus is a multi-agency initiative to meet the needs of people using Norwich’s night time economy. It operates every Friday and Saturday night between 9pm and 3am, staffed by (on average) seven volunteers. The Norwich SOS bus has been operating for ten years; the original project ran from April 2001 to November 2008 and helped 5,050 people. Since November 2008 when a new vehicle was purchased the SOS bus has seen 2,586 people and for almost two thirds of these visits, the reason for attending was linked to drink and/or drugs (61%). This is around 34 people a month. In total the team estimate that they have saved 717 visits to A&E. As well as dealing with medical issues this service also provides advice and information and a safe place for people to wait whilst they wait for their transport home, in this sense it also takes the pressure off the police officers and PCSOs staffing the night time economy in Norwich.

The SOS Project in King’s Lynn has been running since 2008 on a similar basis to the Norwich project (staffed by volunteers, in town centre Friday and Saturday nights). Over the course of a year (November 2010 – October 2011) they helped 382 people, they estimate they helped just over half of these (53%) because of alcohol or drugs (202 people). This project also has good partnership links and reports high levels of referrals from licensed venues, door staff, CCTV and Norfolk Constabulary. The SOS team work with CCTV and advises them of incidents as appropriate, for example broken windows, street urination, building intruder alarms etc. So again, as well as providing medical services they assist in the policing of the night time economy in King’s Lynn.

The Norwich SOS Bus also attends student nights in Gorleston periodically at the request of East Norfolk Sixth Form. Since February 2009 the SOS Bus has supported 127 clients in Gorleston. There is also a SOS bus scheme operated on Friday and Saturday nights in Great Yarmouth by St Johns Ambulance.

**The alcohol and cannabis diversion schemes**
Being drunk and disorderly does not constitute a recorded crime as such, but will earn the offender a penalty notice. In 2011/12 there were 1,221 incidents of people being taken into custody in Norfolk because they were drunk and disorderly. This accounts for 7% of all
custody records. This includes 61 incidents of people who were under the legal drinking age (see figure 40).

Norfolk Constabulary has recently secured funding to set up an Alcohol Diversion Scheme. This means that when problematic binge drinkers are identified they will be given the option to engage in a three hour interactive educational programme. There is a strong evidence base that shows the scheme has made a difference in all the areas of the country that are already using it.

The scheme utilises a fixed penalty system (along similar lines as speed awareness courses) those identified under the Section 5 public order act as being ‘Drunk and Disorderly’ or ‘Drunk and Incapable’ with be given the option of completing the course at a cost of £45, or paying the full £80 fine. Following the initial set up costs, the scheme will be self financing. This scheme will need to ensure that where people require further services are facilitated into the wider alcohol treatment and recovery system.

Norfolk constabulary have also secured funding to set up a ‘Cannabis Diversion Scheme’, on a similar basis, giving people who are issued fixed penalty notices for possession of cannabis the option of paying a smaller fee and attending a three hour educational session. These are both new projects in Norfolk and due to commence in early 2013.

**Recommendation**

It is important that the evidence of the impact of both the Alcohol Diversion Schemes and the Cannabis Diversion Scheme is shared with wider partners.
Chapter 5: Drug and Alcohol Services in Norfolk (Adults)

Brief Interventions

Key findings
- There is good evidence that brief interventions can be effective in reducing substance misuse.
- Focus has primarily been on delivering these in primary health care settings – but there is a potential to create the knowledge and skills amongst a wide range of front line workers to deliver brief interventions.

Most drug and alcohol users do not need specialist or clinical interventions to change their substance use behaviour and of those that do, many will respond to brief interventions delivered in primary care. Highlighting the damage people are causing to themselves and giving them tools to address their substance misuse problems is proven to be effective in reducing problematic drug and alcohol use.187 188

There are two main types of brief intervention: structured brief advice and extended brief intervention. The evidence is mixed on the additional benefit of providing extended brief interventions in healthcare settings and therefore brief advice is recommended as a first step for adults (aged 18 and over) who have been identified as drinking at hazardous or harmful levels. If brief advice does not lead to a reduction in hazardous or harmful drinking (or if an individual wishes further input) then an extended brief intervention, including motivational interviewing, is recommended.189

The use of extended brief interventions is recommended for people aged 16–17. There is limited evidence on the effectiveness of brief interventions for young people under the age of 16, with some data suggesting there could be adverse outcomes.190

A recent study concluded that a universal programme of alcohol brief interventions in primary care is cost-effective, under all but the most pessimistic assumptions and estimates of programme costs and effectiveness.191 The Department of Health will include alcohol and identification of any subsequent brief advice needs within the NHS Health Check for adults from age 40 to 75 from April 2013.

188 WHO (2008) The Effectiveness of Brief Intervention for Illicit Drugs Linked to the ASSIT in Primary Care Settings. World Health Organisation.
Specialist Drug and Alcohol Treatment and Support Services for Adults in Norfolk

**Key findings**

- A new provider will take over the running of the adult treatment and support system in Norfolk from April 2013 (a partnership of current providers called Norfolk Recovery Partnership [NRP])
- This will be accessed through a Single Assessment and Coordination System (SACS)
- NRP will provide structured treatment and non-structured support including advice and information, needle exchange, and access to BBV interventions – supporting people at all levels of the recovery journey.

People who require more than a brief substance misuse intervention can access specialist substance misuse support and treatment. The DAAT currently commissions six separate organisations across a number of sites to provide drug and alcohol treatment to adults in Norfolk on behalf of the Norfolk Drug and Alcohol Partnership (N-DAP). However, the situation will be different from April 2013 as the DAAT has taken forward a tender to procure a single Adult Treatment System for Norfolk (this was a whole system redesign excluding inpatient detoxification and residential rehabilitation services). The contract was awarded to the Norfolk Recovery Partnership (NRP), which is a partnership of Norfolk and Suffolk NHS Foundation Trust (which includes TADS), The Matthew Project and RAPt (Rehabilitation for Addicted Prisoners Trust). Transition to the new system is underway and this service will commence on 1st April 2013.

One major difference between the current system and the new is the development of a Single Assessment and Coordination System (SACS). This is a single point of contact that delivers person centred coordinated care from end to end of the recovery journey, ensuring the system is easy to access and navigate for all clients. Professionals will continue to be able to refer into the system (although current referral forms will be revised) and individuals will be able to self-refer into the open access service though a new website, by dropping into a recovery café or calling a 24/7 helpline.

NRP will offer a menu of services which will include group work, talking therapies, substitute prescribing, outpatient detoxification and access to residential treatments. As well as providing specialist treatment NRP will offer unstructured, ad hoc support in the form of brief advice and information, needle exchange, aftercare support and general harm reduction interventions. NRP will also coordinate and make referrals to other partner agencies in order to support people with drug and alcohol problems to arrange suitable accommodation, manage their finances, liaise with social services, access physical and mental healthcare and get into employment, training or volunteering opportunities.

**Recommendation**

Provision of alcohol-related brief interventions is highlighted in the Government’s 2012 Alcohol Strategy; this is particularly in healthcare settings, but substance misuse brief interventions could take place in a number of service including:

- Housing services
- Social services
- Criminal Justice agencies

This relies on staff having knowledge, skills and confidence to provide them. The training of ‘Tier One’ or non-specialist workers in general substance misuse knowledge/skills forms a central part of the N-DAP training plan for 2013. The partnership should consider what more needs to be done in order to make the provision of drug and alcohol brief interventions a reality in a wide range of Norfolk support services.
Non-structured drug and alcohol support in Norfolk
As outlined above, not all services provided by drug and alcohol treatment agencies in Norfolk constitute structured, care planned treatment. People may receive advice, information and support in the form of a brief, one-off intervention. Or they may have contact with a treatment provider a number of times before deciding they are ready to commence structured treatment. In addition, services will continue to support people after they have completed structured treatment, offering ongoing ad hoc support throughout the recovery journey. There is currently a 24-hour helpline operated by the Matthew Project which provides advice to people concerned about their own, or someone else’s substance misuse, and this will continue under the new system. All drug and alcohol treatment providers also offer a needle exchange programme, as detailed in the Blood Borne Virus section on page 61.

Structured Drug and Alcohol Treatment in Norfolk (Community)

Key findings
- 4,368 adults received structured drug and alcohol treatment in Norfolk in 2011/12
- Around half of these were treated for problems with opiates and crack (51%), 42% for alcohol problems and 7% of problems with other drugs.
- The rates of clients in treatment is correlated with deprivation – with the more deprived areas of the county having more people displaying drug and alcohol treatment needs.
- This is particularly true of people with opiate and crack problems, with levels of people with alcohol problems fluctuating less.

Over 2011/12 there were 2,216 people in Norfolk who received treatment for their problems with opiates (like heroin) and /or crack cocaine, 1,836 people received treatment for their problems with alcohol and a further 316 for other drugs. While many people with drug and alcohol dependency resolve problems on their own without formal treatment, there is also consistent and strong evidence that appropriate and well-delivered treatment plays a key role in the lives of these people and is associated with reduced substance use and related problems.

Overall rates of clients
Around 8.7 people in every 1,000 in Norfolk (aged 18-64) received drug and alcohol treatment last year. This is slightly above the regional average rate, but below the average for England (see figure 41).

194 Rate information uses ONS Broad Age Structure Estimates, available at: http://www.norfolkinsight.org.uk/metadata/view/dataview?id=53&norefer=true
When the numbers receiving substance misuse treatment are considered as a rate of the general population, it suggests differing levels of need across the different areas of the county. The graph below shows the differing rates of clients in the various CCG areas when the number of adults treated in a year is compared to the number of adults living in those areas (see figure 42).

Numbers in drug and alcohol treatment correlate with deprivation, those areas of the country that are known to have the highest levels of deprivation (Norwich and Great Yarmouth) also have the highest number of clients, and therefore this suggests they have the greatest drug and alcohol treatment and support needs.

The Drug/Alcohol split
Furthermore the type of substance misuse problem also seems to be linked to the wider characteristics of the area. Some areas seem to have more of a problem with people using opiates and crack, and others have more people with alcohol problems (see figure 43).
When the whole year is looked at, it is only really Norwich that has considerably more OCU clients than alcohol clients, and North Norfolk actually sees more people with alcohol problems overall. The picture for other areas is far more balanced. Therefore we can conclude that in most areas there is a similar level of need for drug and alcohol treatment, but need for OCU treatment is greater in Norwich and Great Yarmouth.

Despite this, as the graph below demonstrates, there are usually more OCU clients in treatment at any one time than there are alcohol clients, and this is true for all areas of the county, but most pronounced in Norwich and Great Yarmouth, (it is less obvious in the West, South and Norfolk CCG areas – see figure 44).
Treatment journeys for alcohol clients are much shorter than for OCU, and while there are fewer alcohol clients in treatment at any one time, there is a higher turnover of alcohol clients with more unique individuals receiving treatment.

Primary problem substance is just one way to divide the treatment population, this has been used here because of the differing demographics of these groups, and the different treatments provided. However, it should be noted that of those receiving treatment for problems with drugs (heroin, crack or otherwise) nearly a quarter also report problems with alcohol (22%). A similar proportion of those with a primary alcohol problem also report problems with other drugs (23%).\(^{195}\) Furthermore there is some evidence of ex-OCU returning to treatment as alcohol clients (although this is difficult to quantify with current data). These groups should not therefore be seen as completely separate populations.

**Opiate and Crack Users (OCU) Clients**

**Key findings**

- A significant proportion of OCU in treatment have been there been there for a long time - just over a third of Norfolk OCU clients have been in treatment for more than four years and 21% have been in treatment for more than six years.
- The proportion of OCU clients successfully completing treatment in Norfolk has dropped each month between April 2012 and October 2012.
- A general review of how shared care is provided in the county is needed including exactly what shared care GPs are contracted to do and how these contracts can be managed in the future to ensure that people are supported to move through treatment appropriately.
- It is essential that recovery capital is assessed when a client enters treatment and care planning includes actions to increase recovery capital accordingly. This emphasises a need for treatment services to build strong links with partner agencies to ensure that client needs are met in terms of their health, housing and employment and to help clients to build social networks that support their recovery goals.
- Best practice is to provide clients with a menu of treatment and support services with a planned approach to phasing a layering of treatment. This includes appropriate access to psychosocial therapies. The new adult treatment and support system in Norfolk needs to ensure that it reflects this new guidance.

People with Opiate and Crack problems (OCUs) form the bulk of the specialist substance misuse treatment population in Norfolk in that they make up around 50% of all of the people treated in a year, but around 70% of those in treatment at any one time (2,216 treated in 2011/12).

There are more OCU in treatment in certain areas of the county, this indicates that there are greater needs in these areas – but may also reflect greater service provision. There are particularly high numbers of clients in Norwich, Great Yarmouth and King’s Lynn, but also in Thetford and East Dereham (see figure 45).

\(^{195}\) NDTMS (2012) Drug and Alcohol Treatment data for 2011/12. National Treatment Agency
Norwich has the highest rate of OCU clients as a proportion of the adult population with 7.1 per 1,000 of the population aged 18-64, followed by the Great Yarmouth area of HealthEast CCG with 6 per 1,000 of the population. The lowest is 1.7 per 1,000 adults in North Norfolk (see figure 46).

Treatments
There is a wealth of evidence to suggest that substitute prescribing for opiate dependence is an effective intervention. Opiate Substitution Therapy (OST) has been reliably linked with the following benefits:

- Prevents people dropping out of treatment
- Suppresses illicit heroin use
The 2010 Drug Strategy outlined a change in focus in drug treatment from previous strategies:

“The investment made in the drug treatment system over the last decade has built capacity and enabled people to access treatment for a sufficient period of time to bring about substantial health gains. We now need to make the same progress in treating those with more severe alcohol dependence and to become much more ambitious for individuals to leave treatment free of their drug or alcohol dependence so they can recover fully. **We will create a recovery system that focuses not only on getting people into treatment and meeting process-driven targets, but getting them into full recovery and off drugs and alcohol for good**”

Despite this change of focus, OST remains a central component of drug treatment, and in Norfolk 95% of OCU clients receive a prescription (no change from last year). However, one of the issues associated with treating OCUs is how to move people on from receiving substitute prescriptions and on to further recovery.

One way to measure this is to look at the proportion of OCU that leave treatment successfully as a percentage of all of those in treatment, otherwise known as the ‘rate of successful completions’. The most recent data (October 2012) shows that 184 OCU successfully completed treatment in the preceding 12 months. This is 8.7% of all of the OCU clients in treatment in Norfolk. The national average for that period was 8.9% (see figure 47).

DAAT areas (usually the same geography as local authority areas) are grouped so that performance can be compared to areas with similar characteristics. Norfolk is in Cluster D, which is the second highest group in terms of complexity, and this translates into lower performance expectations. However, for the successful completion rate of OCU clients, Norfolk is now performing below what would be expected of the cluster as well as being...

199 These characteristics include demographic characteristics of the wider population like rural/urban split and levels of deprivation, and characteristics of the treatment population like number of OCU and proportion reporting housing problems etc.
below the national average. Given the importance of this area and dropping performance, this is clearly something to focus on in the future.

Just over a third of Norfolk OCU clients have been in treatment for more than four years and 21% have been in treatment for more than six years (which increased from just 18% in 2010/11). Data from NDTMS shows that clients who have been in treatment continuously for four years or more, or have very long drug use and treatment careers, are most likely to remain in treatment (see figure 48).

The more complex needs a client has, the more likely they are to need longer in treatment. Norfolk treatment clients have been grouped based on their complexity, which takes into account behaviours such as using opiates, using crack, injecting daily, drinking harmful levels of alcohol and having problems with housing or employment. In Norfolk 37% of adults in drug treatment are rated as having a high or very high complexity compared to an average of 34%.

The proportion successfully completing treatment is negatively related to complexity, with less complex cases generally being more likely to successfully complete treatment (see figure 49).
This is what would be expected given that a large part of “being complex” is displaying more serious substance using behaviour, and therefore these people need to spend longer in treatment.

While recent guidance highlights the need to be more ambitious for clients and develop recovery focused treatment, it also recognises that some OCU have long-term problems and complex needs, meaning their recovery may take much longer as they require time to build their recovery capital. There is an evidence based consensus that it is very difficult to predict the length of time people will need to receive treatment, and it is clear from current knowledge and experience that many of those on OST will need to be on it for several years.\textsuperscript{200}

There is clear evidence that time-limited prescribing of OST (e.g. stating that people can only receive the treatment for a maximum of a year) is not effective, and that arbitrarily or prematurely curtailing an individual’s OST will not help them sustain their recovery and is not in the interests of the wider community either. This would likely lead to an increase in blood-borne virus rates, drug-related deaths and crime.\textsuperscript{201} It should be noted that it is clinically appropriate for some clients to continue to be maintained on OST on a long-term basis.\textsuperscript{202} However, for those who need long-term support, who are perhaps in ill-health, primary care may be better able to hold them and respond to their broader health needs.

Shared care
Long-term prescribing appears to be linked in Norfolk to receiving the prescription directly from a GP rather than in a specialist substance misuse service. Possible explanations for this are that ‘shared care’ GPs are less likely to challenge clients to move on into recovery because they do not see it as their role; or that clients are on a GP prescribing interventions because it is accepted that they have a long-term continuing medical need. It is likely to be a combination of the both, but it is important to segment the clients into relevant groups so that targeted recovery work can occur with the right clients.

Recommendation
A general review of how shared care is provided in the county is needed including exactly what shared care GPs are contracted to do and how these contracts can be managed in the future to ensure that people are supported to move through treatment appropriately.

The experience of long-term maintenance on OST
In 2011 a detailed study was carried out in Norfolk by the UEA into the experiences of people who had been prescribed methadone on a long-term basis (5 years or more). This study found that the experience of being on a long term maintenance script, from the perspective of the participants in this study, was a varied one. For some people, the script was normalised as a medication like any other, and the routines of picking up and consuming the medication were integrated as a normal part of life. However, for some people, the script itself became all consuming, perhaps in much the same way as illicit heroin use had been all consuming in the past, with the focus on daily consumption, and ensuring that the medication was available to prevent withdrawal symptoms occurring, being a constant preoccupation.

Some participants reported a feeling of numbness and disengagement with society, perhaps being at least partly attributed to the effects of methadone. Others reported feeling ‘themselves’, and being able to actively engage with society. Thus the emerging message drawn from a detailed focus on the experience of long term maintenance in Norfolk, is that it is an effective intervention to offer ongoing support and stability for some, yet for others may in time prevent social reintegration and being able to move on, since the medication itself

\textsuperscript{200} NTA (2012) Medications in Recovery: Re-orientating the drug treatment system. National Treatment Agency
\textsuperscript{201} Ibid.
symbolically represented a continuation of addiction, and thus individuals felt that identification with the ‘addict’ role continued.\textsuperscript{203}

\section*{Re-presentation}

While ‘successful completions’ is an important performance area, it must also be viewed alongside rates of re-presentation to treatment. There is research evidence that relapse and numerous attempts in treatment are normal features of the recovery journey for most people, and that for those with severe dependency, the recovery journey will usually last many years.\textsuperscript{204}

The rate of re-presentation to treatment by OCU clients in Norfolk is 17.4\%, which is just within what would be expected of our cluster (10-18\%). This means that of the 121 OCU clients who successfully completed between November 2011 and April 2012 there were 21 who returned to treatment within six months of leaving. It is accepted that as heroin dependency is a chronic, relapsing condition OCU clients may return to treatment a number of times, but relapsing so soon suggests they may not have been ready to leave treatment when they did, which is why this performance measure is used.\textsuperscript{205} While there is a focus on successful completion without re-presentation, there is a cyclical approach to recovery and not a linear path, with clients encouraged to return to structured treatment if they feel that they need it.\textsuperscript{206}

\section*{Recovery capital}

Although recovery from a long-term problem with heroin is difficult, clients must be supported in every way possible to ensure that they have every opportunity to recover, and that this ambition remains a reality for all clients.

Recovery capital is defined in the 2010 Drug Strategy as: “the resources necessary to start, and sustain recovery from drug and alcohol dependence.”\textsuperscript{207} This focuses attention on what an individual needs to begin treatment and those aspects that are needed to maintain or build change. The strategy goes on to list four kinds of recovery capital:

- \textbf{Social}: support from and obligations to family, partners, children, friends and peers
- \textbf{Physical}: finances and safe accommodation
- \textbf{Human}: skills, mental and physical health, a job
- \textbf{Cultural}: values, beliefs and attitudes held by the individual.\textsuperscript{208}

Assessments at the start of treatment need to establish a client’s level of recovery capital and a recovery focused care plan should identify areas to improve. This links back to the needs identified earlier in this document - people with substance misuse problems are more likely to have housing problems, and having housing problems may increase substance use. The same can be said of unemployment. Having these sorts of problems limits a person’s chance of recovering from dependence on drugs and alcohol, which highlights the importance of multi-agency working for drug and alcohol support services.

Substance misuse services need to establish a client’s wider needs at assessment and ongoing care plan reviews and coordinate referrals or signposting to relevant services. These wider needs of clients should be addressed without taking on the work of partner agencies. These functions have been written into the service specification for the new drug and alcohol treatment system that will be delivered across the county from April 2013. This document also outlines how the system will collect and report data on referrals to partner agencies.

\textsuperscript{204} ACMD (2013) Recovery from Drug and Alcohol Dependence: an overview of the evidence. Advisory Council on the Misuse of Drugs
\textsuperscript{206} NTA (2012) Medications in Recovery: Re-orientating the drug treatment system. National Treatment Agency
\textsuperscript{208} Ibid
**Recommendation**

It is essential that recovery capital is assessed when a client enters treatment and care-planning includes actions to increase recovery capital accordingly. This emphasises a need for treatment service to build strong links with partner agencies in order to ensure client’s needs in terms of their health, housing and employment are met; and to help clients to build social networks that support their recovery goals.

**Treatments associated with successful completion**

Appropriate assessment and planning of care is essential to ensure people receive the right support and treatment. Recovery care plans should be personally meaningful documents, developed over a period of comprehensive assessment, and reviewed and adapted regularly, so that they are important to and owned by the patient. A care plan audit was carried out with current drug and alcohol treatment providers in December 2010. It was found that there is considerable variation in the standards and practices relating to record keeping and care planning, with clear examples of where improvement needs to be made. Action plans were developed for each provider as a result and progress against these has been monitored at contract review meetings. The need to develop recovery focused care plans is outlined in the services specification for the new adult treatment system, along with a requirement to carry out regular care plan audits.

Best practice is to provide clients with a menu of treatment and support services to develop a person-centred package of care. The phasing and layering of different treatment interventions through care pathways and treatment phases is already used in many substance misuse services, with care often phased and layered on a case-by-case basis through independent clinical and/or managerial decisions. However, recent guidance advocates a more planned approach to service design, as this can assist in meeting the full range of need. It can also assist in developing the competence of staff to meet this range of need in a more planned and strategic way.²⁰⁹

The diagram below represents an example of this approach (figure 50)

![The treatment journey diagram](figure50)

**Recommendation**

The new adult substance misuse treatment and support system in Norfolk needs to ensure that it reflects and responds to this new national guidance (Medications in Recovery: Re-orientating the drug treatment system), and this should be monitored by commissioners.

Substitute prescribing is only one element in the treatment of opiate users, best practice guidance is for formal psychosocial treatments to also be made available including Behavioural Couples Therapy and Cognitive Behavioural Therapy. In Norfolk 50% of those receiving a prescription were also recorded as receiving specialist psychosocial interventions. Unfortunately it is not possible to compare Norfolk to other areas to ascertain

²¹⁰ Ibid
whether this proportion is normal, and this is largely because of a lack of confidence in how intervention data is recorded across the country. Major changes have been made to the dataset which aim to rectify these problems; these come into force in April 2013, and should allow for this analysis in the future.

The 2011 UEA study into long-term clients in Norfolk also identified that increased provision and use of psychosocial interventions alongside substitute prescription would contribute to more people moving on from structured treatment. As covered in the mental health section (page 64) there is a higher prevalence of low level mental health problems such as anxiety and depression amongst people with substance misuse problems, and evidence suggests that the treatment outcomes for this group are improved by access to formal psychosocial therapies such as Cognitive Behavioural Therapy (CBT) and Motivational Interviewing. Not all people receiving a prescription will benefit from these interventions; the key is to match the clients to the right treatment. While there has always been provision of psychosocial treatment interventions in Norfolk, there is undoubtedly scope to improve access to counselling and other talking therapies. The transfer of treatment services from current providers to NRP offers opportunities to review provision, and ongoing care plan reviews with clients will mean this continues to be addressed.

Alcohol Clients

**Key findings**
- Treatment for this group is characterised by much shorter spells in specialist treatment, a greater rate of successfully completion, and generally higher recovery capital than OCU clients.
- There is a more even gender split among alcohol clients, with 61% male compared to 71% of OCU. Alcohol clients are also generally older than drug clients - 6% of alcohol clients are aged over 65.

Alcohol clients make up the second largest group of people in specialist substance misuse treatment in Norfolk (1,836 in 2011/12). See figure 51.

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The rate of alcohol clients as a proportion of adults aged 18-64 is less varied across the different CCG areas than OCU clients. Where as for OCU use see wildly different numbers in Norwich and North Norfolk, for alcohol clients this is more grouped around the average of 3.6 per 1,000 adults, although there is still considerable difference between 5.1 people in alcohol treatment per 1,000 of the population in Great Yarmouth, compared to 2.4 per 1,000 in South Norfolk (see figure 52).

The treatment that most people received in 2011-12 for alcohol problems was a structured psychosocial intervention, normally consisting of ‘talking therapies’ such as cognitive behavioural therapy, which help people to understand and then change their attitudes and behaviour towards alcohol. Certain specialist substances are also prescribed to people who are in treatment for their alcohol use. Using the end of year snapshot, 133 alcohol clients...
were receiving a prescription, which is only 12% of those in treatment with a primary substance of alcohol, meaning prescribing is much more common among OCU clients. There are similar levels of planned, inpatient detoxifications of people with alcohol problems as with OCU clients; there were 104 inpatient detoxes of alcohol clients in 2011/12, and 109 for OCU.

Treatment for this group is characterised by much shorter spells in specialist treatment, a greater rate of successfully completion. Only 18% of alcohol clients have been in treatment for longer than a year, compared to 69% of OCU. 67% of clients successfully completed treatment last year in Norfolk; this rate has above the national average of 60%, but has remained static for the last year meaning performance has not improved.

Alcohol clients are more likely than OCU clients to be in employment and be less likely to have housing problems; it can therefore be said that alcohol clients start treatment with a generally higher recovery capital than OCU clients. However, this does not mean that their treatment outcomes cannot be improved by recovery-focused care planning which aims to increase recovery capital, especially in terms of developing social networks that support a client’s recovery goals.213

There is a more even gender split among alcohol clients, with 61% male compared to 71% of OCU. Alcohol clients are also generally older than drug clients, with the peak age in treatment being in the 45-54 age group, where as OCU peaks at 35-44 and other drug clients at 25-34 (see figure 53). Furthermore 6% of alcohol clients are aged over 65, whereas less than 1% of drug clients are in this group.

Other Drug Clients

**Key findings**

- The most common primary problem substance among this group is cannabis (50% of other-drug clients); this is followed by cocaine, amphetamine and ketamine.
- While this represents a small proportion of those in treatment at the moment - given the changing patterns of drug use we may expect this group to expand in the future.

There is a small group of people who receive treatment for drug other than opiates and crack, these are known as Non-OCU or ‘other-drug clients’. There are around 130 of these

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people in structured treatment at any one time in Norfolk, with around 300 treated across the county in a year. The most common primary problem substance among this group is cannabis (50% of other-drug clients); this is followed by cocaine, amphetamine and ketamine.

This group of clients is sometimes known as ‘AACCE’. The phrase was coined in 2007 to describe a type of drug user thought to be distinct from the OCU. It stands for Alcohol, Amphetamine, Cannabis, Cocaine and Ecstasy (AACCE). It was noted that nationally, fewer and fewer under 18s were entering treatment for problems with opiates and instead appeared to be using the range of drugs encompassing AACCE and similar substances (as covered in the prevalence section). Given the changing patterns of drug use we may expect this group to expand in the future, especially if efforts are made to do more to treat people experiencing problems with prescription drugs.

These clients typically receive structured psychosocial interventions, although a small proportion does receive a prescription (prescribed benzodiazepines or amphetamine substitutes).

These clients have more in common with Alcohol clients in that they have a far higher rate of successful completions than OCU clients. They are generally younger (see graph above), and are significantly more likely to be in paid employment than OCU clients. Again, this does not mean that their treatment outcomes cannot be improved by recovery-focused care planning which aims to increase recovery capital, especially in terms of developing social networks that support a client’s recovery goals.

Residential Treatments (Findings from the Tier Four Review)

Key findings

- There are already a number of valuable resources that offer Tier Four treatment in Norfolk
- There is no strategic plan that provides a framework and pathways for the commissioning and delivery of Tier Four treatment and links it with wider community based resources.
- Current planned inpatient detox provision takes place in six block booked beds allocated between psychiatric wards - all evidence suggests that such an environment is not appropriate and plans to look at future options are being taken forward.

In late 2012 N-DAP commissioned a full review of Tier Four or residential drug and alcohol treatments in Norfolk. The following findings and recommendations are based on interviews with 56 professionals (commissioners, managers, and operational staff) and 11 service users. Interviews took place in September and October 2012. The report will be made available in the near future.

Strategic issues

Current Tier Four treatment rightly includes access to planned inpatient detox, residential rehab and aftercare. However, the overall picture is mixed; whilst there are examples of good practice throughout, this is usually due to operational resourcefulness rather than strategic vision. The four most significant issues with existing provision are:

1. Lack of a strategic plan that provides a framework and pathways for the commissioning and delivery of Tier Four treatment and links it with wider community based resources.

2. Lack of flexibility and creativity that reduces the capacity to provide needs-led treatment.
3. Lack of abstinent provision for both community based treatment and accommodation that severely undermines treatment progress for newly abstinent individuals.
4. Minimal and inaccurate activity and outcome data meaning that commissioning decisions are not fully informed.

Norfolk already has valuable Tier Four resources, but they are not part of a formalised pathway, and thus their effectiveness may be reduced. These include:
- Carrow Hill Relapse Prevention Pilot
- Hebron aftercare – accessible for women returning from out of county rehabs.
- Avenue Road – a dry house that could easily become an aftercare facility.

Inpatient detox

Current planned inpatient detox provision takes place in six block booked beds allocated between psychiatric wards in the Fermoy, Hellesdon and Northgate. One bed is allocated for Suffolk detoxes. Decisions to undertake inpatient rather than community detox were all risk led. All evidence suggests that such an environment is not appropriate and plans for a dedicated unit are already under consideration.

However, this research, and the simultaneous Central Clinical Commissioning Group (CCG) research showed that detoxes were taking place (or not) in an ad hoc way via different routes, with little evidence of GPs referring patients to TADS/ CADS coordinated pathways. These included:
- GPs undertaking community based detox themselves.
- GPs not willing to undertake detoxes and signposting to non clinical agencies.
- Detoxes undertaken on acute wards either via GP/ consultant referrals or A&E.

Due to the high risk of relapse for individuals returning to high tolerance hostels post detox, Highwater House has refused to be part of detoxes for their residents unless they could be moved on to abstinent based accommodation. Herring House has a specialist unit within the hostel for community based detoxes that enabled individuals to live apart from substance misusing peers.

Whilst there were good examples of care coordination, there were also reports of individuals post detox ‘falling through’ community based support. This was partly due to many individuals not wanting or being appropriate for rehab. It was felt that this cohort was particularly at risk of relapse.

Specialist agencies approximate that 60% of their detoxes are planned inpatient, and 40% community based. 214 planned inpatient detoxes occurred in 2011/12 in county for Norfolk residents. A further 9 planned inpatient detoxes took place out of county, giving a total of 223 planned inpatient detoxes in 2011/12, which is significantly more than surrounding counties. Approximately 500 inpatient detoxes occur each year on acute wards.

Residential rehab

Longer term residential rehabilitation is commissioned by a panel that meets monthly to consider applications. In 2011/12 funding was agreed for 22 individuals, and 14 of these actually took up the place and commenced residential treatment (64%). Of these 14, nine completed their treatment (64%). All of those who did not complete left within the first two months of the placement, usually for non-compliance.

The NTA suggests that for individuals attending rehab: 30% overcome dependency, 60% require further community support and 10% drop out. The Norfolk completion rate (overcoming dependency) is higher at 64%, but is not known how many leaving rehab/aftercare required community support. The drop out rate is worse.
Many interviewees considered that the threshold for rehab treatment was too high, with rehab not used creatively to help individuals become abstinent until their addiction was extremely severe. For rare cases of offenders in custody wishing to go to rehab direct from prison, a process was reported whereby they transfer to HMP Wayland for the RAPt programme to test motivation as preparation for applying for funding.

**Aftercare**

Norfolk already has valuable aftercare provision in Carrow Hill, Hebron House and potentially with Avenue Road. Interviewees suggested that aftercare could be more flexible and creative, and something that could be developed in county for individuals returning from out of county rehab as well as post detox individuals.

### Recommendations

This review has highlighted the lack of a strategically planned, integrated Tier 4 framework, but at the same time, identified valuable in county resources that already provide Tier 4 interventions or are closely aligned and support such delivery. Based on extensive quantitative and qualitative findings, the following recommendations are suggested:

**Strategic plan**

- Strategic planning is needed to develop Tier 4 treatment into an integrated, creative, needs-led, and person-centred framework, committed to by partner agencies. This means integrating what is already working well within and around current Tier 4 provision into a formal, equitable system.

- Current funding routes for planned inpatient detox, rehab and aftercare require improved coordination. This would improve activity monitoring and effectiveness of funding.

- Central to the model should be the commitment to a flexible framework that acknowledges that individuals require a choice of possible Tier 4 ‘routes’ to best meet their needs and circumstances; offering a more tailor made system rather than ‘one size fits all’ should increase recovery outcomes and potentially reduce ‘revolving door’ clients.

- Abstinence based post treatment provision and accommodation needs to be available in the community to mirror treatment successes and promote stable recovery. It is recognised that this is a challenge, but the existing Avenue Road facility is a valuable starting point if it can be incorporated into a formal framework.

**Inpatient detox**

- Effective detox environments: To respond to best practice, planned inpatient detox should be moved to a specialist unit. Whilst this will increase the calibre of treatment expertise of staff, and peer support, careful consideration needs to be given to location to avoid barriers to uptake.

- Detox pathways: Work with GPs is required to understand issues surrounding their low rate of referrals to specialist substance misuse services for subsequent coordination of planned inpatient and community detox.

- Planned inpatient detox capacity should be carefully monitored to ensure that it can meet any future increase in numbers from GP or acute ward caseloads.
Conclusion to Tier Four Review

This review concluded that nationally, Tier Four treatment has suffered from being isolated from community based Tier Two and Three treatment, and that despite the best efforts of professionals to help applicants match their needs to the right Tier Four intervention, in practice, a ‘one size fits all’ system has arisen. It is therefore not surprising that a similar situation has occurred in Norfolk. However this study found extraordinarily high number of professionals who were willing to take part in the review and offer suggestions for the development of Tier Four in Norfolk. It also found that there are already a number of resources that offer Tier Four treatment, or are aligned closely to its delivery. It is therefore concluded that it is timely to develop a strategic plan that will offer flexible, person centred and integrated Tier Four treatment system that meets individual needs in a creative way and improves recovery outcomes.

Tier Four Recommendations (cont.)

- To reduce the numbers of detox cancellations for clients relapsing whilst on waiting list, robust care coordination and key working is required to ‘hold’ clients whilst they wait. A reduction in cancellations would lead to improved capacity planning for inpatient facilities.

- Herring House has a dedicated unit for community detoxes. Assistance with ensuring it is working to capacity may decrease the numbers of planned inpatient detoxes in Northgate.

- Post detox support: Abstinence based accommodation is required for individuals post detox to maximise recovery outcomes.

Residential rehab

Further investigation is required to ensure that for the few cases where a prisoner wants to access rehab directly on release, programmes are accessible to test motivation.

Improvements in the timeliness and content of progress information are required between rehabs and commissioners as well as social workers and community based professionals awaiting updates of funding applications.

Aftercare

Aftercare provision has the capacity to be creatively and flexibly offered to best meet the needs of individuals. It is recommended that the ‘Tier 4: Four route commissioning model’ develops a range of Tier 4 aftercare in county to complement out of county choices.

In county aftercare should be offered as:

- Formal packages (similar to what has been traditionally offered)
- Bespoke packages to meet specific need, using a range of providers to build up a programme. This could include one to one support from 3rd sector agencies offering packages of care to Personal Budget holders & non budget holders (e.g. Julian Support).

Tier 4 aftercare must be aligned with abstinence based accommodation to maximise recovery outcomes. In county aftercare could include existing provision:

- Carrow Hill Relapse Prevention Programme
- Hebron aftercare for women wanting to return to Norfolk
- Avenue Road that could be developed into an aftercare facility

Post aftercare

Tier 2 and 3 provision should offer abstinence based support to individuals post Tier 4 treatment. For some individuals, this will be required post detox if Tier 4 treatment is not appropriate or they are not willing to access it.
Mutual Aid

Key findings
- There is a strong evidence base that mutual aid groups support recovery
- There are limited mutual aid options in Norfolk, especially for those living in rural communities
- N-DAP has a role to play in stimulating mutual aid groups and encouraging specialist treatment services to link their clients into groups.

‘Mutual aid’ refers to members of a group who give each other social, emotional and informational support at every stage during their recovery from drug or alcohol dependence. These groups can include people who are thinking about stopping their drug or alcohol use, or those who want to stay stopped. The most common mutual aid groups in the UK are 12-step fellowships and SMART Recovery.216

According to NICE there is good evidence that 12-step has a positive impact on substance misuse outcomes, so treatment staff should routinely provide people with information about mutual aid groups and facilitate access for those who are interested in attending.217 Mutual aid has an extra effect when combined with structured treatment.218 By providing a continuing support structure, mutual aid can also reduce rates of post-treatment relapse.

There are 48 AA and NA groups that are known to meet across the county at 29 locations (see figure 54).

Figure 54 Mutual Aid Groups in Norfolk (mapped with CCG boundaries added for context)

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216 NTA (2013) Turning Evidence into Practice: Helping clients to access and engage with mutual aid. National Treatment Agency
However, not everyone is comfortable with the 12-step model of mutual aid that is used in AA and NA. There are alternative approaches, of which the most well established is “SMART Recovery”. At the moment there are no such groups in Norfolk. SMART offers a partnership scheme where by members of staff in each treatment site are trained to kick-start meetings within services, and identify service users to train as facilitators and start new peer-led meetings in the community.

N-DAP can improve the availability of SMART recovery in Norfolk by encouraging or incentivising NRP to become a Partner. Or the DAAT can become a partner using the “whole DAAT roll-out model” that was developed in partnership with Bristol DAAT.

### Recommendation

Given that part of funding for substance misuse services is based on the numbers successfully completing treatment it can be argued that using funds to kick-start alternative mutual aid options in the county would provide a cost effective way of encouraging peer-led recovery in Norfolk.

### The Recovery Community

Supporting people to continue their recovery beyond specialist substance misuse services is far broader than just specialist mutual-aid groups. There are many projects and voluntary groups that can support people who are in recovery, to build skills and confidence and improve to physical and mental health and allow them to integrate back into the wider community.

It is beyond the scope of this needs assessment to map all of the groups and organisations that already exist in Norfolk that can aid the development of the recovery community. Norfolk DAAT has recently appointed a Recovery and Engagement Co-ordinator who is taking this work forward as a central part of her role. In support of this the DAAT is carrying out a piece of research in partnership with Voluntary Norfolk to consult the voluntary sector on the development of N-DAP’s strategic priorities and to map the contribution of the sector (current and potential) to supporting people with substance misuse problems in Norfolk.

N-DAP also set up “The Community Substance Misuse Recovery Fund” at the end of 2012 with grants of up to £10,000 to innovate capacity in Norfolk’s small, grassroots charities, voluntary and community groups, with an aim to raise awareness of substance misuse and in support those with substance misuse issues and their families and friends. Eleven bids were received and money distributed to eight organisations. Reports on the use of the money and outcomes will be available in due course, and a second round of funding is planned for 2013.

### Recommendation

Support for recovery within communities needs to be a priority area of development. Building community capacity and resilience are shared priorities across a range of partner agencies, opportunities to embed recovery from substance misuse into these needs to be explored and implemented as appropriate.

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**Drug and Alcohol Treatment and Support Services in Norfolk Prisons**

The links between substance misuse and offending suggest a need for substance misuse treatment in prisons as well as in the community. 63% of sentenced male prisoners and 39% of female sentenced prisoners admit to hazardous drinking prior to entering prison, with half of these having a severe alcohol dependency, and up to 55% of people entering prison being problematic drug users. Drug treatment programmes in prison and community can be successful in both reducing dependency and reoffending, and have been shown to decrease criminal behaviour by 26%.

There are three prisons in Norfolk: HMP Norwich, HMP Wayland and HMP Bure. From April 2013 the Norfolk Recovery Partnership will be providing non-clinical drug and alcohol treatment and support services both in the prisons and in the community. NRP will be responsible for ensuring all prisoners have access to appropriate services regardless of their length of sentence, and that transition between prison and into community services is smooth and fully integrated. Each of the three prisons populations have their distinct characteristics that creating different substance misuse needs.

The National Drug Treatment Monitoring System is a national database that all drug treatment providers return data to on a monthly basis. Historically prison drug treatment was not included in this, but in order to support the integration of the commissioning of these services and to aid the transition of clients between prison and community services, prisons began returning to NDTMS in April 2012. The data relating to number in treatment quoted below is drawn from the most recent NDTMS returns and therefore relate to Quarter 2 of 2012/13 – rather than the whole year of 2011/12 as used elsewhere in this needs assessment. A full health needs assessment has been completed for each prison by the Public Health Information Team at NHS Norfolk and Waveney, which take into account the wider health needs and demographics of each establishment accordingly.

**HMP Bure**

**Key findings**

- HMP Bure has a lower proportion of opiate using prisoners in treatment than is usually seen, but still a significant number of prisoners needing treatment for their problems with alcohol and other drugs. Therefore there is more emphasis on non-clinical services (psychosocial) than clinical at this prison.
- 30% of prisoners who are not engaging with non-clinical services stated that they were not introduced to them during the induction process.
- A significant proportion of the caseload has a dual diagnosis (substance misuse and mental health) but there is no dual diagnosis policy at Bure.

Located eleven miles to the north east of Norwich, HMP Bure opened in April 2010 and houses category C adult male sex offenders with an operational capacity of 523. The Integrated Drug Treatment Service (IDTS) was established at Bure in 2009. As the need is small compared to other Category C prisons, there is no dedicated wing per se, although anyone enrolled on IDTS is housed together on F wing to ease the logistics of movement for medication dispensing. IDTS clinical care is provided by primary healthcare nursing staff and a GP. All prisoners on the clinical caseload are engaged in methadone reduction detoxifications.

There are usually fewer than 10 on the clinical caseload at Bure, which is a small proportion of the population compared to other prisons. The specific type of offender means that this prison has a very different substance misuse profile to the other two Norfolk prisons; where

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221 Home Office. Meeting the needs of offenders with a drug dependence. Reducing Re-offending Unit.
as elsewhere heroin is the primary problem substance, at HMP Bure it is alcohol. Sexual 
offences are not linked to substance misuse in the way that other crimes, such as acquisitive 
and drugs crimes are believed to be. Only 18% state they have a problem with opiates, 41% 
have problems with other drugs (most frequently cannabis) and 41% have alcohol as their 
primary problem substance (see figure 55).

The clinical team works closely with the current non-clinical CARAT (Counselling, 
Assessment, Referral, Advice and Through-care) service. The CARAT team accepts 
referrals from prisoners and professionals; most are self-referrals or from Offender 
Supervisors. The team input to the induction package, so all new receptions are aware of 
their service and how to contact them. They are currently conducting approximately 8 new 
assessments per month and have no waiting list.

CARATs offer the following:
- One-to-one sessions
- A six session Relapse Prevention programme (aimed at generic substance misuse)
- SMART recovery - peer-led group held once a fortnight during association time
- Tackling Drugs Through Physical Exercise – a gym-based programme of 12 weekly 
  sessions. The gym will assess and monitor the progress of prisoners on this 
  programme. The inclusion criterion is men with a history of substance abuse who 
  would not normally access the gym facilities.

The current caseload is 182, comprised of 91 active and 91 suspended clients (this means 
that they have been through the service but are kept as an open case and reviewed 
approximately every six months). 35% of the active caseload are primary alcohol clients, 
19% are OCU and the remaining 46% are other drug clients (again cannabis being the most 
frequently cited ‘other drug’ followed by cocaine).

The CARAT team in Bure carried out a survey with 10% of the establishment population 
including those who are current CARAT clients and also those that have either not engaged 
or are no longer engaged. A total of 52 questionnaires were completed based on a 
population of 519. On the whole 96% (which is more than the 2011 needs analysis whereby 
86%) of the CARAT clients completing the questionnaires felt that the service was meeting 
their needs. All respondents confirmed that they had been involved in developing their care 
plan.

Just under half of CARAT clients suggested that improvements could be made to the service. 
A quarter of these clients suggested that there should be more group work sessions, 17%
suggested more structured one-to-one sessions, 17% suggested that more support prior to release would improve the service. Other suggested improvements including: CARATs to be more involved in the induction process, more involvement in the clinical detox decisions, more emphasis on alcohol awareness, and access to alternative therapies such as acupuncture.

Ensuring inductions are delivered to all new receptions is important and a good quality induction should inform offenders how to access the service at a later date should they choose not to engage initially. All of the non-CARAT clients had heard of the CARAT service, but 30% stated that they did not see them during the induction process; and of those that had, 21% stated they did not know how to access the service. Therefore there is still room to improve induction procedures.

Half of non-CARAT clients surveyed stated that they had used substances prior to custody, of these 83% were alcohol users and 17% of those classed themselves as heavy users. The remaining had used cannabis and cocaine.

**Recommendations**

- The number of non-CARAT clients responding to the service who report using alcohol heavily indicates that more could be done to encourage heavy alcohol users who do not see their alcohol use as problematic to engage with the CARATs service.
- Given that there are a significant number of alcohol clients but no specific alcohol treatments the Bure health needs assessment recommended that “The need for alcohol specific therapeutic support should be investigated and implemented accordingly”.
- The Bure health needs assessment found that while a significant proportion of the IDTS caseload has a dual diagnosis, there is no dual diagnosis policy at Bure, and therefore recommends one be written and implemented.

**HMP Wayland**

**Key findings**

- Nine out of ten clients receiving treatment at HMP Wayland do not live in Norfolk or Suffolk and therefore this represents a greater challenge to ensuring appropriate transfer to services in the community on release.
- Over a quarter of new receptions commence substance misuse treatment.
- The majority are drug clients with just 16% having a primary problem substance of alcohol.
- Although there is mutual-aid provision in the prison, these all follow the 12-step model and consideration is being given to introducing alternatives.

Located 12 miles to the north east of Thetford, HMP Wayland is a category C adult male training prison and has an operational capacity of 1,017. There are more prisoners here on longer-term sentences, and a significant proportion (52%) of offenders housed in HMP Wayland come from London, 93% of people on the clinical caseload are not local residents (Norfolk or Suffolk). This has implications for drug services in Wayland, meaning there is more opportunity to do longer term interventions but providing challenges in terms of ensuring effective care coordination on release and transition to treatment services across the country.

The Integrated Drug Treatment Service (IDTS) was established at Wayland in 2009 and is housed in D Wing with a total capacity of 124. The wing now has its own dispensary, dedicated nursing staff, pharmacy staff and GP sessions. The clinical team (provided through
Serco) works closely with the CARATs (Counselling, Assessment, Referral, Advice and Through-care) service.

The clinical team offer medicated detoxes from opiates using methadone or subutex. Assessment of withdrawal using the SOWS (Subjective and Objective Withdrawal Scale) is completed for any prisoner who is experiencing symptoms. All IDTS patients are seen monthly for a care plan review and seen every 13 weeks for a wider review with the doctor, IDTS nurse and CARAT Worker.

In quarter 2 of 2012/13 just over a quarter (26%) of new receptions began a drug treatment episode (this is compared to just 13% at Norwich and Bure). The majority of prisoners receiving treatment for their substance misuse problems have a drug as their primary problem substance with over half (54%) stating they have a problem with opiates (see figure 56).

![HMP Wayland drug and alcohol treatment client by primary problem substance (2012/13 Quarter 2)](image)

Over 2011/12 there was an average of 73 clients receiving clinical services each month at HMP Wayland, 88% of these are receiving methadone and the remainder subutex. The prescribing focus is very much on reduction towards detoxification, on average six clients completed their reduction each month in 2011/12. Some clients are on a maintenance dose, and this indicates a flexible approach that ensures clients are being worked with at a pace that is appropriate to them.

A 60 bed drug-free wing opened in January 2012, this houses prisoners who are not currently on drug treatment and are keen to maintain a drug-free life. Prisoners housed on this wing must agree to voluntary drug testing, alcohol breath testing and increased dog searches. CARAT staff are available on the wing along with peer support and groups run by trained staff. Prisoners can self-refer to this wing, and applications are assessed by the wing’s specialist staff in collaboration with other relevant parties such as IDTS and CARAT.

Best practice guidance is for those clients receiving a prescription to also be receiving psychosocial treatment. Most clients at Wayland are engaged in both clinical and non-clinical treatment interventions. Only 2% of drug clients and 0% of alcohol clients are receiving only clinical interventions.

Psychosocial services are (until April 2013) provided by Phoenix Futures CARAT services who had an active caseload of 316 prisoners in 2011/12. As a snapshot of activity in October 2012 shows, the team conducts around 47 structured one-to-ones with clients a month. Group work is delivered in the form of two evidence based programmes, PASRO (Prisoners...
Addressing Substance Related Offending) which is open to those currently on treatment regimens and RAPt (Rehabilitation of Addicted Prisoners Trust) provide a relapse prevention programme open to those who have become drug-free and are off all opiate-based medication. Anecdotal evidence indicates that these programmes are very popular and are increasingly being incorporated into prisoners’ sentence plans. Approximate numbers of prisoners going through the groups per month are 18 for PASRO and 4 for RAPt, 43 prisoners completed the RAPt programme in 2011/12. There are also AA and NA mutual aid groups operating in the prison, and the CARAT team is also taking steps to introduce a SMART recovery group to offer an alternative model of mutual aid.

In 2010 a need for alcohol treatment was identified, a prisoner survey found that 27% of prisoners indicated that they consumed alcohol on a daily basis in the six months prior to custody. Given the link between alcohol and offending this clearly showed a need for alcohol treatment at HMP Wayland. An Alcohol Related Violence (ARV) course was implemented that targets those serving sentences for alcohol-related violent crime. However, this did not address the needs of prisoners serving sentences for alcohol related non-violent crimes (such as theft, drink driving, antisocial behaviour etc.). In response a new service was developed called REACT (Referral and Education for Alcohol using Clients in Treatment). 80% have rated the service as useful or very useful in motivating them to address their alcohol misuse.

The health needs assessment at Wayland made no recommendations in relation to drug treatment. The main actions arising from the CARAT needs assessment for 2013 include improving mutual-aid provision, implementing the new treatment system provided by NRP and ensuring staff and prisoners are made aware of the new service and increasing awareness of drug and alcohol treatment in HMP Wayland.

HMP Norwich

**Key findings**
- HMP Norwich predominately serves the courts of Norfolk and Suffolk, this means the majority of prisoners are on short-term sentences.
- High turnover of prisoners means a significant numbers of assessments, providing short-term interventions, and ensuring care coordination between treatment in prison and local treatment services.
- 20 people on average each month have inpatient detoxifications for alcohol.
- The new adult drug and alcohol support system in Norfolk offers particular opportunities to join up prison and community services, including a programme where by prisoners are met by an NRP Key Workers on release.

Located to the north east of Norwich city centre, HMP Norwich predominately serves the courts of Norfolk and Suffolk, this means the majority of prisoners are on short-term sentences (less than 12 months). The prison has an operational capacity of 767. Offenders committing multiple non-violent acquisitive crimes (characteristic of people with high-level opiate and crack problems) will often be given short sentences and these offenders make up a significant proportion of Norwich prisoners. High turn over of prisoners means a significant number of assessments, provision of short-term interventions, and ensuring care coordination between treatment in prison and local treatment services. Of those receiving clinical services 87% are local residents (Norfolk or Suffolk).

The majority of prisoners receiving treatment for their substance misuse problems have a drug as their primary problem substance with 46% stating they have a problem with opiates (see figure 57).
Clinical services are provided on a comprehensive primary care centre including a pharmacy, a wing for 210 prisoners serving as a first night centre with 60 prisoner places identified for the safe delivery of clinical services. The clinical substance misuse service operates on two landings which have clinical rooms and a safe supervised consumption area (all cell doors have hatches).

Over 2011/12 an average of 130 clients received clinical services each month at HMP Norwich, 81% of these are receiving methadone and the remainder subutex. On average six clients completed their reduction each month in 2011/12. Some clients are receiving a maintenance dose, which indicates a flexible approach, working with clients at an appropriate pace. There are also 20 people on average each month having inpatient detoxifications for alcohol.

Best practice guidance is for those clients receiving a prescription to also be receiving psychosocial treatment. Most clients at HMP Norwich are engaged in both clinical and non-clinical treatment interventions. Only 9% of drug clients and 1% of alcohol clients are receiving only clinical interventions (although this is higher than HMP Wayland).

As with the other prisons in Norfolk psychosocial services are currently provided by the CARAT team by Phoenix Futures. A snapshot of activity in October 2012 shows the team conduct around 62 structured one-to-one sessions a month. HMP Norwich has 12 places per session on the RAPt programme, with a yearly target of 80 completions – 99 completed in 2011/12.

Transfer between prison and community services

One of the greatest challenges for drug and alcohol services in prisons is ensuring a smooth transition into services in the community. Leaving prison can be unsettling for some people and offer sudden easy access to substance, which can increase risk of relapse. There is a significant risk of death by using drugs on release (especially heroin) because of reduced tolerance. The new adult treatment and support system in Norfolk provides opportunities to improve this – and to make the transfer of clients and their associated data smooth and seamless. The current system of multiple providers and multiple data systems has made transitions difficult in the past – particularly in cases of early release where there has not been sufficient opportunity to prepare for transfer. These issues are particularly pertinent for HMP Norwich because the majority of prisoners are on remand or short-term sentences. NRP are planning to run a programme where by people are met by an NRP Key Workers on release to manage their transfer into community services. While transition of care will always
be difficult, particularly in the case of unexpected releases, the new system should offer an improved service to people experiencing drug and alcohol problems in custody.

The Cost Effectiveness of Drug Treatment

**Key finding:**
- For every £1 spent on the local substance misuse system £4.54 is gained in total benefits.

The costs of substance misuse to society are incurred through drug related crime, health problems, children being placed into Local Authority care, unemployment and many other areas. Accessible and effective structured drug treatment can help reduce the economic and social costs to society of drug-related harm. In fact, many studies have repeatedly shown that the economic benefits of treatment far outweigh the costs.222

In 2010 the NTA released its “Value for Money” (VFM) tool that provides invaluable insights into the benefit of providing money to fund drug treatment services (this does not include alcohol treatment) in terms of preventing crime and health problems and natural benefits as a result of drug users entering services and overcoming their dependency. The costs which are included in the model are the Adult Pooled Treatment Budget and local substance misuse funding (this only relates to community service and not drug treatment provided in Prisons).

**Methodology**

The tool is based on a number of assumptions that are derived from robust research, which means that figures generated are estimates and are indicative only. These assumptions include:

- Research shows that the average drug using carer of an OCU is 20 years. NDTMS data shows that the mean time in a drug taking career to start treatment it eight years after beginning to take drugs. NDTMS data also shows that for clients who successfully recover, the average time in treatment is four years. Therefore, for this group, treatment has reduced their drug taking career by eight years. The crime costs saved by treating drug users are based on these eight years where drug related crimes are likely to have been committed.223

- According to the National Institute for Health and Clinical Excellence (NICE), the cost of providing health services to an injecting drug user (IDU) over their lifetime is £35,000.224

- Drug users (both IDUs and non-IDUs) are estimated to cost the National Health Service between £283m and £509m a year, in addition to the specific addiction treatment they may be receiving. The cost per user is approximately £1,000 per year (in 2000-01 prices).225

The tool also takes into account (and assigns a cash value to) the Quality Adjusted Life Years (QALYs) accrued by receiving treatment for a drug problem. This takes into account the irrevocable damage to the health of problem drug users as a result of their addiction and how their life has been extended in comparison with users who did not achieve recovery. It also takes into account the QALY aspect of crime in terms of the physical and emotional impacts on direct victims as a consequence of crime. The cost effectiveness of a QALY is

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222 Godfrey, C., Stewart, D. and Gossop, M., (2004) *Economic Analysis of Cost and Consequences of the Treatment of Drug Misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS).*


expressed as £ per QALY. NICE (National Institute for Health and Clinical Excellence) uses this system to determine whether treatments are cost-effective. Generally, if a treatment costs more than £20,000-30,000 per QALY, then it would not be considered cost effective by NICE. The NTA has estimated that the cost-per-QALY of drug treatment for both OCUs and non-OCUs is well below this threshold, with the cost-per-QALY for treatment for an OCU roughly £7,000 and £15,000 for a non-OCU drug user.\(^{226}\)

Health

The vast majority of people complete a general healthcare assessment when they come into drug and alcohol treatment, this includes questions relating to both physical and mental health, medications taken and injecting behaviour. Working to improve physical and mental health is a significant part of drug and alcohol treatment, and there are huge health benefits to entering treatment as well as achieving recovery and breaking dependence on drugs and alcohol. In 2010/11 there were 2,160 OCUs in treatment in Norfolk and just under 700 had achieved a sustained recovery over the last five years; the NTA estimate that overall this resulted in a cashable cost-saving of over £1.6m (£1,589,570). The also estimate that ‘natural benefits’ based on the improved quality of life derived from better health has elicited another £17m saving (£17,406,714).

Crime

Given the well established link between drug use and crime it is possible to estimate the number of crimes that have been prevented by supporting the recovery of drug users in Norfolk. These estimates are based on Home Office analysis that shows that OCUs receive fewer convictions while they are in treatment and when they have successfully completed treatment. In 2010/11 there were 2,160 OCUs in treatment and just under 700 had achieved a sustained recovery over the last five years, this resulted in 32,500 fewer incidents of shoplifting, 1,300 fewer thefts from vehicles, 1,900 fewer burglaries and 2,300 other acquisitive crimes. Overall this resulted in a cashable cost-saving of over £16m (£16,085,676). The NTA also estimated ‘natural benefits’ based a factors including the emotional impact on victims of crime, they estimate drug treatment has elicited another £2.5m saving (£2,585,770).

Cost-benefit ratio

The estimated total cost to public services between 2011 and 2015, if no OCUs were treated for their addiction, is £442m in real terms. Based on the total estimated spend in Norfolk (£31.2m), the total benefits accrued in terms of cost savings and natural benefits are:

- An estimated crime cost saving and natural benefits of £70.4m
- An estimated health cost saving and natural benefits of £70.9m

This gives a cost-benefit ratio of 1: 4.45. In other words, for every £1 spent on the local substance misuse system £4.54 is gained in total benefits.

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Chapter 6: Conclusion to Adults Section

This needs assessment shows that trends in drug use are changing and this presents new challenges for the partnership. Use of opiates like heroin may be falling but an older cohort of entrenched heroin users poses a challenge, as does providing an adequate response to new psychoactive substances and increasing understanding of prescription drug misuse. Alcohol is used by 85% of the population and some risky forms of drinking, such as binge drinking is increasing among some groups. 3.5% of the population are estimated to be dependent on drugs and 6% on alcohol, and therefore a significant number of people in Norfolk are affected by the substance misuse.

Both alcohol and drug related hospital admissions continue to rise year on year and represent a significant drain on NHS resources. Other substance misuse related health implications include blood borne viruses, poor mental health and ultimately death for some Norfolk residents. Harmful drug and alcohol use also impacts on many other areas of society by being a cause of fires and road traffic collisions. People with substance misuse problems will often experience multiple issues and therefore form a cohort of the people receiving social care services, as well as employment and housing support. There are specific issues with certain Black, Minority and Ethnic groups, particularly in terms of access to drug and alcohol services.

Substance misuse is notable cause of crime and antisocial behaviour in the county, particularly in terms of alcohol-related violence, this is both associated with the night time economy and in terms of domestic violence. Drug crime is also associated violence and acquisitive crime. Substance misuse related crime and antisocial behaviour impacts of perceptions of safety amongst the wider community and represents an unnecessary burden on police resources.

The impact that substance misuse has on the health and wellbeing of Norfolk highlights the importance of supporting people to recover from their dependency on drugs and alcohol. Treatment and support for adults with substance misuse problems must be provided as part of a balanced system which is flexible and responsive to individual client needs. Brief interventions will be sufficient to change harmful substance use behaviours in the majority of people, but for those that continue to use substance harm reduction interventions such as needle exchange will remain essential. Some clients will need to receive a prescription to help them address their substance misuse issues, and all clients should always have the option of psychosocial interventions. Other clients will require residential care and would benefit from a clear and simple pathway to access this.

All agencies working with people with substance misuse issues need to be ambitious about the outcomes clients can achieve. A greater emphasis will be placed on ensuring Norfolk has a balanced, recovery focused system that links in with mutual aid support groups and the wider voluntary and community sector.

The substance misuse system cannot support client recovery in isolation. Other public and voluntary sector providers in the criminal justice system, employment and benefit services, children and family services, housing services and the NHS have a responsibility to work in partnership to support people with substance misuse problems. There is much these agencies can do themselves to address substance misuse, above and beyond referring their service users for treatment. Support services such as these ultimately have a shared goal of reducing the number of people requiring their services, and given that substance misuse is a factor in increasing need, there are gains for everyone in tackling it together.

A wide range of treatment options and integrated support from the full range of partnership agencies is needed to in order to fully support the recovery of people affected by drug and alcohol misuse in Norfolk.
Substance Misuse in Norfolk

Section 4: Older People
Introduction

Older people are one of the fastest growing population groups in society. 20% of people in Norfolk are aged 65 and above.\textsuperscript{227} North Norfolk is projected to have one of the largest proportions of older people in the country, with 32% aged 65 and over by 2016. Therefore it is more relevant now than ever to consider the substance misuse needs of older people, and the nuances of providing services to them.

Alcohol and Older People – Prevalence and trends

\begin{table}[h]
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\begin{tabular}{|c|c|}
\hline
\textbf{Key findings} & \\
\hline
Older people are a significant population in Norfolk & \\
Alcohol consumption among older age groups appears to be increasing. & \\
The negative effects of alcohol are more damaging to older people. & \\
\hline
\end{tabular}
\caption{Key findings}
\end{table}

Alcohol consumption among middle and older age groups is lower than for younger age groups, however in recent years there has been a small but steady increase in the amount of alcohol consumed by older people. The trend is consistent across different surveys and different consumption measures.\textsuperscript{228} The annual NHS health survey shows that 8% of 65-74 year olds had exceeded the daily recommended drinking allowance in the last week, and this was 2% of people aged over 75.\textsuperscript{229} As people get older their ability to break down alcohol slows, and they are more sensitive to the effects of alcohol, and therefore drinking over recommended levels may be more harmful. Also, general health and balance gets worse with age and even a small amount of alcohol can make an older person more unsteady and more likely to fall.\textsuperscript{230}

Given the stigma associated with problematic alcohol use it is difficult to accurately estimate the scale of problem drinking among older people, but is estimated that 3% of males and 0.6% of females over the age of 65 can be diagnosed as dependent on alcohol.\textsuperscript{231}

About a third of older people with drinking problems develop them for the first time in later life. The average age that an alcohol client in Norfolk starts structured treatment is 44 years, compared to a drug client which is 34. Bereavement, physical ill-health, difficulty getting around and social isolation can lead to boredom and depression and physical illness causes physical pain. It is thought that older people may use alcohol to make these difficulties more bearable. There may be less pressure to give up drinking than for a younger person, fewer family responsibilities, and no pressure to go to work each day.\textsuperscript{232}

Unmarried, widowed or divorced men are most likely to engage in health damaging behaviours in older age, followed by married older men, then married older women (particularly if their husband drinks) and then unmarried, widowed or divorced women, who usually display the best health behaviours.\textsuperscript{233}

In 2011/12 there were 126 people who were aged 64 or over that received structured alcohol treatment in Norfolk. Of these 61% were male and 39% female (this is a similar gender split to younger adults in treatment).

**Impact of substance misuse in older people: Falls**

Falls represent the most frequent and serious type of accident in the over 65’s age group with around 30% of this age group falling every year. This suggests 53,010 in Norfolk would be expected to fall each year, 11,084 would be likely to attend A&E and 3,809 be admitted to hospital in a year.\(^{234}\) It is estimated that 12% of falls in males over the age of 64 and 4% of females are attributable to alcohol,\(^{235}\) if an average of 8% is used, we can estimate there are around 420 preventable alcohol-related falls among older people each year in Norfolk.

**Impact of substance misuse in older people: Dementia**

Dementia can affect people of any age, but is most common in older people. At any given time about 55% of the population aged 65 years and over will have mild dementia, 32% moderate and 13% severe. Severity increases with age as the disease progresses. There are estimated to be of over 13,000 people in Norfolk with dementia. Because of the trend towards an aging population in Norfolk, this will rise significantly to over 24,000 by 2030.\(^{236}\)

Heavy drinking in persons with longstanding alcohol dependence can also cause a full-blown dementia that may be permanent. Dementia has been diagnosed in 12-25% of older alcoholics in treatment. Alcohol-induced persisting dementias account for 20-25% of cases in dementia registries.\(^{237}\) This equates to an estimated 3,800 people in Norfolk.

The distinction between alcohol-induced persisting dementia, Alzheimer’s and other dementias is not always easy and may require repeated observation and testing over time. Alcohol-induced dementia may plateau or improve with abstinence and it is important to abate alcohol use in anyone suffering from dementia because continued drinking hastens cognitive decline. Research shows that patients with mild to moderate dementia may still be productively engaged in general treatment as long as treatment is tailored to their capacities. However, for those with severe of worsening dementias community based alcohol treatment is unlikely to be effective and specialist residential or assisted programmes are required.\(^{238}\)

Identifying the factors contributing to dementia is critical. A recent large study of elderly people found that new use of benzodiazepines (i.e. starting using them in the three years prior to the study) was associated with a significant (approximately 50%) increase in the risk of dementia.\(^{239}\)

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\(^{238}\) Ibid

Benzodiazepines are prescribed more often to elderly patients than to younger people, and the older a patient is, the more likely they are to be receiving multiple medications. Some research suggests that at least 25% of older people are taking psychoactive drugs, such as antidepressants or sedatives. These drugs have been demonstrated to increase the risks of falls (and thus fractures); they can cause impairment to driving skills, disrupt sleeping patterns, and, among the frail elderly cause excessive disability. Furthermore, prescribed medication taken in conjunction with alcohol can cause adverse side effects and generally, older people are advised not to drink when they are taking other drugs. Problems caused by using alcohol and other drugs concurrently may include a diminished effect of the drugs in an individual who drinks regularly and the increased sensitivity to drugs conferred by malnutrition and severe liver damage, for example cirrhosis.

The group of drugs known as ‘hypnotics’ includes commonly prescribed benzodiazepines and other sleep-related drugs, and Norfolk has the third highest rate of spending on hypnotics of the 75 PCTs in the southern half of England, and Great Yarmouth and Waveney is fourth. The national average (median) spending on hypnotic drugs is £180 per 1,000 patients, but in Norfolk and in Great Yarmouth the figure is around £270 per 1,000 patients (see figure 58).

An audit of 23 GP practices in Norwich was carried out in September 2011 and March 2012 because it was recognised that the prescribing of hypnotics was above the national average.

Key findings

- Benzodiazepines and other hypnotics are more commonly prescribed to older people than other groups, with significant health implications.
- There is now a cohort of older people who are long-term serious drug users who require specific services.
Just 14% of those receiving a hypnotic prescription at the second audit were under the age of 65.\textsuperscript{245, 246}

**Recommendation**
There is a need for further research into the prescribing of hypnotics, given that these drugs are open to abuse, and that current NHS guidance advises against long-term prescriptions of these drugs, which highlights the negative effects for older people in particular.

**Older opiate users**

As described in the ‘Drug use by Adults’ section the population of people in substance misuse treatment with heroin problems is getting older. The success of harm minimisation interventions such as needle exchange and substitute prescribing mean that people with serious, high-level drug problems - like those who inject heroin – are now surviving into older age. This has implications for services such as drug treatment, but also adult social care, residential services and healthcare as a life-time of chronic drug use often leaves these people with serious health conditions.

In 2011/12 there were 13 people who were aged 64 or over that received structured drug treatment in Norfolk, the majority of these are opiate clients, and all were white males. Research suggests that older drug users are likely to suffer from the negative social consequences of decades of drug use. Studies report that older drug users are often socially excluded and isolated from their family, friends and social networks outside the drug users’ networks. They are more marginalised, have higher levels of unemployment, lower levels of education, they are more often homeless, and they are more likely to have been in prison. Older drug users tend to have smaller social networks composed mainly of other older drug users, caused by having lost contact with non-drug using family and friends and losing peers to death. In addition, they are less likely than younger drug users to make new friends, and are more prone to the loss of close friends and the associated feelings of depression, isolation and loneliness. Finally, the general quality of life of older drug users is worse than that of younger drug users and these factors mean that it may be more difficult for older drug users to achieve recovery from dependency.\textsuperscript{247}

**Identifying Substance Misuse Problems in Older People**

Some helpful screening tools for alcohol misuse are available, the most commonly used is AUDIT, or the MAST tool has versions which have been specifically adapted for working with older drinkers.\textsuperscript{248} Some believe that health professionals do not spot heavy drinking in older people as often as they should, because:

- Older people tend not to talk about their drinking, perhaps because of embarrassment.
- They mistake the effects of alcohol for a physical or mental health problem.
- They forget that older people may have drink problems so they do not look as hard for symptoms.\textsuperscript{249}

Identifying older people with inappropriate, long-term prescriptions of drugs like benzodiazepines and other hypnotics is an issue for primary healthcare providers to consider.

\textsuperscript{245} NHS Norfolk and Waveney (2012) *Hypnotic Audit Summary*. NHS Norfolk and Waveney
\textsuperscript{246} For more information see NHS Clinical Knowledge Summaries: [http://www.cks.nhs.uk/benzodiazepine_and_z_drug_withdrawal/background_information/reasons_for_stopping](http://www.cks.nhs.uk/benzodiazepine_and_z_drug_withdrawal/background_information/reasons_for_stopping)
\textsuperscript{247} EMCDDA (2012) *Treatment and Care for Older Drug Users*. European Monitoring Centre for Drugs and Drug Addiction
Providing Drug and Alcohol Services for Older People

**Key findings**

- Older people may not feel traditional drug and alcohol services are appropriate to them.
- Substance misuse by older people has particular significance for adult social care and those providing residential services.

In Norfolk 20% of the population (84,200 people) are aged over 65. In this age group, there are 116 people in alcohol treatment in Norfolk. There are specific issues for the treatment of older people with alcohol problems; it may be that they do not feel traditional specialist drug and alcohol services are suitable for them and are more likely to rely more on primary health care, like their GP. Also, ill health would make them less suitable for outpatient detoxification, and therefore require inpatient detoxification.

The provision of suitable substance misuse services for older people in the community must take into account that clients can have a fear of drug users. Older people may prefer to be seen in their own homes over any type of clinical primary care setting, or failing that, by a GP rather than in a specialist agency. The most effective interventions are believed to be the companionship that comes from a visit by an outreach worker.

Some research suggests that a difference in schooling, social structures and possibly workplace practices, means that older people are not used to working in groups – they find them intimidating in comparison to younger people who tend to be more open-minded. This may make mutual-aid groups and peer support less attractive to older people.

There are also issues in terms of providing residential services for older people with alcohol problems. Large numbers of older people live in supported accommodation and residential homes, or experience time in nursing care settings. A national survey of social workers found there were often difficulties in setting up suitable care for older people who also have alcohol and/or drug problems in a residential setting, because care agencies are not always happy to provide support for those that misuse substances. This study also found that unsuitable residential placements may actually increase consumption. There can be a tension in residential services for older people between protection and supporting their right to self-determination in consuming alcohol. Various care settings will have differing policies about alcohol consumption and such policies need to be explored with older people and their families prior to placement. Social Workers can work with residential care staff to ensure that care plans reflect positive drinking, support needs and risk management.

**Recommendation**

All people providing support and care to older people should be given the appropriate skills based training to discuss alcohol and drug consumption with their service users, provide brief interventions and know how to signpost into treatment if appropriate.

Specialist substance misuse agencies need to consider how to make their services more accessible to older people, there is a potential need for more flexible provision, which may take the form of outreach.

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Conclusion to Older People’s Section

Alcohol consumption appears to be rising amongst older people and has specific health impacts for this group, especially in terms of falls and dementia. Prescription drug use is high amongst this group and there may be a significant number who are being inappropriately or over prescribed. There is also an aging cohort of older opiate users with specific health and care needs.

Less is known about the substance misuse needs of older people than for other age groups and further research and accurate data collection/sharing is required to estimate these needs. What we do know is that age does not negate problematic substance use, and given that Norfolk has an aging population, the substance misuse needs of older people will increasingly be a key consideration in service planning. As with other age groups a wide range of agencies need to work together to identify older people with substance misuse needs, and to ensure that there are appropriate services are available. A coordinated multi-agency approach is required to ensure the people of Norfolk are supported to enjoy the later years of their lives free from dependency on drugs and alcohol.
Substance Misuse in Norfolk

Needs Assessment 2013

Section 5: Conclusion
N-DAP Needs Assessment 2013 Conclusion

This needs assessment shows that people of all ages can be negatively affected by substance misuse, either suffering because of their own drug and alcohol use, or that of someone close to them.

It has been demonstrated that people who have substance misuse problems usually have some other needs, which may include health, housing, employment or all of the above. Preventing problems becoming serious and promoting successful recovery are built on a foundation addressing these wider needs. This is true for young people, working age adults and older people. Substance misuse support services cannot provide a ‘one stop shop’ and need to utilise other specialist services.

Most support services in Norfolk also work with some people with substance misuse problems. All agencies should recognise the benefits for their clients, and therefore their service, to identifying substance misuse and ensuring people receive help and support.

A major recurring theme throughout the document is the need to ensure that all professionals that come into contact with people with substance misuse problems feel confident in having a conversation with that person about their substance use, and know how to at least signpost them towards help and support. Realistically there is a fairly long way to go before this is a reality. Training and adequate promotion of services will be a start, and this can be supported by substance misuse competencies being included in the competency frameworks of a wide range of professions. The new adult substance misuse treatment and support system with its single assessment and referral system provides an ideal opportunity to re-launch and promote services. Promotion should raise awareness about drug and alcohol problems and in turn help to reduce stigma.

This needs assessment also shows there are developments necessary for the substance misuse treatment and support system itself to provide the best service to support people with drug and alcohol problems. This includes reviewing the way services are provided to the friends and families of people with substance misuse problems, reviewing drug and alcohol education in schools, increasing access to mutual-aid peer-led recovery support, improving access to Tier Four residential treatments and improving joint working so that people are supported to return to work and live in stable accommodation. People in treatment should be offered person-centred recovery-focused care which successfully engages them in treatment, but also offers them the best chance of moving on from that treatment.

The key findings and opportunities identified in this needs assessment will be considered by the N-DAP Board, the DAAT team and the wider partnership to inform the development of ongoing strategy and action plans with a view to ensuring that all the people of Norfolk, young and old, are supported to live lives free from dependency on drugs and alcohol. N-DAP will continue to work towards the overarching goal of preventing and reducing drug and alcohol related harms, to individuals, families and communities in Norfolk.