Oxfordshire Drug and Alcohol Needs Assessment

2018/2019

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OXFORDSHIRE COUNTY COUNCIL

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ABBREVIATIONS

HNA= Health Needs Assessment

OCC= Oxfordshire County Council

NDTMS= National Drug Treatment Monitoring System

TVP= Thames Valley Police

EU= European Union

ACMD= Advisory Council on the Misuse of Drugs

COPD= Chronic Obstructive Pulmonary Disease

HMP= Her Majesty Prison

DRR= Drug Rehabilitation Requirement

ATR= Alcohol Treatment Requirement

POM= Prescription-only medicines

OTC= Over-the-counter medicines

NPS= New Psychoactive Substances

HIV= Human Immunodeficiency Virus

SWIP= Sex Workers Interventions Panel

1. EXECUTIVE SUMMARY

1.1 Synopsis

A Health Needs Assessment (HNA) has been developed to inform commissioning of community-based alcohol and drug misuse treatment services in Oxfordshire. It was decided to conduct a joint HNA for both alcohol and drug users due to the likely substantial shared needs and opportunities for intervention. It is envisaged that this HNA will guide the development of relevant partnerships by the Oxfordshire County Council (OCC) Drug and Alcohol Team, and provide an evidence base to support the development of services which best meet the needs of the Oxfordshire population. The HNA is focused on the needs of Oxfordshire inhabitants aged 18 years and over who use alcohol, illicit drugs or other substance misuse in a manner of irregular harmful misuse or dependence, regardless of whether they are already in contact with treatment services. A variety of data sources have been used to inform the HNA, including the local treatment services database and Public Health England National Drug Treatment Monitoring System (NDTMS) reports, scientific literature and Government reports. The HNA would also not have been possible without input from stakeholders, and members of the service user focus groups who offered their time, experience and wisdom to the project. This accompanying report compares current and changing performance data against regional and national benchmarks, and outlines recommendations for consideration in future commissioning of services.

1.2 Key findings

- Individuals with alcohol dependence or substance misuse face substantial associated socioeconomic and health inequalities, including higher rates of premature morbidity and mortality.

- Young white males who live in socioeconomically deprived urban areas have the highest rates of alcohol and drug misuse in Oxfordshire.

- Rates of alcohol dependence and opiate and/or crack use in Oxfordshire, 10 per 1000 people and 6.68 per 1000 people respectively, are estimated to be lower than national rates, which are 13.5 per 1000 people and 8.57 per 1000 people respectively.

- Overall national rates of drug use among young adults aged 16-24 has declined over time from 1996 to 2017/18. However, there has been an upward trend in Class A drug use among young adults from 2011/12 to 2017/18. Approximately one in five young adults aged 16-24 in England and Wales 2017/18 reported some drug use in the preceding year, and 8.4% reported that they had taken a class A drug in the preceding year, near double the equivalent rates for adults.

- The estimated 'unmet need' in Oxfordshire is 87% of alcohol-dependent adults and 40-60% of crack and/or opiate users. The true extent of unmet need is difficult to quantify as the reported data only incorporates 'tier 3' structured treatment, and do not include tier 2 treatment in the form of for example brief interventions to reduce harm for those who do not feel that they are ready, or who do not need, structured treatment services.

- Among new presentations to treatment services in Oxfordshire in 2017/18, 24% of alcohol only service users and 16% of drug treatment service users reported living with children.

- In 2017/18, alcohol misuse was identified as a risk factor in 22.0% of assessments by Children's Social Care in Oxfordshire, compared to a national rate of 18.4% in England. Similarly, drug misuse was identified as a risk factor in 22.6% of assessments in Oxfordshire in 2017/18, compared to a national rate of 21.0% in England.

- National drug use rates among older adults aged 44-59 has increased over time. This is thought to mainly reflect increased cannabis use, but reported use of powder cocaine has also increased. Most older adults who reported using cocaine identified as infrequent users, whereas 49% of older cannabis

users reported being frequent users. In line with national trends, from 2016-2017 to 2017-18 the proportion of older drug users aged 40+ increased from 39% to 43% of service users.

- Among new presentations to alcohol treatment services in Oxfordshire, 51% were identified as having a mental health treatment need. Of these, 94% were recorded to be receiving treatment from mental health services.

- UK government reports have estimated that more than 80% of alcohol dependent and near 100% of opioid dependent users nationally also smoke, and research has suggested that alcohol and drug users are more likely to die from smoking-related illnesses than drug use.

- Oxfordshire has a higher rate of alcohol-specific hospital admissions (in which alcohol is always causally implicated), but a lower rate of alcohol-related hospital admissions (which incorporates all alcohol-specific conditions in addition to conditions where alcohol may sometimes be causally implicated), when compared to similar local authorities.

- Fourteen percent of individuals with an alcohol-specific hospital admission in Oxfordshire 2015/16 had two or more alcohol-specific hospital admissions in the preceding 24 months, compared to 17% nationally.

- Out of 140 drug and alcohol treatment service users released from prison services in 2017/18, 30 service users (21.4%) were picked up and commenced treatment in Oxfordshire within 3 weeks, which is below regional and national averages.

- Most new alcohol and drug treatment service users in Oxfordshire are of white British ethnicity, born in the United Kingdom, of heterosexual sexuality, and of no religious faith. Alcohol treatment service users are most frequently in regular employment, whereas drug treatment service users are most frequently unemployed or economically inactive. Ethnic minority groups, as

those of Asian, African or Caribbean ethnicities, are currently under-represented in treatment services.

- Poland is the second most common birth country of alcohol treatment service users in Oxfordshire, and Lithuania is the second most common birth country of drug treatment service users.

- The majority (54%) of Oxfordshire service users in treatment for alcohol misuse cite other concomitant substance misuse; the most commonly cited drugs being crack, cannabis, and cocaine.

- Compared to 2016/2017, new presentations to treatment for opiate misuse in Oxfordshire 2017/18 decreased by 17% (n=346), new presentations for non-opiate use increased by 32% (n=108), new presentations for alcohol and non-opiate use increased by 15%, and the overall number of new presentations to treatment decreased by 5% (n=575).

- The proportion of the total drug treatment population citing use of prescription-only- or over-the-counter medicines, with or without concomitant illicit drug use, is higher in Oxfordshire compared to the national average, 31% vs 14% respectively.

1.3 Recommendations

This HNA puts forward the following recommendations:

1. Increasing drug misuse among older ages, alongside an aging general population, highlights a need to ensure treatment services are accessible to older service users, and tailored to their needs. For example, older service users may be more resistant to attend drug treatment services alongside younger people, and may benefit from dedicated treatment times and/or

locations, and awareness campaigns of services should be available at locations that may be more visible to older service users, such as health-care centres or pubs. Given that most older drug users commence drug use before the age of 40, preventive strategies should be particularly mindful of initiation of drug use in younger age groups, and target preventive strategies at the under 40 population.

2. Facilitate close input from mental health services during substance misuse treatment and as part of follow-up care to maximise potential for recovery and reduce substance-misuse associated health inequalities. To reach individuals in the community for whom untreated mental health issues are a barrier to seeking substance misuse treatment there should be shared intelligence between mental health services and alcohol and drug treatment services (for example through inclusion of mental health services in any substance misuse strategic working group), streamlined referral pathways, and joint outreach work to shared high-risk groups (such as the homeless).

3. Consider close cooperation with children's support services and charities during provision of substance misuse treatment to mitigate the impact on children who have a parent in structured treatment, and to support the identification of high-risk groups such as children living in toxic-trio households, i.e. domestic risk factors including domestic abuse, substance misuse and mental health illness. Further, explore if there is a need and/or adequate provision of child-care support for parents for whom child-caring responsibilities may be a barrier to fully engaging with treatment services.

4. Blood-borne viruses are a significant public health concern among drug users but recording of hepatitis B and C testing and/or vaccination rates are however not well captured in standardised recording practices. It is therefore vital to amend recording practices to ensure that there is good understanding and monitoring of testing and vaccination uptake rates in Oxfordshire. Ensuring high uptake rates of viral testing, antiviral treatments, opioid substitution therapy and sterile injecting equipment are important strategies to protect drug users and

the broader community, reduce drug use-associated health inequalities, and provide long-term cost-savings.

5. Recognise the important roles of the alcohol liaison nurse and community safety practitioner in OUH Accident and Emergency departments, and support joint working between these posts and community-based drug and alcohol teams. Further, explore if there is a need to expand signposting to community alcohol treatment services within the hospital inpatient departments with the highest burden of alcohol-related illnesses, such as gastroenterology, transplant, or cardiology, in order to reduce the high financial and resource costs associated with repeat hospital admissions for alcohol-related causes.

6. Outreach and awareness efforts of substance misuse treatment services should target the most deprived districts in Oxfordshire, notably Oxford City and Cherwell, where current levels of need from alcohol- and drug- associated harm are highest.

7. It is known that certain ethnic groups, such as Asian or African/Caribbean are under-represented in treatment services compared to their representation in the general Oxfordshire population. However, the need for drug and alcohol treatment services in these ethnic groups in Oxfordshire is not understood, and it is not known if their need is proportionate to their demographic representation. Community engagement and awareness efforts should be developed to target these minority groups, and should developed with consideration to particular cultural, religious or language barriers that these communities may face in accessing treatment services. Overcoming such barriers may require the involvement of community or religious leaders. This may help to address existing health inequalities among ethnic minorities. Similar approaches should be taken in raising awareness of treatments services among Eastern European migrant communities in Oxfordshire which are constituting a rising proportion of alcohol and drug treatment service users, and which are known to represent a high-risk group for alcohol and drug misuse.

8. Establish close ties and joined up pathways between local criminal justice and prison systems and community treatment services, with specific regard to individuals who enter or leave prison services, or who are given community substance misuse treatment orders. This may help address a large area of need in increasing successful and timely pick-up rates by community substance misuse treatment services of service users released from prison. This is likely to not only support recovery of service users, but also benefit the broader community and criminal justice system by acting to prevent criminal re-offending associated with substance misuse.

9. There is a substantial community of individuals who are thought to engage in harmful levels of alcohol and drug misuse, but who are not in contact with treatment services and represent so-called ‘unmet need’. The underlying drivers of unmet need should be explored (and interventions developed if appropriate), such as e.g. characterising barriers to accessing treatment, awareness of services available and awareness of what constitutes harmful substance misuse.

10. Close collaboration between alcohol and drug treatment services and smoking cessation services. This should involve streamlined referral processes and monitoring of the proportion of referred service users who take up smoking cessation services, and their outcomes. Further, staff providing alcohol and drug treatment services should be trained in smoking cessation, and vice versa. Failure to ask about smoking and to provide smoking cessation to service users may otherwise represent an important missed opportunity to support successful substance misuse recovery, and to reduce an important driver of substance misuse associated health inequality. Further, it is recommended to maintain communication pathways between community alcohol and drug treatment services and GPs, particularly GPs who disproportionately treat individuals with alcohol or drug misuse, to facilitate access to early detection testing for respiratory diseases such as Chronic Obstructive Pulmonary Disease for service users with a high-risk smoking history.

11. Similarly, there are substantial overlapping communities of need across several public health services, such as relatively high rates of substance misuse alongside sexual health issues. Close collaborative working and streamlined referral pathways between different public health services could therefore ensure a more holistic approach to care management, by for example offering needle exchange services in sexual health centres and by utilising client contact with substance misuse treatment services as a vital opportunity to offer testing for sexually transmitted infections. Further, the data suggest a particular missed opportunity to incorporate HIV testing into other points of contact with services, or to offer novel self-testing opportunities for clients.

12. Awareness/promotion initiatives and treatment services could be integrated into large centres which are attended by a wide range of people in order to gain higher visibility. For example, this includes emerging large GP 'supercentres' which could be utilised for TV advertising in waiting rooms or via distribution of leaflets. Similar approaches could also be used in shopping centres which may be more visible and accessible to individuals who misuse drugs or alcohol, in part because of greater transport links.

13. Close partnership working with agencies that support sex workers from the private, public and voluntary sector, including through existing collaborations such as the Sex Workers Intervention Panel. It would be helpful for partnership work to also facilitate monitoring of uptake of substance misuse treatment support in this high-risk group. Further, it is vital that close communication is maintained with Children's Social Services as part of partnership working. Reducing substance dependency among sex workers would likely not only affect sex workers themselves, but also affected children given that the majority of sex workers have reported that a need to support their children is a driver of sex work.

14. Parents who misuse drugs or alcohol have reported fear of engagement from social services as an important barrier to accessing treatment services. This particularly relates to concerns with regard to whether their children would be taken into care if it was found that the parents misuse drugs or alcohol. A

component of partnership working with Children's Social Services should therefore include to consider how the negative perception of the role of social services can be improved among this community.

15. Close partnership working with relevant organisations in the public, private and voluntary sector, such as Thames Valley Police, local fire services, adult and children social care services, and charities focused on issues such as county lines, child drug exploitation and modern slavery. Partnership working facilitates a holistic approach to alcohol and drug misuse treatment and the development of services which are responsive to a changing social environment. Moreover, it is important to enhance data quality, accessibility to data and data sharing pathways across partnership work to combine intelligence.

2. BACKGROUND

2.1 Introduction

Use of alcohol or drugs at some stage in life is common; it is estimated that approximately 10.4 million adults in England consume alcohol at levels associated with some risk to their health, and that nearly one in three of the adult population have tried illegal drugs.[1] For a proportion of these individuals their alcohol and drug use may reflect dependency or excessive consumption and may be associated with substantial harmful consequences such as health problems or encounters with the criminal justice system. Alcohol is one of the leading modifiable life-style related drivers of non-communicable diseases alongside smoking and obesity, and it is estimated to be the behavioural risk factor with the second highest impact on the NHS budget after poor diet.[2] Use of alcohol and drugs has also been highlighted as one of the six key drivers of crime due to associations with behavioural disorders and

[1] Health Survey for England 2015, NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/health-survey-for-england-2015 Last accessed 01/10/2018.
[2] Scarborough P, Bhatnagar P, Wickramasinghe KK, Allender S, Foster C, Rayner M. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an update to 2006-7 NHS costs. J Public Health (Oxf) 2011;33(4):527-35.

violence: it is estimated that 1 in 100 people each year will be a victim of an alcohol-related violent crime.[3-4] The impact of alcohol and drug use on wider communities can be far-reaching, and include 1) direct economic costs on health and social care services, the criminal justice system and the social welfare system; 2) indirect costs from low productivity, unemployment, absenteeism and premature mortality or morbidity; and 3) intangible costs to the affected individual or their family members from anxiety, pain, financial worries and reduced quality of life.[3] Alcohol and drug treatment services have an important and evidence-based role in mitigating the personal and financial costs of alcohol and drug misuse, and have the potential to provide cost-efficiency savings for a range of public services including health and social care, housing and welfare, and the criminal justice system. This HNA will comparatively describe the needs of alcohol and drug users in Oxfordshire and will highlight areas of potential service improvement or partnership development to better meet these needs.

2.2 Aims and objectives

This HNA aims to 1) use epidemiological approaches and a broad range of quantitative and qualitative data sources to comprehensively and comparatively assess the needs of the population of Oxfordshire in relation to alcohol and drug use, 2) to identify areas of currently unmet need and inequalities, and to 3) make recommendations to address the needs of the local community in future service commissioning.

3. LOCAL CONTEXT

Oxfordshire is a county in the South East of England composed of a mixture of towns and rural villages. The county is represented by the OCC Local Authority and there are five district councils representing Cherwell, Oxford City, South Oxfordshire, Vale

[3] Secretary of State for the Home Department, ''The Government's Alcohol Strategy', HM Government, 2012:(1);8–9 https://www.gov.uk/government/publications/alcohol-strategy Last accessed 01/10/2018.
[4] Institute of Alcohol Studies. http://ias.org.uk/Alcohol-knowledge-centre/Crime-and-social-impacts/Factsheets/Alcohol-related-crime-in-the-UK-what-do-we-know.aspx Last accessed 01/10/2018.

of White Horse and West Oxfordshire, as shown in Figure 3.1. Oxfordshire population estimates by district highlight an expanding population size across the county, highest in absolute terms in Vale of White Horse and Oxford City, as shown in Figure 3.2. In the most recent mid-year population estimates from the Office for National Statistics in 2017, Oxfordshire county was estimated to have 682,400 residents, including both students and armed forces, and representing an increase of 22,400 (3.4%) residents over the five years since mid-2012. The county has a substantial rural population with one third of its residents living in towns and villages of less than 10,000 inhabitants, as shown in Figure 3.3.[5]

Figure 3.1. Geographical representation of the five Oxfordshire districts[6]

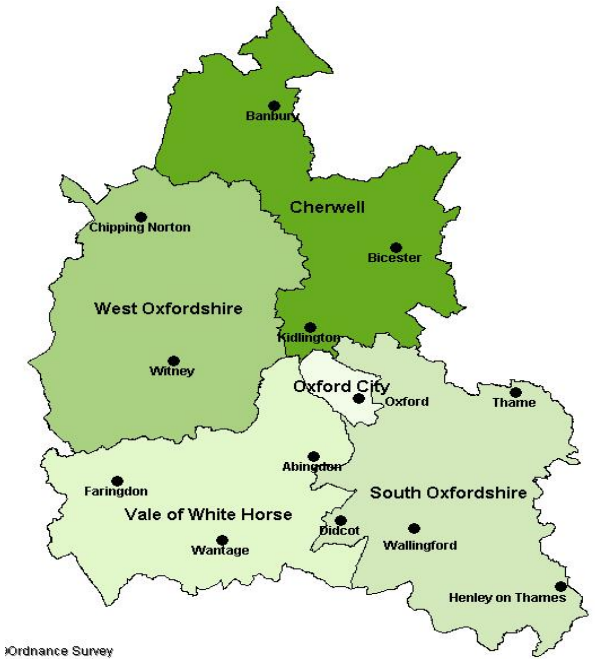


Figure obtained from Oxfordshire Insight

Figure 3.2. Distribution of the Oxfordshire population across its constituent districts in mid-2016, and the absolute change in district populations from mid-2015 to mid-2016

[5] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018.
[6] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018.

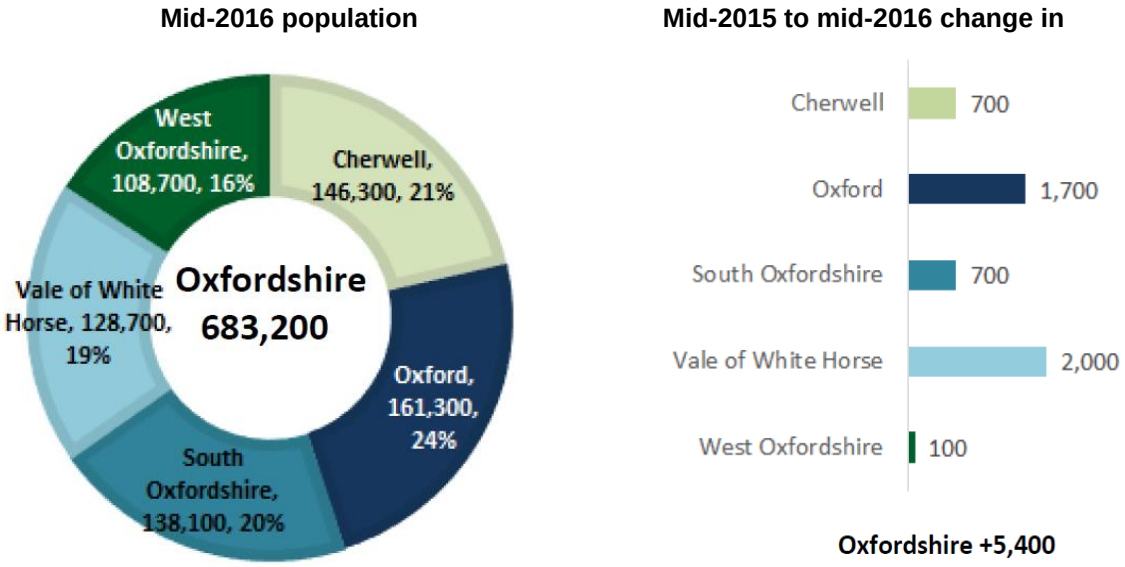


Figure obtained from Oxfordshire Insight

Figure 3.3. Rural and urban population distribution by Oxfordshire district [7]

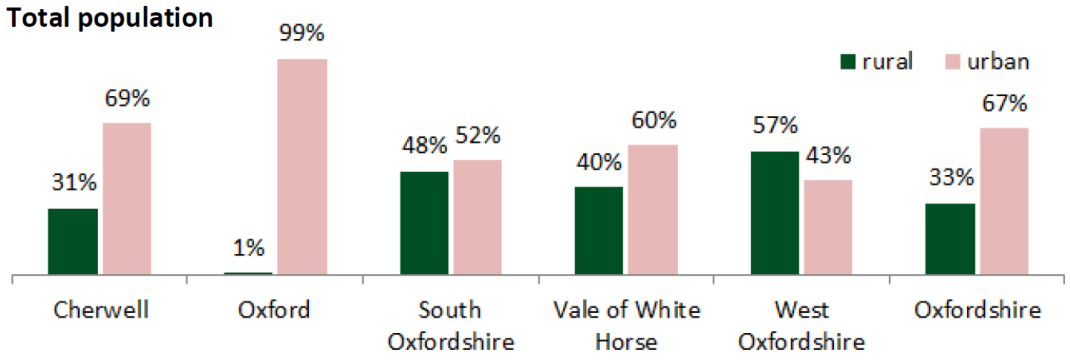


Figure obtained from Oxfordshire Insight, using data from the Office for National Statistics

3.1 Population demographics

3.1.1 Age distribution

[7] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018.

Oxford City is the most densely populated of the districts and has a younger age distribution compared to Oxfordshire overall. This is in part explained by the substantial student population within the city, which encompasses two large universities. Alongside national trends, the life expectancy in Oxfordshire is rising and the elderly population (age 65+) is increasing in all Oxfordshire districts. This trend has been most prominent in the 65-69 age group which rose by 41% in Oxfordshire between 2006-2016, and most markedly in rural compared to urban areas. The distribution of the Oxfordshire population by age and gender in 2016, with projections for 2031, is shown in Figure 3.4.

Figure 3.4. Oxfordshire population distribution by age and gender in 2016, and projections for 2031[8]

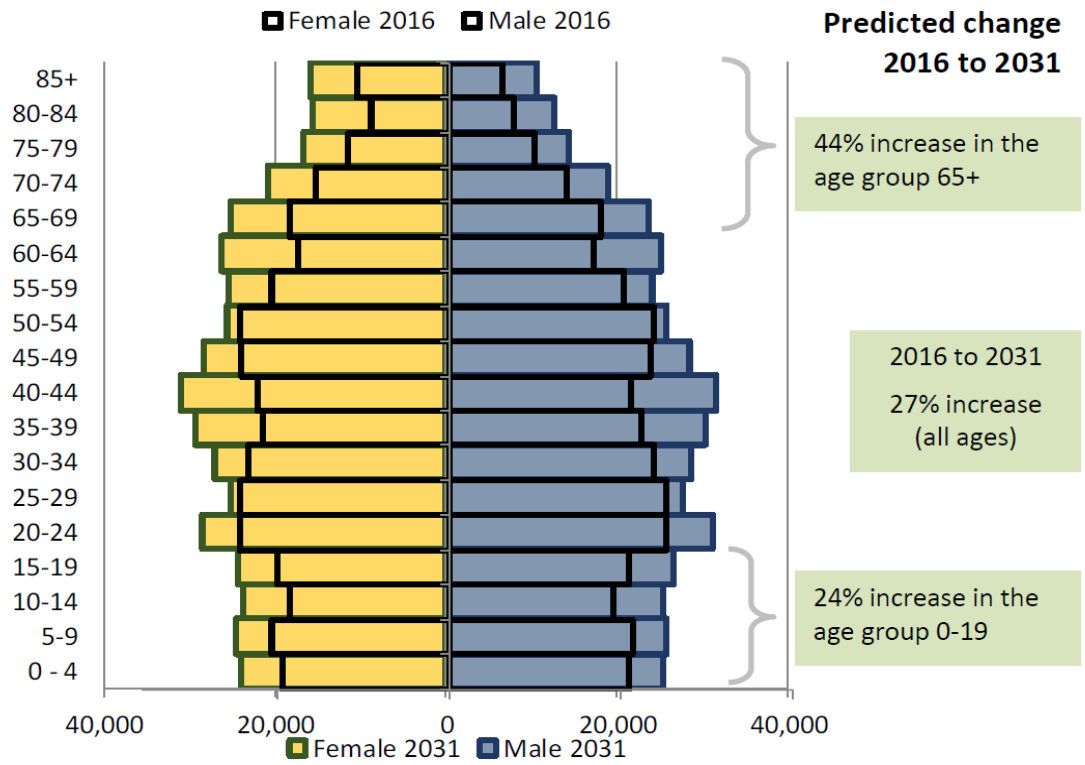


Figure obtained from Oxfordshire Insight

3.1.2 Ethnic distribution

White British represents the largest ethnic group in Oxfordshire, but as per the 2011 Census there are approximately 107,000 ethnic minority residents in the county

[8] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018.

(representing 16% of the total Oxfordshire population, compared to a national average of 20%), as shown in Figure 3.5.[9] The change in the proportion (%) of ethnic groups by district from the 2001 to 2011 census is shown in Figure 3.6, highlighting that the Cherwell and Oxford districts have seen the largest increases in ethnic minority populations over time. Further, ethnic minority residents appear to be clustered in urban and younger parts of the county, in part explained by higher migration into more densely populated areas and a larger student population in these areas. For example, Oxford City has the second highest ethnic minority population in the South East of England after Slough. The highest proportion of ethnic minority residents in Oxford City are in the 25-49 age group, of which ethnic minorities represent 22% of the local population. In contrast, ethnic minorities represent only 6% of Oxfordshire residents aged 65+.[10]

Figure 3.5. Ethnic distribution in Oxfordshire as per the 2011 census

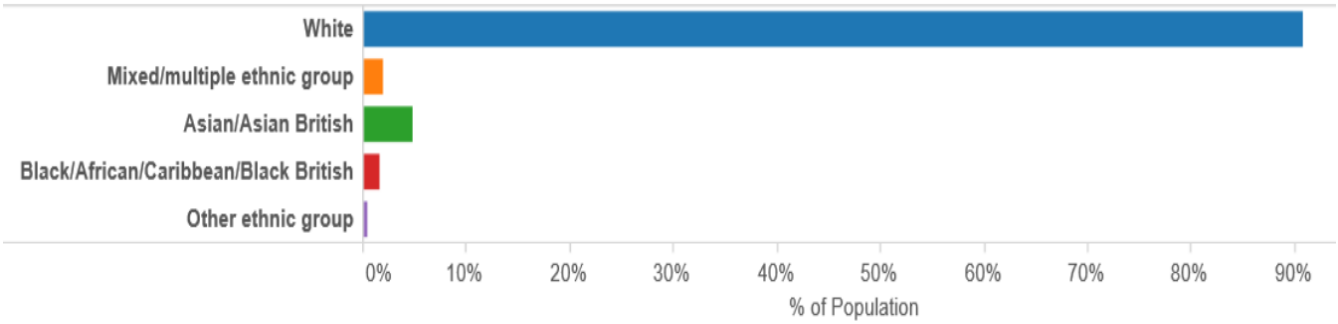


Figure obtained from Oxfordshire Insight

Figure 3.6. Change in proportions (%) of ethnic groups by Oxfordshire district from the 2001 to 2011 census

[9] 2011 Census. Office for National Statistics.
[10] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018.

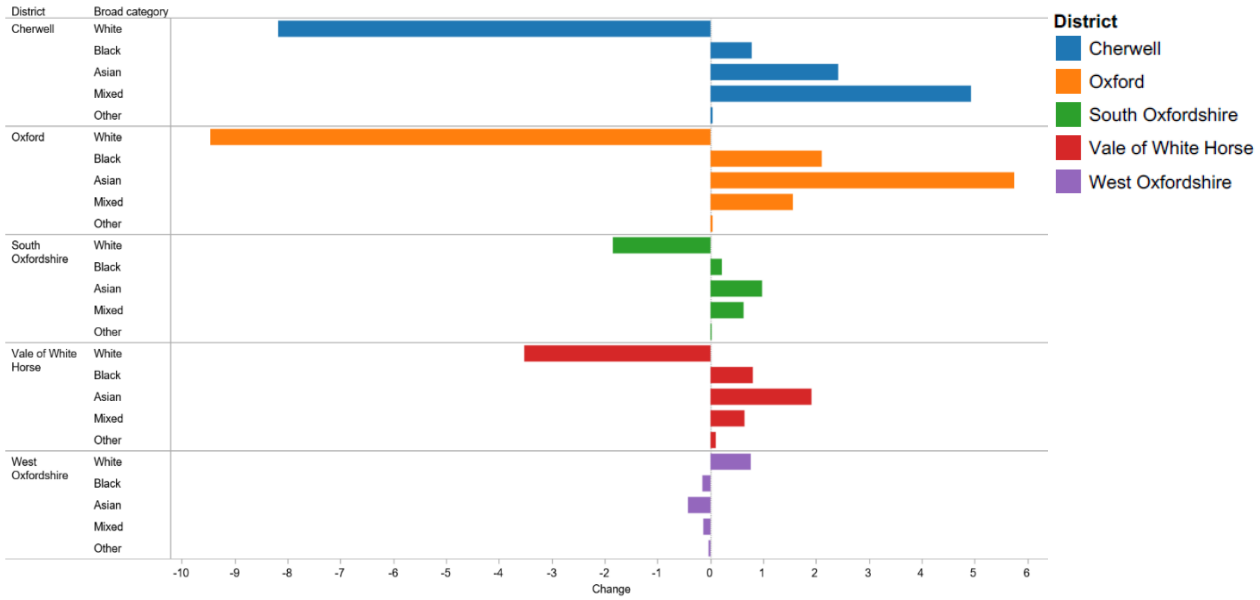


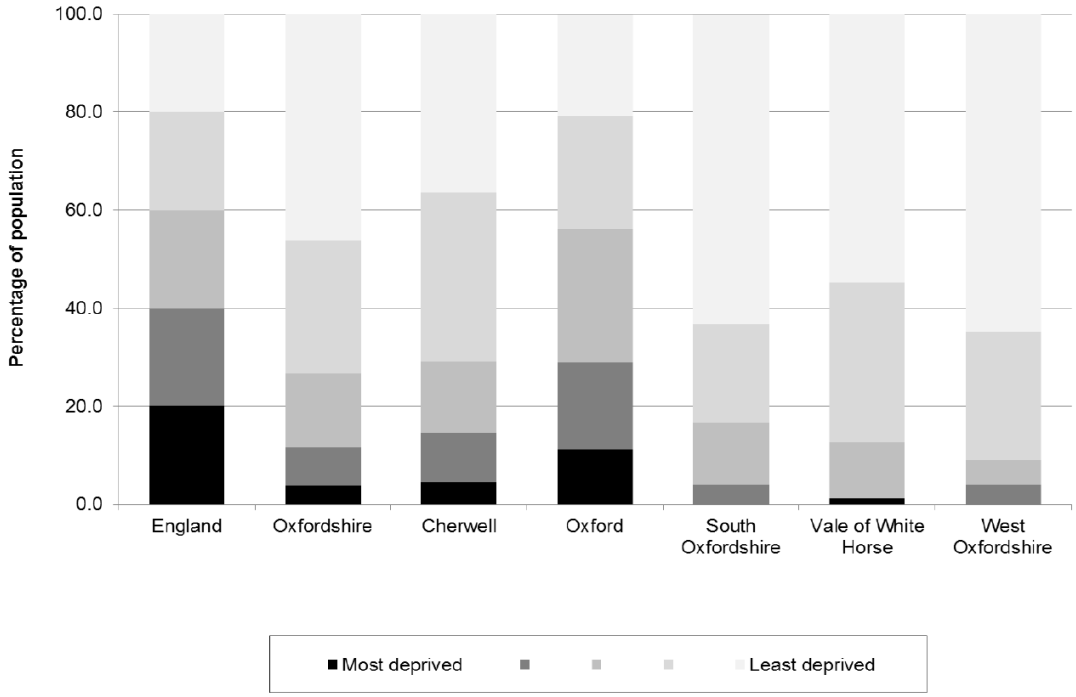
Figure obtained from Oxfordshire Insight

3.1.3 Multiple Deprivation & homelessness

Oxfordshire County is comparatively affluent with a lower proportion of its population living in deprivation compared to the national average. However, the county contains pockets of substantial income deprivation, particularly in the urban Oxford City district in which three areas have been ranked as among the three most income deprived in Oxfordshire, including parts of Blackbird Leys, Rose Hill and Iffley, and Northfield Brook wards. Furthermore, levels of deprivation are often described comparatively to a national quintile of deprivation, as shown in Figure 3.7. This measure identified Oxford City and Cherwell as districts with a relatively high proportion of residents living within the most deprived national quintile, as compared to other Oxfordshire districts.[12.] The unemployment rate in Oxfordshire, which is estimated as a percentage of the economically active population, is also relatively low in Oxfordshire and has been estimated at 3.4%, which is below the national average of 4.6%.[11]

[11] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018.

Figure 3.7. Proportion of residents in each Oxfordshire district living within each national quintile of deprivation



Based on the Indices of Deprivation 2015. Populations used to estimate percentages in deprived quintiles are based on the 2014 lower layer super output areas.

The number of homeless households in Oxfordshire, as indicated by the number of decisions taken by the Oxfordshire Local Authority on homelessness applications, in 2017-18 was 676, representing a rate of 2.4 per 1,000 households in Oxfordshire, and compares to 4.7 per 1,000 households nationally.[12] Furthermore, there has been a rise in the number of presentations who are accepted as statutorily homelessness and in priority need, from 279 households in 2011/12 to 304 households in 2016/17 in Oxfordshire. Out of these, there were 23 households in priority need in 2016/17 because of mental illness, and 11 because of physical illness.[13] There is substantial variability in levels of homelessness between districts, as shown in Figure 3.8. There have also been increases in the number of individuals presenting as homeless but not deemed to be in priority need, from 50 households in 2011/12 to 85 households in 2016/17, of which most cases were in West Oxfordshire (n=26 households), Cherwell (n=29 households) or Oxford City (n=27 households). The local housing

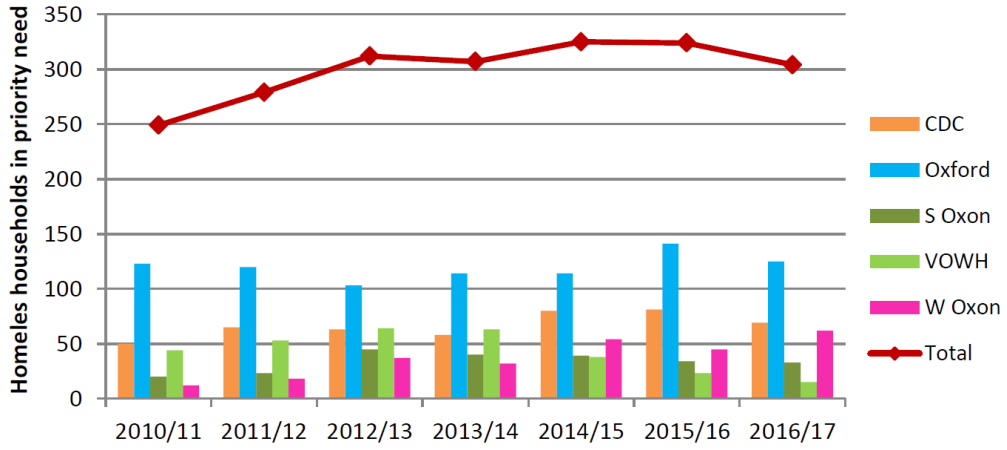
[12] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[13] Health Improvement Board Basket of Indicators for Housing and Health Annual Report 2016-17.

authorities have a duty under homelessness legislation to identify alternative housing for households deemed to be in priority need, which includes for example households with pregnant women, dependent children or disabilities.[14] The underlying drivers of homelessness in Oxfordshire are also changing, with loss of private rented housing a rising cause of homelessness, exceeding exclusion by family and friends as the main cause of homelessness in some districts. Similarly, housing costs are reported to be rising at a higher rate than earnings in Oxford, and have meant that Oxford is the least affordable city in the UK when comparing average earnings to average house prices.[15] However, there has been an overall decline in the number of people aged 18-24 accepted as homeless in Oxfordshire, from 122 people in 2011/12 to 78 people in 2016/17, with variability between districts shown in Figure 3.9. The number of households reported in temporary accommodation in Oxfordshire has also declined over time overall, as shown by district in Figure 3.10. The estimated total number of individuals sleeping rough in Oxfordshire in 2016/17 was 79, with overall rising trends over time shown in Figure 3.11. Counts of rough sleepers by site bedded down within the Oxford City Council district occur at regular quarterly intervals, with the last count in September 2018 between 00:00 and 04:00 at night, with 36 rough sleepers identified and verified during that night, of which 89% (n=32) were male. [83] The data suggest that the majority of individuals 'rough sleeping' within the district sleep within the City Centre, representing 67% (n=24) of rough sleepers at the September 2018 count in Oxford (2018 Quarter 2).[16] This is consistent with prior counts, but the data also suggest some increase over time in the numbers observed sleeping rough in Cowley. The support needs of the 36 rough sleepers identified in the September 2018 count in Oxford are shown in Figure 3.12, highlighting a high prevalence of alcohol and drug treatment support needs in this population (44% and 39% of rough sleepers, respectively). The majority of these rough sleepers (69%) had more than one support need out of drugs, alcohol, mental and physical health, highlighting their typically complex needs which warrant a multidisciplinary approach. Of note, recording challenges arising from difficulties in identifying and defining individuals

[14] Thames Valley Police Crime Recording System - NICHE RMS, Date Extracted: 16/10/2018
[15] Centre for Cities. Cities Outlook 2018. http://www.centreforcities.org/reader/cities-outlook-2018/city-monitor/ Last accessed 01/10/2018.
[16] Rough Sleeping & Single Homelessness Team, Oxford City Council. Quarterly Street Count Report. The number and nature of people sleeping rough in Oxford. September (Quarter 2) 2018-19.

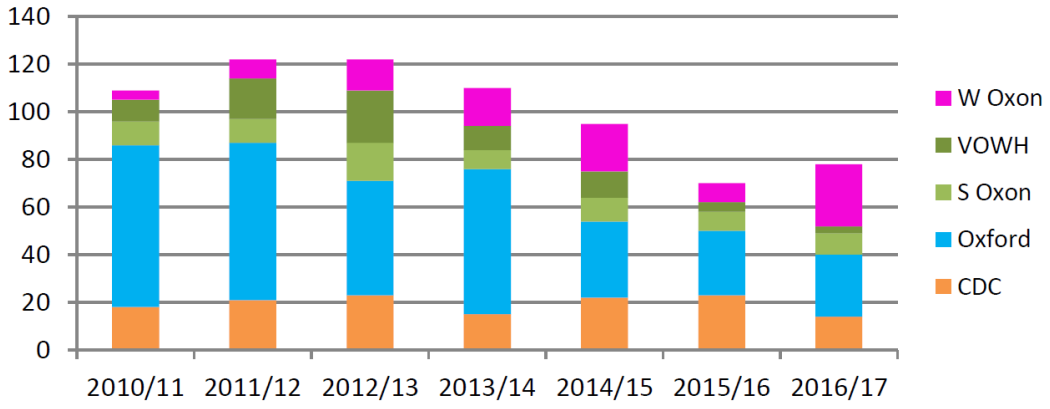
sleeping rough means that these figures are likely to represent underestimates and should be considered within the context of such limitations.

Figure 3.8. Total number of statutorily homeless households in priority need by Oxfordshire district 2010/11 to 2016/17 [17]



CDC= Cherwell District Council, Oxford= Oxford City Council, S Oxon= South Oxfordshire District Council, VOWH= Vale of White Horse District Council, W Oxon= West Oxfordshire District Council

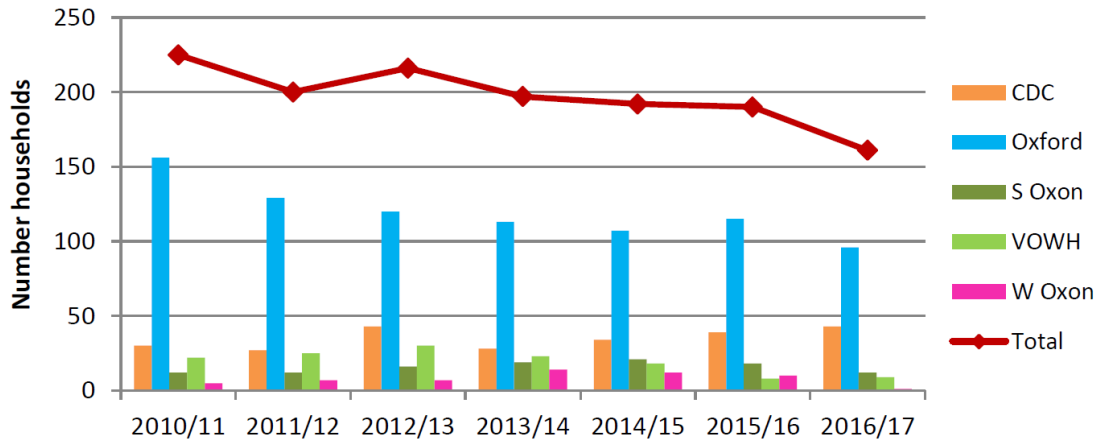
Figure 3.9. Total number of homeless applicants (unintentionally homeless and in priority need) aged 18-24 by Oxfordshire district 2010/11 to 2016/17



CDC= Cherwell District Council, Oxford= Oxford City Council, S Oxon= South Oxfordshire District Council, VOWH= Vale of White Horse District Council, W Oxon= West Oxfordshire District Council

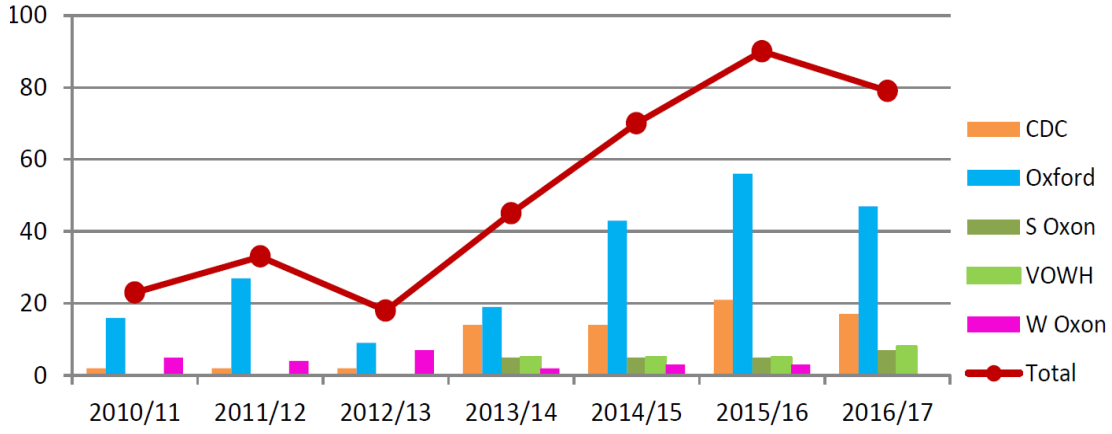
Figure 3.10. Total number of households in temporary accommodation by Oxfordshire district 2010/11 to 2016/17 [18]

[17] Health Improvement Board Basket of Indicators for Housing and Health Annual Report 2016-17.
[18] Health Improvement Board Basket of Indicators for Housing and Health Annual Report 2016-17



CDC= Cherwell District Council, Oxford= Oxford City Council, S Oxon= South Oxfordshire District Council, VOWH= Vale of White Horse District Council, W Oxon= West Oxfordshire District Council

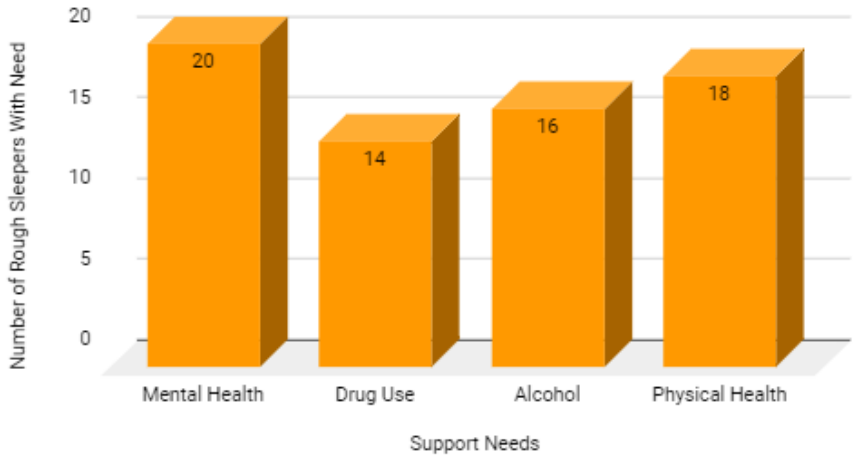
Figure 3.11. Estimated total numbers of people sleeping rough, overall and by district in Oxfordshire, 2010/11 to 2016/17[19]



CDC= Cherwell District Council, Oxford= Oxford City Council, S Oxon= South Oxfordshire District Council, VOWH= Vale of White Horse District Council, W Oxon= West Oxfordshire District Council

[19] Health Improvement Board Basket of Indicators for Housing and Health Annual Report 2016-17.

Figure 3.12. Support needs among rough sleepers identified during a count within Oxford City on one night in September 2018 [20]



Twenty-five out of 36 rough sleepers had more than one support need, and are therefore counted more than once

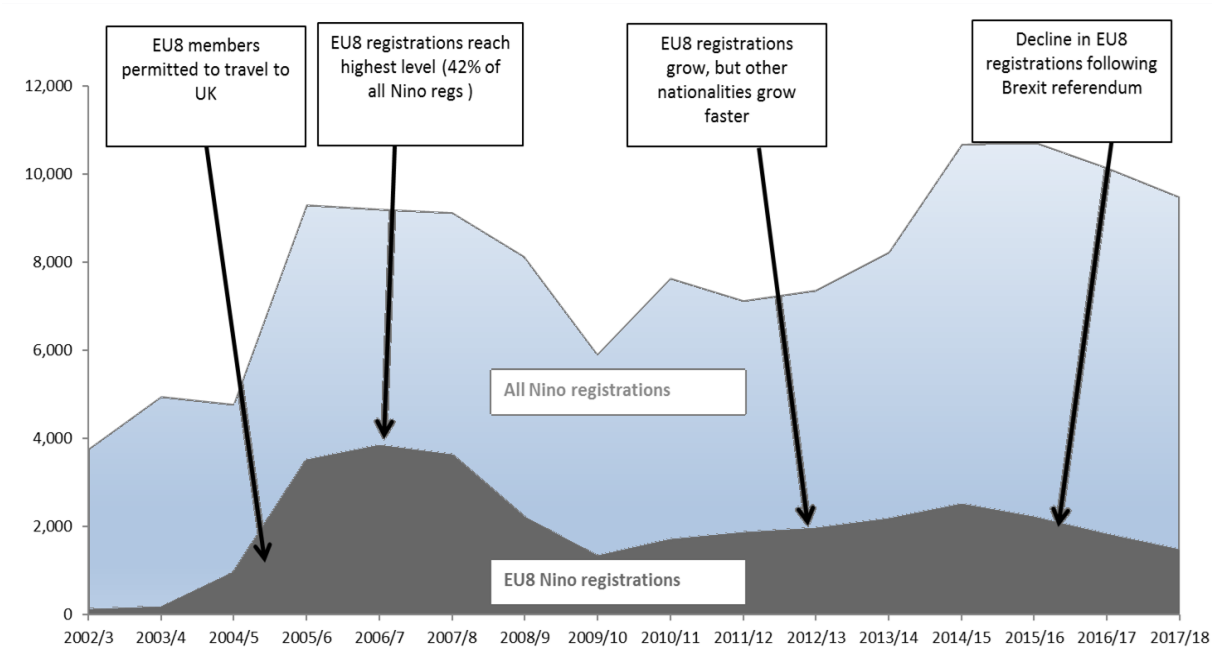
3.1.4 Migrant workers

Migrant workers from Eastern European countries have been reported to have among the highest rates of alcohol and drug use globally, particularly among males.[21] The Eastern European population in England is largely made up of individuals who moved to England for work following the entry of the EU8 into the European Union (EU). The EU8 consists of Slovenia, Slovakia, Poland, Lithuania, Latvia, Hungary, Estonia, and the Czech Republic, which are the eight countries that joined the EU in 2004 and which are commonly grouped together due to their relatively lower income per capita compared to the EU average.[22] There were 1460 new registrations for work of EU nationals in Oxfordshire from EU8 countries in 2017/2018, representing 0.2% of the total Oxfordshire population.[23] Trends in new registrations for national insurance numbers in Oxfordshire from the EU8 are shown in Figure 3.13 and highlight a substantial increase in the Oxfordshire Eastern European population after 2004, and a (smaller) decline in new registrations since

[20] Rough Sleeping & Single Homelessness Team, Oxford City Council. Quarterly Street Count Report. The number and nature of people sleeping rough in Oxford. September (Quarter 2) 2018-19.
[21] World Health Organisation. Global Status Report on Alcohol and Health 2011. http://www.who.int/substance_abuse/publications/global_alcohol_report/msbgsruprofiles.pdf
[22] https://en.wikipedia.org/wiki/A8_countries Last accessed 01/10/2018
[23] Oxfordshire County Council

the Brexit referendum. Some Oxfordshire districts, such as Cherwell, have experienced comparatively higher inflows of EU8 migrant workers compared to other areas of the county, as shown in Figure 3.14, which may affect their burden of substance misuse. Total numbers of new national insurance number registrations by Oxfordshire district in 2017/18, from the EU8 or otherwise, demonstrates a disproportionate influx of migrant workers from the EU8 to Oxfordshire, compared to other nationalities. As shown in Table 3.1, EU8 nationals account for approximately 1 in 3 of all EU registrations, and more than 1 in 4 of all international registrations for work. Of note, these data do not include UK nationals who obtain their national insurance numbers automatically at the age of 16 and are not included as part of new registrations. The relatively high influx of EU8 migrants since 2004 may disproportionately affect drug and alcohol treatment service needs compared to prior migration patterns due to relatively high levels of substance misuse in these populations, relative socioeconomic deprivation, and potential language barriers to seeking help early.

Figure 3.13. National insurance number registrations for work in Oxfordshire from the EU8, and overall, from 2002/03 to 2017/18 [24]



Nino= national insurance number registrations

[24] Oxfordshire County Council

Figure 3.14. New registrations for work from the EU8 in 2017/2018 by Oxfordshire district, as proportions of the total district population [25]

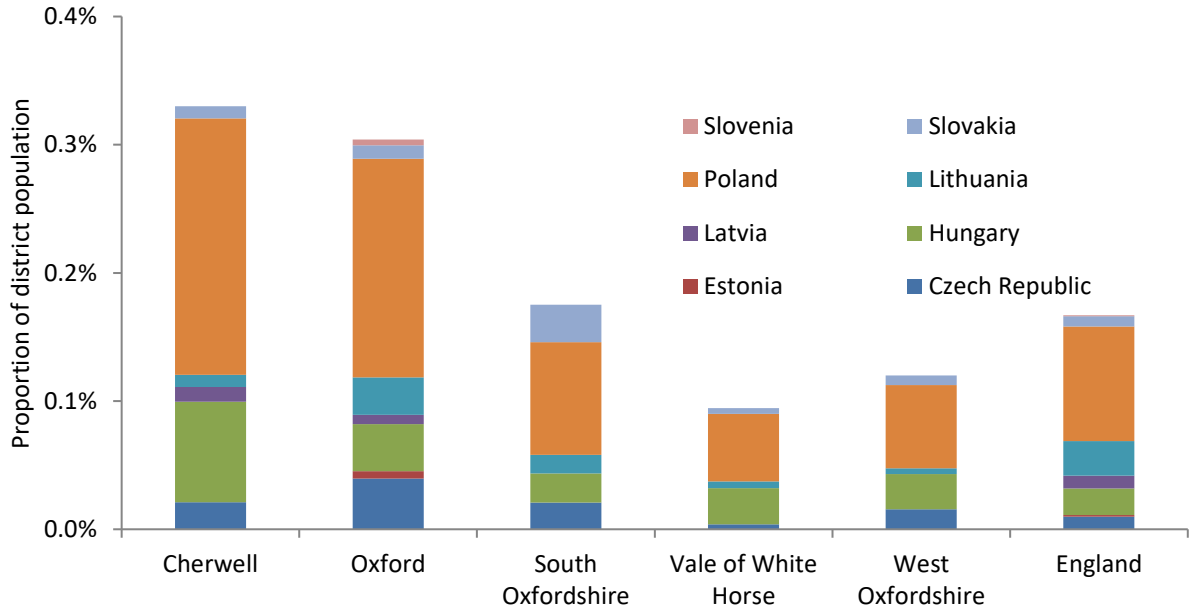


Table 3.1. Total new registrations for national insurance numbers by Oxfordshire district in 2017/18

	Cherwell	Oxford	South Oxfordshire	Vale of White Horse	West Oxfordshire	England
EU8	493	459	254	127	127	92,812
All EU	1,503	3,172	736	616	560	429,698
All nationalities	1,892	5,135	950	828	680	603,471

4. PREVALENCE OF ALCOHOL AND DRUG MISUSE

4.1 Alcohol misuse in the general population

Guidance on alcohol consumption was revised in 2016 by the Chief Medical Officer and amended to state that adults should consume no more than 14 units of alcohol per week to maintain a low risk of alcohol-related harm. Nationally, one in four adults are thought to consume above this low-risk level and could therefore benefit from

[25] Oxfordshire County Council

intervention in some form. A Public Health England report (prepared by the University of Sheffield) calculated estimations of the number of alcohol dependent adults by local authority in England in 2014/15.[26] They reported a national point estimate of the prevalence of alcohol dependent individuals who were potentially in need of specialist treatment as 595,131 individuals, representing 1.4% of the adult population.[23] Out of these, 0.73% were estimated to represent mild dependence, 0.41% moderate dependence and 0.25% severe dependence.[23] Further, 57.3% of all alcohol dependent adults were estimated to have a desire to reduce their alcohol intake. Separate estimations by local authority highlighted a six-fold difference between the highest and lowest local authority. Further, analysis of data from the Adult Psychiatric Morbidity Survey 2014 highlighted that high-risk drinking was associated with being younger, male, of white ethnicity, and living in the highest (compared to lowest) levels of deprivation. Regional figures for Oxfordshire have estimated an alcohol-dependent population of 5374 individuals in 2014/15, slightly increased from 5292 in 2010/11. The estimated number and proportion of alcohol-dependent adults by age and sex in 2014/15 is shown in Table 4.1, demonstrating that young males have the highest rate of dependence in Oxfordshire.

Table 4.1. Estimated number and proportion of alcohol-dependent adults by age and sex in Oxfordshire 2014/15

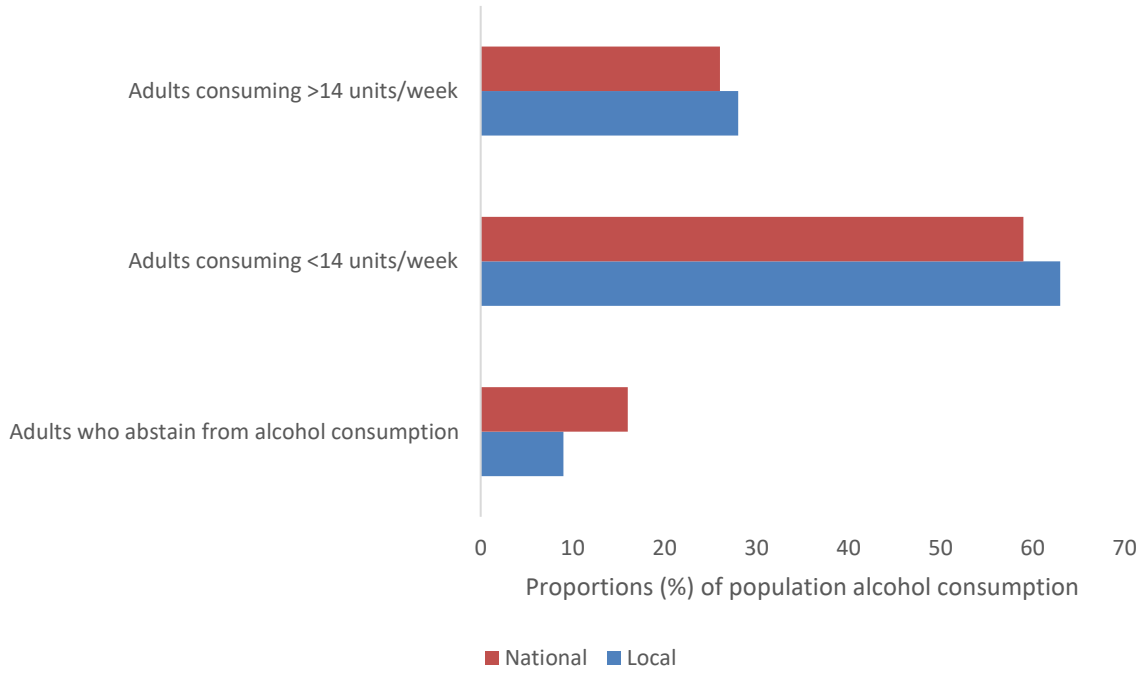
Age Band	Sex	Dependent Population	Dependence Rate (%)
18-24	Male	748	2.1
18-24	Female	387	1.2
25-34	Male	1188	2.5
25-34	Female	286	0.6
35-54	Male	1662	1.8
35-54	Female	487	0.5
55+	Male	424	0.5
55+	Female	192	0.2

[26] Pryce R, Buykx P, Gray L, et al. Estimates of Alcohol Dependence in England based on APMS 2014, including Estimates of Children Living in a Household with an Adult with Alcohol Dependence. https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf Last accessed 01/10/2018.

Oxfordshire and national patterns of alcohol consumption estimated by the Health Survey for England combined data 2011-2014 are shown in Figure 4.1.[27] The number of alcohol dependent adults who need specialist alcohol treatment (alcohol only or alcohol and non-opiates) was estimated to be 5,531 individuals (rate of 10 per 1000) in Oxfordshire, compared to 589,101 nationally (national rate of 13.5 per 1000). However, 741 individuals in Oxfordshire in 2016/17 were reported to be receiving alcohol treatment, and 103,471 individuals were reported to be receiving alcohol treatment nationally. Together, these reports highlight that a substantial proportion of alcohol-dependent individuals in potential need of alcohol treatment likely represent so-called 'unmet' need, who would potentially benefit from treatment services but are not currently receiving treatment. In total, 'unmet' need in 2016-2017 was therefore thought to represent 87% of alcohol-dependent adults in Oxfordshire and 82% of alcohol-dependent adults nationally. However, although an unmet need undoubtedly exists, these estimates of the extent of unmet need are likely to represent overestimates as they are based only on structured 'tier 3' levels of alcohol treatment, and do not include for example tier 2 treatment in the form of e.g. brief interventions to reduce harm for those who do not feel that they are ready, or who do not need, structured treatment services.

Figure 4.1. Weighted Oxfordshire and national population proportions (%) by level of alcohol consumption from the Health Survey for England combined data 2011 to 2014

[27] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

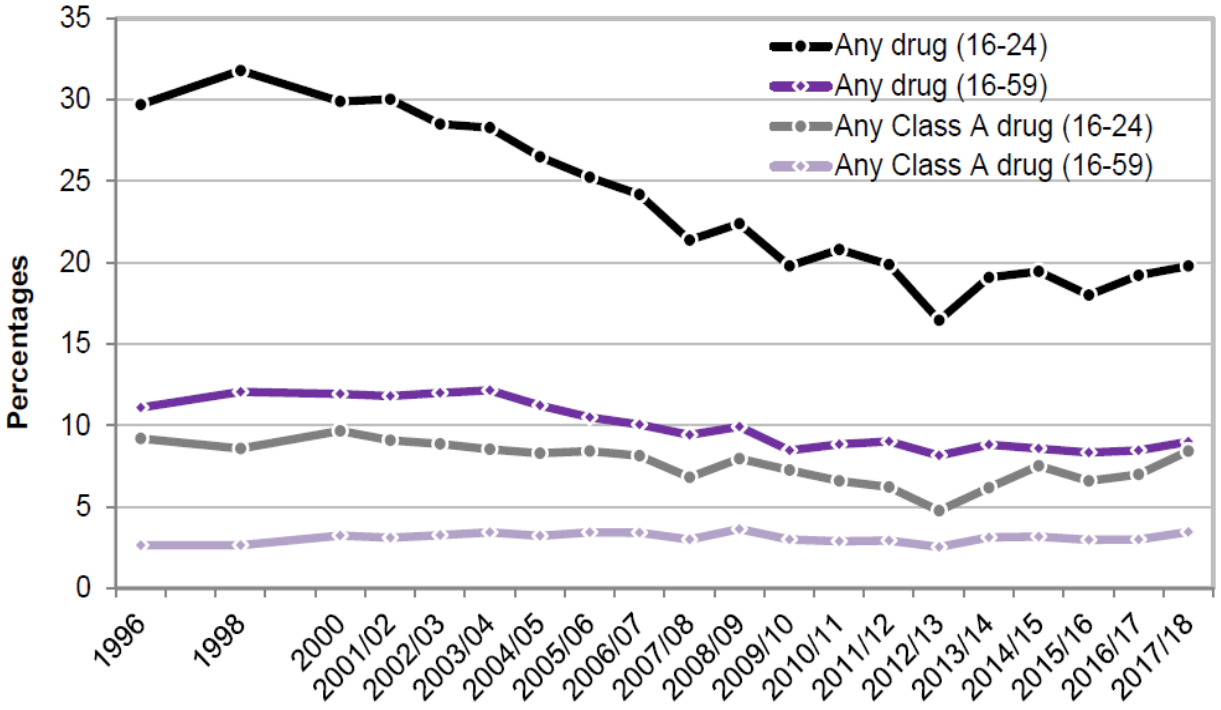


4.2 Drug misuse in the general population

The Crime Survey for England and Wales in 2017/18, which surveys approximately 50,000 adults aged 16-59 about the crimes they have experienced in the past year, estimated that approximately 1 in 11 (9.0%) adults nationally had taken a drug in the past year, equivalent to 3 million people.[28] The prevalence of drug use has remained relatively constant since the 2009-2010 survey, where the survey estimate was 9.4%, as shown in Figure 4.2. Approximately 1 in 29 (3.5%) adults reported having taken a Class A drug in the last year, and any drug use was more commonly reported by individuals who were younger, male, lived in urban areas, and those who reported more often frequenting pubs, bars, or nightclubs.

Figure 4.2. Trends in any drug use reported in the preceding year among adults aged 16-59 from the 1996 to 2017/18 Crime Survey for England and Wales

[28] Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf Last accessed 01/10/2018



The estimated rate of opiate and/or crack users (OCUs) in Oxfordshire aged 15-64 in 2014-15 was 6.68 per 1000, lower in comparison to the national rate of to 8.57 per 1000, as shown in Table 4.2.[29] The proportion of these individuals in need of specialist treatment for their substance misuse, but who are not currently receiving treatment and represent so-called 'unmet need', are thought to represent approximately 40-60% of the crack and/or opiate users both in Oxfordshire and nationally, shown in Table 4.2. However, measures of unmet need may represent some overestimation and should be considered in the context of recording limitations. For example, individuals who are receiving support for drug use including tier 2 harm reduction interventions, but who are not yet in structured 'tier 3' treatment, would not be included as part of these data.

Table 4.2. Prevalence estimates of opiate and/or crack users aged 15-64 in Oxfordshire 2014-15, and proportions of estimated unmet need

	Local n	Rate per 1000	Unmet need (%)	National rate per 1000	National unmet need (%)
OCU	2,933	6.68	45	8.57	51

[29] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

Opiate	2,811	6.4	44	7.33	46
Crack	2,416	5.5	57	5.21	62

OCU= opiate and/or crack users

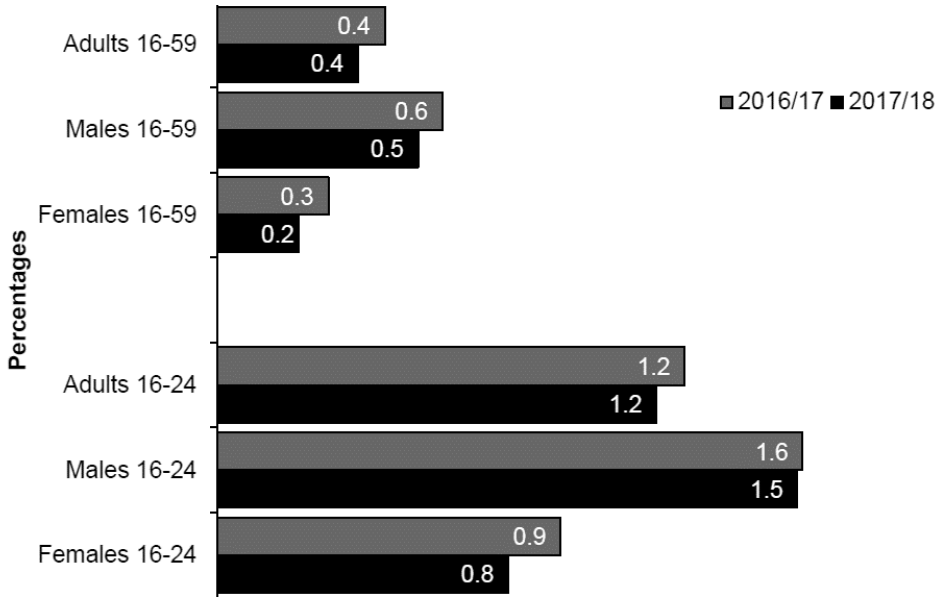
4.3 New psychoactive substances and nitrous oxide

New psychoactive substances (NPS) refer to newly emerged drugs which aim to mimic the effects of older drugs such as cannabis, ecstasy and cocaine.[30] Previous evidence has suggested that use of NPS is particularly high in prisons and homelessness settings, which represent groups not captured in the Crime Survey for England, and the use of NPS may therefore be underestimated. Nonetheless, the Crime Survey for England report 2017/18 highlighted that use of NPS had not changed from 2016/17 to 2017/2018, and that approximately 0.4% of people aged 16-59 (about 121,000 individuals) reported having used NPS in the preceding year, as shown in Figure 4.3. Approximately 50% of users of NPS were estimated to be aged 16-24, and use was more common among those who concomitantly used alcohol or another drug, or who frequented pubs or nightclubs. The most commonly used NPS was 'herbal smoking mixture', which had been used by a third of NPS users aged 16-59, but there had also been an increase in the use of liquids.[31]

Figure 4.3. National prevalence of use of new psychoactive substances in the 2016/17 and 2017/18 Crime Survey for England and Wales, by sex and age group

[30] Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf Last accessed 01/10/2018.

[31] Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf Last accessed 01/10/2018



The Crime Survey for England and Wales surveys approximately 50,000 adults aged 16-59 about the crimes they have experienced in the past year

Out of adults surveyed aged 16-59, 2.3% reported some use of nitrous oxide in the preceding year, a similar rate to the 2016/17 survey estimate of 2.4%. The rate was highest among young adults aged 16-24 (8.8%) and among men (2.9% of males compared to 1.8% of females age 16-59).

5. VULNERABLE GROUPS

5.1 Families with alcohol and drug misuse: hidden harm

Substance misuse among adults with children, or who live with children, is likely to have serious adverse effects on the health and development of these children and has been associated with harmful effects at each age from conception through to adulthood. Further, such children are more likely to themselves misuse drugs or alcohol later in life. In 2011 the Advisory Council on the Misuse of Drugs (ACMD) produced a report focused on children under the age of 16 in the UK who live with a

parent or guardian who misuses drugs.[32] The ACMD estimated that between 250,000 and 350,000 children in the UK have a parent who is a problem drug user, which equates to approximately one child per problem drug user. In 2012, estimates based on a further analysis of the 2007 National Psychiatric and Comorbidity Survey reported that 6.7% of infants (out of 186 parents) were found to be living with a parent using illicit drugs, and 12.4% lived with a hazardous drinker.[33]

Within Oxfordshire, 24% (n=85) of adult alcohol only treatment presentations in 2017-18 reported that they were living with children and 29% (n=101) reported being parents but not living with their children.[34] For presentations to drug treatment services, 16% (n=92) of new presentations were recorded to be living with children and 38% (n=218) reported being parents who were not living with their children. In total, 162 children were reported to be living with alcohol service users entering treatment and 190 children were reported to be living with drug service users entering treatment in 2017/2018. These proportions are similar to nationally reported rates, as shown in Table 5.1, and demonstrate a need to consider close cooperation with children's support services and charities during provision of substance misuse treatment services, to consider the effect on children of a parent entering treatment, and the potential impact of child-caring responsibilities on adherence to structured treatment services. Data on new presentations to drug treatment who live with children under the age of 18 by type of substance misuse in the period 01/04/2017 to 31/03/2018 shows that children are more likely to be living with users of either alcohol or non-opiates, as compared to opiate users or those who use both alcohol and non-opiates, as shown in Figure 5.1.[35]

Table 5.1. Parental status of new adult presentations for a) alcohol treatment services and b) drug treatment services in Oxfordshire 2017-2018 [36-37]

[32] Advisory Council on the Misuse of Drugs. 'Hidden harm' report on children of drug users. 2011. https://www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-users Last accessed 01/10/2018.
[33] Manning V. NSPCC. Estimates of the number of infants (under the age of one year) living with substance misusing parents. https://www.nspcc.org.uk/globalassets/documents/research-reports/estimates-number-infants-living-with-substance-misusing-parents-report.pdf Last accessed 01/10/2018.
[34] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[35] NDTMS DIAGNOSTIC OUTCOMES MONITORING EXECUTIVE SUMMARY 17-18 update Q3
[36] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[37] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

a)

Parental status	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)	Proportion of new presentations nationally (%)
Living with children (own or other)	85	24	20	31	24
Parents not living with children	101	29	33	23	25
Not a parent/no child contact	162	47	47	46	50
Incomplete data	0	0	0	0	1
Total	**348**				

b)

Parental status	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)	Proportion of new presentations nationally (%)
Living with children (own or other)	92	16	12	28	18
Parents not living with children	218	38	37	41	34
Not a parent/no child contact	264	46	52	30	48
Incomplete data	1	0	1	0	1
Total	**575**				

Figure 5.1. New presentations to substance misuse treatment services in Oxfordshire who live with children under the age of 18, by substance type, in 2017/2018 [38]

[38] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

	Latest period		National average
	(%)	(n)	(%)
Opiate	10.9%	36 / 331	13.1%
Non-opiate	29.1%	30 / 103	23.7%
Alcohol	23.9%	81 / 339	23.3%
Alcohol and non-opiate	18.3%	21 / 115	21.2%

5.2 Families with alcohol and drug misuse: toxic trio

'Toxic trio' describes a combination of domestic abuse, mental illness and substance misuse within a domestic household, and is an important indicator of children and young people at heightened risk of harm. These components often interact, with one influencing the development of another. For example, an individual with harmful substance use may be more likely to encounter and get into a relationship with a violent and/or volatile person. Similarly, a personal history of being a victim of domestic abuse may lead someone to engage in substance misuse, or mental illness may be a consequence or cause of substance misuse.[39] An Oxfordshire County Council Strategic Review of Domestic Abuse highlighted that there are rising numbers of victims with 'toxic trio' or other complex needs, and substantial challenges for services in meeting their needs.[40] Within Oxfordshire from September 2015 to September 2018, out of over 18,000 assessments by Children's Social Care, which represent assessments following referrals accepted by the local authority children's social care team, almost half (8706) identified one or more of the 'toxic' trio being present; 3030 identified two or more being present and 725 children identified to be living in households with all three risks i.e. domestic risk factors including domestic abuse, substance misuse and mental health illness being present.[41]

A breakdown of recorded toxic trio cases by Oxfordshire district is shown in Table 5.2. The highest absolute number of children living in toxic trio households were

[39] https://www.wirralsafeguarding.co.uk/toxic-trio/ Last accessed 01/10/2018

[40] Oxfordshire Strategic Review of Domestic Abuse 2016. https://www2.oxfordshire.gov.uk/cms/sites/default/files/folders/documents/fireandpublicsafety/DomesticAbuseStrategicReview.pdf Last accessed 01/10/2018

[41] Children's Social Care, Oxfordshire County Council

recorded in Oxford City and Cherwell. Further, Table 5.3 shows the numbers of assessments in which each risk factor component of the toxic trio was individually identified from 6,231 assessments by Children's Social Care conducted in 2017/2018.[42] Similarly, data reported from local authorities to central government give an overview of alcohol and drug misuse risk factors identified during conduct of children in need assessments by social services in the South East local authorities.[43-44] Table 5.4 shows that from national reporting data in 2017/18, alcohol misuse was identified as a risk factor in 22.0% of Oxfordshire assessments, compared to a national rate of 18.4% in England and 19.1% for the South East. Similarly, drug misuse was identified as a risk factor in 22.6% of assessments in Oxfordshire in 2017/18, compared to a national rate of 21.0% in England and 20.9% in the South East.

Table 5.2. Children identified to be living in households with the 'toxic trio' risk factors from Sept 2015 to Sept 2018, by district in Oxfordshire [45]

	One factor		Two factors		Three factors	
	No.	**%**	**No.**	**%**	**No.**	**%**
Cherwell	1520	27%	580	25%	168	23%
Oxford	1532	27%	578	25%	178	25%
South Oxfordshire	926	16%	433	19%	136	19%
Vale of White Horse	963	17%	435	19%	139	19%
West Oxfordshire	735	13%	279	12%	104	14%
Total	5676		2305		725	

Excludes children with postcodes outside of Oxfordshire

Table 5.3. The proportion of assessments by Children's Social Care in which each risk factor component of the 'toxic trio' was individually identified in Oxfordshire 2017/2018[46]

	No.	**%**

[42] Children's Social Care, Oxfordshire County Council
[43] Public Health England. Parental drug and alcohol use: south east local authorities. Last accessed 28/11/2018.
[44] https://www.gov.uk/government/collections/statistics-children-in-need Last accessed 28/11 /2018
[45] Children's Social Care, Oxfordshire County Council
[46] Children's Social Care, Oxfordshire County Council

Parental alcohol misuse	844	14%
Parental drug misuse	672	11%
Parental domestic violence	1836	29%
Parental mental health	1489	24%
Total	6231	

One child may be counted more than once across groups

Table 5.4. Percentage of assessments by Children's Social Care identifying risk factors (for child and parent) in Oxfordshire compared to the South East and England overall, in 2017/18

	Alcohol misuse (%)	Drug misuse (%)	Domestic violence (%)	Mental health (%)
England	18.4	21.0	51.1	42.6
South East	19.1	20.9	54.1	42.6
Oxfordshire	22.0	22.6	50.3	42.0

National reporting does not distinguish between parental and child risks

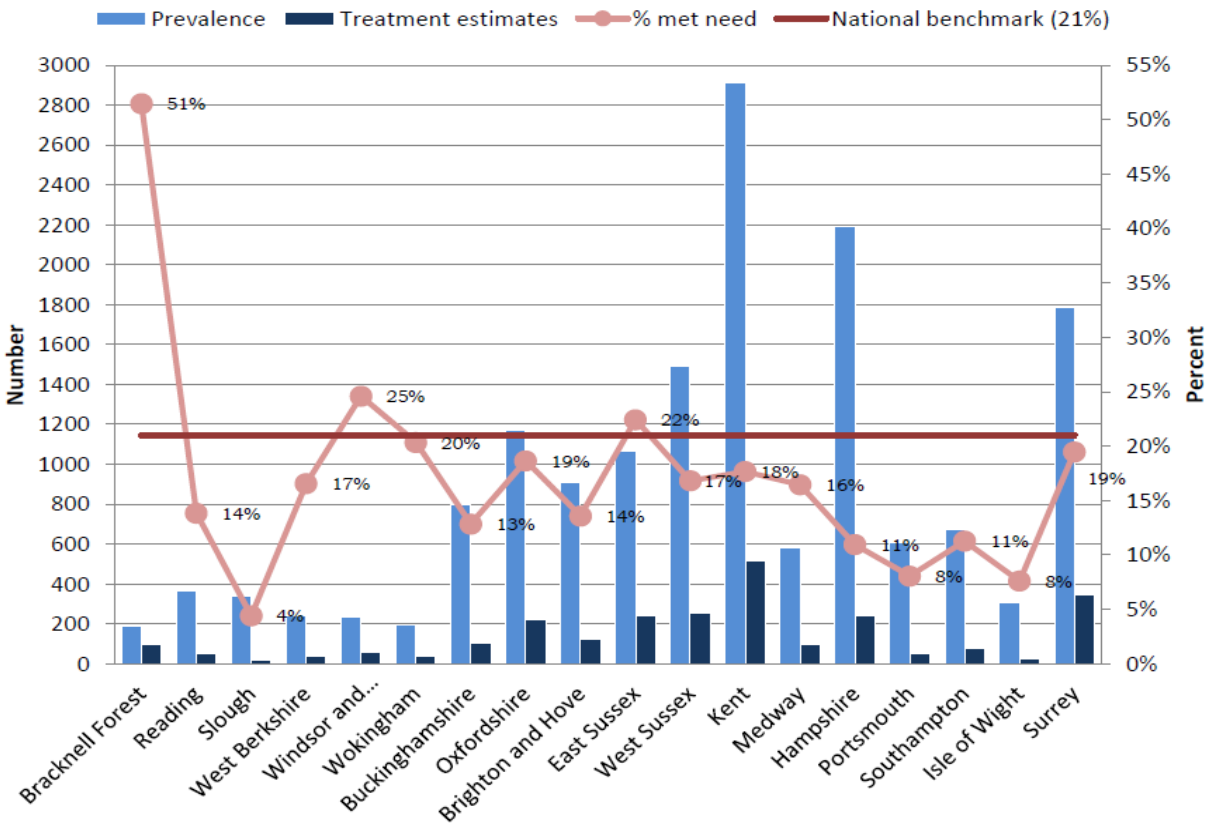
5.3 Families with alcohol and drug misuse: treatment need

Parental drug misuse can have important adverse impact on children living within the same household.[47] Using data from NDTMS alongside local prevalence estimates of alcohol and drug dependence, rates of met need have been calculated by dividing the number of alcohol or opiate users who are in treatment, who live with one child or more, by the estimated prevalence. Figure 5.2 demonstrates estimates of treatment need for alcohol dependent parents in 2014/15 to 2016/17, and Figure 5.3 shows the trend over time in unmet treatment need for alcohol dependent parents from 2014/15 to 2016/17. Opiate users who are also identified as being alcohol dependent are captured for estimation purposes as opiate, rather than alcohol, dependent in order to avoid double counting in calculations. Although the treatment need identified for

[47] Public Health England. Parental drug and alcohol use: south east local authorities. Last accessed 28/11/2018

Oxfordshire is slightly below the national average of 21%, this was not a statistically significant difference. However, the data show a declining trend in Oxfordshire of unmet alcohol treatment over time. Figure 5.4 demonstrates estimates of treatment need for opiate dependent parents in 2014/15 to 2016/17, and Figure 5.5 shows the trend over time in unmet treatment need for opiate dependent parents from 2014/15 to 2016/17. Oxfordshire is shown to exceed the national average in meeting treatment need estimates (54% vs 52% respectively), with a small increase over time from 2014/15 to 2016/17.[48] These data estimates on treatment need should be considered in the context of structured community-based treatment, and do not capture tier 2 level treatment, or treatment from hospital primary care services not recorded via NDTMS.

Figure 5.2 Estimates of treatment need met for alcohol dependent adults who live with children in the South East of England 2014/15 to 2016/17



[48] Public Health England. Parental drug and alcohol use: south east local authorities. Last accessed 28/11/2018

Figure 5.3 Trend over time from 2014/15 to 2016/17 in estimates of treatment need met for alcohol dependent parents in the South East of England 2014/15 to 2016/17 [49]

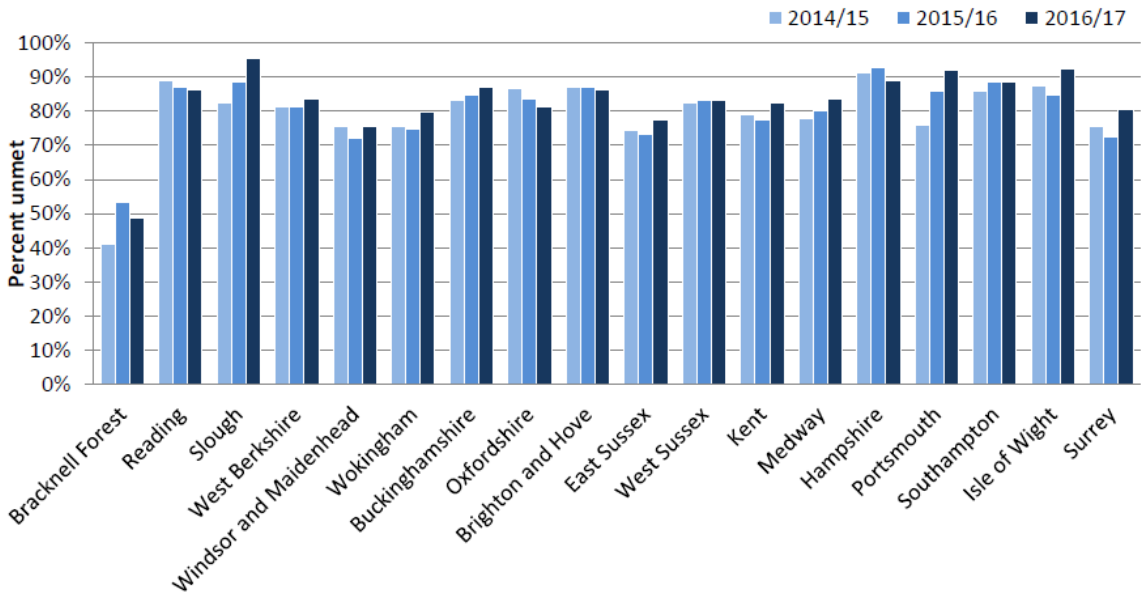


Figure 5.4 Estimates of treatment need met for opiate dependent adults who live with children in the South East of England 2014/15 to 2016/17

[49] Public Health England. Parental drug and alcohol use: south east local authorities. Last accessed 28/11/2018

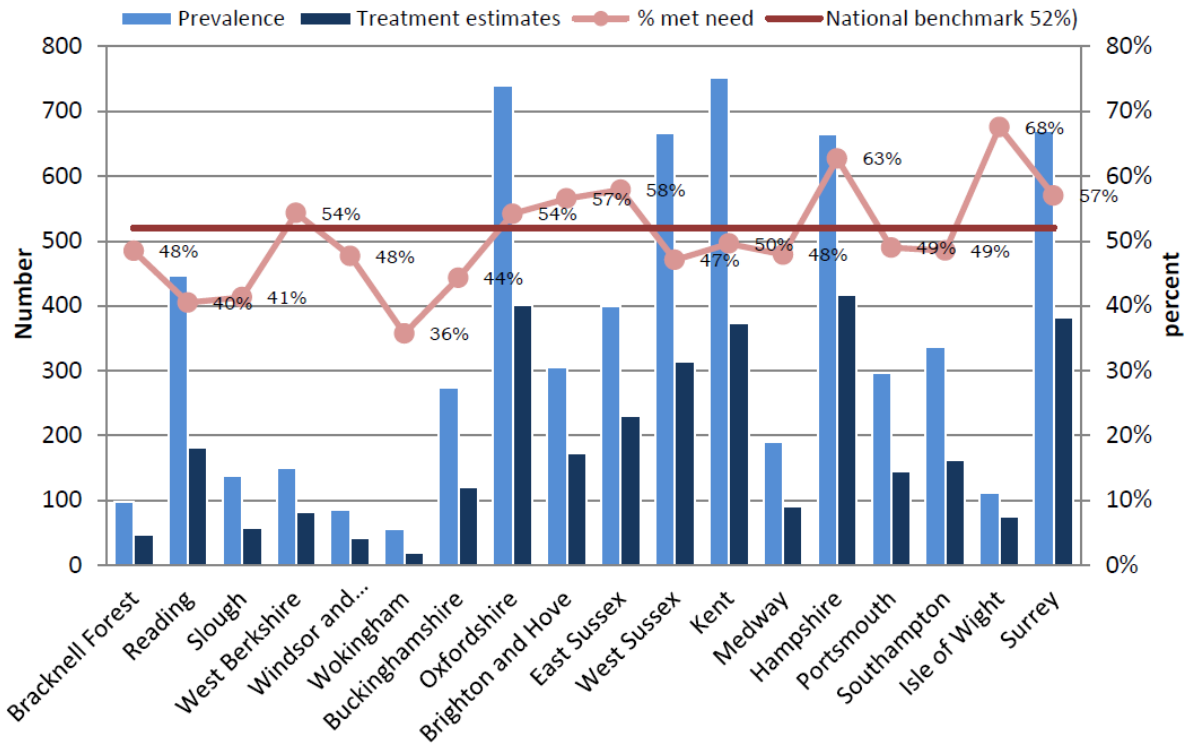
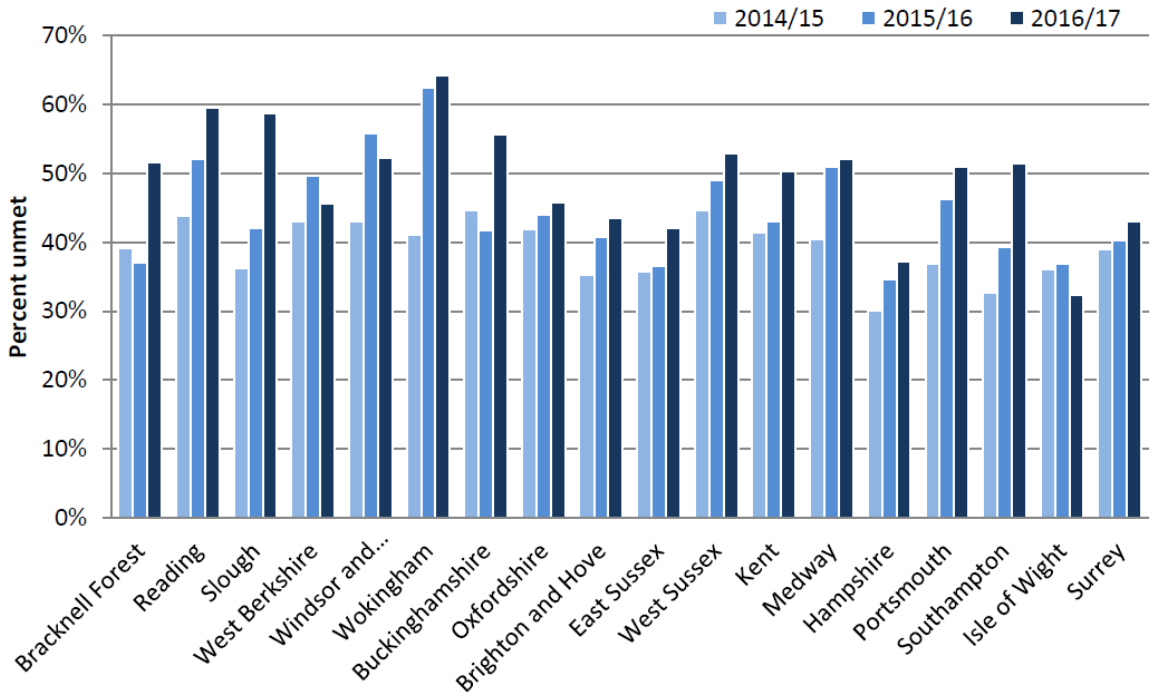


Figure 5.5 Trend over time from 2014/15 to 2016/17 in estimates of treatment need met for opiate dependent parents in the South East of England 2014/15 to 2016/17[50]



[50] Public Health England. Parental drug and alcohol use: south east local authorities. Last accessed 28/11/2018

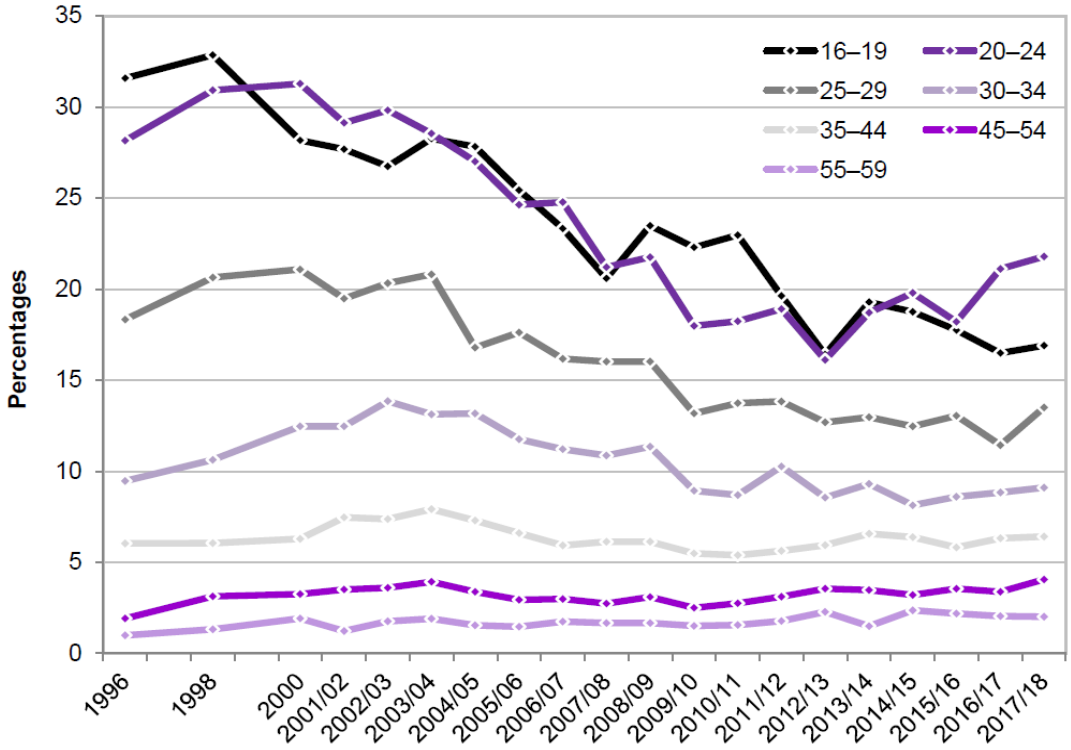
5.4 Young people with substance misuse

In line with previous trends, the Crime Survey for England and Wales 2017/2018 estimated that national drug use was highest among younger age groups, as shown in Figure 5.6, and prevention and treatment services may therefore be most effective if targeted at these groups. Levels of use of all drug types was highest in the 20-24 age group, who also reported the highest use of class A drugs (10.6% in the preceding year, compared to 0.2% of those aged 55-59). Approximately one in five (19.8%) of young adults aged 16-24 nationally reported some drug use in the preceding year, and 8.4% reported that they had taken a class A drug in the preceding year, near double the equivalent rates for adults (9% and 3.5% respectively).[51] Class A drug use among young adults in 2017/2018 had not significantly changed from 2016/2017, but there was a longer term upward trend of 2.2% from the 2011/2012 estimate, thought to be reflective of increased use of powder cocaine and ecstasy.[52] However, overall drug use among 16-24 year-olds has declined from 1996 to 2017/2018 estimates, and also, but to a smaller degree, for 25-29 year olds. There has been no meaningful change in overall drug use from 2016/17, except notably increased use of hallucinogens and cannabis among young people aged 25-29.

Figure 5.6. Proportion of 'any drug use' in the preceding year by age group in the Crime Survey for England and Wales, from 1996 to 2017/18

[51] Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf Last accessed 01/10/2018

[52] Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf Last accessed 01/10/2018



The Crime Survey for England and Wales surveys approximately 50,000 adults aged 16-59 about the crimes they have experienced in the past year

5.5 Older service users aged 40-59

National drug use among older adults remains lower than younger adults, but has increased overall from 1996 to 2017/2018.[14] This is in contrast to overall rates of drug among adults aged 16-59, which have declined over the same period. For example, in the 45-54-year age group the use of any drugs in the preceding year was reported by 1.9% of individuals in 1996 and 4.1% of individuals in 2017/2018. Similarly, in the 55-59-year age group, any drug use in the preceding year was reported by 1% of individuals in 1996 compared to 2% of individuals in 2017/2018.[53] This rising trend is thought to be primarily driven by greater use of cannabis in older age groups (which nonetheless remains below levels of cannabis use in younger age groups). The Crime Survey for England in 2014/2015 conducted more in-depth analysis of drug use among older adults and through this work highlighted that the reported use of powder cocaine had also increased among older ages, from 0.2% in

[53] Drug Misuse: Findings from the 2017/18 Crime Survey for England and Wales. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729249/drug-misuse-2018-hosb1418.pdf Last accessed 01/10/2018

2001/02 to 0.6% in 2014/15. Notably, whereas most older adults who had reported using cocaine or ecstasy in 2014/2015 identified themselves as infrequent users, 49% of older cannabis users in 2014/15 reported being frequent users. Almost all drug users in older age groups, including >95% of ecstasy, cocaine and cannabis users, had begun using drugs by the age of 40. This highlights a potential opportunity to focus prevention work in young adulthood to prevent drug use in older ages, and suggests that such preventative efforts may be effective as joint efforts to mitigate drug use in both younger and older ages. However, as alcohol and drug users age alongside aging of the general population, treatment services for existing users need to ensure they are known and accessible to older adults in need of structured treatment.

5.6 Sex workers

Regional, national, and international reports have highlighted that substance misuse is often a key driving factor in an individual getting involved, and remaining in, sex work.[54] The Office for National Statistics has estimated that there were approximately 72,800 sex workers in the UK in 2015, of which 88% were estimated to be female, 6% male, and 4% transgender.[55-56] Further, being a parent is thought to be common among sex workers, with a report finding that 74% of off-street sex workers reported a need to do sex work to help support their household and children.[57-58] Concomitantly, the prevalence of sex work is believed to have risen alongside austerity, benefit sanctions, and increased housing costs. Substance misuse in sex workers can make it more difficult for an affected individual to tackle other challenges often faced by sex workers, including housing needs, healthcare, or employment challenges, thereby effectively 'trapping' sex workers in an environment enabling drug dependency. Concomitant substance misuse may also heighten

[54] Brighton and Hove City Council Public Health Intelligence Team. Sex work in Brighton and Hove. 2016.http://www.bhconnected.org.uk/sites/bhconnected/files/Sex%20Work%20Rapid%20Needs%20Assessment%20-%20key%20findings.pdf Last accessed 01/10/2018.
[55] Brooks-Gordon B, Mai N, Perry G, Sanders T. Production, Income, and Expenditure from Commercial Sexual Activity as a measure of GDP in the UK National Accounts. Report for Office of National Statistics (ONS), 2015.
[56] http://prostitutescollective.net/2016/11/facts-sex-work/ Last accessed 01/10/2018
[57] Home Office. Paying the Price: A Consultation Paper on Prostitution 2004. https://prostitution.procon.org/sourcefiles/paying_the_price.pdf Last accessed 01/10/2018
[58] http://prostitutescollective.net/2016/11/facts-sex-work/ Last accessed 01/10/2018

inherent risks of sex work, as individuals with substance dependency needs are less likely to be 'selective' of service users, less likely to obtain regular health checks and are rendered more vulnerable to sexual exploitation.[59] The prevalence of drug use among sex workers is unknown and difficult to characterise. A study of 71 women in 2004 reported that 95% of female sex workers were problematic drug users.[60] However, there are substantial concerns over the generalisability of surveys targeted at engaging the most vulnerable women (for example, 2 out of 3 were also homeless), and such surveys may therefore not reach female sex workers who are not drug users.

In late 2016 an audit was conducted by the Sex Workers Intervention Panel (SWIP) of known Oxford City sex workers from the commencement of the SWIP in late 2007 to 31st of July 2016.[61] This was the first audit to track all known sex workers in Oxford City during that time-frame, and the audit aimed to identify any sex worker supported by known agencies from the statutory or voluntary sector. In total 70 individuals were identified over the time period as sex workers in Oxford City (this does not mean all 70 were all in Oxford City at any one time). Strikingly, every sex worker identified was also identified to have drug or alcohol substance misuse problems. In late 2016 a new audit was commenced in SWIP meetings. From the 6th of December 2016 to 1st of July 2018 a total of 46 individuals were identified as sex workers, of which 37 were identified as individuals with drug or alcohol substance misuse problems. Of note, this new audit was commenced without access to details of the prior identified sex workers and may therefore include some of the sex workers identified in the prior audits, meaning that the figures should not be considered mutually exclusive.[62] Estimates of the number of sex workers may represent underestimates due to known data collection issues, including changes in services provisions, the fact that sex workers are often difficult to engage with public services and given that sex workers often only transiently stay in any one area. Nonetheless, these data highlight a high burden of alcohol and substance misuse

[59] Brighton and Hove City Council Public Health Intelligence Team. Sex work in Brighton and Hove. 2016.http://www.bhconnected.org.uk/sites/bhconnected/files/Sex%20Work%20Rapid%20Needs%20Assessment%20-%20key%20findings.pdf Last accessed 01/10/2018
[60] Jeal N, Salisbury C. A Health Needs Assessment of Street-based Prostitutes: Cross-sectional Survey. J Public Health (Oxf) 2004;26(2):147-51
[61] Oxfordshire Treatment and Intervention System (OTIS)
[62] Oxfordshire Treatment and Intervention System (OTIS)

among this vulnerable group, and the need to consider alcohol and drug treatment services as a vital component in both the prevention of sex work, and in supporting individuals to get out of sex work.

5.7 County lines, drug trafficking and modern slavery

'County lines' is used to describe a method used by urban gangs to expand their drug networks from urban areas to rural parts of counties, potentially bringing high crime levels, violence and exploitation to rural communities. County lines gangs typically exploit children or vulnerable adults, such as individuals with financial struggles or mental health issues, to store and transport drugs (mainly crack cocaine and heroin) using methods of intimidation, building debt, violence or coercion.[63] A dedicated mobile phone line is usually established to order drugs and this phone line is typically operated by a third party remotely.[64] County lines activities often also involve taking over the homes of vulnerable adults to sell or store drugs, commonly known as 'cuckooing'. The latest National Crime Agency report on 'county lines' drug exploitation and supply in 2017 assessed the issue of county lines using information provided by all 43 territorial forces in England and Wales. Thirty-eight (88%) of forces reported evidence of county lines, 25 (58%) forces reported that local drug users were being used to transport drugs by being complicit or coerced, and 61% of forces reported exploitation of drug users.[65] Based on figures from 19 forces which provided actual numbers of county lines, a conservative estimate was generated of at least 720 county lines in England and Wales, based on each force which reported evidence of county line activity having at least one county line. However, this figure is likely to represent a substantial underestimate as many regions will have several lines. The principal commodity distributed via county lines is believed to be crack cocaine and heroin, and the rail network is a principal method of accessing markets and transporting vulnerable juveniles.[65] County lines are anticipated to increase as a drug distribution method as increasing numbers of criminal gangs adopt the

[63] Carey MP, Carey KB, Meisler AW. Psychiatric symptoms in mentally ill chemical abusers. Journal of Nervous and Mental Disease, 1991;179:136–138
[64] National Crime Agency. National Briefing Report- County Lines violence, exploitation and drug supply, 2017. http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file Last accessed 01/10/2018
[65] National Crime Agency

strategy.[66] The presence of county lines in Oxfordshire is clear, and Thames Valley Police is thought to represent one of the busier police forces in dealing with county lines, particularly within Oxford and Banbury.[67]

Modern slavery is 'the illegal exploitation of people for personal or commercial gain'.[68] This can incorporate several facets of criminal activity, including for example human trafficking, slavery, sexual exploitation, and forced labour, often enforced by means of coercion, deception or violence. Perpetrators of modern slavery include organised crime groups in addition to individual persons. Accurately characterising figures affected by modern slavery is difficult at both a regional and national level; the Global Slavery Index has estimated that on any given date there were 136,000 people living in modern slavery in the UK in 2016, equivalent to a prevalence of 2.1/1000 people.[69] Similarly, the UK Home Office estimated that there were approximately 10,000-13,000 modern slavery victims in 2014, but this was noted by the UK National Crime Agency as a likely substantial underestimate, in part due to under-reporting.[70] The National Crime Agency in 2017 identified 5,145 potential victims of modern slavery referred via the National Referral Mechanism, representing a 35% rise in referrals from 2016 (however of note, changes made to recording methodology has meant that 2017 totals are not directly comparable to prior years). Females represented 47% of referrals, and 41% of referrals were for children aged under 18. The most common nationalities of referred potential victims of modern slavery in 2017 were UK nationals, Albanian, Vietnamese, Chinese and Nigerian.[71] Independent research commissioned by The Salvation Army and the Black Country Women's Aid charity in England and Wales demonstrated close ties between substance misuse and modern slavery, reporting that victims were often coerced to

[66] National Crime Agency. National Briefing Report- County Lines violence, exploitation and drug supply, 2017. http://www.nationalcrimeagency.gov.uk/publications/832-county-lines-violence-exploitation-and-drug-supply-2017/file Last accessed 01/10/2018
[67] Force Intelligence Hub, Thames Valley Police

[68] Thames Valley Police. https://www.thamesvalley.police.uk/advice/protecting-yourself-and-others/modern-slavery Las accessed 01/10/2018
[69] The Global Slavery Index. https://www.globalslaveryindex.org/2018/findings/country-studies/united-kingdom/ Last accessed 01/10/2018
[70] National Crime Agency. Law enforcement steps up response to modern slavery, Government of the United Kingdom. 2017. http://www.nationalcrimeagency.gov.uk/news/1171-law-enforcement-steps-up-response-to-modern-slavery Last accessed 01/10/2018
[71] National Crime Agency. National Referral Mechanism Statistics - End of Year Summary 2017, Government of the United Kingdom. 2018;1.1:1-88.

engage in substance misuse and that drugs or alcohol were often used as 'payment' for labour to strengthen dependency and their grip of exploitation.[72] The charities further emphasised that victims of modern slavery are encountering support services in increasing numbers with concomitant drug or substance misuse. It is therefore vital that these victims of modern slavery also have access to support from alcohol and drug treatment services to mitigate their risk of facing return into slavery for fear of losing access to drugs. Modern slavery offences as recorded by Thames Valley Police Crime Recording System in Oxfordshire between 01/01/2015 to 30/09/2018, affecting both children and adults, are shown in Table 5.5 and Table 5.6, suggesting a rise in modern slavery in the county.

Table 5.5. The number of modern slavery crimes in Oxfordshire where a child aged 17 or under has been recorded as the victim between 01/01/2015 - 30/09/2018 [73]

Year	Number of crimes
2015	-
2016	-
2017	11
2018	12
Total	**23**

Table 5.6. The number of modern slavery crimes in Oxfordshire where an adult aged 18 or over has been recorded as the victim between 01/01/2015 - 30/09/2018

Year	Number of crimes
2015	3
2016	26
2017	54
2018	48
Total	**131**

Of note, the crime recording system from which these figures are obtained is dynamic, and ongoing investigations may result in reassessment of the crime classification over time

[72] The Salvation Army. The links between substance misuse and modern slavery. July 2018. https://www.salvationarmy.org.uk/victims-modern-slavery-trapped-forced-drug-and-alcohol-use Last accessed 01/10/2018

[73] Thames Valley Police Crime Recording System - NICHE RMS, Date Extracted: 16/10/2018

Further, within Oxfordshire, among 5,790 assessments completed by Children's Social Care in 2017/2018, 7 children were identified as victims of trafficking, and 68 were identified as members of gangs.[74] In data obtained by Thames Valley Police, Table 5.7 and Table 5.8 show the number of drug-related crimes in Oxfordshire where a child aged 17 or under has been recorded as a victim, suspect or offender of drug-related crimes, and may provide an approximate indication of the potential scale of the rising burden of child drug exploitation in Oxfordshire. Of note, for data regarding children as suspects or offenders, the numbers equate to the number of crimes in which a child aged 17 or under was a suspect or offender, and not the actual number of children involved.[80] These data should be considered in the context of recording limitations and are likely to represent substantial underestimates due to undetected crimes.

Table 5.7. The number of drug-related crimes in Oxfordshire where a child aged 17 or under has been recorded as the victim, between 01/01/2015 - 30/09/2018 [75]

Year	Number of crimes
2015	2
2016	4
2017	2
2018	-
Total	**8**

Table 5.8. The number of drug-related crimes in Oxfordshire where a child aged 17 or under has been recorded as a suspect or offender, between 01/01/2015 - 30/09/2018

Year	Number of crimes
2015	178
2016	182
2017	225
2018	223
Total	**808**

Of note, the crime recording system from which these figures are obtained is dynamic, and ongoing investigations may result in reassessment of the crime classification over time

[74] Children's Social Care, Oxfordshire County Council.
[75] Thames Valley Police Crime Recording System - NICHE RMS, Date Extracted: 16/10/2018

6. COMORBIDITIES, HOSPITAL ADMISSIONS AND MORTALITY

6.1 Mental health conditions

Mental illness comorbidity alongside substance misuse is common, and associated with heightened risk of psychiatric inpatient admissions, suicidal behaviour, and poorer treatment outcomes from both psychiatric and substance misuse care. In a cross-sectional prevalence survey among patients of community mental health teams (CMHTs) and substance misuse services in four urban UK centres, 44% of CMHT team patients reported a problem with harmful drug or alcohol use in the preceding year, and 75% of drug treatment services users and 85% of alcohol treatment service users reported a psychiatric disorder in the preceding year.[76] Further, it was identified that the majority of substance misuse patients on psychiatric case-loads did not receive support with their substance misuse, and a third of substance misuse patients with concomitant mental health issues did not receive mental health support. Within Oxfordshire, the number of service users who initiated alcohol treatment in 2017/2018 who were identified as having a mental health treatment need were 177, representing 51% of new presentations (46% of males and 59% of females), and compared to 41% of new presentations nationally. However, 94% of these service users in Oxfordshire were recorded to be receiving treatment from mental health services, as shown in Table 6.1. Anecdotal evidence from the Oxfordshire community drug and alcohol treatment services suggests that among service users in treatment, large numbers experience ongoing mental health needs but find it difficult to access mental health services due to their substance misuse problems. Further, it is possible that those individuals with concomitant mental health issues and substance misuse that are already receiving mental health treatment may be most likely to access substance misuse treatment services. These figures may therefore underestimate the true mental health need alongside substance misuse in the community as untreated mental health issues among

[76] Weaver T, Madden P, Charles V, et al. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. British Journal of Psychiatry 2003;183(4):304-313

individuals with alcohol and drug a misuse may be a factor hindering service users from engaging with substance misuse treatment services.

Table 6.1. Proportion of alcohol treatment service users who initiated treatment in Oxfordshire in 2017/18 who were identified as having a mental health treatment need and who were also receiving treatment for their mental health needs [77]

Treatment	Local n	Proportion of service users with mental health needs (%)	National proportion of service users with mental health needs (%)
Already engaged with the Community Mental Health Team/Other mental health services	25	14	21
Engaged with IAPT	0	0	3
Receiving mental health treatment from GP	126	71	53
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	18	10	2
Has an identified space in a health-based place of safety for mental health crises	*	<5	1
Total individuals receiving mental health treatment	**167**	**94**	**79**

IAPT= improving access to psychological therapies
*= Raw data removed where small counts may be identifiable

Among adults who entered drug treatment services in 2017/2018, 44% (n=251) were identified as having a mental health treatment need, compared to 41% nationally, and representing 40% of opiate users, 45% of non-opiate drug users, and 52% of alcohol and non-opiate drug users. Rates were higher among females compared to males, 56% vs 39% respectively. However, 94% of the 44% of service users with a mental health treatment need were recorded to be receiving treatment from mental

[77] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

health services, compared to 71% nationally, as shown in Table 6.2.[78] These data highlight mental health treatment as an important consideration to occur in unison with substance misuse treatment.[79]

Table 6.2. Proportion of drug treatment service users who initiated treatment in Oxfordshire in 2017/18 who were identified as having a mental health treatment need and who were also receiving treatment for their mental health needs

Treatment	Local n	Proportion of service users with mental health needs (%)	National proportion of service users with mental health needs (%)
Already engaged with the Community Mental Health Team/Other mental health services	31	12	23
Engaged with IAPT	*	<5	2
Receiving mental health treatment from GP	172	69	43
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	34	14	2
Has an identified space in a health-based place of safety for mental health crises	*	<5	1
Total individuals receiving mental health treatment	**236**	**94**	**71**

IAPT= improving access to psychological therapies
*= Raw data removed where small counts may be identifiable

6.2 Smoking and Chronic Obstructive Pulmonary Disease

Smoking prevalence among alcohol and drug users is very high, with 74-98% of individuals in treatment or recovery for substance use disorders reported to also

[78] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20
[79] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

smoke.[80] UK government reports have cited that more than 80% of alcohol dependent treatment service users smoke, and near 100% of opioid dependent treatment service users.[81] Further, these individuals are at particularly elevated risk of smoking-associated harm due to being more likely to initiate smoking earlier in life, and more likely to consume higher levels of smoking.[82] As a result. alcohol and drug users have been reported to be more likely to die from smoking-related illnesses than their substance misuse. For example, in a study of individuals who were ex-alcoholics and ex- drug addicts, half of deaths in the cohort resulted from smoking-related illness.[83] However, tobacco cessation initiatives are often neglected or postponed in this cohort and smoking cessation rates among alcohol and drug users remain below the general population. This may be in part due to misconceptions among health professionals that alcohol and drug users are less motivated to quit, or that smoking cessation efforts may compromise alcohol and drug treatment outcomes. Similarly, evidence has suggested that individuals who have comorbid smoking and illicit drug use may be less inclined to undertake smoking cessation over concerns that this may adversely influence their drug use by requiring them to use more drugs to compensate for smoking cessation.[84] However, research has shown that whereas drug users may require more intensive and prolonged smoking cessation treatment, such initiatives alongside drug cessation treatment does not compromise treatment outcomes of substance misuse treatment but could in fact have a positive impact in improving long-term alcohol and drug abstinence. A meta-analysis of smoking cessation interventions in 19 randomised controlled trials of individuals in addiction treatment or recovery observed that users who concomitantly underwent treatment for both smoking and substance misuse were 25% more likely to be abstinent from alcohol and drugs long-term.[85] Supportively, behavioral studies have suggested that smoking can trigger alcohol and drug cravings, and therefore

[80] Thurgood SL, McNeill A, Clark-Carter D, Brose LS. A systematic review of smoking cessation interventions for adults in substance abuse treatment or recovery. Nicotine Tob Res 2016;18(5):993-1001
[81] https://www.gov.uk/government/case-studies/a-lung-health-clinic-in-an-addictions-service Last accessed 01/10/2018
[82] Richter KP, Arnsten JH. A rationale and model for addressing tobacco dependence in substance abuse treatment. Subst Abuse Treat Prev Policy 2006;1:23
[83] Hurt RD, Offord KP, Croghan IT, et al. Mortality following inpatient addictions treatment. Role of tobacco use in a community-based cohort. JAMA 1996;275(14):1097–1103
[84] National Centre for Smoking Cessation and Training. Local Stop Smoking Services; service and delivery guidance 2014. http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf Last accessed 01/10/2018.
[85] Mendelsohn CP, Wodak A. Smoking cessation in people with alcohol and other drug problems. 2016;45(8):569-573

potential relapses.[86] The incorporation of smoking cessation treatment as part of alcohol and drug treatment programs is therefore encouraged in public policy, including in guidance developed by the England National Centre for Smoking Cessation and Training in 2014.

Tobacco smoking among alcohol treatment service users in Oxfordshire is common. Out of all service users in treatment in 2017/2018, 35% (n=127/359) were identified as tobacco smokers at the start of treatment, compared to 42% nationally. Smoking was more prevalent among male compared to female service users (38% vs 32% respectively). For service users identified as smokers at the start of treatment, who subsequently had a treatment outcome review, 35% (44/127) identified as having changed their status to abstinent from smoking, compared to 34% nationally. Among service users who identified as non-smokers at the start of treatment and who subsequently had a treatment outcome review, 9% (22/232) of service users reported having initiated smoking during treatment, compared to 13% nationally. However, less than 5% of service users who identified as smokers at the start of treatment received smoking cessation interventions, similar to national figures.[87] The low rate of smoking cessation interventions offered to treatment service users is likely to in part reflect the fact that in Oxfordshire smoking cessation interventions are not provided by the same service commissioned to provide alcohol and drug treatment services, but users are referred by the substance misuse treatment service to a separate provider for smoking cessation, with referral rates not reflected in these figures.

Out of all service users in drug treatment services in 2017/2018, 69% (n=365/531) were identified as tobacco smokers at the start of treatment, compared to 64% nationally.[88] By drug type, this was estimated as 75% of those in treatment for opiate misuse, 61% of non-opiate misuse, and 52% of those with alcohol and non-opiate misuse. Smoking was more prevalent among males compared to females (71% vs 64% respectively). For service users identified as smokers at the start of treatment, who subsequently had a treatment outcome review, 24% (87/365) identified as

[86] Sees KL, Clark HW. When to begin smoking cessation in substance abusers. J. Subst Abusem Treat 1993;10:189-195.
[87] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[88] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

having changed their status to abstinent from smoking, compared to 25% nationally. Among service users who identified as non-smokers at the start of treatment and who subsequently had a treatment outcome review, 31% (52/166) of service users reported having initiated smoking during treatment, compared to 32% nationally. Initiation of smoking identified at outcome review was particularly common among opiate users, among whom 47% of those initially cited as abstinent reported having initiated smoking at their outcome review, compared to 3% of non-opiate service users and 22% of alcohol and non-opiate service users. However, less than 5% of service users who identified as smokers at the start of treatment received smoking cessation interventions, similar to national figures. As above, data on the number of service users who receive smoking cessation interventions is subject to substantial recording limitations as smoking cessation is provided externally.

Chronic Obstructive Pulmonary Disease (COPD) is the fifth biggest killer in the UK, for which smoking is identified as a leading risk factor. COPD is thought to disproportionately affect individuals with alcohol and drug dependency and contribute to a heightened mortality risk from respiratory diseases among these individuals.[89] This is likely due to a multifactorial cause, including that a) alcohol and drug users are often part of marginalised communities in society, with less access to primary or secondary health-care services, b) evidence has shown that most service users in drug treatment services smoke tobacco and have at some point smoked other substances such as cannabis, heroin, crack cocaine or psychoactive substances, and c) there are thought to be direct links between inhalation of heroin and crack cocaine and more severe early-onset COPD.[90] The rate of emergency hospital admissions for COPD in Oxfordshire is lower than national rates, and has remained relatively consistent over time, as shown in Figure 6.1.[91] Nonetheless, given that COPD is not curable, a substantial cause of morbidity and mortality, and associated with high health-care service usage and expense, an elevated COPD risk among alcohol and drug treatment service users should further emphasise the value

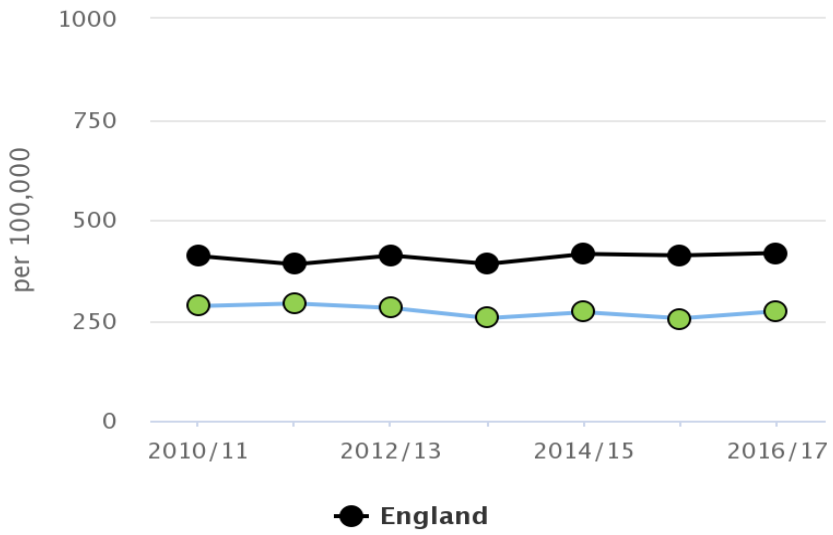
[89] Pierce M, Bird SM, Hickman M, Millar T. National record linkage study of mortality for a large cohort of opioid users ascertained by drug treatment or criminal justice sources in England, 2005-2009. Drug Alcohol Depend 2015;146:17-23

[90] Elkin T, et al. Anchoring copd screening to drug services in heroin and crack smokers to improve diagnosis. Thorax, 2016

[91] https://fingertips.phe.org.uk/ Last accessed 01/10/2018

in primary and secondary of COPD through concomitant smoking and substance misuse cessation interventions.

Figure 6.1. Directly standardised rates of emergency hospital admissions for chronic obstructive pulmonary disease per 100,000 in Oxfordshire 2010/11-2016/17



6.3 Sexual health and human immunodeficiency virus

Individuals who misuse alcohol and drugs are thought to experience heightened risks to their sexual health including sexual assaults, sexually transmitted diseases and unintended pregnancies. For example, drug use may cause a state of intoxication and disinhibition, which may result in an individual taking part in sexual activities they may later regret, they may have sexual activity coerced upon them in a non-consensual manner, or individuals with alcohol or drug dependence may engage in the sex industry to help fund their addiction, as discussed above. Further, substance misuse is also associated with less frequent attendance at cervical

screening and irregular use of contraceptive safeguards.[92-93] In addition to these risks, users who share needles or other drug injecting equipment are at particularly high risk of blood-borne viruses. For these individuals, facilitating needle exchange and sterile equipment, as well as provisions of opioid substitution therapy or antiviral treatment could be a cost-efficient approach to protect both drug users and the broader community.

National data exists on human immunodeficiency virus (HIV) infection rates associated with intravenous drug use.[94] There were 145 new HIV diagnoses associated with intravenous drug use in 2016 in the UK, lower than the national 2006-2015 average of 168 new diagnoses per year, as shown in Figure 6.2. Although the majority of intravenous drug users in the UK who live with HIV know of their diagnosis and are utilising HIV treatment services, the occurrence of late diagnoses remains an issue. Just over half (51%) of new HIV diagnoses in 2016 among intravenous drug users occurred at a late stage of HIV infection, which is associated with a ten-fold increased risk of death within a year of diagnosis compared to those who are promptly diagnosed. Further, a late diagnosis is likely to mean a prolonged period during which infected individuals expose others to an increased transmission risk. Most intravenous drug users who reported that they had either not been tested or had not been tested in the preceding two years, reported that within the preceding year they had seen their GP, received a prescribed drug substitute, or used a needle and syringe exchange programme, suggesting a missed opportunity to incorporate HIV testing into other points of contact with healthcare services.

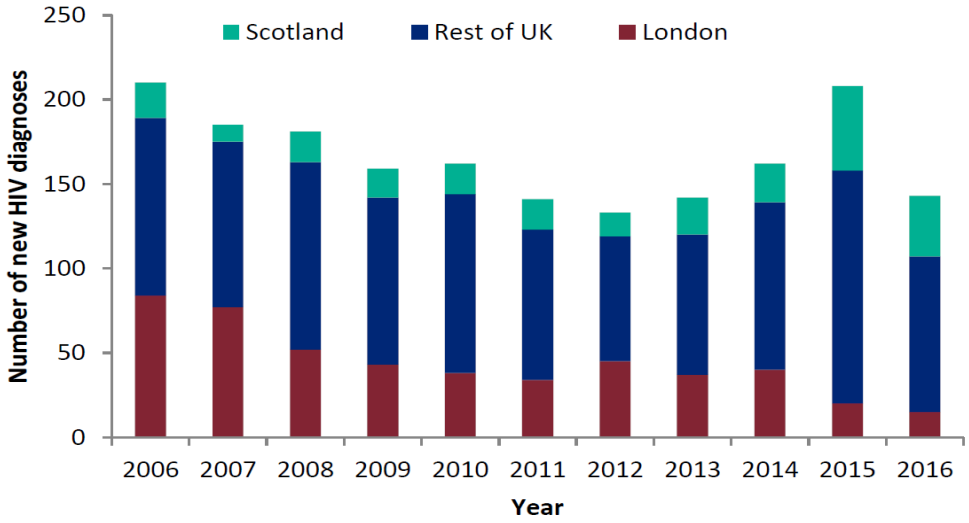
Figure 6.2. Yearly national average of new HIV diagnoses associated with intravenous drug use in London, Scotland and the rest of the UK [95]

[92] Bowden-Jones O. Joining up sexual health and drug services to better meet client needs. 2017. https://core.ac.uk/download/pdf/132547534.pdf Last accessed 01/10/2018

[93] Hwang LY, Ross MW, Zack C, et al. Prevalence of sexually transmitted infections and associated risk factors among populations of drug abusers. Clin Infect Dis 2000;31:920–926

[94] Public Health England. Shooting Up: Infections among people who inject drugs in the UK, 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663003/Shooting_Up_2017_report.pdf Last accessed 02/10/2018

[95] Public Health England. Shooting Up: Infections among people who inject drugs in the UK, 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663003/Shooting_Up_2017_report.pdf Last accessed 02/10/2018



6.4 Blood-borne viruses

Blood-borne viruses are a major public health concern among intravenous drug users, particularly if injection equipment is shared between users. Most new infections of hepatitis C are acquired via intravenous drug use, and the incidence of hepatitis C among individuals who inject drugs has been estimated from UK surveys. These data are likely to be subject to data quality issues including under-reporting and detection, but suggest a stable incidence rate over time from 2008 to 2016, with the incidence rate estimated as 16 per 100 person-years among people who inject drugs.[96] Individuals who inject drugs are also at increased risk of hepatitis B compared to the general UK population, but 96% of hepatitis B cases in the UK are thought to be acquired abroad. The overall annual incidence of hepatitis B in England was estimated at 0.8 per 100,000 people in 2017, and 0.49-0.68 per 100,000 people in the South East of England.[97] Drug treatment service users in Oxfordshire who have received vaccination/treatment for hepatitis B and C infections are routinely monitored. In 2017/2018, 42% (n=171) of adults new to drug treatment services who were eligible for hepatitis B vaccinations accepted the offer, which is higher than the national rate of 37%.[98] There was no gender discrepancy in likelihood to accept testing (41% of eligible males and 43% eligible females).

[96]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/632465/HCV_in_the_uk_report_2017.pdf Last accessed 11/01/2019
[97]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/736145/hpr3118_hepB.pdf Last accessed 11/01/2019
[98] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

However, only 12% (n=21) of those who accepted hepatitis B vaccinations were reported to have commenced a vaccination course, and only 6% (n=11) completed a vaccination course. Further, only 16% (n=152) of current or previous injectors new to drug treatment in 2017/2018 who were eligible for a hepatitis C test received one, compared to 20% nationally. However, despite there being 42 service users who had a positive hep C (n=29) antibody test or a positive hep C (PCR) RNA test (n=13), no service users were recorded as having been referred for treatment. It is likely that these low figures are, at least partly, explained by regional variation in local systems and pathways. For example, some Oxfordshire hepatitis B and C testing and treatment services are funded and provided via a separate service, but take place within the facilities of the substance misuse treatment service provider, and are therefore not always captured in standardised recording. Providing opioid substitution therapy (OST), sterile injecting equipment, viral testing and antiviral treatments are important strategies to protect drug users and broader communities and provide long-term cost-savings.

6.5 Hospital admissions

6.5.1 Alcohol-related inpatient hospital admissions

Hospital admissions in which alcohol has a causal role can be divided into 'alcohol-specific' admissions, in which alcohol is always causally implicated such as alcohol poisoning or alcoholic liver disease, or 'alcohol-related' admissions, which incorporates all alcohol-specific conditions in addition to conditions where alcohol may sometimes be causally implicated, such as hypertension and some cancers.[99] Within the indicator of alcohol-related admissions there are two categories; the 'broad' measure is an indication of total alcohol-related harm in Oxfordshire, whereas the 'narrow' measure indicates the number of admissions where the alcohol-related condition was the primary reason for admission or was identified as an external cause. The directly standardised rate of hospital admission episodes for alcohol-specific conditions per 100,000 across all ages in Oxfordshire 2016/2017 was 426,

[99] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

which was in the lowest national quartile of harm, as compared to a national rate of 563.

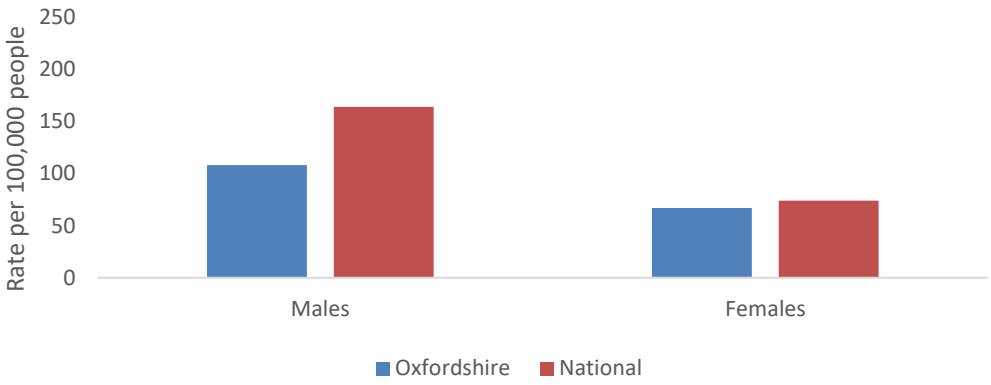
However, in comparing Oxfordshire with other local authorities using a 'nearest neighbour approach', which incorporates the 15 areas with similar demographic, socio-economic and geographic characteristics, Oxfordshire was in the third highest quartile of harm and therefore had a higher level of harm than the benchmark for similar local authorities. In considering only alcohol-related admissions, Oxfordshire performs in the lowest quartile of harm, and therefore lower than the benchmark, both compared to national and 'nearest neighbour' rates, and both as a 'broad' and 'narrow' indicator. The rate of alcohol-related admissions in 2016/17 using the 'broad' definition across all ages was 1,684 per 100,000 in Oxfordshire, compared to 2,185 per 100,000 nationally. In considering a narrow definition of alcohol-related admissions, where the alcohol-related condition had to constitute the primary reason for admission or be identified as an external cause, the Oxfordshire hospital admission rate was 493 per 100,000, compared to 636 per 100,000 nationally.[100] It is estimated that 65% of alcohol-related admissions are men, who have a higher prevalence of harmful levels of alcohol consumption compared to women.[101] Directly standardised rates of admissions for different alcohol-related conditions by gender in Oxfordshire and nationally are shown in Figure 6.3. These data show consistently lower rates alcohol-related admission rates in Oxfordshire compared to national rates and highlight a higher rate of admissions for alcohol-related admissions among males, except for intentional self-poisoning which is more frequent among females. Alcohol-related hospital admissions nonetheless represent a financial- and resource-costly impact of harmful alcohol use on the health service, and highlight the value of community-based preventive treatment services to limit the impact on more costly secondary care services. Trends in admission rates for alcohol-related and alcohol-specific conditions are shown in Figure 6.4.[102]

Figure 6.3. Directly standardised rates of hospital admissions per 100,000 for alcohol-related conditions including a) alcohol-related liver disease (broad

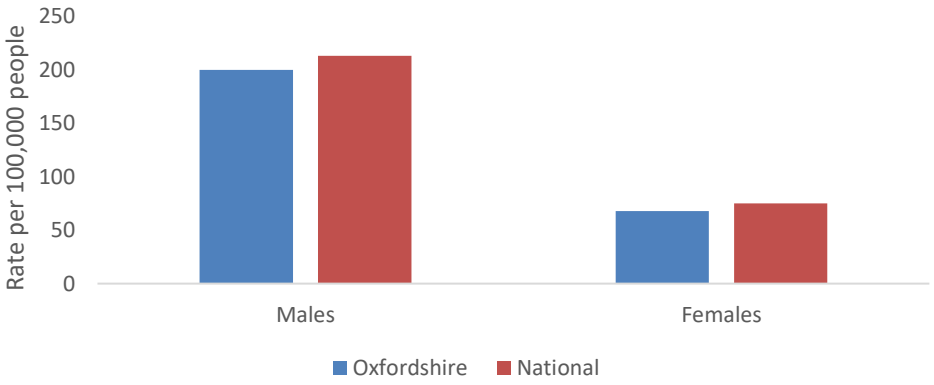
[100] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[101] Statistics on alcohol 2017, NHS digital
[102] Classen DC, Pestotnik SL, Evans S, Lloyd JF, Burke JP. Adverse drug events in hospitalized patients: excess length of stay, extra costs, and attributable mortality. JAMA 1997;277(4):301-306

definition), b) alcohol-related unintentional injuries (narrow definition), c) mental and behavioural conditions due to use of alcohol, d) admission episodes for intentional self-poisoning by and exposure to alcohol condition (narrow definition), and e) admission episodes for alcohol related cardiovascular disease conditions (broad definition), in 2016/17

a) Alcohol-related liver disease

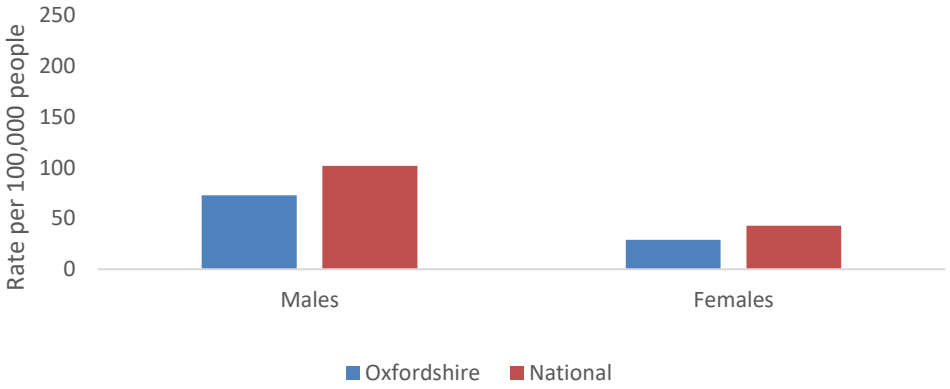


b) Alcohol-related unintentional injuries[103]

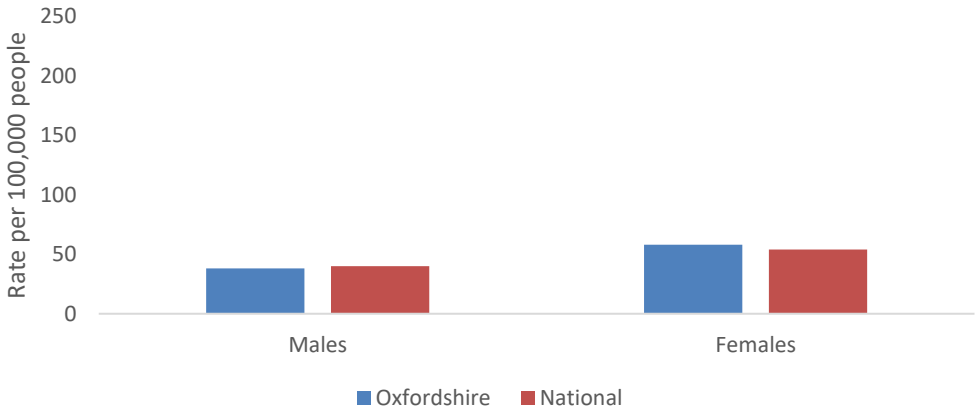


c) Mental and behavioural conditions due to use of alcohol

[103] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20



d) Admission episodes for intentional self-poisoning by and exposure to alcohol condition



e) Admission episodes for alcohol related cardiovascular conditions

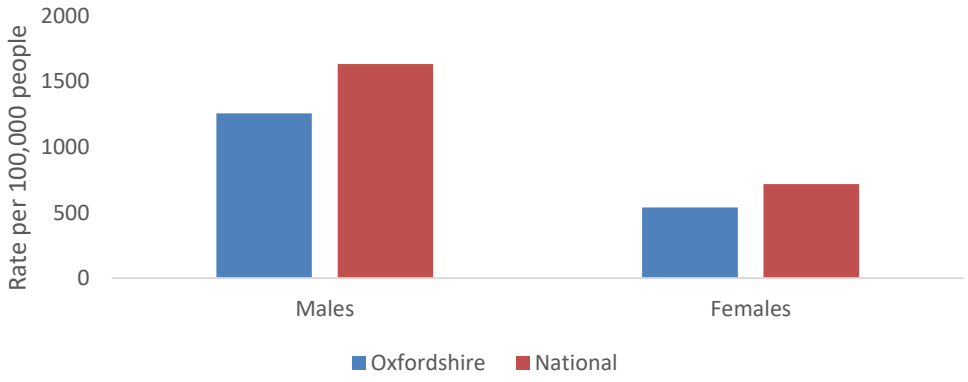
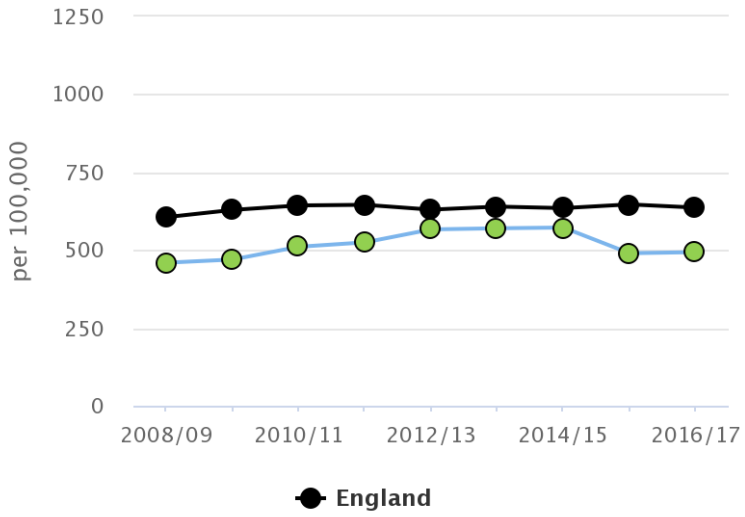


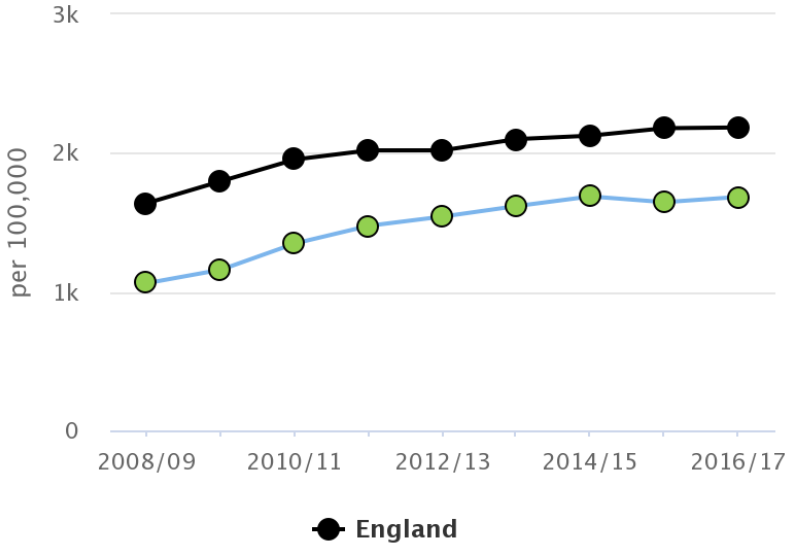
Figure 6.4. Oxfordshire and national trends in directly age standardised admission rates per 100,000 population for a) alcohol-related conditions

(narrow), b) alcohol-related conditions (broad), and c) alcohol-specific conditions [104]

a)

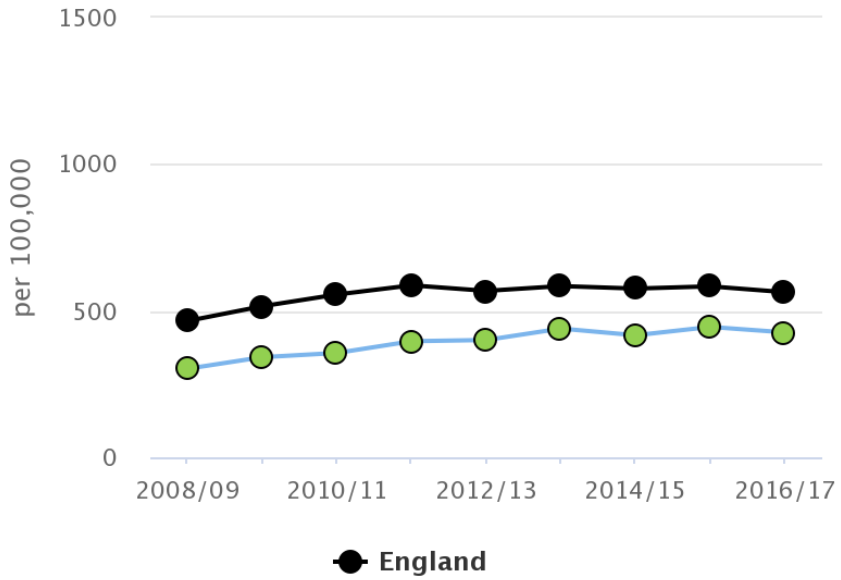


b)



[104] https://fingertips.phe.org.uk/ Last accessed 01/10/2018

c)



The 'broad' measure is an indication of total alcohol-related harm in Oxfordshire, whereas the 'narrow' measure indicates the number of admissions where the alcohol-related condition was the primary reason for admission or was identified as an external cause.

Within the total number of hospital admissions there are some individuals who are repeat attenders to hospital and who will represent a disproportionate burden on healthcare and other public services. Individuals who repeatedly attend hospital for alcohol-specific conditions are also likely to represent individuals who are likely to have not been in contact with, or successfully engaged with, community treatment services. Table 6.3 shows the number and rate of individuals with an alcohol-specific hospital admission in 2015-16 who had one or more alcohol-specific hospital admissions in the preceding 24.[105] Fourteen percent of individuals with an alcohol-specific hospital admission in Oxfordshire 2015/16 had two or more alcohol-specific hospital admissions in the preceding 24 months, compared to 17% nationally. Individuals with repeat admissions represent important priority groups who place a particularly high burden and cost on public services and may particularly benefit from targeted intervention.

[105] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

Table 6.3. Number and rate of individuals with an alcohol-specific hospital admission in 2015-16 who had one more alcohol-specific hospital admissions in the preceding 24 months

	Local n	Local rate per 100,000	National n	National rate per 100,000
No preceding admission	1,405	207	129,719	237
One preceding admission	219	32	24,771	45
Two or more preceding admissions	261	39	30,879	56

All person crude rate per 100,000

Further, the alcohol-related and alcohol-specific admission rates for each individual Oxfordshire district were lower than the national average, except for Oxford City which had a similar alcohol-related hospital admission rate to the national rate, and a higher alcohol-specific admission rate compared to the national rate, as shown in Figure 6.5.[106] Hospital admissions for alcohol attributable conditions by ward area in Oxfordshire from 2010-11 to 2014-15 are shown in Figure 6.6, highlighting that Northfield Brook and Blackbird Leys, which are the most socioeconomically deprived wards within Oxford, have the highest alcohol attributable hospital admissions ratios.[107] This suggests that regional variation in hospital admissions rates by district may be related to higher levels of homelessness and socioeconomic deprivation in Oxford City, which is also more urban than other districts. Nationally, alcohol-related hospital admissions occur more commonly in the lowest three national deciles of socioeconomic deprivation, and individuals in these deciles account for 50-55% of all admissions for mental and behavioural disorders due to alcohol use, admissions for intentional injuries, admissions for alcoholic liver disease, and admissions for alcohol-related complications in pregnancy and childbirth.

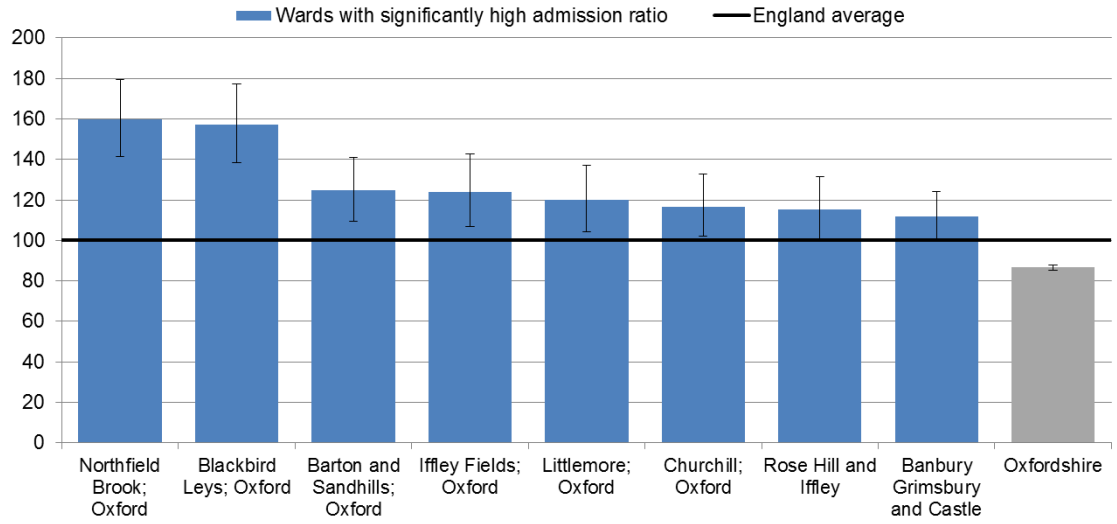
[106] https://fingertips.phe.org.uk/ Last accessed 01/10/2018
[107] Oxfordshire Joint Strategic Needs Assessment Annual Report 2017. http://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202017%20FINAL_1.pdf

Figure 6.5. Directly age standardised admission rates for alcohol-related and alcohol-specific conditions per 100,000 population by Oxfordshire district 2016/17 [108]

Indicator	Period		England	Oxfordshire	Oxford	West Oxfordshire	Vale of White Horse	South Oxfordshire	Cherwell
10.01 - Admission episodes for alcohol-related conditions (Narrow)	2016/17		636	493	643	495	451	426	496
9.01 - Admission episodes for alcohol-related conditions (Broad)	2016/17		2185	1684	2214	1618	1455	1426	1826
6.02 - Admission episodes for alcohol-specific conditions	2016/17		563	426	725	407	311	315	420

Figure 6.6. Standardised admission ratios of hospital admissions for alcohol attributable conditions by ward level in Oxford 2010-11 to 2014-15 [109]

[108] https://fingertips.phe.org.uk/ Last accessed 01/10/2018
[109] Oxfordshire Joint Strategic Needs Assessment Annual Report 2017. http://insight.oxfordshire.gov.uk/cms/system/files/documents/JSNA%202017%20FINAL_1.pdf



The data are based on the total number of admissions for alcohol-related conditions, and not the total number of people with an alcohol-related condition

6.5.2 Drug-related inpatient hospital admissions

Hospital admissions from non-fatal overdoses can be an important indicator of likely future drug misuse-related deaths.[93] The crude rate of hospital admissions per 100,000 people in which drug poisoning was coded as either the primary or secondary reason for admission in 2017-2018 were 40.5 per 100,000 people in Oxfordshire, which is a similar rate to other local authorities in the same decile of deprivation as Oxfordshire, and is lower in comparison to the national rate of 55.2 per 100,000 nationally.

6.5.3 Emergency department presentations

Alcohol- and assault-related presentations to the Accident and Emergency departments of the John Radcliffe Hospital and the Horton Hospital of the Oxford University Hospitals NHS Foundation Trust from the 1st April 2016 to 31st March

2017 are shown in Table 6.4.[110] These data highlight the burden of alcohol-related presentations on hospital emergency departments, particularly among males, at a time when emergency departments are already facing unprecedented demands. Hence, in addition to potentially reducing alcohol-related crimes, effective drug and alcohol treatment services may mitigate levels of demand across emergency care services, including ambulance callouts, emergency department visits and emergency hospital admissions.

Table 6.4. Number of alcohol-related and alcohol- and assault-related presentations to the Oxford University Hospitals emergency departments, all ages, 2016/2017

	Alcohol-related presentations	Alcohol and assault-related presentations
Female	1,296	54
Male	2,170	277
Total	3,466	331

6.6 Years of life lost and alcohol- and drug misuse-related deaths

Alcohol misuse is an important national contributor to premature deaths, with alcohol-related mortality thought to account for approximately 5% of all deaths.[111] Further, cases of alcohol-related mortality are likely to be preceded by decades of heavy and persistent alcohol consumption and associated substantial chronic demands on health and social care services. Out of alcohol-related deaths, one third is thought to be from alcohol-specific causes such as alcohol poisoning or alcoholic pancreatitis, and approximately two thirds are thought to be from conditions partly related to alcohol consumption such as cancer or cardiovascular diseases. A small remaining proportion is accounted for by acute consequences of alcohol consumption such as self-harm or road traffic accidents. Rates of alcohol-related and

[110] Oxfordshire County Council

[111] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

alcohol-specific mortality in Oxfordshire are comparatively low, and are in the lowest quartile of harm compared to both similar neighbour counties and to national rates.[112] However, rates by district shows that Oxford City and Cherwell districts have the highest rates of alcohol-specific and alcohol-related mortality in the county, with rates in Oxford City similar to national rates. This is consistent with the fact premature deaths due to alcohol-related conditions disproportionately affects individuals from lower socioeconomic groups. In 2016 a total of 224 alcohol-related deaths were reported in Oxfordshire, of which there were 55 in Cherwell, 51 in Oxford, 47 in South Oxfordshire, 39 in Vale of White Horse, and 32 in West Oxfordshire.[113] Figure 6.7 shows the number and rate of alcohol-related deaths in Oxfordshire, by district and sex. Years of life lost from premature deaths and trends in mortality due to alcohol-related and alcohol-specific causes of death in Oxfordshire are shown below in Figures 6.8 and 6.9, demonstrating overall slightly declining trends in rates of alcohol-related and alcohol-specific mortality, but a higher burden of premature mortality from alcohol-related causes in males compared to females.

Figure 6.7. Number and rate of alcohol-related mortality per 100,000 people in Oxfordshire, for a) all persons, b) males and c) females

a)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	23,839	46.0	45.5	46.6
Oxfordshire	–	224	35.1	30.7	40.1
Cherwell	–	55	40.3	30.3	52.5
Oxford	–	51	46.9	34.7	62.0
South Oxfordshire	–	47	33.2	24.4	44.1
Vale of White Horse	–	39	29.8	21.2	40.8
West Oxfordshire	–	32	27.7	18.9	39.3

Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

b)

[112] https://fingertips.phe.org.uk/ Last accessed 01/10/2018
[113] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	15,751	66.3	65.3	67.4
Oxfordshire	–	143	49.0	41.2	57.8
Cherwell	–	33	52.6	35.9	74.4
Oxford	–	36	70.7	48.9	98.7
South Oxfordshire	–	29	45.6	30.3	65.9
Vale of White Horse	–	25	42.7	27.5	63.2
West Oxfordshire	–	20	37.0	22.4	57.5

Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

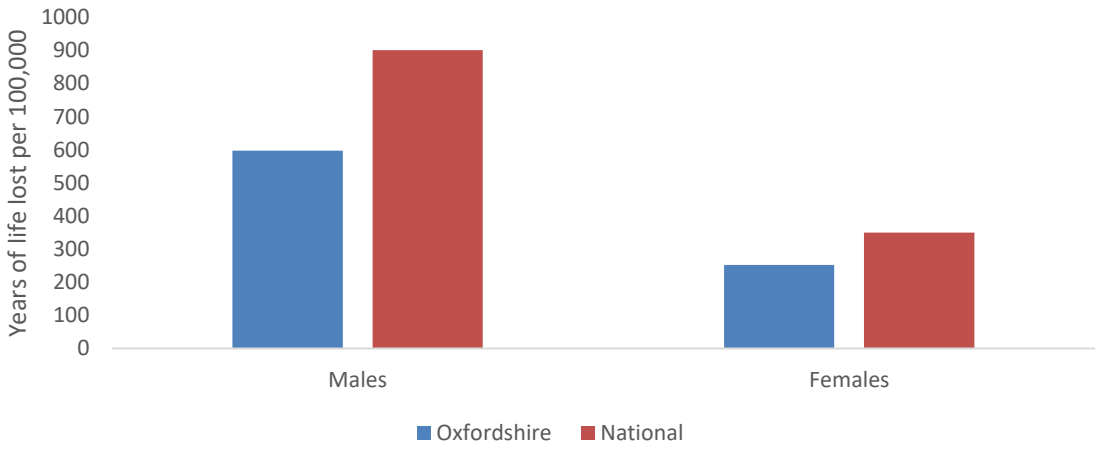
c)

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	8,088	28.8	28.2	29.4
Oxfordshire	–	81	23.2	18.4	28.9
Cherwell	–	22	30.1	18.7	45.6
Oxford	–	15	25.2	13.8	42.2
South Oxfordshire	–	19	23.2	13.7	36.6
Vale of White Horse	–	14	18.8	10.2	31.7
West Oxfordshire	–	12	19.8	9.9	35.1

Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

*Yellow shading indicates a similar rate in Oxfordshire compared to the national benchmark

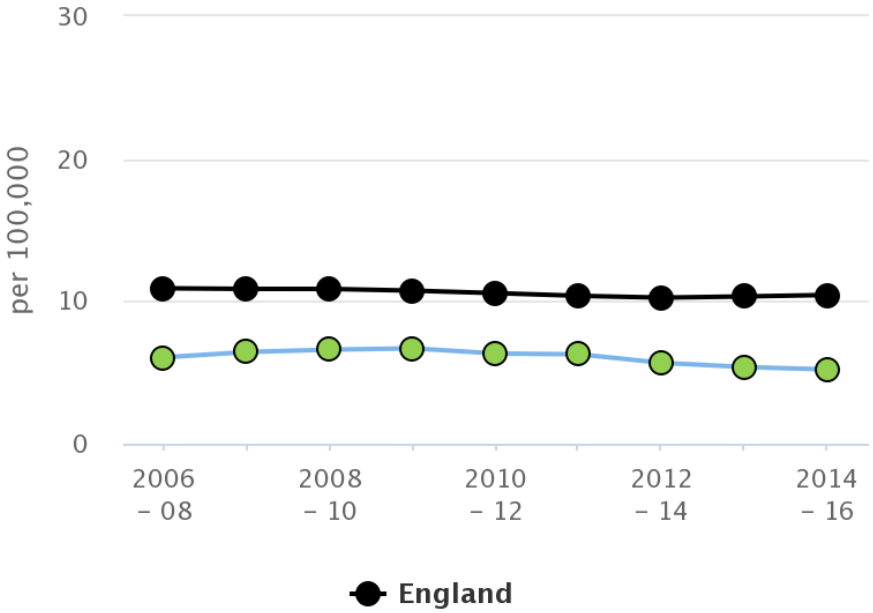
Figure 6.8. Directly standardised rates of years of life lost per 100,000 people due to alcohol-related conditions in 2016, by gender [114]



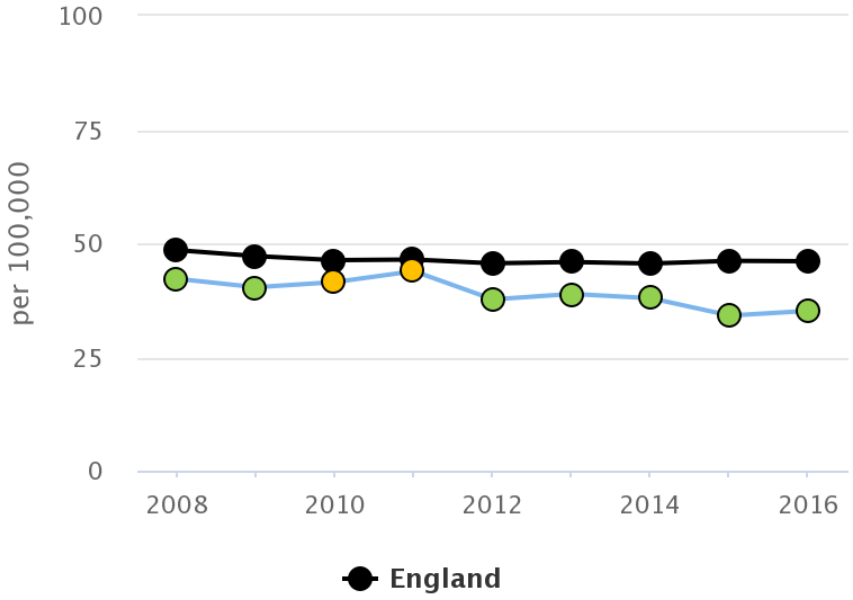
[114] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

Figure 6.9. Trends in age-standardised a) alcohol-specific and b) alcohol-related mortality rates per 100,000 people in Oxfordshire [115]

a)



b)

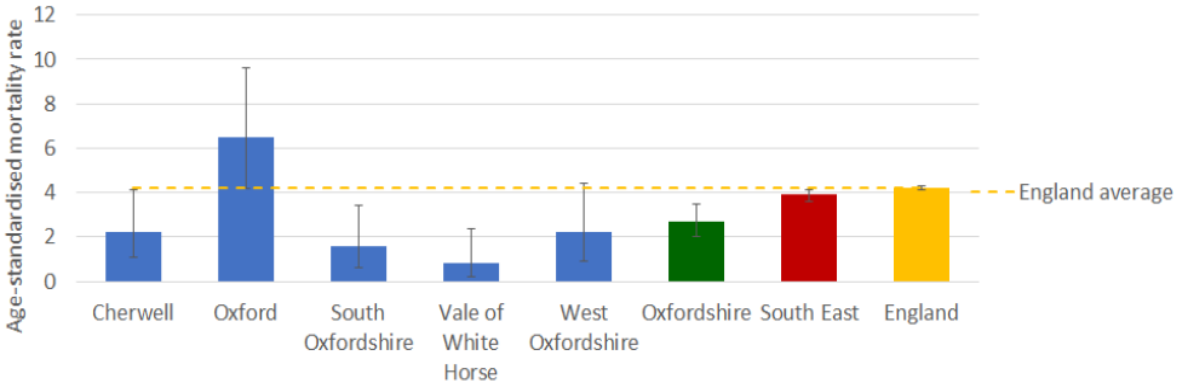


There was a total of 53 drug misuse-related deaths in Oxfordshire County in 2014-2016, of which 50% occurred in the district of Oxford City. The rate of drug misuse-

[115] https://fingertips.phe.org.uk/ Last accessed 01/10/2018

related deaths (not including smoking and alcohol) in Oxfordshire overall is below the national rate, but the rate in Oxford City is higher than the national rate, as shown in Figure 6.10.[116] Drug misuse-related deaths as a directly age-standardised rate per 100,000 people in Oxfordshire 2015-17 was 2.5 per 100,000 people, which is similar to other counties of the same level of deprivation, and lower in comparison to a national rate to 4.3 per 100,000.[117]

Figure 6.10. Comparative age-standardised mortality rates for drug-misuse related deaths per 100,000 people in 2014-2016, by Oxfordshire district



6.7 Alcohol and drug-related crimes

Within TVP, the rate of reporting of crimes for drug possession is above average in Oxford City compared to Thames Valley overall, 2.28 vs 1.52 per 1,000 population respectively, and below the average Thames Valley rate in Cherwell and West Oxfordshire (1.29 per 1000 people), and in South Oxfordshire and Vale of White Horse (0.88 per 1,000 people).[118] Furthermore, data collected by TVP in the period from 01/09/2017 to 28/02/2018 showed that, during 159 incidents, 106 individuals had been arrested for possession of controlled drugs with intent to supply (PWITS). Of these arrests, 50% took place in Oxford central, which includes Oxford City Centre, Botley Road and New Hinksey, and 71% of offenders had a home address in

[116] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018.
[117] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20
[118] Oxfordshire Insight. http://insight.oxfordshire.gov.uk Last accessed 01/10/2018

Oxford (followed by 6% in Abingdon and 6% in Thame).[119] The largest proportion of individuals arrested as PWITS were aged 19-29 (47%), followed by those aged 13-18 (28%), 30-39 (16%), and 40+ (9%). The most frequent drug of possession of offenders were class A drugs (36%), and other common drugs were cannabis resin (20%), class B other (14%), crack cocaine (10%) and cocaine (9%). Moreover, Table 6.5 shows the substantial number of arrests recorded across Oxfordshire in 2016/2017 and 2017/2018 in which the words 'drug', 'drink' or alcohol' featured in the reason for arrest. These data include individuals who have been arrested on several occasions with each arrest counted separately.

Table 6.5. Number and percentage of arrests in which 'drug', 'drink' or 'alcohol' was featured in the recorded reason for arrest in Oxfordshire 2016-2018

	2016/17		2017/18	
	Number	**Percentage of total arrests**	**Number**	**Percentage of total arrests**
All drug-related arrests	879	11%	1036	14%
All alcohol-related arrests	596	8%	572	8%

Further, a relatively high proportion of the Oxfordshire substance misuse treatment population experience encounters the criminal justice system. For example, the numbers of individuals in alcohol or drug treatment services who were in contact with the criminal justice system, defined as service users taken onto a criminal justice interventions team caseload within 42 days from the earliest triage or the earliest referral source of their substance misuse treatment journey, between 01/04/2017 and 31/03/2018 are shown in Figure 6.11.[120-121]

Figure 6.11. Number of service users in alcohol or drug treatment services who were taken onto a criminal justice interventions team caseload within 42 days from the earliest triage or the earliest referral source of their substance

[119] Thames Valley Police Crime Recording System - NICHE RMS, Date Extracted: 16/10/2018

[120] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[121] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

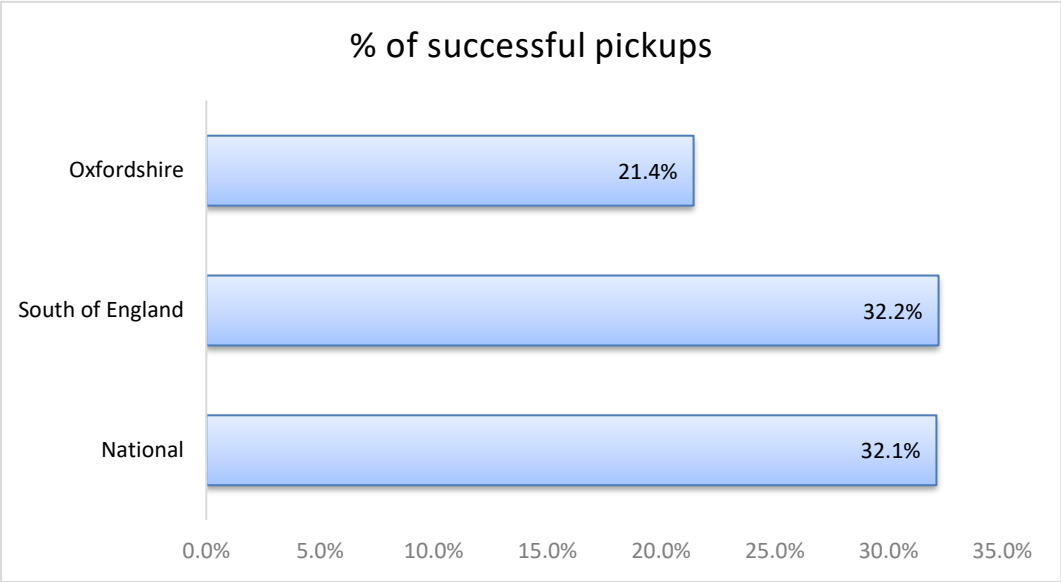
misuse treatment journey as proportions of all service users in treatment services in Oxfordshire between 01/04/2017 and 31/03/2018

	Latest period		National average
	(%)	(n)	(%)
Opiate	9.9%	154 / 1562	20.9%
Non-opiate	5.2%	8 / 153	13.3%
Alcohol	5.1%	28 / 550	6.4%
Alcohol and non-opiate	5.1%	9 / 176	11.6%

Moreover, if an individual is released from prison with ongoing alcohol and drug treatment needs, referrals can be made to regional alcohol and drug treatment services. Within Oxfordshire, referred individuals are most commonly released from Her Majesty Prison (HMP) Bullingdon, followed by HMP Woodhill, HMP Eastwood Park, and HMP Foston Hall. Out of 140 service users released from prison services in 2017/18, 30 service users (21.4%) commenced treatment in Oxfordshire within 3 weeks, which is below the regional and national average, as shown in Figure 6.12.[122] This suggests that there is a need to better join pathways to ensure a smooth transition from prison to community-based substance misuse treatment services, which would likely also support prevention of re-offending. Approximately 6% of service users who were referred re-presented to prison-based treatment services within three weeks of release, compared to 8% nationally.

Figure 6.12. Proportion of successful pickups of individuals referred to Oxfordshire alcohol and drug treatment services on release from prison in 2017/18

[122] National Drug Treatment Monitoring System



In April 2005 Community Orders were introduced as a sentencing option in line with the provisions outlined in the 2003 Criminal Justice Act. Requirements as part of a community order or a suspended sentence order may include a Drug Rehabilitation Requirement (DRR) or an Alcohol Treatment Requirement (ATR). The number of DRR or ATR orders placed by the Banbury Magistrates Court, the Oxford Crown Court and the Oxford Magistrates Court in 2016-2018 are shown in Table 6.6.[123]

Table 6.6. Numbers of a) Drug Rehabilitation Requirement (DRR) and b) Alcohol Treatment Requirement (ATR) orders placed by the Banbury Magistrates Court, the Oxford Crown Court and the Oxford Magistrates Court 2016-2018 [124]

a) Drug rehabilitation requirement orders

Court Name	2016	2017	2018
Banbury Magistrates Court	21	25	17
Oxford Crown Court	18	28	19
Oxford Magistrates Court	66	71	53
Grand total	**105**	**124**	**89***

*please note 2018 figures only apply from 01/01/2018 to 28/09/2018

[123] Communication from Turning Point, Oxfordshire.
[124] Communication from Turning Point, Oxfordshire.

b) Alcohol treatment requirement orders

Court Name	2016	2017	2018
Banbury Magistrates Court	15	20	6
Oxford Crown Court	8	7	6
Oxford Magistrates Court	50	45	27
Grand total	**73**	**72**	**39***

*Note 2018 figures only apply from 01/01/2018 to 28/09/2018

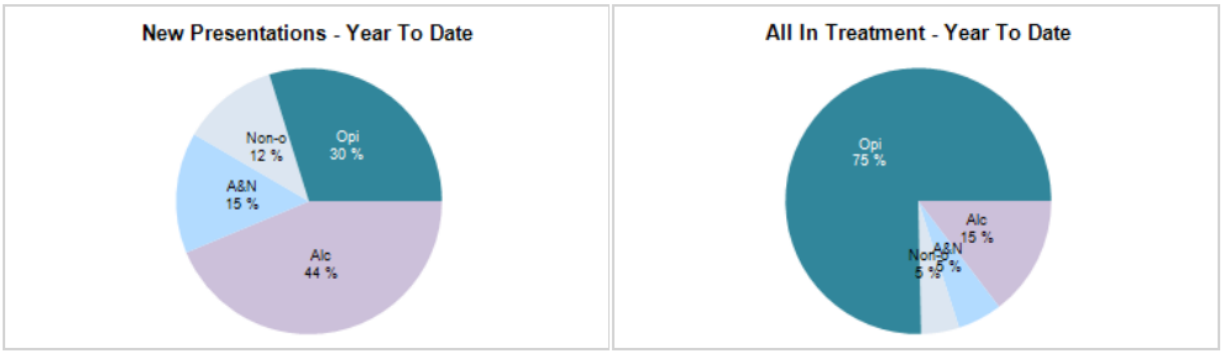
7. ALCOHOL AND DRUG SERVICE USERS IN TREATMENT SERVICES

7.1 Numbers of service users in treatment services

In the year 2017-2018 there were a total of 951 new service users to alcohol and drug treatment services, and the total number of service users in treatment over that time period was 2,524 service users. Figure 7.1 shows the breakdown by substance misuse type for all and new treatment service users for the most recently reported quarter of 2018.[125] The highest proportion of new service users are those with alcohol only needs which represented 44% of new presentations, but the highest proportion of all service users in treatment are opiate service users, which represent 75% of the total alcohol and drug treatment service users. The total number of substance misuse treatment service users year on year has remained relatively unchanged, with a small overall rise between 2016 and 2018. The yearly rolling number of total drug and alcohol treatment service users is shown in Figure 7.2.

Figure 7.1. New presentations and total number of substance users in alcohol or drug treatment services from 01/04/2018 to 30/06/2018 in Oxfordshire

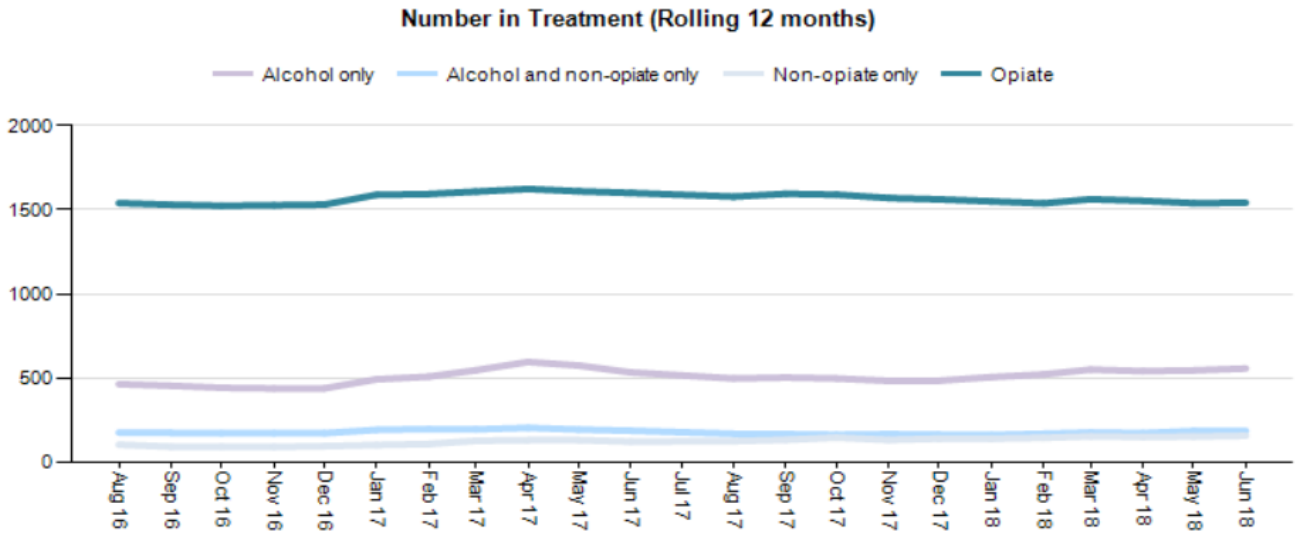
[125] NDTMS Adult Partnership Activity Report. From: 01/04/2018 to 30/06/2018.



Substance Category	New Presentations
Alcohol only (Alc)	104
Alcohol and non-opiate only (A&N)	35
Non-opiate only (Non-o)	28
Opiate (Opi)	71
Total Clients	**238**

Substance Category	Nos in Treatment
Alcohol only (Alc)	243
Alcohol and non-opiate only (A&N)	90
Non-opiate only (Non-o)	77
Opiate (Opi)	1252
Total Clients	**1662**

Figure 7.2. Rolling 12 months of total alcohol and drug treatment service users in Oxfordshire from 2016 to 2018 [126]



7.1.1 Shared care cases

Within Oxfordshire there are 27 GP practices that offer opiate substitution therapy. In these Practices the GP provides the clinical intervention with the support of a nurse or drug worker from the community treatment service. Service users at these

[126] NDTMS Adult Partnership Activity Report. From: 01/04/2018 to 30/06/2018

practices may choose to have pharmacological interventions provided by the commissioned service provider or their GP where appropriate. In July 2018 there were a total of 405 treatment service users recorded as under the Drug Misuse GP Service, i.e. 'shared care' with their GP practice.[127]

7.2 Characteristics of service users in alcohol treatment services

7.2.1 Demographic characteristics

Recorded characteristics of individuals receiving structured alcohol treatment are based on those who stated that alcohol was their sole substance misuse (unless otherwise stated below).

In the year 2017/2018 there were a total of 561 alcohol only service users in treatment, of which 57% were male and 43% were female. More than half of these service users (62%, n=348) were new to treatment, suggesting a relatively high turnover of alcohol treatment service users, which is also seen nationally (67% new to treatment nationally).[128] The age distribution of all 2017/2018 alcohol service users is shown in Table 7.1, highlighting that most service users are between 30-59 years old and that the age distribution among service users is younger than the age distribution in the Oxfordshire general population. The majority of new service users were of white British ethnicity (87%), born in the United Kingdom (89%), of heterosexual sexuality (94%), in regular employment (43%), and of no religious faith (60%: the largest represented faith was Christianity, which represented 30% of new service users). Compared to the general Oxfordshire population, new service users had a higher proportion of individuals of white ethnicity, and a much smaller representation of Asian, African or Caribbean ethnicities (1% of new service users were recorded as Indian, and none recorded as African or Caribbean). This suggests that current treatment services may not be sufficiently successful in engaging ethnic minority groups, who may face particular cultural, religious or language barriers in accessing treatment services. Of interest, the relatively high influx of Eastern

[127] Oxfordshire County Council
[128] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

European migrants since the entry of the EU8 into the European Union in 2004 is partly reflected in the fact that Poland represents the second most common country of birth of service users (after the UK). Further, 7% of new presentations identified as having at least one disability, of which behaviour and emotional disability was the most frequent (3% of new service users). A housing problem was reported by 10% (n=32) of new alcohol treatment service users, of which 3% (n=9) reported their housing need as urgent. Among adult treatment service users who successfully completed treatment, 82% (n=18) reported that they no longer had a housing need, compared to 84% nationally. For those individuals with housing needs on entering treatment, provision of a safe and stable home environment is vital to support long-term recovery and to prevent service users from returning to being part of the homeless community where the prevalence of substance misuse is particularly high. Below tables and figure illustrate characteristics of alcohol treatment service users in more detail.

Table 7.1 Age of adults in alcohol treatment in Oxfordshire 2017-2018 [129]

Age group	Local n	Proportion of all service users (%)	Proportion by gender (% male)	Proportion by gender (% female)	Proportion of all service users nationally who are within each age group (%)
18-29	53	9	9	10	9
30-39	125	22	26	17	22
40-49	169	30	28	34	31
50-59	145	26	27	24	26
60-69	53	9	8	11	10
70-79	16	3	2	4	2
80+	0	0	0	0	0
Total	**561**				

Table 7.2. Ethnicity of new adult presentations for alcohol treatment in Oxfordshire 2017-2018

[129] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

Ethnicity	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
White British	304	87	88	87
Other White	24	7	7	7
Other Mixed	*	<5	-	-
White Irish	*	<5	-	-
Indian	*	<5	-	-
Missing/Incomplete	*	<5	-	-
Total	**340**			

*= Raw data removed where small counts may be identifiable

Table 7.3. Country of origin of new adult presentations for alcohol treatment in Oxfordshire 2017-2018

Country	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
United Kingdom	309	89	89	89
Poland	9	3	2	3
Ireland	*	<5	-	-
Kenya	*	<5	-	-
Australia	*	<5	-	-
Missing/Incomplete	11	3	3	4
Total	**335**			

*= Raw data removed where small counts may be identifiable

Table 7.4. Religion of new adult presentations for alcohol treatment in Oxfordshire 2017-2018

Religion	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
Christian	103	30	28	32
Bahai	*	<5	-	-
Hindu	*	<5	-	-
No religion	210	60	61	59
Missing/Incomplete	20	6	7	4
Total	**335**			

*= Raw data removed where small counts may be identifiable

Table 7.5. Sexuality of new adult presentations for alcohol treatment in Oxfordshire 2017-2018

Sexuality	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
Heterosexual	326	94	93	95
Gay/Lesbian	10	3	4	1
Bi-sexual	*	<5	-	-
Not stated/not known/Missing/Incomplete	7	2	2	2
Total	**348**			

Individuals that stated 'other' are not displayed
*= Raw data removed where small counts may be identifiable

Table 7.6. New adult presentations by disability for alcohol treatment in Oxfordshire by 2017-2018

Disability	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
Behaviour and emotional	9	3	2	4
Mobility and gross motor	7	2	2	1
Learning disability	*	<5	-	-

No disability	319	92	92	91
Not stated/Missing/Incomplete	*	<5	-	-
Number of individuals with at least one disability	24	7		

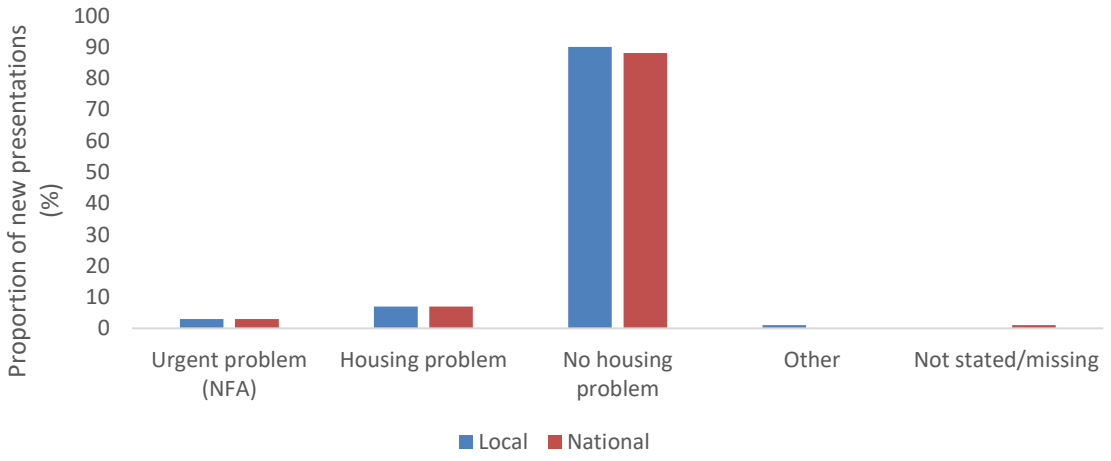
Individuals that stated 'other' are not displayed
*= Raw data removed where small counts may be identifiable

Table 7.7. Self-reported employment status of new adult presentations at the start of alcohol treatment in Oxfordshire by 2017-2018

Employment	Local n	Proportion of new presentations (%)	Proportion of new presentations nationally (%)
Regular employment	148	43	32
Unemployed/Economically inactive	105	30	32
Unpaid voluntary work	*	<5	0
Long term sick/disabled	71	20	25
In education	*	<5	1
Other	10	3	3
Missing/Incomplete	*	<5	6
Total	**348**		

*= Raw data removed where small counts may be identifiable

Figure 7.3. Self-reported accommodation status for new presentations to adult alcohol treatment services nationally and in Oxfordshire 2017/2018



OXFORDSHIRE COUNTY COUNCIL

7.2.2 Drinking levels

Volume and frequency of alcohol consumption can be used to approximate levels of alcohol dependency and potential alcohol-associated health risk. Estimation of current patterns of alcohol consumptions can be particularly important as a predictor of future alcohol-related harm, due to a likely prolonged time lag between consumption of alcohol and onset of chronic alcohol-related conditions. The number of units of alcohol consumed in the 28 days prior to treatment initiation by 316 males and 240 females in alcohol treatment services in 2017/2018 and for whom unit data was available (i.e. was not recorded as missing) are shown in Table 7.8. Although men were reported to be more likely to consume higher quantities of alcohol, it should be noted that women in general can experience dependency at lower consumption levels compared to men. Further, it should be considered that it is possible that the number of individuals in the lowest category of alcohol consumption are over-represented due to that some individuals with moderate or severe dependency may have decreased or stopped any alcohol consumption in the lead-up to treatment, for example if they were hospitalised or imprisoned.[130] Table 7.9 shows alcohol dependency levels among 212 male and 136 female treatment service users as recorded by the Severity of Alcohol Dependence Questionnaire (SADQ).[131]

Table 7.8. Units of alcohol consumed in the 28 days prior to entering alcohol treatment services in 2017/2018

Units of alcohol	Proportion of males (%)	Proportion of females (%)
0 units	11	9
1-199	29	38
200-399	19	26
400-599	18	13

[130] National Drug Treatment Monitoring System

[131] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

600-799	9	7
800-899	6	2
1000+	9	5

Individuals with missing unit data are not included here

Table 7.9. Alcohol dependence score of alcohol treatment service users as recorded by the Severity of Alcohol Dependence Questionnaire (SADQ) 2017/2018

SADQ score	Proportion of males (%)	Proportion of females (%)
0-15 mild dependence	31	33
16-30 moderate dependence	25	24
31+ severe dependence	22	14
Declined to answer	0	0
Not stated/not known	17	25
Missing/incomplete	5	4

7.2.3 Concomitant alcohol and drug use

There is a cohort of treatment service users with concomitant alcohol and drug misuse problems, who may have particularly high support needs. In 2017/2018 there were a total of 1,214 individuals with alcohol misuse in treatment services, of which 46% (n=561) cited alcohol misuse as their only substance misuse problem. Among the remainder, 86 service users (7%) cited alcohol and opiate use, 180 service users (15%) cited alcohol and non-opiate drug use, and 387 (32%) cited alcohol, opiate and non-opiate drug use. The most commonly used drugs among individuals who cited both alcohol and drug use were crack (n=336, 28%), cannabis (n=194, 16%), and cocaine (n=129, 11%). Of note, these categories are not mutually exclusive, and individuals may have cited more than one drug category.

7.3 Characteristics of service users in drug treatment services

7.3.1 Demographic characteristics

In the year 2017/2018 there were a total of 1,916 adults in structured drug treatment in Oxfordshire who cited an illicit substance misuse problem, of which 575 (30%) represented new presentations to drug treatment services.[132] Compared to both alcohol treatment service users and to the general Oxfordshire population, a larger proportion of drug treatment service users were in younger age groups with 89% of service users aged between 18-49. In line with national trends, from 2016-2017 to 2017-18 the proportion of older drug users aged 40+ increased from 39% to 43% of service users. Most new service users were of white British ethnicity (83%), born in the United Kingdom (91%), of heterosexual sexuality (92%), unemployed or economically inactive (34%) and of no religious faith (65%: the largest represented faith was Christianity, which represented 21% of new service users). Further, 8% of new presentations identified as having at least one disability, of which mobility and gross motor disability was the most frequent (3% of new service users). Of note, new presentations to drug treatment services were slightly less white compared to the general Oxfordshire population (88% vs approximately 90%), showed similar representation of the African/Caribbean community, but disproportionately low representation of Asian communities. Lithuania was the second most common country of birth of drug treatment service users (after the UK), likely to reflect a high burden of substance misuse in Eastern Europe and a relatively high influx of Eastern European migrants for work as part of the European Union. A housing problem was reported by 30% (n=170) of new drug treatment service users, out of which 93% (n=42) completed treatment reporting that they no longer had a housing need, compared to 86% nationally. Characteristics of drug treatment service users are shown in Tables 7.10-7.16 and Figure 7.4. Compared to 2016/2017, new presentations to treatment for opiate misuse in 2017/18 decreased by 17% (n=346), new presentations for non-opiate use increased by 32% (n=108), new presentations for alcohol and non-opiate use increased by 15%, and the overall number of new presentations to treatment decreased by 5% (n=575).

[132] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

Table 7.10. Age of adults in drug treatment in Oxfordshire 2017-2018 [133]

Age group	Local n	Proportion of all service users (%)	Proportion by gender (% male)	Proportion by gender (% female)	Proportion of all service users nationally who are within each age group (%)
18-29	330	17	15	23	17
30-39	778	41	41	40	37
40-49	592	31	32	27	32
50-59	185	10	11	7	12
60-69	31	2	1	2	2
70-79	0	0	0	0	0
80+	0	0	0	0	0
Total	**1916**				

Table 7.11. Ethnicity of new presentations for drug treatment in Oxfordshire 2017-2018

Ethnicity	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
White British	476	83	81	88
Other white	30	5	5	5
White & Black Caribbean	13	2	3	1
Pakistani	9	2	1	2
Caribbean	6	1	1	1
Missing/Incomplete	9	2	1	3
Total	**543**			

[133] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

Table 7.12. Country of origin of new presentations for drug treatment in Oxfordshire 2017-2018

Country	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
United Kingdom	521	91	90	93
Lithuania	*	<5	-	-
Pakistan	*	<5	-	0
Italy	*	<5	-	0
Portugal	*	<5	-	0
Missing/Incomplete	15	3	3	2
Total	**554**			

*= Raw data removed where small counts may be identifiable

Table 7.13. Religion of new adult presentations for drug treatment in Oxfordshire 2017-2018 [6]

Religion	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
Christian	119	21	21	20
Muslim	17	3	4	1
Buddhist	*	<5	-	-
No religion	373	65	65	64
Missing/Incomplete	46	8	7	12
Total	**560**			

*= Raw data removed where small counts may be identifiable

Table 7.14. Sexuality of new adult presentations for drug treatment in Oxfordshire 2017-2018

Sexuality	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
Heterosexual	529	92	94	86
Gay/Lesbian	6	1	1	1
Bi-sexual	14	2	1	7
Not stated/not known	14	2	2	3
Missing/Incomplete	12	2	2	3
Total	**575**			

Individuals that stated 'other' are not displayed

Table 7.15. New adult presentations by disability for drug treatment in Oxfordshire 2017-2018

Disability	Local n	Proportion of new presentations (%)	Proportion by gender (% male)	Proportion by gender (% female)
Mobility and gross motor	15	3	2	4
Learning disability	10	2	2	1
Behaviour and emotional	9	2	1	3
No disability	516	90	91	87
Not stated	*	<5	-	0
Missing/Incomplete	12	2	2	3
Number of individuals with at least one disability	45	8		
Total	**610**			

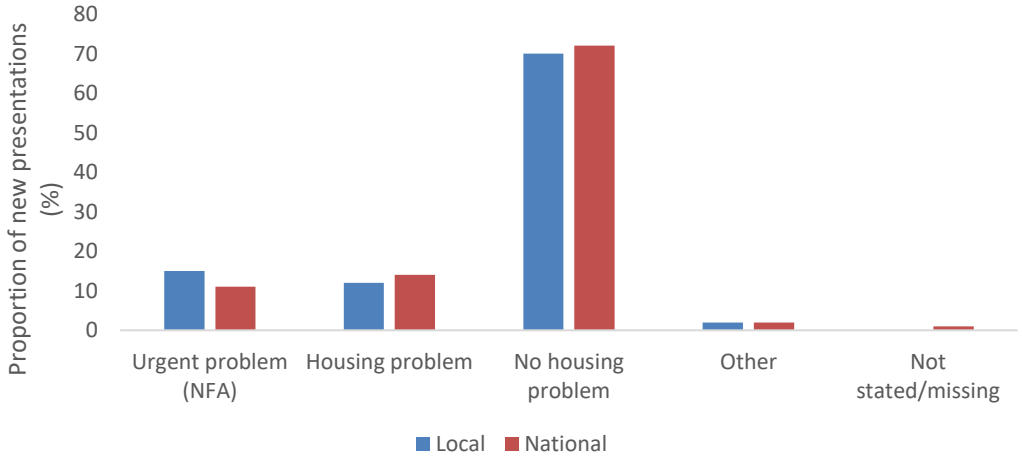
Individuals that stated 'other' are not displayed
Service users may cite more than one disability
*= Raw data removed where small counts may be identifiable

Table 7.16. Employment status of new adult presentations for drug treatment in Oxfordshire by 2017-2018

Employment	Local n	Proportion of new presentations (%)	Proportion of new presentations nationally (%)
Regular employment	167	29	22
Unemployed/Economically inactive	197	34	38
Unpaid voluntary work	*	<5	0
Long term sick/disabled	171	30	30
In education	*	<5	1
Other	10	2	3
Missing/Incomplete	25	4	7
Total	**575**		

*= Raw data removed where small counts may be identifiable

Figure 7.4. Self-reported accommodation status for new presentations to adult drug treatment services in Oxfordshire and nationally, 2017/2018



7.3.2 Prescription and over-the-counter medicine

The proportion of the total drug treatment population citing use of prescription-only medicines (POM) or over-the-counter medicines (OTC), with or without concomitant use of illicit drugs, is notably higher in Oxfordshire compared to the national average, 31% vs 14% respectively, as shown in Table 7.17. In 2017/2018, there were a total of 426 males and 163 females who reported POM/OTC use.[134]

Table 7.17. Use of prescription and over-the-counter medicine with or without concomitant illicit drug use among the total drug treatment population in Oxfordshire 2017/2018

Adults citing POM/OTC use	Local n	Proportion of treatment population (%)	Proportion of treatment population nationally (%)
Illicit use	534	28	11
No illicit use	55	3	3
Total	589	31	14

7.3.3 New psychoactive substances and 'club drugs'

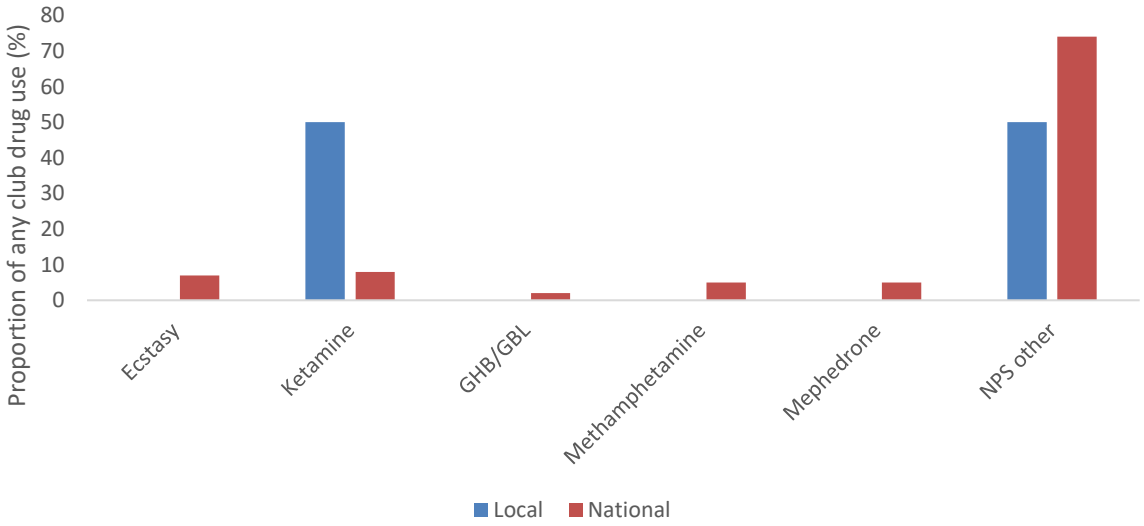
Among adults new to drug treatment services in 2017/2018, 2% of opiate users and 7% of non-opiate users cited some use of NPS/club drugs, which shows similar rates of use compared to national figures. NPS/club drug users with no additional opiate use are likely to represent individuals with personal resources to maximise potential treatment gains, such as employment, a social support network and housing. Ketamine and ecstasy are the most commonly used NPS/club drugs among non-opiate drug users, cited by 47% and 27% respectively. Ketamine and 'NPS Other-Predominantly cannabinoid' drugs are the most commonly used NPS/club drugs

[134] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

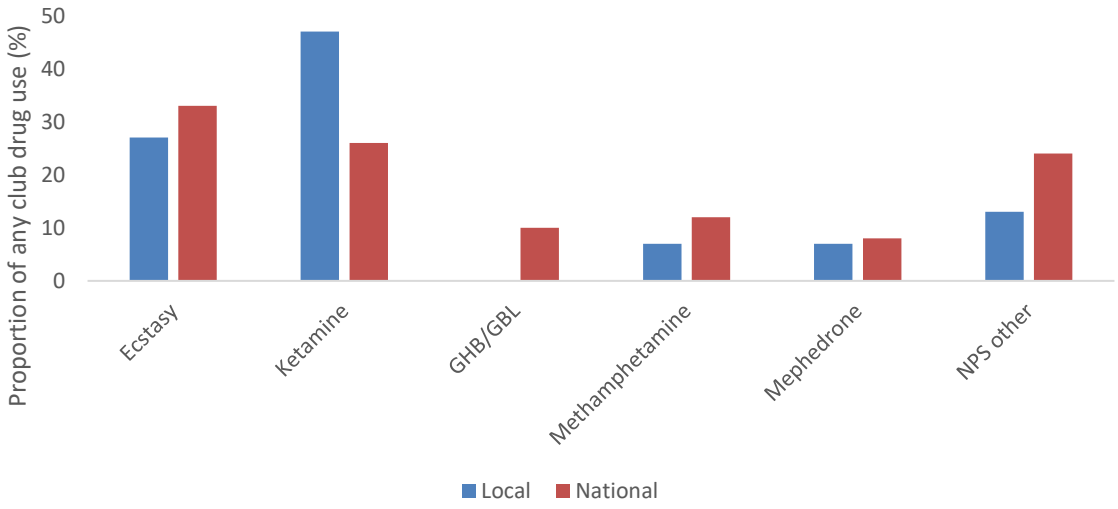
among opiate users, each cited by 50% of club drug users, as shown in Figure 7.5.[135]

Figure 7.5. Use of new psychoactive substances/'club' drugs as a percentage of any club drug use among new treatment users who at the start of treatment reported a) concomitantly using opiate drugs, or b) using no other drug or only non-opiate drugs

a)



b)



NPS= New Psychoactive Substances

Use of multiple club drugs will be counted separately under each cited drug, and total proportions may therefore add up to more than 100%

[135] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

7.3.4 Pharmacological interventions

Over the past 3 years there have been substantial increases in the number of service users recorded as being prescribed naloxone as a pharmacological supervised intervention, which likely reflects changes in the legal framework to facilitate naloxone to be administered directly by community drug treatment services, shown in Table 7.18.[136] Further, Figure 7.6 shows the proportions of treatment service users in 2017/2018 who received supervised prescribing of methadone or buprenorphine as reported to NDTMS, as proportions of those prescribed the specified drug, suggesting higher rates of supervised prescribing of methadone in Oxfordshire (80.3%) compared to national figures (53.7%). However, these data on supervised prescribing should be considered in the context of data limitations, which include regional discrepancies in how and when these data are recorded. For example, the data shown here in Figure 7.6 may represent underestimates as these data, as obtained from the NDTMS, do not include service users who receive pharmacological sub-interventions from their GP as part of a shared care agreement. Further, the data on supervised prescribing in Oxfordshire are completed retrospectively and are therefore more prone to inaccurate recording.

Table 7.18. Numbers of service users prescribed naloxone supervised intervention 2015-2018

	Naloxone treatment numbers
2015-2016	75
2016-2017	517
2017-2018	894

Figure 7.6. Number of treatment service users over the 2017/2018 year who received a prescribed medication sub-intervention of supervised prescribing of a specific drug, as a proportion of the number of treatment service users

[136] Communication from Turning Point, Oxfordshire.

with a prescribed medication sub-intervention of any prescribing of the specified drug*[137]

	Latest period		National average
	(%)	(n)	(%)
Client prescribed supervised methadone	80.3%	598 / 745	69.3%
Client prescribed supervised buprenorphine	55.6%	170 / 306	53.7%

*Of note, data do not include prescribing as part of shared care with GP services

7.3.4.1 Pharmacological interventions- tier 2 prescribing

Data discussed above only considers structured drug and alcohol treatment services, yet within Oxfordshire 'non-structured' tier 2 treatment constitutes an important aspect of the service offered to the community.[138] Tier 2 treatment includes brief interventions to reduce harm for those who for example do not need structured treatment services or who have recently been released from prison without sufficient time to be assessed for structured treatment. The numbers of service users accessing tier 2 treatment has increased year on year since the beginning of the current recording system in 2016, as shown by tier 2 prescribing data in Table 7.19. Most of the tier 2 prescribing service users are based in Oxford, and the majority move on to structured treatment from tier 2 treatment. These data suggest that tier 2 prescribing is being used a gateway to commencement of tier 3 treatment, for example following release from prison services. The use of tier 2 prescribing should therefore not be long-term, and needs to be monitored to ensure transfer to tier 3 treatment takes place as soon as is possible and appropriate. Among service users who were still receiving tier 2 prescribing by the end of the second quarter of the 2018 reporting period, the most common substance misuse category was 'opiate and non-opiate' (51%), opiate only (24%), and 'opiate, alcohol and non-opiate' (14%).

Table 7.19. Numbers of service users who accessed the tier 2 prescribing modality in Oxfordshire 2016-2018*

[137] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

[138] Oxfordshire Treatment and Intervention System (OTIS).

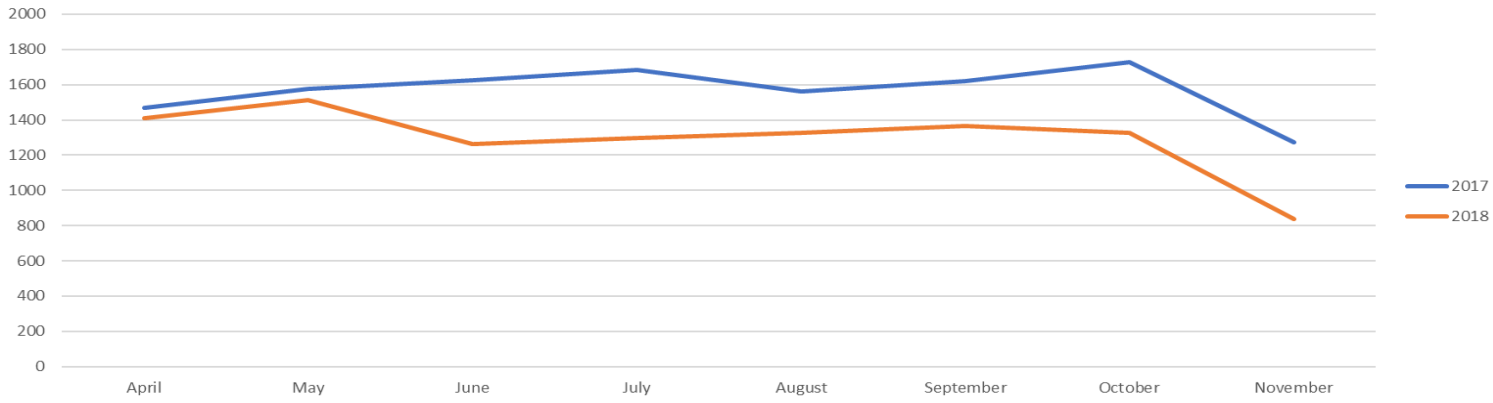
Reporting period	Q4-2016	Q1-2017	Q2-2017	Q3-2017	Q4-2017	Q1-2018	Q2-2018
Number in tier 2 prescribing							
Number who started modality	6	10	20	84	107	120	124
Number who stopped modality	-	10	11	58	101	91	115
Locality where modality started							
Oxford	6	10	20	74	83	77	76
Banbury	0	0	0	-	18	27	25
Didcot	0	0	0	-	-	10	10
Witney	0	0	0	-	-	-	11
GP surgery**	0	0	0	-	-	-	-
Prison referrals							
Number released from prisons who started modality	-	6	11	16	23	17	20
% from prisons	-	60%	55%	19%	22%	14%	16%
Tier 2 to Tier 3 move							
Number that stopped tier 2 modality who moved to structured treatment	-	9	7	32	73	67	87
Percentage of those who stopped tier 2 modality who moved to structured treatment	-	90%	64%	55%	72%	74%	76%

Q= quarter of calendar year
*Old system of recording, to be removed in the future as a treatment location
**Cells of less than 6 individuals are not shown

7.3.5 SWOP- Needle Exchange Scheme

The current needle exchange service in Oxfordshire, known as the Sterile Work from Oxfordshire Premises (SWOP), is available from thirty-eight pharmacies across Oxfordshire, two Turning Point Hubs in Oxford and Banbury, and the O'Hanlon Hostel in Oxford. The number of SWOP transactions in Oxfordshire between April-November 2017 and 2018 are shown in Figure 7.7.[139] Each transaction represents one occurrence of a person collecting needles, irrespective of how many packs are collected. The data shows an overall decrease in the number of SWOP transactions in 2018 compared to 2017. The pharmacy-specific number of transactions has however increased by at least 20% in six Oxfordshire pharmacies in 2018 compared to 2017 (notably, in Henley on Thames, Cowley, Charterton, Wallingford, Wood Farm and Abingdon).

Figure 7.7. Comparing overall SWOP service in Oxfordshire between Apr-Nov 2017 and 2018



7.5 Distribution of treatment services for alcohol vs drug users

The estimated 'unmet need' in Oxfordshire is thought to represent 87% of alcohol-dependent adults and 40-60% of adults who use crack and/or opiates (with noted caveats to data recording described previously).[140] Further, the absolute number of individuals who are estimated to require specialist alcohol treatment is estimated to be higher than the number of opiate and/or crack users (rate of 10 per 1000 vs rate

[139] Oxfordshire County Council Public Health Directorate
[140] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

of 6.68 per 1000, respectively). Although these figures may suggest that there should be a higher number of individuals with alcohol misuse compared to drug misuse in treatment services, in 2017/18 there were 561 alcohol only users in treatment compared to 1,916 drug users in treatment.[141-142] However, there is a relatively higher turnover of alcohol only service user compared to drug service users, for example, in 2017/18 in Oxfordshire there were 348 new alcohol treatment service users compared to 575 new drug treatment service users. On the corollary, it could be argued that in making a determination of the appropriate distribution of treatment resources these figures should be considered in the context of their impact on society. For example, alcohol misuse tends to affect individuals of an older age compared to individuals with drug misuse: the majority of service users for alcohol misuse in Oxfordshire in 2017/18 were aged between 30-59, compared to service users for drug misuse among whom the majority (89%) were aged between 18-49. However, in line with national trends, the proportion of older drug users aged 40+ in Oxfordshire is rising. Moreover, drug misuse is thought to be associated with higher crime levels compared to alcohol misuse. In 2017/18 in Oxfordshire there were 1036 drug-related arrests and 572 alcohol-related arrests.[143] Further, investment in drug treatment services is thought to yield a higher initial social return on investment compared to investment in alcohol treatment services, but the vice versa is true in the longer term. In considering benefits to social care, crime prevention, health gains and improvements in quality-adjusted life-years (QUALYs), it is estimated that investment in alcohol treatment yields a return of £3 per £1 invested, which rises to a total of £26 over 10 years.[144] Similarly, it is estimated that investment in drug treatment yields a return of £4 per £1 invested, which rises to a total of £21 over 10 years.

7.6 Waiting times to access treatment services

[141] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[142] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20
[143] Thames Valley Police Crime Recording System - NICHE RMS, Date Extracted: 16/10/2018
[144] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest Last accessed 30/10/201

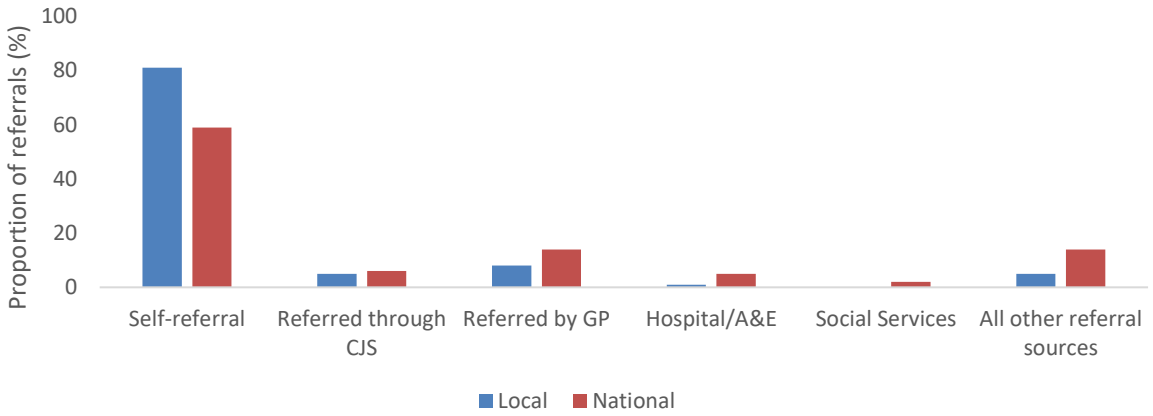
Keeping waiting times low is an important consideration in providing support for recovery from alcohol or drug misuse. Out of alcohol treatment service users waiting for their first intervention in their alcohol treatment package in 2017/2018, 98% (n=389) had a waiting time of less than three weeks, which was the same proportion nationally, and only 1 client had a wait of over six weeks to start treatment. Similarly, in 2017/2018 99% (n=793) of drug treatment service users waiting to start treatment started treatment within 3 weeks, the same as the national proportion, and only 1 client waited over 6 weeks.

7.7 Referral routes into treatment services

Various referral routes are used by treatment service users to access alcohol and drug treatment services. The proportions of referrals by referral route into treatment in 2017/2018 (only including those for which referral source is known) are shown in Figure 7.8. There was a total of 348 referrals to alcohol treatment services and 575 referrals to drug treatment services, of which largest proportion of referrals represented self-referrals to treatment (81% of alcohol treatment referrals and 73% of drug treatment referrals).

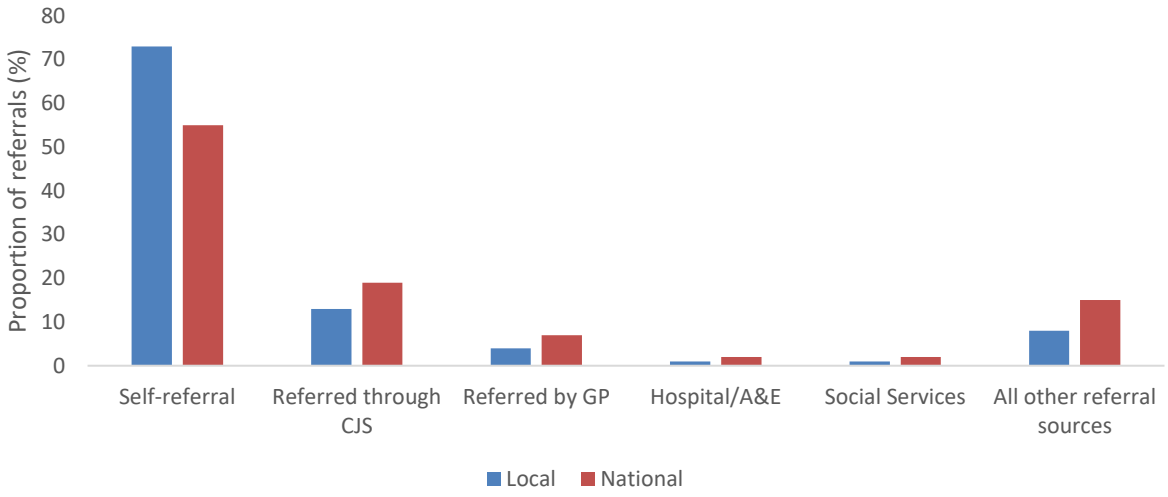
Figure 7.8. Proportion of new referrals by source of referral in 2017/2018, for a) alcohol treatment services and b) drug treatment services [145-146]

a



[145] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20
[146] South East - Oxfordshire - Adults – Drug commissioning support pack - key data 2019-20

b)



'Referred through CJS' means referred through an arrest referral scheme, via an Alcohol Treatment Requirement (ATR), probation service or the probation service.

7.8 Residential rehabilitation

The majority of structured alcohol treatment takes place in a community setting to facilitate use of client support sources such as families, friends or other support networks. However, residential rehabilitation may be indicated for particularly serious cases of dependency. There were 40 adult alcohol-only service users in Oxfordshire in 2017/2018 who accessed residential rehabilitation treatment during their most recent treatment period (which may have commenced prior to 2017/2018), representing 7% of the total local alcohol treatment population, compared to 3% nationally.[147] Similarly, 129 drug misuse service users accessed residential treatment during their most recent treatment period (which may have commenced prior to 2017/18), representing 7% of the Oxfordshire drug treatment population, compared to 2% nationally. Within the year 2017/18, a total of 34 individuals with opiate or non-opiate drug misuse, and 25 individuals with alcohol misuse entered out-of-county residential rehabilitation.

[147] South East - Oxfordshire - Adults - Alcohol commissioning support pack - key data 2019-20

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