Alcohol, Drugs and Tobacco in Lancashire
Drugs data compendium

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Intelligence for Healthy Lancashire (JSNA)

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Introduction

There is substantial public health and medical evidence available that shows that people who use and misuse alcohol, drugs and tobacco experience poorer health outcomes than those who do not, and these behaviours are associated with increased morbidity and mortality. These negative effects often extend to affect the health and wellbeing of family members, friends and the wider community.

Increased use and misuse of alcohol, drugs and tobacco is strongly associated with deprivation and poverty[1] [2]. In 2010, the Marmot Review[3] highlighted the significance of the 'social gradient' and its effect on health, and argued that reducing inequalities is a matter of social justice and fairness. In Lancashire, a county with areas of extreme deprivation and poverty as well as areas of affluence and wealth, large inequalities are expected in terms of alcohol, drug and tobacco use and misuse, as well as health outcomes between the affluent and the deprived. In 2009 the JSNA team assessed health inequalities in Lancashire by deprivation and highlighted the ten most significant[4]. Many of these inequalities, including liver disease, numerous cancers, coronary heart disease, extreme anxiety and depression, diabetes and accidents, are related to the use and misuse of alcohol, drugs and tobacco. Reducing the use of these substances was therefore identified as a goal to address these inequalities and improve the health and wellbeing of Lancashire residents.

It is anticipated that this joint strategic needs assessment (JSNA) will be able to provide data, analysis and recommendations to aid commissioners to make informed decisions to narrow these inequalities across Lancashire for the benefit of Lancashire residents. Specifically the JSNA is designed to provide a focus for commissioners from a variety of organisations so that the services they

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[1] Jarvis and Wardle (2006) 'Social patterning of individual health behaviours: the case of cigarette smoking,' p.224 in Marmot and Wilkinson (eds), *Social Determinants of Health* (2nd edn). Oxford: Oxford University Press.
[2] Marmot and Wilkinson (2003) *Social Determinants of Health: the Solid Facts* (2nd edn), p. 24. World Health Organisation.
[3] Marmot, M (2010) *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010*. Available online: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review [accessed March 2012].
[4] See: http://www.lancashire.gov.uk/corporate/web/?siteid=6117&pageid=35405&e=e

commission complement and enhance each other rather than work in isolation. This holistic approach – commissioning based on need rather than organisational boundaries – is one of the strengths of the JSNA approach.

This JSNA is also an opportunity to inform how Lancashire responds to changes in national policies, such as those outlined in *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-Free Life*[5]; and *Healthy Lives, Healthy People: A Tobacco Control Plan for England*[6], published in December 2010 and March 2011 respectively. It is also an opportunity to assess and identify how to respond to the changing demographics of those that use and misuse alcohol, drugs and tobacco.

National policy and legislation require that a JSNA is produced for each upper tier authority. In Lancashire, is has been agreed to conduct a combined JSNA covering Lancashire County Council, Blackburn with Darwen and Blackpool and their respective PCTs. It is believed this will allow those contributing to and using the JSNA will be able to make comparisons across the whole of Lancashire more straightfoward, as well as simplify and rationalise the work, enabling it to be carried out more efficiently.

Policy Context

This JSNA is being prepared during a time of extensive upheaval and reorganisation in the NHS and local government which will inevitably affect how services are commissioned and provided. Any findings and recommendations from this JSNA will therefore necessarily need to be responsive to these changes. In addition, revised national strategies and guidance for alcohol, drugs and tobacco have recently been published and this JSNA will need to complement these.

An outline of these reforms and revised policies are provided below.

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[5] http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010
[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Health Reforms

There are four elements to the new health and wellbeing system: system management and co-ordination; public health; accountability and public involvement; and service-specific commissioning. Currently the reforms are due to be completed and the new system operating by April 2013, with shadow structures in the new system being established from 2011 and 2012.

The strategic co-ordination of the system will include the establishment of a health and wellbeing board for each upper-tier local authority, increased emphasis on the JSNA, and the development of the health and wellbeing strategy. The health and wellbeing board in each area will be a statutory committee of upper-tier local authorities that will be responsible for:

- Assessing the needs of the local population and leading the statutory integrated strategic needs assessment (JSNA).
- Promoting integration and partnership working by encouraging joined–up commissioning plans across the NHS, social care and public health.
- Supporting joint commissioning and pooled budget arrangements when applicable.
- Reviewing major service redesigns of health and wellbeing related services provided by the NHS and local government.

From April 2013 the local authority and the clinical commissioning groups, together with the local HealthWatch, will be required to prepare a JSNA which includes a comprehensive analysis of the current and future health and wellbeing needs and assets of their area. Based on the priorities emerging from the JSNA, the Lancashire health and wellbeing board will develop a joint, high-level, health and wellbeing strategy for Lancashire. The health and wellbeing strategy is intended to inform the commissioning decisions made by local partners to ensure they meet the needs of service users and communities, and tackle the factors that affect health and wellbeing across organisational boundaries. The health and wellbeing strategy will also need to take account of the NHS commissioning board's mandate from the Secretary of State for Health.

Local authorities, clinical commissioning groups and the NHS commissioning board will be required to produce commissioning plans that pay due regard to the local JSNA and health and wellbeing strategy to ensure their plans complement each other and address agreed priorities.

The public health aspect of the new health and wellbeing system includes a new national public health organisation, Public Health England, will be established as an executive agency within the Department of Health. It will have three main functions:

1. Delivering services to national and local government, the NHS and the public.
2. Leading for public health.
3. Supporting the development of the specialist and wider public health workforce.

It is expected that Public Health England will have four regional hubs, in addition to a national office, to support and deliver local services with local authorities and other organisations. Public Health England will operate alongside a local public health service, which will transfer to upper-tier local authorities from primary care trusts. A 'ring-fenced' grant for public health will be used by upper-tier local authorities to commission a range of public health services. Local authorities will be mandated to ensure the provision of:

- Appropriate sexual health services (excluding termination of pregnancy services which will be commissioned nationally).
- Plans to protect the health of the population.
- Public health advice to NHS commissioners when required.
- the national child measurement programme (NCMP).
- NHS health check assessment.

The local authority public health functions will be expected to commission a wide range of additional public health services across the life cycle in response to local health and wellbeing priorities such as:

- Stop smoking and tobacco control services.
- Workplace health services.
- Drug and alcohol services services.
- Dental public health.
- Affordable warmth.
- Preventing infant deaths.

In addition public health in Lancashire will commission:

- Alcohol and drug misuse services.
- Public health services for children and young people aged 5-19 (and in the -longer term all public health services for children and young people).
- Interventions to tackle obesity.
- Public mental health services.
- Accidental injury prevention.
- Interventions to reduce and prevent birth defects.
- Campaigns to prevent cancer and long-term conditions.

- Health protection plans including immunisation and screening.
- Health protection incidents, outbreaks and emergencies.
- Initiatives to reduce excess deaths as a result of seasonal mortality.
- Public health aspects of community safety and violence prevention.
- Initiatives to tackle social exclusion.

In Lancashire a director of public health will be appointed by April 2012, with public health staff appointed on 1st April 2013.

The accountability and public involvement element of the new health system includes the overview and scrutiny panel and HealthWatch. *Liberating the NHS* stresses the importance of capitalising on opportunities to strengthen the role of local authority health scrutiny following the reforms, although to date there has been little guidance on this nationally. In addition, one of the intentions of the reforms is for local communities to have a greater say in decisions about services. To realise this ambition, local people will be empowered through the local HealthWatch to have their say about their health and social care needs to ensure that services act upon feedback and can demonstrate that they have done so. The local HealthWatch will need to be accountable to:

- The local community it serves and represents.
- HealthWatch England, which will set relevant standards.
- The local authority commissioning HealthWatch services, who will be responsible for ensuring that HealthWatch is effective and represents good value for money.

Local HealthWatch will be established by April 2013, with HealthWatch England established from October 2012 to provide leadership and support to local HealthWatch.

Finally, as the service specific commissioning element of the new health and wellbeing system, clinical commissioning groups (CCGs) will commission the majority of NHS services. In addition the national commissioning board will commission general practice services and some specialist services. It will authorise CCGs and ensure they are effective commissioners of NHS services.

By April 2012 all CCGs across the country should meet their legislative requirements and will take over responsibility for commissioning from April 2013. Currently there are six clinical commissiong groups in Lancashire, one for Blackburn with Darwen, and one for Blackpool:

- Chorley and South Ribble CCG
- Greater Preston CCG – including Longridge
- Lancaster, Morecambe, Carnforth and Garstang CCG
- Pennine CCG - including Pendle, Burnley, Rossendale, Hyndburn and Ribblesdale (excluding Longridge)
- West Lancashire CCG (exploring close working with Sefton)
- Wylde CCG - Wyre and Fylde including Fleetwood
- Blackburn with Darwen CCG
- Blackpool CCG

Further details about the reforms of the health and wellbeing system are available from a number of national policy documents:

- *Equity and Excellence: Liberating the NHS*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
- *Healthy Lives, Healthy People White Paper: Our Strategy for Public Health in England* and *Healthy Lives, Healthy People White Paper: Update and Way Forward.* Available from: http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

- Health and Social Care Bill 2011. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/HealthandSocialCareBill2011/index.htm
- *Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategies Explained*. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131702
- Department of Health Factsheets - *Public Health in Local Government*. Available from: http://healthandcare.dh.gov.uk/public-health-system/

Drugs Strategies and Policy

- Misuse of Drugs Act 1971
- *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*. Drug Strategy 2010.
- Police Reform and Social Responsibility Act 2011

In 2010 the Government produced a new drug strategy *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*. It signals a significant shift in emphasis from focusing primarily on reducing harms caused by drug misuse to offering every support for people to choose recovery as an achievable way out of dependency. The strategy is structured around three themes: reducing demand (early intervention, education and legislation); restricting supply (law enforcement, prisons and targeting 'legal highs') and building recovery in communities (putting the user at the heart of everything we do, locally led and owned services and a whole systems approach focused on outcomes).

Report Limitations

Every attempt has been made to ensure that the JSNA is comprehensive. Despite this, we know that the data on alcohol, drugs and tobacco is far from complete and not always available for all areas of Lancashire. Any gaps have been highlighted within the document and recommendations made to address these where appropriate or possible.

The analysis in the document is primarily based upon secondary data and it would be useful in the future to carry out some primary research to further understand how people use and misuse alcohol, drugs and tobacco.

Report Structure

This report is section two of three that form the complete alcohol, drugs and tobacco JSNA. Each section has a summary of relevant national and local strategies and policies; outlines relevant data and analyses; and contains recommendations and priorities for each topic.

A Profile of Lancashire

Geography

The county of Lancashire, although a historic and geographic whole, is currently administered for NHS and local government purposes by five Primary Care Trusts (PCTs), three upper-tier local authorities and twelve district authorities.

Three of the primary care trusts (PCTs) – Central Lancashire PCT, East Lancashire PCT and North Lancashire PCT – administer the area managed by Lancashire County Council. Twelve district councils operate on this same 'footprint'. Blackburn with Darwen Care Trust Plus and Blackpool PCT share a boundary with Blackburn with Darwen and Blackpool unitary authority, respectively. From April 2013 the commissioning functions for the NHS currently provided by the PCTs will be managed by clinical commissioning groups (CCGs).

County councils and unitary authorities – collectively referred to as ‘upper-tier’ authorities - have responsibility for social services for children and young people and adults.

Table 1 - PCT and administrative areas covered

Council with Social Services Responsibilities	Local Authority District	PCT	Future CCG
Lancashire County Council	Chorley	Central Lancashire PCT	Chorley and South Ribble CCG
	South Ribble		
	Preston		Greater Preston CCG
	West Lancashire		West Lancashire CCG
	Burnley	East Lancashire PCT	East Lancashire CCG
	Hyndburn		
	Pendle		
	Ribble Valley		
	Rossendale		
	Fylde	North Lancashire PCT	Fylde and Wyre CCG
	Wyre		
	Lancaster		Lancaster, Morcambe, Carnforth and Garstang CCG
Blackburn with Darwen Borough Council		Blackburn with Darwen Care Trust Plus	Blackburn with Darwen CCG
Blackpool Council		Blackpool PCT	Blackpool CCG

The geographical area administered by Lancashire County Council, the twelve district councils and Central, East and North PCTs will be referred to in this report as the county of Lancashire or 'Lancashire-12' (referencing the number of district councils). The Lancashire sub-region (or Lancashire-14) is used to refer to the area administered by Lancashire County Council, Blackburn with Darwen and Blackpool unitary authorities, along with their respective PCTs.

Population

The sub-region of Lancashire is home to more than 1.4 million people, which is projected to increase but at a rate below both regional and national averages. Areas such as Burnley, Blackburn with Darwen and Hyndburn are projected to experience a reduction or very low rates of population growth over the period which stems from the decline of the manufacturing sector as a primary employer. Conversely, the

districts on the M6 corridor such as Chorley, Lancaster, Preston and South Ribble are predicted to experience stronger population growth as a result of economic growth experienced in recent years.

Ethnicity

The Lancashire sub-region is a less ethnically diverse area than the average for England. Approximately 90.9% of the population is white, the majority of these white British, compared to 87.5% nationally. Of the remaining ethnicities, Asian or Asian British comprise 6.5% of the Lancashire population, or approximately 94,000 individuals.

Deprivation

Lancashire has some of the most deprived parts of the country within its boundaries. Blackpool, Burnley, Blackburn with Darwen, Hyndburn, Preston and Pendle are ranked as being in the most deprived 50 local authorities nationally according to the 2010 Index of Multiple Deprivation (IMD).

Further Information

More detailed demographical information about Lancashire is available from Lancashire Profile[7].

[7] http://www.lancashire.gov.uk/profile

Drug Use

Drug and alcohol misuse are complicated, cross-cutting issues that continue to present significant challenges both locally and nationally. The harms arising from illicit and licit substance use are diverse. Drug-related harms do not only vary according to the different types of drugs being used but also the way a drug is used, the way it is used in combination with other substance and the social context in which they are used.

Drugs do not only impact on those involved in misuse but on society as a whole. From crime in local neighbourhoods, families affected by dependency to the corrupting effect of drug dealing and international organised crime, drugs have a profound and negative effect on communities, families and individuals.

This problem affects all socio-economic groups and communities. Substance misuse is not a problem exclusive to deprived neighbourhoods but is also prevalent in areas of affluence. Equally, the solutions to the effects caused by misuse are to be found within those communities.

Definitions

The Misuse of Drugs Act 1971 is the principle legislation in the United Kingdom with respect to the control and supply of drugs that are considered dangerous or otherwise harmful when misused. This act divides such drugs into three classes, A, B and C, to broadly reflect their relative harms and set maximum criminal penalties for possession, supply and production. Examples of drugs in each class are:

Class A

- Cocaine (powder cocaine and crack cocaine).
- Ecstasy.
- Opiates (heroin, methadone).
- Hallucinogens (LSD, magic mushroom).

- Methamphetamine (and any other amphetamines prepared for injecting).

Class B

- Cannabis.
- Barbiturates.
- Cathinones (mephedrone) since April 2010.
- Amphetamine (except those listed in Class A above).

Class C

- Anabolic steroids.
- Ketamine.

A new power extending the remit of the Misuse of Drugs Act 1971 to control new psychoactive substances which raise sufficient concern to justify a faster legislative response forms part of the government's new drug strategy published in 2010[8]. Schedule 151 and 17 of the Police Reform and Social Responsibility Act 2011 made the provision for the power to invoke a temporary class drug order. Importation, exportation, production and supply of a temporary class drug will be prohibited, although simple possession will not be unlawful.

General Use

Within Lancashire a survey conducted in the night-time economy in town and city centres found that 70% of respondents had taken illegal drugs at some point in their lifetime, and 33% had taken two or more illegal drugs within the past year[9]. Lifetime prevalence was highest for: cannabis (62%); cocaine (43%); skunk (40%); and ecstasy (39%), while only 28% of respondents had tried speed although this was

[8] Home Office (2010) *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life.* Available online: http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/ [accessed March 2012].
[9] Lancashire University and Lancashire Drug and Alcohol Action Team (2011) *Emerging Drug Trends in Lancashire: Night Time Economy Surveys Phase One Report*. Available online: www.ldaat.org/files/emerging_trends_report.pdf [accessed October 2011].

higher in Preston. However, caution must be used with these figures as the study was conducted in a situation likely to involve drug taking.

The same study also found that mixing illegal drugs and alcohol was commonplace, with those described as poly users consuming more alcohol than non-poly users. Poly use of cocaine and alcohol was the most common mix on a night out in Lancashire.

Crack and Opiates

It is estimated that in the Lancashire County Council administrative area (Lancashire012) there are:

- 7,418 opiate and/or crack cocaine users.
- 5,945 opiate users.
- 3,072 crack users.

In Blackburn with Darwen there are an estimated:

- 1,317 opiate and/or crack cocaine users.
- 1,179 opiate users.
- 840 crack cocaine users.

The estimation for Blackpool is:

- 2,101 opiate and/or crack cocaine users.
- 1,941 opiate users.
- 1,181 crack cocaine users.

The majority of opiate and/or crack cocaine users are estimated to be in the 25-34 age-group. All estimates taken from Lancashire Drug and Alcohol Action Team (LDAAT)[10].

In Blackburn with Darwen and Blackpool the proportion of opiate and/or crack cocaine users is significantly higher than the North West average across all age groups (15-24; 25-34; and 35-64). In Lancashire-12 the proportion of crack and/or opiate users is above the North West average for the 25-34 age group, but below the North West average for the 15-24 and 35-64 age groups.

Overall the North West regional rate is 21.82 users per 1,000 population. This is slightly higher at 22.26 per 1,000 in Lancashire; higher again in Blackburn with Darwen at 27.9 users per 1,000 population; and nearly double the North West rate in Blackpool at 55.7 users per 1,000.

Heroin

Heroin is reported as being the most significant drug for those in treatment across Lancashire, with the impact of serious and organised crime groups (OCGs) playing a significant role with a mixed structure of open and closed markets to supply the demand[11]. The hotspot wards for drugs offences are: Claremont; Talbot (Blackpool); Preston City Centre; and Daneshouse with Stoneyholme (Burnley)[12].

Naloxone is a treatment used by paramedics to treat heroin overdoses.There are five main areas where Naloxone administrations are significantly higher than other areas across the county:

- Bloomfield (Western).
- Preston Town Centre.

[10] LDAAT Treatment Bullseye
[11] 89% of OCGs are primarily involved in drug supply, most of which supply multiple drug types but predominantly cocaine, heroin and cannabis. There is an over-representation in MOSAIC type 42 (South Asian communities experiencing social deprivation) and type 69 (vulnerable young parents needing substantial state support) in drug OCG nominals (see Steele, L (2011) *Lancashire Drugs Threat Assessment*, p 6).
[12] Steele, L (2011) *Lancashire Drugs Threat Assessment*.

- Wensley Fold (Eastern).
- Daneshouse with Stoneyholme (Pennine).
- Bank Hall (Pennine).

Bloomfield, Preston Town Centre and Daneshouse with Stonyholme have also been identified as hotspots for drug activity across Lancashire with the latter two identified as high priority areas.

AACCE Profile

The alcohol, amphetamine, cannabis, cocaine and ecstasy (AACCE) is used as short-hand for non-opiate and/or crack cocaine use. One of the central themes of the AACCE hypothesis is that the use of non-opiate substances amongst young people in contact with treatment indicates shifting substance use patterns that will eventually impact on adult services as these individuals mature. This necessitates focusing on increasing competency in psychosocial approaches within both young people (YP) and adult services for those aged 18-30.

The British crime survey indicates that drugs within the AACCE profile are the most widely used illicit substances in the UK. In Lancashire-14 the majority of adults accessing drug treatment, excluding for alcohol, are heroin users (74% Lancashire-12; 74% Blackburn with Darwen; and 80% Blackpool). Conversely the majority of young people accessing drug treatment are cannabis users, followed by alcohol, constituting 90%, 93% and 87% of the in-treatment populations of Lancashire-12, Blackburn with Darwen and Blackpool respectively.

Approximately three quarters of people in contact with services with an AACCE profile of use are under 25 years of age suggesting that the younger age group are using different substances than their older counterparts and are not progressing to other substances, specifically heroin, as their drug use progresses. Only a small proportion of AACCE profile clients progressed to opiate use, and they tended to be older and more likely to have used amphetamines and benzodiazepines within their earlier treatment episode.

Legal Highs

So-called 'legal highs' include a group of drugs in the amphetamine and cathinone classes and cover a wide range of psychoactive substances such as mephedrone, MDAI, and NRG-1[13]. Lifetime and past year use in Lancashire for mephedrone was 13% and 11% respectively; and use for 'bubble'[14] was 18% and 16% respectively. Use of bubble was significantly higher in Lancaster than the other research sites in Lancashire. While these figures is relatively low compared to the past use of mephedrone in the Mixmag survey (61% and 25% respectively), it is still noticeable that one in twenty people surveyed on the streets of Lancashire on a Friday night had consumed methedrone or bubble after they had been banned. Additionally, people consuming bubble may not know, or be concerned about, exactly what they are consuming.

Demographics

Sex

Drug consumption by males seems to be significantly higher than for females. Nationally the ratio of consumption is 2:1, and evidence suggests this is similar in Lancashire (69% of primary drug clients are male). 58% of young people in treatment are male, slightly lower than the adult proportion.

Age

46% of primary drug clients in treatment are aged 30 to 39 years, based on data from April – December 2011. Of the young people in treatment, 77% are aged 15 to 17 years, with nearly a third (29%) aged 16.

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[13] Lancaster University and Lancashire Drug and Alcohol Action Team (2011) *Emerging Drug Trends in Lancashire: Night Time Economy Surveys*. Available: http://www.ldaat.org/files/emerging_trends_report.pdf [Accessed October 2011].

[14] 'Bubble' is commonly used to refer to any synthetic legal high with stimulant effects.

Ethnicity

77% of primary drug clients are White British, although 20% of records have missing ethnicity codes or ethnicity has not been stated. 92% of young people in treatment are White British.

Deprivation

There is a strong relationship between indicators of drug use, drug harm and their impacts and deprivation. Estimated prevalence of drug use, drug related deaths, drug use among offenders and drug related offending all have their highest prevalence in Blackburn, Blackpool, Burnley and Preston, all of which are significantly higher than the national averages for each indicator. Fourteen percent and 13% of offenders in Burnley and Preston are assessed as having a severe drug misuse issue. Offenders that misuse drugs in these areas are also more likely to have a history of injecting. Possession and trafficking of drugs offences are also highest in Preston, Blackpool, Burnley and Blackburn.

Perceptions of Drug Use

There is a very strong association between people who think that drug use or drug dealing is a problem in their local area and deprivation. Rates are above what the national pattern would predict in Rossendale, Pendle, Blackburn with Darwen and Burnley. There is a large inequality gradient in perceptions of drug use or dealing as a problem across the Lancashire sub-region with those in the most deprived 20% of the population four times as likely to perceive drug use and drug dealing as a problem in their local area. 25% of respondents to the Living in Lancashire survey in 2011 (wave 35) felt that people using or dealing drugs was a problem in their local area. This rises to 50% amongst BME respondents. Sixteen percent of children in the Lancashire county council area report being worried about drugs or solvents being brought into the school, increasing to one in four children in Burnley reporting these concerns.

Adverse effects

The table below summarises the adverse effects associated with drug use and their associated effect when used concurrently and other drugs.

Table 2 - Summary of adverse effects of drug use

	Effects association with concurrent use of:	
	Alcohol	**Illicit drugs**
Amphetamines	• Increases perceived total intoxication. • Increases adverse cardiovascular effects.	• Limited evidence. • Concurrent use with cocaine may have adverse consequences on the central nervous system.
MDMA and related analogues	• Reduces subjective sedation associated with alcohol, but not alcohol-induced impairments. • Increase in plasma levels of MDMA. • Decrease in blood alcohol levels. • May enhance the temporary impairment of immune cells associated with MDMA use (transient immune dysfunction).	Cannabis: • Users may potentially experience cumulative CNS impairment. • May increase susceptibility to infection. Cocaine • Evidence from animal studies suggests an increased risk of neurotoxicity.
Anabolic agents	• None documented.	Cocaine • Potential for clenbuterol and AAS to exacerbate the adverse cardiovascular effects of cocaine.
Cannabis	• Reduction in driving performance.	
Cocaine	• Increases blood levels of cocaine and the active metabolite cocaethylene; users may perceive a more intense feeling of intoxication. • Users may perceive a reduction in the sedating effects of alcohol. • Combination potentially increases adverse cardiovascular effects. • Patients with coronary artery disease or alcohol dependence may be particularly vulnerable to the combined toxic effects of alcohol and cocaine.	Ketamine • Potential to exacerbate the cardiovascular risks of cocaine (crack). Methadone • Increases adverse cardiovascular effects (for example increased blood pressure and heart rate).
GHB	• Increases the risk of respiratory depression.	• None documented.

Nitrites	• None documented	• Misuse of drugs for treating erectile dysfunction (e.g. viagra). • Increases hypotensive effects (abnormally low blood pressure).
Opioids	• Increases the depressant effects of alcohol on the central nervous system; can be fatal. • Acute use of alcohol and methadone appears to result in lower blood-alcohol levels – clinical significance unclear	Benzodiazepines • Increase the depressant effects of opioids on the central nervous system.
Prescription drug misuse	Benzodiazepines • Increase the depressant effects of alcohol on the central nervous system. • May reduce the anxiety reducing (anxiolytic) effects of benzodiazepines. Diazepam • Increases plasma levels of alcohol. • May increase aggression and/or amnesia. CNS stimulants • Increases methylphenidate levels and exacerbates effects on the central nervous system.	
Source: Department of Health (2011) *A Summary of the Health Harms of Drugs.*		

Hidden Harm

There is consistent evidence that the children of parents who misuse substances are at greater risk of adverse outcomes compared to the children of parents who do not misuse substances. In 2003 the Advisory Council on the Misuse of Drugs (ACMD) published a report stating that between two and three percent of all children under the age of 16 years are effected by drug using parents[15]. While the effects are wide-ranging, it has an impact on early onset of drugs, alcohol and tobacco use, lower educational attainment and a range of associated health problems. Within Lancashire 37% of the adult in-treatment population live with children, and a further 15% are parents but do not live with children. Those living with children are slightly higher than the national average at 34% and 18% respectively.

[15] Home Office (2003) *Hidden Harm.* Available online: http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/hidden-harm-full

Drugs and Community Safety

The misuse of drugs has a significant impact on crime and perceptions of community safety in Lancashire. These impacts are both direct – criminal activity associated with using and selling drugs classified under the misuse of drugs act (1971) – and indirect – drug use being a facilitating factor in a wide range of criminal behaviour, such as violent behaviour, enticing victims, and acquisitive crime to fund drug use. Use of different drugs is associated with different types of offences.

Drug-Related Offending

In 2010/11 there were 3,689 drug offences across Lancashire. There were 939 trafficking offences and 3,581 possession offences in this period. Cannabis is most common in drug offences across Lancashire, recorded in approximately 70% of drug offences during the six month period between 1 March 2011 and 31 August[16]. There is emerging evidence of links between organised crime and cannabis distribution and production. It has also been noted that cannabis, mephedrone and other legal highs can be associated with youth nuisance and anti-social behaviour. Opiate and/or crack cocaine use is more likely to have an impact on acquisitive and serious and organised crime. 89% of organised crime groups (OCGs) are primarily involved in drug supply, most of which supply multiple drug types but predominantly cocaine, heroin and cannabis. Cocaine and alcohol taken together increase the blood levels of cocaine and the active metabolite cocaethylene, leading to increased risk of violent and antisocial behaviour. The hotspot areas for drug-related crime are: Claremont; Talbot; Bloomfield (western division); Town Centre (central division); Danehouse with Stoneyholme; and Trinity (Pennine division).

The vulnerable Localities Index (VLI), developed by the Jill Dando Institute of Crime Science, identifies neighbourhoods that require prioritisation by community safety agencies. Those that score 200 or more across the six variables require specific attention. Within Lancashire there are 436 output areas (each on average 125 households) with a VLI score of 200 or above. 46% of those fall within 22

[16] Steele, L (2011) *Lancashire Drugs Threat Assessment*.

wards and 25% within just 9. These are: Bloomfield; Brunswick; Claremont and Park (West Lancashire); St. Matthews and Tanhouse (Central/South Lancashire); Mill Hill; Shadsworth with Whitebirk (East); and Trinity (Pennine)[17].

Domestic violence/abuse

There is a strong two-way relationship association between substance misuse and domestic violence or abuse, and it can be a factor in violence against women and girls. In turn domestic violence or abuse can lead to an increased risk of substance misuse among both victims and perpetrators, perhaps as a coping mechanism. Lancashire (and lower level) data on this issue is limited due to low reporting[18]. Domestic violence or abuse can be a precursor to more serious crime and affects other issues, such as mental wellbeing, physical health, employment and social services intervention, for both the victim and perpetrator. Reported domestic violence incidents have increased year-on-year from 17.5 per 1,000 population in 2007/8 to 19.1 in 2010/11.

Offender Drug Use

Lancashire Probation Trust regularly assesses the drug misuse status of offenders that they are case managing. Data from this process indicates that 67% of offenders in Lancashire report having used drugs at some point, with the highest proportions in Preston and Burnley (75% of offenders) and Blackburn with Darwen and Blackpool (69%). Drug use is assessed as a significant factor for more than a third of offenders in the current or previous offending. Nationally 58% of offenders under probation supervision with a history of acquisitive offending had a direct risk of reoffending due to drug misuse[19]. This compares to 44% of Lancashire offenders. Nationally 33% of offenders supervised by probation (excluding violent, acquisitive or sex offenders) demonstrate a link between drug misuse and reoffending, whereas in Lancashire it is 28%. The most common drug used by offenders in Lancashire is cannabis (used by 52% of those assessed at some point), followed by cocaine and crack cocaine (19%) and heroin (18%). It is likely these drugs have been used

[17] Steel, L (2011) Lancashire Drugs Threat Assessment, 3rd November 2011
[18] Ibid.
[19] NOMS Commissioning Intentions 2012/13

concurrently. Ten per cent of those assessed are currently using heroin, crack, cocaine, opiates, methadone or misusing prescribed drugs, with 16% using drugs on at least a weekly basis. Eight per cent of offenders have injected drugs at some point, while 14% per cent of offenders spend a significant amount of time during their day preoccupied with either procuring monies for drugs or misusing drugs, with the highest percentage in Burnley and Preston. Five per cent of offenders are assessed as not motivated to tackle their drug misuse, with 19% demonstrating some level of motivation to change their behaviour. For 11% of offenders, their drug use is assessed as providing a risk of serious harm either to themselves or others.

Drug-Related Deaths

The misuse of drugs leads to a number of preventable deaths each year in Lancashire, with a significant impact on families and communities in the county. Drug-related deaths are defined as deaths where the immediate underlying cause is poisoning, drug abuse or dependency and where any of the substances used are controlled under the Misuse of Drugs Act (1971)[20]. During 2009-10 there were 67 drug related deaths in Lancashire, estimated to account for 2,589 years of life lost. The majority of these were concentrated around the four core urban areas: Blackburn, Blackpool, Burnley and Preston. There were pockets of drug-related deaths in some more rural areas in East Lancashire.

It is important to be aware that patterns of drug-related deaths in small areas need to be interpreted with caution and variations may be in some part explained by differences in reporting, classification, and, as drug-related deaths are more prevalent in certain age groups, in differences in the age structure of the smaller areas. The small number of deaths makes age standardising data for smaller areas unreliable.

[20] Office for National Statistics (2003). 'Deaths Related to Drug Poisoning: Results for England and Wales 1993 to 2003'. *Health Statistics Quarterly*, 65-71.

Comparisons with England

The Confidential Inquiry into Drug-Related Deaths in Lancashire 2009/10 by Lancaster University analysed data from all drug-related deaths in the sub-region. The largest proportion of the cohort was male, between 26 and 45 years of age, unemployed and living alone in the community. However, a considerable proportion of the deaths were among people with different characteristics. Blackburn with Darwen had a much higher mean age at death for drug-related deaths in 2009-10 than Lancashire, Blackpool and the national average.

Data on drug-related deaths shows that as well as the risk factors that appear to increase the likelihood of incidents, there seem to be a range of protective factors or recovery capital that many members of the cohort had available to them, including family, relationships, education and training, employment and volunteering, and peer mentoring . Of the drug-related deaths among parents, 75% had little or no contact with their children, indicating that contact with children is a protective factor in relation to unsafe drug taking behaviour.

The analysis of the Confidential Inquiry into drug-related deaths in Lancashire revealed far more deaths were caused by recreational drug use in this year's cohort than by stereotypical opiate use as seen in previous years. In 87% of drug related incidents, hypnotic and sedative substances were implicated. There was also significant evidence of poly drug use overall. According to the data, only a relatively small proportion (30%) of the 2009/10 cohort had ever accessed service misuse services at any point in their lives. A significant proportion of the cohort had a criminal record or mental health issues, and many had experienced both. There was also a noticeably higher proportion of suicide verdicts in 2009/10 (22%) compared to 2008/09 (13%).

If these trends in drug-related deaths continue there will be implications for the design and provision of drug services, and partner organisations will need to develop new ways to ensure harm reduction measures reach the population at risk of drug-related deaths.

Child Deaths

The Lancashire, Blackburn with Darwen and Blackpool child death overview panel (CDOP) reviewed a total of 298 child deaths in Lancashire-14 between April 2008 and April 2009. Of these, 74 were identified as avoidable had a factor been identified and changed.

Five cases (7%) identified substance misuse in the parent as a contributory factor in the child's death; and in 5 cases (7%) substance misuse in the child was a contributory factor in the death.

This data has the following limitations, however. First, there will be some variance in how individual professionals gather and record information. Second, these factors are often present together or alongside other factors such as domestic violence.

Treatment and Reducing Drug Use

The drug strategy signals a significant shift in emphasis from focusing primarily on reducing harms caused by drug misuse to offering every support for people to choose recovery as an achievable way out of dependency. The strategy is structured around three themes:

Reducing demand

Creating an environment where the vast majority of people who have never taken drugs continue to resist pressure to do so and making it easier for those that do to stop. Elements include:

- Early intervention and prevention.
- Education and information for all.
- Intensive support for young people.
- Legislation, sentencing and diversion.
- Work with offenders.

Restrict Supply

Drugs cost the UK £15.4 billion each year. The drug strategy aims to make the UK an unattractive destination for drug traffickers by attacking profits and driving up risks. The focus is on:

- Law enforcement reforms.
- Reducing drug supply in prisons.
- Targeting criminal businesses.
- Addressing the issues of so called 'legal highs'.

- Strengthening international partnerships to tackle trade.

Building Recovery in Communities

Working with people who want to take the necessary steps to tackle their dependency on drugs and alcohol is one of the key aims of the drugs strategy, by putting the goal of recovery at the heart of everything that is done and building capacity in treatment. The government's aim is to:

- Put the user at the heart of their own journey.
- Locally led and owned treatment systems.
- Outcomes focused services .
- Whole system approach (focused on housing, education and employment).
- Giving users the resources to sustain recovery.

Available Services

At the end of 2010-11 there were 5,147 adult drug clients and 749 young people in treatment services. Lancashire has the largest in-treatment population in the North West and the second highest in the country behind Birmingham. 13% of those that started a new treatment during 2011-12 had a dual diagnosis.

There are a range of diverse services available across Lancashire for those misusing illicit and non-illicit drugs and alcohol. In all areas of Lancashire there are fully integrated, recovery-focused services, including community, criminal justice, and prison-setting interventions. These services incorporate peer mentoring, volunteering, education, housing, family support, and group work, as well as a range of tiered interventions. The following tiered services are available:

- Tier 2 – open access, non-care-planned support comprising information and advice, screening, assessment, brief psychosocial interventions and referral into structured treatment.
- Tier 3 – structures, care-planned interventions comprising of specialist assessment and co-ordinated care-planned treatment. These include comprehensive assessment, regular key working sessions and the co-ordination of more complex needs.
- Tier 4 – comprises of residential, specialist treatment which is care-planned and care co-ordinated and include specialist inpatient detoxification and residential rehabilitation.

These services are available to residents in all areas of Lancashire for both adults and young people. Alongside these services are a range of harm reduction, early intervention and prevention and GP-lead interventions, such as needle exchange, outreach, diversionary activities and GP-led primary care services.

There is also a service-user function across Lancashire designed to work with current or ex-service users to help sustain recovery and widen participation in volunteering, peer mentoring, education and training, and paid employment.

Harm Reduction

Raising awareness of the harm caused by drug use, such as drug-related deaths and blood borne virus infections, is an important part of LDAAT's work. Campaigns such as OD999 have helped educate drug users about harm reduction, helping our service providers provide help and support to their service users.

LDAAT works with its service providers to help stabilise people in treatment, support them in becoming abstinent, offer substitute treatments and complimentary therapies.

The main aims of this treatment are:

- Reduce the harm to user, family, community and society.

- Encourage a healthier, more active lifestyle and cut drug-related deaths.
- Help people achieve a stable life with access to family, friends and community.
- Reduce the amount of illicit drug use.
- Reduce crime and anti-social behaviour.

TOP Outcome Reports

Through the outcomes reports that are available in Lancashire we know that engaging people in treatment people reduce their drug use, reduce injecting, commit less crime, improve health, access education, housing and employment.

Return on Investment

Lancashire has access to a value for money tool that indicates the return on the investment that drug treatment services offer across the county. This takes into account crime and health costs associated with drug clients, local market forces, factors such as real estate and wages, and deprivation. It can be adjusted to factor in changes to numbers accessing treatment or investment to measure the impact of decisions. Under current investment every £1 spent on services in Lancashire generates £5.62 of total real-term benefits.

There is also a cohort of clients that are using prescription-only or over-the-counter medicine. Looking at all those in treatment, 25% of clients are using these substances. Rates of prescription-only and over-the-counter drug use as a primary substance is only 2%, with the rest using illicit drugs as a primary substance.