Alcohol harm & drug misuse JSNA Summary

- The harmful use of alcohol causes a large disease, social and economic burden
- In England, alcohol misuse is the biggest risk factor attributable to early mortality, ill-health and disability for those aged 15-49
- The use of illicit drugs – particularly strongly addictive drugs like heroin, cocaine and methamphetamine – is associated with a range of physical, psychological and social harms

Key causes & risk factors for substance misuse

- **Sex**
  - Men are more likely to drink alcohol and to binge drink, and drug-related deaths are much higher in men than women

- **Economic status**
  - Drug dependence is most common in the economically inactive and unemployed, while the wealthiest drink the most

- **Homelessness**
  - Substance misuse is both a cause and effect of homelessness, with notably higher rates among homeless people

- **ACEs**
  - Adverse Childhood Experiences (ACEs) increase the risk of substance misuse and dependence in adulthood

- **Parental influence**
  - Children of substance abusing parents are over 2x as likely to have a substance use disorder by young adulthood

- **Military service**
  - Substance misuse is more prevalent among military personnel and veterans and is associated with PTSD

- **Sexual orientation**
  - Alcohol and drug misuse are notably more common among LGB people

- **Poor mental health**
  - Mental illness is strongly associated with substance misuse

What the stats show

- Hertfordshire’s substance misuse statistics are generally better than those of England as a whole, but the costs to public health and the demand on public services from harm caused by the misuse of drugs and alcohol are considerable
- There is notable variation across the county with regard to alcohol harm, with Watford and Stevenage generally experiencing worse outcomes
- Increases in related hospital admissions and an estimated increase in opiate usage demonstrate that substance misuse remains a public health priority for Hertfordshire

Recommendations

- Apply a whole system approach to tackling alcohol harm and drug misuse across the life course, incorporating individual level and population level prevention
- Focus resources proportionately to address the higher levels of alcohol harm in Watford and Stevenage, while retaining a Hertfordshire-wide approach to reducing harm from alcohol
- Commission a new integrated substance misuse service, informed by applicable NICE guidance and Public Health England commissioning tools, which meets the varied needs of substance users, reaches underserved groups and adopts a ‘whole person’ approach
How to use this document

Hertfordshire’s JSNA reports* use a standard format for easy navigation:

A one-page ‘infographic style’ summary gives the key messages from the report in a concise format. A PDF of the one-page summary can also be downloaded separately.

What’s the issue? defines the topic, explains why it is important in understanding the overall needs of our population, and sets out the relevant subthemes which will be covered in the report.

Causes & risk factors summarises key points from the academic and professional literature about what lies behind the issue and what makes people more likely to be affected by it, broken down by the subthemes set out in the previous section.

Scale of the issue provides a summary of the relevant statistical data under each of the subthemes. You can find all of the corresponding graphs in an appendix at the back of the document. This information will be the latest available at the time the report is published; however, if you need up-to-date figures for any of the statistical indicators included here, or require further information about them, please visit the data hub at www.hertshealthevidence.org in the first instance.

Solutions summarises key points from the academic and professional literature about what works to address the issues covered in the report and describes current service provision in the county.

Analysis presents discussion and conclusions about what the evidence presented in the previous sections tells us about the needs of the local population and where there are opportunities to do more to meet those needs. As it’s equally as important to know what a needs assessment can’t tell us as well as what it can, this section also includes an acknowledgement of the key limitations of the report.

Recommendations are then made, based on the analysis, to inform commissioners and decision-makers. It is important to note that JSNA recommendations themselves do not constitute Hertfordshire County Council or Hertfordshire Health & Wellbeing Board policy – rather, they are intended to inform commissioning and policy and strategy setting, as part of wider decision-making processes. (Please note that commissioners are advised to read the full document, as this is likely to contain further information pertinent to their decision-making in addition to the headline points covered in the recommendations section and the one-page summary.)

* New format applies from July 2016. Note that ‘JSNA Snapshot’ reports have a different set format.

References are included as appropriate and listed at the back of the document, before the appendices, in the Vancouver citation format.
**Appendices** include:

- information on the topic specifically for people undertaking equality impact assessments (with a section for each protected characteristic and one for military personnel and armed forces veterans highlighting any relevant key points)

- data charts and tables from which the key messages set out in the ‘Scale of the issue’ section are drawn

Additional appendices containing further supplementary information may also be included in some reports, such as:

- colour coded data tables, commonly known as ‘tartan rugs’, which provide an easy comparison of key data across different geographies

- case studies describing the experiences of local service users or illustrating the work of local services or interventions

*Please visit the data hub at [www.hertshealthevidence.org](http://www.hertshealthevidence.org) or contact PH.intelligence@hertfordshire.gov.uk if you require the most up-to-date statistics.*
## Contents

**Summary** 2  
**How to use this document** 3  
**List of figures** 7  

1.0 What’s the issue? 9  

2.0 Causes & risk factors 12  
2.1 Alcohol harm 12  
2.1.1 Children and young people 12  
2.1.2 Adults 13  
2.2 Drug misuse 18  
2.2.1 Children and young people 18  
2.2.2 Adults 19  

3.0 Scale of the issue 22  
3.1 Alcohol harm 22  
3.1.1 Children and young people 22  
3.1.2 Adults 23  
3.2 Drug misuse 27  
3.2.1 Children and young people 27  
3.2.2 Adults 28  

4.0 Solutions 31  
4.1 Alcohol harm 31  
4.1.1 What works? 31  
4.1.2 Local services and approaches 35  
4.2 Drug misuse 41  
4.2.1 What works? 41  
4.2.2 Local services and approaches 43
## List of figures

### Alcohol harm

#### Children and young people

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig. 1.1</td>
<td>Admission episodes for alcohol-specific conditions (under 18)</td>
<td>55</td>
</tr>
</tbody>
</table>

#### Adults

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fig. 2.1</td>
<td>Years of life lost due to alcohol-related conditions (aged under 75)</td>
<td>55</td>
</tr>
<tr>
<td>Fig. 2.2</td>
<td>Alcohol-specific mortality (all ages)</td>
<td>56</td>
</tr>
<tr>
<td>Fig. 2.3</td>
<td>Alcohol-related mortality (all ages)</td>
<td>56</td>
</tr>
<tr>
<td>Fig. 2.4</td>
<td>Admission episodes for alcohol-specific conditions (all ages)</td>
<td>57</td>
</tr>
<tr>
<td>Fig. 2.5</td>
<td>Admission episodes for alcohol-related unintentional injuries (Narrow) (all ages)</td>
<td>57</td>
</tr>
<tr>
<td>Fig. 2.6</td>
<td>Admission to hospital for mental and behavioural disorders due to alcohol (Narrow) (all ages)</td>
<td>58</td>
</tr>
<tr>
<td>Fig. 2.7</td>
<td>Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) (all ages)</td>
<td>58</td>
</tr>
<tr>
<td>Fig. 2.8</td>
<td>Claimants of benefits due to alcoholism (Persons - Males 16-64; Females 16-61)</td>
<td>59</td>
</tr>
<tr>
<td>Fig. 2.9</td>
<td>Alcohol-related road traffic accidents (aged 17+)</td>
<td>59</td>
</tr>
<tr>
<td>Fig. 2.10</td>
<td>Successful completion of alcohol treatment (aged 18-75)</td>
<td>60</td>
</tr>
<tr>
<td>Fig. 2.11</td>
<td>Proportion waiting more than 3 weeks for alcohol treatment (aged 18+)</td>
<td>60</td>
</tr>
<tr>
<td>Fig. 2.12</td>
<td>Percentage of adults drinking over 14 units of alcohol per week (aged 18+)</td>
<td>61</td>
</tr>
<tr>
<td>Fig. 2.13</td>
<td>Alcohol-related crime</td>
<td>61</td>
</tr>
</tbody>
</table>
Drug misuse

Children and young people

Fig. 3.1  Hospital admissions due to substance misuse (aged 15-24) 62
Fig. 3.2  Percentage who have taken drugs (excluding cannabis) in the last month (aged 15) 62

Adults

Fig. 4.1  Concurrent contact with mental health services and substance misuse services for drug misuse (aged 18+) 63
Fig. 4.2  Adults with substance misuse treatment need, who successfully engage in community-based structured treatment following release from prison (aged 18+) 63
Fig. 4.3  Deaths from drug misuse (all ages) 64
Fig. 4.4  Proportion waiting more than 3 weeks for drug treatment (aged 18+) 64
Fig. 4.5  Classification of drugs 65
Fig. 4.6  Possession of drugs, numbers by class, 2014/15-2016/17 65
Fig. 4.7  Possession of drugs, Class A, 2014/15-2016/17 65
Fig. 4.8  Possession of drugs, Class B, 2014/15-2016/17 66
Fig. 4.9  Test on Arrest in Hertfordshire, 2016/17 66
1.0 What’s the issue?

1.1 Alcohol harm

- Alcohol is a psychoactive substance with dependence-producing properties that has been widely used in many cultures for centuries. The harmful use of alcohol causes a large disease, social and economic burden in societies.\(^1\)

- Alcohol consumption is associated with many chronic health problems including psychiatric, liver, neurological, gastrointestinal and cardiovascular conditions and several types of cancer. It is also linked to accidents, injuries and poisoning.\(^2\)

- For most alcohol-related diseases and injuries, there is a clear dose-response relationship between the volume of alcohol consumed and the risk of a given harm. With increasing dose, there is increasing risk.\(^3\)

- In England, alcohol misuse is the biggest risk factor attributable to early mortality, ill-health and disability for those aged 15 to 49 years, for all ages it is the fifth most important.\(^3\)

- Alcohol-use disorders (see Box 1) are associated with relationship breakdown, domestic abuse, poor parenting, unsafe and regretted sex, truancy, delinquency, antisocial behaviour and homelessness.\(^2\)

- Drinking during pregnancy can also have an adverse effect on the developing foetus. The resulting problems can include lower birth weight and slow growth, learning and behavioural difficulties and facial abnormalities (see Box 2).\(^2\)

- Regular drinking by mid-adolescence has the potential to determine life trajectories by adversely affecting successful transitions between roles and statuses such as gaining employment or commencing training after leaving school.\(^4\)

- The harmful use of alcohol can also result in harm to other people, such as family members, friends, co-workers and strangers. Moreover, the harmful use of alcohol results in a significant health, social and economic burden on society at large.\(^1\) The costs of alcohol misuse have been estimated as follows:\(^5\)
  - NHS in England – £3.5 billion per year (at 2009/10 costs).
  - Crime in England – £11 billion per year (at 2010/11 costs).
  - Lost productivity in the UK – £7.3 billion per year (at 2009/10 costs).

**Box 1. Alcohol-use disorders\(^2\)**

- Alcohol-use disorders cover a wide range of mental health problems as recognised within the international disease classification systems (ICD-10, DSM-IV). These include hazardous and harmful drinking and alcohol dependence.
• The alcohol-use disorders identification test (AUDIT) is an alcohol screening test designed to see if people are drinking harmful or hazardous amounts of alcohol. It can also be used to identify people who warrant further diagnostic tests for alcohol dependence.

Box 2. Drinking in pregnancy

• Drinking in pregnancy can lead to long-term harm to the baby – the more alcohol is consumed, the greater the risk.

• Drinking alcohol, especially in the first three months of pregnancy, increases the risk of miscarriage, premature birth and the baby having a low birth weight.

• Drinking heavily throughout pregnancy can cause the baby to develop a serious condition called foetal alcohol syndrome (FAS).

• Children with FAS have:
  o poor growth
  o facial abnormalities
  o learning and behavioural problems

• Drinking less heavily, and even drinking heavily on single occasions, may be associated with lesser forms of FAS.

1.2 Drug misuse

• The use of illicit drugs – particularly strongly addictive drugs like heroin, cocaine and methamphetamine – is associated with a range of physical, psychological and social harms. This can include deaths from overdose, long-term adverse effects on health, dependence, and harms to families and communities.

• Not all illicit drugs are equally harmful and the extent of harm varies between individuals and depends on the level and pattern of drug use, as well as the pharmacological properties of each drug. Harm is also influenced by the setting in which the substances are used and the combination of substances used. The level of harm is affected by the dosage of the drug, the pattern of drug use and the mode of administration as well as the purity of the drug - many illicit drugs are commonly found to contain adulterants that can increase the risk of morbidity and mortality.

• Heroin and crack cocaine have been scored by an expert group as the most harmful drugs to individuals. Cannabis and heroin, in particular, have been shown to have the highest rates of dependence.

• The primary health harms associated with illicit drug use result from the acute and chronic toxic effects of individual drugs, as well as drug dependence (i.e. where the risk
of harm is intrinsically raised due to the chronic drug use). Acute toxicity can lead to short-term harms, ranging from unpleasant side-effects such as vomiting and fainting, to more serious impacts such as seizures, tissue and neural damage or death. In the longer term, repeated drug use can lead to chronic physical and psychological health effects, as well as dependence.\textsuperscript{7}

- Problem drug use does not happen in a vacuum and there are frequently links to a range of other factors such as mental health, alcohol misuse and homelessness.\textsuperscript{9}

- Many acquisitive crimes (including theft, burglary and robbery) are committed by people whose drug use has become an addiction. Their offending often escalates to keep up with the rising cost of their drug use. Some also support their drug use with low-level dealing or prostitution.\textsuperscript{9}

- The social and economic cost of drug supply in England and Wales is estimated to be £10.7 billion a year – just over half of which (£6 billion) is attributed to drug-related acquisitive crime (e.g. burglary, robbery, shoplifting).\textsuperscript{10}
2.0 Causes & risk factors

2.1 Alcohol harm

2.1.1 Children and young people

2.1.1(i) Sex

- In the UK, girls aged 15–16 years report binge drinking (see Box 3) and drunkenness more than boys. Girls are also more likely than boys to be admitted to hospital for alcohol related harm.\(^{11}\)

2.1.1(ii) Parental and family influence

- During childhood, the home and family are often a child’s primary source of what is normal or acceptable drinking, and parents exert a powerful influence on drinking behaviour in their offspring.\(^ {12}\)

- Some parents choose to give their children alcohol with the view that it will increase their child’s resistance to peer influence and protect them from alcohol-related problems later in life; however, parental supply of alcohol has been shown to be associated with alcohol use, intentions to drink and risky drinking, in adolescents.\(^ {12}\)

- Patterns of alcohol consumption of parents, grandparents and siblings are associated with alcohol misuse by children and young people. Adolescent hazardous drinking is more prevalent among boys and girls with alcohol misusing parents versus those whose parents do not misuse alcohol.\(^ {13}\)

2.1.1(iii) Peer influence

- A study from the Netherlands which tested the influence of peer drinking norms on male adolescents’ willingness to drink found that young people adapted their willingness to drink substantially to pro-alcohol (i.e., more willing to drink) as well as anti-alcohol (i.e., less willing to drink) norms of their peers. They were more influenced by high-status than low-status peers. Anti-alcohol norms of popular peers were found to be more influential than pro-alcohol norms and that anti-alcohol norms became internalized.\(^ {14}\)

2.1.1(iv) Adverse Childhood Experiences (ACEs)

- Heavy and binge drinking by young people can be a mechanism for coping with stress or anxiety.\(^ {13}\)

- There appears to be a direct pathway from chronic stress exposure in pre-pubertal children via adolescent problem drinking to alcohol dependence in early adulthood; however, this route can be moderated by genetic and environmental factors.\(^ {15}\)
• Physical and sexual abuse in childhood may lead to later drinking behaviour.\textsuperscript{16}

2.1.1(v) Exposure to marketing

• Exposure to alcohol marketing increases the risk that children will start to drink alcohol, or if they already drink, will consume greater quantities.\textsuperscript{3}

2.1.1(vi) LGBTQ status

• Lesbian, gay, bisexual, and transgender (LGBT) youth are at increased risk for alcohol misuse.\textsuperscript{17}

• There is significant heterogeneity in the etiological pathways that lead to alcohol use in LGBT youth and correlates of drinking are similar to those found in general populations.\textsuperscript{17}

2.1.1(vii) Behaviour

• Early behaviour problems in children place them at especially high risk of alcohol problems, particularly if there is a family history of alcohol problems.

• Children and young people who are sensation-seeking or have impulsive personality types may drink in large quantities.\textsuperscript{13}

• Antisocial behaviour and inter-personal problems in pre-adolescent children, which may be predictive of substance use disorders.\textsuperscript{13}

2.1.1(viii) Access to alcohol

• Social contexts perceived to provide easier access to alcohol and drugs have been found to be the clearest predictors of early onset alcohol use.\textsuperscript{18}

2.1.2 Adults

2.1.2(i) Sex

• In 2016, men were more likely to be drinkers than women - 62.8\% of men drank in the previous week compared with 51.3\% of women.\textsuperscript{12}

• Men are slightly more likely than women to binge drink (see Box 3). In 2016, 28.2\% of males in Great Britain stated that they exceeded 8 units of alcohol on their heaviest day, whereas 25.3\% of females stated that they exceeded 6 units of alcohol.\textsuperscript{12}

• A study of older adults’ drinking habits in the UK published in 2015 found that, compared with older drinkers as a whole, a higher proportion of older unsafe drinkers were men.\textsuperscript{19}
2.1.2(ii) Genes

- Research shows that genes are responsible for about half of the risk for alcohol use disorder. Environmental factors, as well as gene and environment interactions account for the remainder of the risk.\(^{20}\)

2.1.2(iii) Ethnicity

- In Great Britain, drinking in the past week is more common among those who report being White (61.5%) relative to those who report being any other ethnicity (25.7%).\(^{12}\)
- The level of teetotalism is lower amongst those who are White (15.7%) compared with all other ethnicity groups (56.0%).\(^{21}\)
- Abstinence is high amongst South Asians, particularly those from Pakistani, Bangladeshi and Muslim backgrounds. But Pakistani and Muslim men who do drink do so more heavily than other non-white minority ethnic and religious groups.\(^{21}\)
- People from mixed ethnic backgrounds are less likely to abstain and more likely to drink heavily compared to other non-white minority ethnic groups.\(^{21}\)
- People from Indian, Chinese, Irish and Pakistani backgrounds on higher incomes tend to drink above recommended limits.\(^{21}\)
- Over time generational differences may emerge:\(^{21}\)
  - Frequent and heavy drinking has increased for Indian women and Chinese men.
  - Drinking among Sikh girls has increased whilst second generation Sikh men drink less than first generations.
- People from some ethnic groups are more at risk of alcohol-related harm:\(^{21}\)
  - Irish, Scottish, and Indian men, and Irish and Scottish women have higher than national average alcohol-related deaths in England and Wales.
  - Sikh men are overrepresented for liver cirrhosis.
  - People from minority ethnic groups have similar levels of alcohol dependence compared to the general population, despite drinking less.
- A study of older adults’ drinking habits in the UK published in 2015 found that, compared with older drinkers as a whole, older unsafe drinkers contained a higher proportion of white and Irish ethnic groups and a lower proportion of Caribbean, African and Asian groups.\(^{19}\)

2.1.2(iv) Age

- Young people aged 16 to 24 years in Great Britain are less likely to drink than any other age group; when they do drink, consumption on their heaviest drinking day tends to be higher than other ages.\(^{12}\)
- A 2017 survey of Hertfordshire residents aged 50+ found that while the overall frequency of alcohol consumption in this age group followed a similar pattern to that of the general adult population nationally, they were generally at lower risk of an alcohol use disorder. See also 3.1.2(xiii).

2.1.2(v) **Socioeconomic status**

- Lower socioeconomic groups often report lower levels of average consumption, yet experience greater or similar levels of alcohol-related harm. This is particularly true for mortality from chronic liver disease. This gives rise to what has been termed the ‘alcohol harm paradox’ whereby disadvantaged populations who drink the same or lower levels of alcohol, experience greater alcohol-related harm than more affluent populations (see Box 4).

- The highest earners, those earning £40,000 and above annually, are more likely to be frequent drinkers and binge on their heaviest drinking day when compared with the lowest earners.

- In 2016, almost 4 out of 5 people (77.4%) in the highest income band (annual income of £40,000 or more) said they drank alcohol in the last week and alcohol consumption generally falls with the level of income. Around 3 in 10 (29.4%) people in the lowest income band stated that they were teetotal compared with less than 1 in 10 (9.0%) for the highest income band. Binge drinking is also more common among those high earners. Specifically, binge drinking was two times more common among the highest earners (21.8%) when compared with the lowest earners (10.7%).

- Age and sex differences between high earners and the general adult population could play a role in explaining this relationship.

2.1.2(vi) **Deprivation**

- The proportion of men and women who drink increases as neighbourhood deprivation decreases; i.e. the highest rates of alcohol consumption are in the least deprived areas.

**Box 3. Binge drinking**

- Binge drinking usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk.

- UK researchers commonly define binge drinking as consuming more than six units of alcohol in a single session for men and women.

- Six units is equivalent to drinking between:
  - 2 and 3 standard glasses (175ml) of 13% strength wine
  - 2 and 3 pints of 4% strength beer

- This is not an exact definition for binge drinking that applies to everyone, as tolerance
to alcohol can vary from person to person and the speed of drinking in a session can also alter alcohol's effects.

- Drinking too much, too quickly on a single occasion can increase a person's risk of:
  - accidents resulting in injury, causing death in some cases
  - risk-taking behaviour
  - loss of self-control, e.g. having unprotected sex

### Box 4. Alcohol harm paradox

- Internationally, studies show that similar levels of alcohol consumption in deprived communities (vs. more affluent) result in higher levels of alcohol-related ill health.

- Hypotheses to explain this alcohol harm paradox include deprived drinkers: suffering greater combined health challenges (e.g. smoking, obesity) which exacerbate effects of alcohol harms; exhibiting more harmful consumption patterns (e.g. bingeing); having a history of more harmful consumption; and disproportionately under-reporting consumption.

- A UK study concluded that: deprived increased/higher drinkers are more likely than affluent counterparts to consume alcohol as part of a suite of health challenging behaviours including smoking, excess weight and poor diet/exercise. Together these can have multiplicative effects on risks of wholly (e.g. alcoholic liver disease) and partly (e.g. cancers) alcohol-related conditions. More binge drinking in deprived individuals will also increase risks of injury and heart disease despite total alcohol consumption not differing from affluent counterparts.25

### 2.1.2(vi) Homelessness

- Alcohol misuse is both a cause and effect of homelessness. High levels of alcohol consumption present a major health risk among the homeless population.26

- People who are both homeless and have addictions face further difficulties in both finding housing and overcoming their substance use. This is due to both stigma associated with homelessness and substance misuse and low levels of social support.26

### 2.1.2(viii) LGBTQ status

- A US study found that compared to transgender-identified people, nontransgender-identified males and females: have fewer heavy episodic drinking occasions (despite nontransgender-identified males having greater prevalence of heavy episodic drinking).27

- A 2009 systematic review of UK research evidence suggested that the 12 month relative risk of alcohol dependence is twice the rate in LGB people compared to control groups. It may be as high as four times the rate in lesbian and bisexual women.28
2.1.2(ix) **Religious beliefs**

- In England, people with a religious understanding of life are less likely to be hazardous drinkers than those who are neither religious nor spiritual (OR = 0.81, 95% CI 0.69–0.96).²⁹

2.1.2(x) **Mental illness (including post-traumatic stress disorder)**

- The high prevalence of co-morbid substance use disorders and mental illness have been well established in both clinical and population-based studies. Findings from the US National Comorbidity Survey showed a significantly higher prevalence of substance use disorders among individuals with mental illness compared to the general population (among individuals with any mental illness, 51% were reported as having a co-morbid substance use disorder, and the odds of having a substance use disorder were more than twice as high among individuals with a mental illness compared to those without any mental illness).³⁰

- A US study found a lifetime diagnosis of any mental illness was associated with higher rates of transition from substance use to substance use disorder compared to individuals without any lifetime diagnosis of mental illness.³⁰

- There is a well-established association between post-traumatic stress disorder (PTSD) and substance misuse (including alcohol misuse).³¹,³² Hazardous alcohol use or dependence is the most common comorbidity in males with PTSD, and the estimated prevalence of alcohol use disorders in individuals with PTSD is higher than that of the general population.³²

- A UK study found that 38.5% of individuals with a substance use disorder (including alcohol) met the diagnostic criteria for current PTSD.³³

- *See also 2.1.2(xi)*

2.1.2(xi) **Military service**

- A growing body of research indicates that harmful or hazardous alcohol misuse, alcohol-related problems and binge drinking are more prevalent in the military than the general population.³⁴

- A survey of serving and ex-serving members of the UK Armed Forces found that 13.0% overall reported alcohol misuse. Among those with probable PTSD, 44.9% reported alcohol misuse. 13.6% of those with alcohol misuse also met the criteria for PTSD.³²

2.1.2(xii) **Caring responsibilities**

- A US study published in 2010 found that caregivers who experience social and emotional burden related to caregiving are at risk for problematic alcohol use.³⁵
2.1.2(xiii) Adverse childhood experiences (ACEs)

- A local study undertaken by Liverpool John Moores University found that (after controlling for socio-demographic factors) the odds of being a high-risk drinker in adulthood were 1.6 times higher for individuals who had experienced 4+ ACEs than those who had experienced none and that they were twice as likely to binge drink.\(^{36}\)

- It was estimated that eliminating adverse childhood experiences could lead to a reduction in binge drinking in Hertfordshire of 22%.\(^{36}\)

2.2 Drug misuse

2.2.1 Children & young people

2.2.1(i) Age

- National statistics on drug use among children in England in 2014 showed that the prevalence of drug use increased with age. 6% of 11 year olds said they had tried drugs at least once, compared with 24% of 15 year olds. A similar pattern was seen for drug use in the last year and the last month. (Children were more likely to have taken cannabis than any other drug.)\(^{37}\)

- The same statistics showed that the prevalence of taking new psychoactive substances (often incorrectly referred to as ‘legal highs’) increased with age (from 11 to 15).\(^{37}\)

2.2.1(ii) Ethnicity

- England data from 2014 showed that the highest proportion of young people who had tried cannabis came from the Mixed ethnic group while the lowest came from the Asian ethnic group.\(^{37}\)

2.2.1(iii) Bullying

- Research has shown that young people who bully are at least twice as likely compared with non-bullying students to use drugs later in life.\(^{38}\)

2.2.1(iv) Emergent mental illness

- Many mental illnesses have symptoms that can emerge during childhood and can increase risk for later drug abuse. Symptoms associated with impulse-control disorders, such as aggressive disruptive behaviour, as well as those associated with affective and psychotic disorders all increase the risk of substance use disorders and related problems in adolescence.\(^{39}\)
2.2.1(v)  
**Parental substance misuse**

- Children of substance abusing parents are more than twice as likely to have an alcohol and/or drug use disorder themselves by young adulthood as compared to their peers.\(^{40}\)

2.2.2  
**Adults**

2.2.2(i)  
**Sex**

- Males accounted for 75% of hospital admissions with a primary diagnosis of drug-related mental and behavioural disorders in England in 2015/16.\(^ {37}\)

- Males accounted for 54% of hospital admissions with a primary diagnosis of poisoning by illicit drugs in England in 2015/16.\(^ {37}\)

- Males accounted for 74% of deaths related to drug misuse in England in 2015.\(^ {37}\)

- Men aged 16-59 in England and Wales in 2015/16 were more than twice as likely to report using cannabis in the last year than women (9.1% of men compared with 3.8% of women). Men were almost three times more likely than women to take powder cocaine (3.3% compared with 1.2%) and ecstasy (2.2% compared with 0.8%) in the last year.\(^ {37}\)

- 4.3% of males aged 16+ in England in 2014 had a drug dependency, compared with 1.9% of females.\(^ {37}\)

2.2.2(ii)  
**Age**

- 8.4% of adults aged 16-59 in England and Wales in 2015/16 had taken an illicit drug in the last year compared with 18.0% of young adults aged 16-24 (both figures were significantly higher in 2005/06 - 10.5% and 25.2% respectively).\(^ {37}\)

- Drug dependence decreases with age. Males in the 16-24 year old age group had the highest prevalence (11.8%) of drug dependence in England in 2014.\(^ {37}\)

- The age profile of opiate users in treatment is older than that of only non-opiate users (excluding those receiving treatment for both non-opiates and alcohol). In 2015/16 in England, more opiate users in treatment were in the 35-39 year old age group than any other, whereas more non-opiate users in treatment were in the 25-29 year old age group than any other.\(^ {37}\)

2.2.2(iii)  
**Ethnicity**

- Based on age-standardised data, adults in the Black/Black British group in England in 2014 had the highest prevalence of drug dependency (7.5%). This may be explained by their higher rates of cannabis use, and could reflect reporting of daily use.\(^ {37}\)
2.2.2(iv) Religious beliefs

- In England, people with a religious understanding of life are less likely to have ever used drugs than those who are neither religious nor spiritual (OR = 0.73, 95% CI 0.60–0.88).²⁹

- Spiritual people are more likely than those who are neither religious nor spiritual to have ever used (OR = 1.24, 95% CI 1.02–1.49) or be dependent on drugs (OR = 1.77, 95% CI 1.20–2.61).²⁹

2.2.2(v) Sexual orientation

- A systematic review found an approximately 2.5 times higher risk of 12 month drug dependence in LGB people compared to controls.²⁸

- Research in Northern Ireland showed that 14.7% of same/both sex attracted students compared to 8.4% of opposite sex attracted students felt pressurised to take illegal drugs.²⁸

2.2.2(vi) Employment status

- Among people aged 16–64 in England in 2014, the prevalence of drug dependence varied with employment status. In men, signs of drug dependence were most common in those classed as economically inactive (9.6%). For women, the highest prevalence was found in those who were unemployed (4.4%).³⁷

2.2.2(vii) Frequenting nightclubs, pubs and bars

- Findings from the 2015-2016 Crime Survey for England and Wales showed that use of any class A drug was around 10 times higher among people who had visited a nightclub at least 4 times in the past month (18%) compared with those who had not visited a nightclub in the past month (2%). A similar pattern was found for those visiting pubs and bars more frequently.⁴¹

2.2.2(viii) Mental illness (including post-traumatic stress disorder)

- Drug misuse is common among people with mental health problems. Research indicates that up to 70% of people in community substance misuse treatment also experience mental illness and there is a high prevalence of drug use among those with severe and enduring conditions such as schizophrenia and personality disorders.¹⁰

- A UK study found that 38.5% of individuals with a substance use disorder met the diagnostic criteria for current PTSD.³³

- See also 2.1.2(ix)
2.2.2(ix) Military service

- Evidence from the US has shown drug use disorder to be a major public health challenge among veterans.$^{42}$

- Research studies using diagnostic criteria to look at the prevalence of drug use disorders among veterans report higher prevalence than those using administrative criteria (20% vs. 5%).$^{42}$

2.2.2(x) Homelessness

- A national survey of 2,590 homeless people published by the charity Homeless Link in 2014 found that 39% reported that they took drugs or were recovering from a drug problem.$^{43}$

2.2.2(xi) Adverse childhood experiences (ACEs)

- There appears to be a direct pathway from chronic stress exposure in pre-pubertal children via adolescent problem drinking to drug dependence in early adulthood; however, this route can be moderated by genetic and environmental factors.$^{15}$

- A local study undertaken by Liverpool John Moores University in 2016 found that (after controlling for socio-demographic factors) the odds of having used cannabis at any point in their lives were 4.7 times higher for individuals who had experienced 4+ ACEs than those who had experienced none. The odds of having used crack cocaine or heroin were 6.6 times higher.$^{36}$

- It was estimated that eliminating adverse childhood experiences could lead to a local reduction in the prevalence of adults who have ever used cannabis of 47% and a reduction in the prevalence of adults who have ever used crack cocaine or heroin of 53.7%.$^{36}$
3.0 Scale of the issue

3.1 Alcohol harm

3.1.1 Children & young people

3.1.1(i) Admission episodes for alcohol-specific conditions (under 18)

- Since 2009/10 - 11/12, Hertfordshire has seen a statistically significantly lower crude rate (per 100,000) of hospital admission episodes for alcohol-specific conditions in people aged under 18 than the England average.

- Between 2013/14 – 15/16, the districts that had statistically significantly better crude rates of admission episodes for alcohol-specific conditions in people aged under 18 than the England average (37.4 per 100,000) were: East Hertfordshire (24.0 per 100,000), North Hertfordshire (19.8 per 100,000) and St Albans (15.1 per 100,000).

- Between 2013/14–15/16, the only district with a statistically significantly better crude rate of admission episodes for alcohol-specific conditions in people aged under 18 than the Hertfordshire average (26 per 100,000) was St Albans (15.1 per 100,000).

3.1.1(ii) Alcohol consumption in primary school children

- Data from the local Health Related Behaviour Survey in 2016 showed that 6% of boys and 2% of girls in Year 5 and Year 6 (ages 9-11) reported that they had had an alcoholic drink (more than just a sip) in the last 7 days.

3.1.1(iii) Alcohol consumption in secondary school children

- The same survey found that 7% of boys and 6% of girls in Year 8 and 22% of boys and girls in Year 10 (ages 12-15) reported that they had had an alcoholic drink in the last 7 days.

- 4% of pupils in these years groups reported that they had got drunk on at least one day in the last week (7% of Year 10 pupils).

- 2% of Year 10 pupils reported buying alcohol from an off-licence in the last week.

- 40% of pupils asked in these year groups when about rules their parents/cares applied to them about drinking alcohol, said no drinking was allowed. 10% said unsupervised drinking was allowed so long as they don’t get drunk and 8% said they had no limits.
3.1.2 Adults

3.1.2(i) Years of life lost due to alcohol-related conditions (aged under 75)

- Between 2011-2015, Hertfordshire had a statistically significantly lower rate (DSR per 100,000) of years of life lost due to alcohol-related conditions than England.

- In 2015, the rates for years of life lost due to alcohol-related conditions in each Hertfordshire district were statistically similar to the Hertfordshire average (393 per 100,000).

- In 2015, Three Rivers (271 per 100,000), North Hertfordshire (292 per 100,000), East Hertfordshire (340 per 100,000) and St Albans (362 per 100,000) all had statistically significantly better rates of potential years of life lost due to alcohol-related conditions than the England average (552 per 100,000).

3.1.2(ii) Alcohol-specific mortality (all ages)

- Between 2009-11 and 2013-15, Hertfordshire had statistically significantly better rates than the England average for alcohol-specific mortality.

- In 2013-15, the CIPFA comparator area with a statistically significantly higher rate of alcohol-specific mortality than the Hertfordshire average (7.5 per 100,000) was Northamptonshire (10.4 per 100,000).

3.1.2(iii) Alcohol-related mortality (all ages)

- In 2015, Hertfordshire had a statistically significantly better rate (DSR per 100,000) of alcohol-related mortality (37.4 per 100,000) than the England average (46.1 per 100,000).

- The rate of alcohol-related mortality in Hertfordshire has not seen any statistically significant changes between 2011-2015.

- In 2015, the Hertfordshire district that had a statistically significantly better rate of alcohol-related mortality than the England average (46.1 per 100,000) was East Hertfordshire (32.1 per 100,000), while the other Hertfordshire districts were statistically similar.

3.1.2(iv) Admission episodes for alcohol-specific conditions (all ages)

- Since 2011/12, Hertfordshire has seen a statistically significantly lower rate (DSR per 100,000) rate of hospital admission episodes for alcohol-specific conditions than the England average.
• However, the rate of admission episodes for alcohol-specific conditions in Hertfordshire has seen a statistically significant increase from (341 per 100,000) in 2011/12 to (366 per 100,000) in 2015/16.

• In 2015/16, the districts that had statistically significantly worse rates of admission episodes for alcohol-specific conditions than the Hertfordshire average (366 per 100,000) were: Watford (525 per 100,000), Stevenage (463 per 100,000), Hertsmere (429 per 100,000) and North Hertfordshire (412 per 100,000).

• The districts with statistically significantly better rates of admission episodes for alcohol-specific conditions than the Hertfordshire average (366 per 100,000) were: Welwyn Hatfield (323 per 100,000), Broxbourne (312 per 100,000) and East Hertfordshire (259 per 100,000).

3.1.2(v) **Admission episodes for alcohol-related unintentional injuries (Narrow) (all ages)**

• Since 2011/12, Hertfordshire had a statistically significantly lower rate (DSR per 100,000) of admission episodes for alcohol-related unintentional injuries than the England average.

• England saw a statistically significant decrease in admission episodes for alcohol-related unintentional injuries from (150.1 per 100,000) in 2011/12 to (139.1 per 100,000) in 2015/16.

• Between 2011/12 - 2015/16, Hertfordshire did not follow the same trend as England and saw an increase in admission episodes for alcohol-related unintentional injuries from (118.2 per 100,000) in 2011/12 to (130 per 100,000) in 2015/16, although this increase was not statistically significant.

3.1.2(vi) **Admission to hospital for mental and behavioural disorders due to alcohol (Narrow) (all ages)**

• Since 2011/12, England has seen a statistically significant decrease in admissions to hospital for mental and behavioural disorders due to alcohol from (87.4 DSR per 100,000) in 2011/12 to (80.1 DSR per 100,000) in 2015/16.

• Hertfordshire, however, has not followed the same trend as England and the rate of admission to hospital for mental and behavioural disorders due to alcohol has increased from (39.4 DSR per 100,000) in 2011/12 to (43.7 per 100,000) in 2015/16, although this increase was not statistically significant.

• In 2015/16, the districts with statistically significantly higher rates of admissions to hospital for mental and behavioural disorders due to alcohol were Watford (73.3 DSR per 100,000) and Three Rivers (58.9 DSR per 100,000) compared to the Hertfordshire average (43.7 DSR per 100,000).

• In 2015/16, the district with a statistically significantly better rate of admissions to hospital for mental and behavioural disorders due to alcohol was Welwyn Hatfield.
(30.7 DSR per 100,000) when compared to the Hertfordshire average (43.7 DSR per 100,000).

3.1.2(vii)  Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) (all ages)

- In 2015/16, the rates (DSR per 100,000) of admission episodes for intentional self-poisoning by and exposure to alcohol were statistically significantly better in Hertfordshire (26.2 per 100,000) and all districts than the England average (51 per 100,000).

- In Hertfordshire, the rate of admission episodes for intentional self-poisoning by exposure to alcohol decreased from 316 per 100,000 in 2011/12 to 304 per 100,000 in 2015/16, though this decrease was not statistically significant.

3.1.2(viii)  Claimants of benefits due to alcoholism (Persons- Males 16-64; Females 16-61)

- Between 2015-2016, the crude rate (per 100,000) of claimants of benefits due to alcoholism in Hertfordshire was statistically significantly better than the England average.

- The districts with statistically significantly worse rates of claimants of benefits due to alcoholism than Hertfordshire (76.5 per 100,000) were Watford (128.9 per 100,000) and Stevenage (128.2 per 100,000).

3.1.2(ix)  Alcohol-related road traffic accidents (aged 17+)

- In 2013-15, the crude rate of alcohol related road traffic accidents in Hertfordshire (26.3 per 1,000) was statistically significantly similar to the England average (26 per 1,000).

- Since 2010-12, there has been a decrease in the crude rate of alcohol related road traffic accident in Hertfordshire, but this change was not statistically significant.

- Between 2010-12 and 2013-15, all ten Hertfordshire districts had statistically similar crude rates of alcohol related traffic accidents when compared to the England and Hertfordshire averages.

3.1.2(x)  Successful completion of alcohol treatment (aged 18-75)

- In 2015, Hertfordshire had a statistically significantly better proportion of successful completions of alcohol treatment (42.7%) than the England average (38.4%).

- In 2015, the CIPFA comparator areas that had statistically significantly smaller proportions of successful completion of alcohol treatment than the Hertfordshire average were: Oxfordshire (27.2%), Essex (37%), and Northamptonshire (32.6%).
• Between 2011 and 2012 in Hertfordshire, there was a statistically significant decrease in the proportion of successful completions of alcohol treatment which then saw a statistically significant increase by 2015.

3.1.2(xi) Proportion waiting more than 3 weeks for alcohol treatment (aged 18+)

• In 2015/16, Hertfordshire (0.6%) had a lower proportion of people waiting more than 3 weeks for alcohol treatment than the England average (4.1%).

• The majority of the CIPFA comparator areas had statistically significantly higher proportions of people waiting more than 3 weeks for alcohol treatment than the Hertfordshire average except for: Hampshire (0.0%), Kent (0.1%), Oxfordshire (0.2%) and Northamptonshire (0.2%).

3.1.2(xii) Percentage of adults drinking over 14 units of alcohol per week (aged 18+)

• In 2011-14, the percentage of adults drinking over 14 units of alcohol a week in Hertfordshire (24.8%) was statistically significantly similar to the England average (25.7%).

• In 2011-14, CIPFA comparator area Warwickshire had a statistically significantly larger proportion of adults drinking over 14 units of alcohol a week (33.1%) than both the Hertfordshire (24.8%) and England averages (25.7%).

3.1.2(xiii) Alcohol Consumption in over-50s in Hertfordshire residents

• Ipsos Mori was commissioned by Hertfordshire County Council to investigate drinking behaviours in older adults. This study was designed to mirror a 2016 national alcohol survey of adults aged 18+, but focus exclusively on the over-50 population. A total of 308 survey responses were collected.

• In Hertfordshire, almost a quarter (24%) said that they never drank alcohol, and another quarter (26%) drank monthly or less. 21% reported drinking 2 or 3 times per week and one in nine (11%) said that they drank 4 or more times per week. Residents of Hertfordshire reported drinking slightly fewer units on a typical day they were drinking than in the national alcohol survey.

• Overall, the most common place of alcohol consumption within the last month in Hertfordshire was at home (46%). This was followed by in restaurants (31%) and then in pubs (29%). Of those who reported consuming alcohol, 48% said that over a half of their alcohol consumption was at home.

• Similar to findings from the national PHE survey, men in Hertfordshire drank more units overall in the previous week than women (13.8 units compared with 8.9 units respectively). Two per cent reported drinking ten or more units on a typical day.
• Compared with the national 18+ survey, a higher proportion of respondents (90%) fell into the Zone 1 category (‘lower risk’) AUDIT score risk group. No participants fell into the Zone 4 category (‘possible dependency’).

3.1.2 Alcohol-related crime

• The rate of alcohol-related crime in Hertfordshire has stayed the same (8.3 per 1,000 population) between 2015/16 and 2016/17.

• The districts with statistically significantly higher rates (per 1,000) of alcohol-related crime in 2016/17 were Stevenage (12.1), Watford (11.9) and Welwyn Hatfield (9.7).

• On the other hand, the districts with statistically significantly lower rates (per 1,000) of alcohol-related crime were East Hertfordshire (7.3), North Hertfordshire (6.4), St. Albans (7.4) and Three Rivers (5.6).

3.2 Drug misuse

3.2.1 Children & young people

3.2.1(i) Hospital admissions due to substance misuse (aged 15-24)

• Since 2009/10–11/12, the rate (DSR per 100,000) of hospital admission due to substance misuse in people aged 15-24 in Hertfordshire was statistically significantly lower than the England average.

• Hertfordshire has experienced a statistically significant increase in the rate (DSR per 100,000) of hospital admissions from 29.5 per 100,000 in 2009/10-11/12 to 67.3 per 100,000 in 2013/14-15/16, following the same trend as the England average.

3.2.1(ii) Percentage who have taken drugs (excluding cannabis) in the last month (aged 15)

• In 2014/15, the proportion of people (aged 15) who have taken drugs (excluding cannabis) in the last month in Hertfordshire (0.7%) was statistically similar to the England average (0.9%).

• All ten CIPFA comparator areas in 2014/15 had statistically similar proportions to the Hertfordshire average.

3.2.1(iii) Drug use in secondary school children

• Data from the local Health Related Behaviour Survey in 2016 showed that 29% of Year 10 pupils had been offered cannabis while 12% reported taking it (6% in the last month). Cannabis was by far the most common drug reported to have been offered and used among this cohort.
3.2.2  Adults

3.2.2(i)  Concurrent contact with mental health services and substance misuse services for drug misuse (aged 18+)

- In 2015, Hertfordshire had a statistically significantly lower proportion of people in concurrent contact with mental health services and substance misuse services for drug use (16.3%) than the England average (22.1%).

- Between 2013/14 and 2015/16, England has seen a statistically significant increase in people in concurrent contact with mental health services and substance misuse service for drug use (19.9% to 22.1% accordingly).

- In 2015, the CIPFA nearest neighbours that had higher proportions of people in concurrent contact with mental health services and substance misuse services for drug use than Hertfordshire (16.3%) were Buckinghamshire (23.7%), Essex (24.3%), Kent (25.4%), and Northamptonshire (25.6%).

3.2.2(ii)  Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison (aged 18+)

- In 2015/16, the proportion of adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison in Hertfordshire (36.4%) was statistically significantly better than the England average (30.3%).

- In 2015/16, the CIPFA nearest neighbours with statistically significantly better proportions of adults with substance misuse treatment need who successfully engage in community based structured treatment following release from prison than the Hertfordshire average (36.4%) were Essex (49.8%) and Cambridgeshire (58.3%).

3.2.2(iii)  Proportion waiting more than 3 weeks for drug treatment (aged 18+)

- Between 2013/14 and 2015/16, Hertfordshire had a statistically significantly lower proportion of people aged 18 and over waiting more than 3 weeks for drug treatment than England, with a figure of 0.4% (6 people).

- In 2015/16, some CIPFA nearest neighbours had better figures than Hertfordshire although several had substantially worse figures (notably Surrey).

3.2.2(iv)  Deaths from drug misuse (all ages)

- In 2013-15, the rate of deaths from drug misuse (DSR per 100,000) in Hertfordshire (2.5 per 100,000) was statistically significantly lower than the England average (3.9 per 100,000).
• Since 2009-11, England saw a statistically significant increase in the rate (DSR per 100,000) of deaths from drug misuse from (3.2 per 100,000) in 2009-11 to (3.9 per 100,000) in 2013-15. The rate of deaths from drug misuse in Hertfordshire also increased during the same time-period, although the increase was not statistically significant.

• In 2013-15, the CIPFA comparator areas which had statistically significantly worse rates (DSR per 100,000) of death from drug misuse than Hertfordshire (2.5 per 100,000) were: Kent (4.4 per 100,000) and Essex (3.5 per 100,000).

3.2.2(v) Possession of Drugs

• In the UK, drugs are classified into three categories, Class A, Class B and Class C. Offences related to Class A drugs attract the most serious punishments and fines.

• In Hertfordshire, between 2014/15 – 2016/2017 there was an increase in the proportion of Class A possessions from 17.5% to 20.2%, though this was not statistically significant; however, the number of Class A possessions has decreased.

• East Hertfordshire and Hertsmere experienced statistically significant increases in the proportion of Class A possessions between 2014/15 and 2016/17, and both also experienced increases in the number of Class A possessions.

• The proportion of Class B possessions in Hertfordshire between 2014/15 and 2016/17 decreased slightly from 82% to 79.5% although this decrease was not statistically significant.

• The district with a statistically significantly higher proportion of Class B possessions in 2016/17 than the Hertfordshire average (79.5%) was Three Rivers (89%). On the other hand, East Hertfordshire during that same time period had a statistically significant lower proportion of Class B possessions (78.6%).

• Between 2014/15 to 2016/17, Hertfordshire saw a decrease in the number and proportion of Class C possessions from 0.5% to 0.3% (n=15 to n=9); however, this decrease in proportion was not statistically significant.

3.2.2(vi) Test on Arrest

• Since April 2016, a total of 1128 offenders were required to be tested; 30 offenders refused to be tested and were subsequently charged with this offence. Out of 1098 drug tests carried out, 864 were positive (78%) and 234 were negative. 33 test results were disputed and sent away from further analysis (8 were found to be negative due to medication and the remainder were positive for class A drugs).

• 580 offenders were tested in the first 6 months of the scheme, of whom 76% were positive for Class A drugs. 107 (25%) of these were treatment naïve, meaning that they had never come into contact with the treatment system. Of these 107, 32 (29%)
successfully entered the treatment system and accessed substitute prescribing, key working and 1-1 sessions.

- The majority of offenders were aged 30-39 and were mainly committing theft/shoplifting. The main drug of choice was cocaine.

3.2.2(vii) Prevalence of opiate and crack use

- Modelled estimates of the number of opiate users produced by Public Health England suggest that in 2014/15 there were 4,226 opiate and/or crack users (5.68 per 1,000) in Hertfordshire in the aged 15-64 population (3,418 opiate users and 3,535 crack users).

- This represents a notable increase in the estimated prevalence of opiate and crack use since the previous published estimates for 2011/12; however, this increase is not statistically significant.

- Hertfordshire’s estimated prevalence rate for opiate and/or crack users combined is statistically significantly lower than the estimated national prevalence rate.

- These estimates should not be regarded as precise figures and should be interpreted with caution due to their wide confidence intervals. For further information, contact Hertfordshire’s Public Health Evidence & Intelligence team.
4.0 Solutions

4.1 Alcohol harm

4.1.1 What works?

4.1.1(i) Children and young people

- NICE guidance on school-based interventions to prevent and reduce alcohol use among children and young people was published in 2007. Its scope included encouraging children and young people not to drink, delaying the age at which they start drinking and reducing the harm to those who do drink.\(^44\) This guidance includes recommendations on:
  - alcohol education
  - adopting a ‘whole school’ approach
  - one-to-one advice or referrals to an external service
  - working with a range of local partners

This guidance is currently in the process of being updated in light of new evidence. All recommendations will be updated and some new areas will be considered. The new guidance will differ from that published in 2007 in that it will not cover children under age 11, but will cover children and young people 18-25 with special educational needs or disabilities.

- NICE guidance on identifying, assessing and managing alcohol-use disorders (harmful drinking and alcohol dependence), including in young people aged 10–17 years, was published in 2011.\(^45\) It aims to reduce harms (such as liver disease, heart problems, depression and anxiety) from alcohol by improving assessment and setting goals for reducing alcohol consumption. This guideline includes recommendations on:
  - principles of care
  - identification and assessment
  - interventions for alcohol misuse

- NICE has also published quality standards covering children and young people on the topics of preventing and identifying alcohol problems in the community and the diagnosis and management of alcohol-use disorders (see Box 5).

- Public Health England has published a set of prompts for commissioners to guide them in commissioning universal and targeted drug, alcohol and tobacco prevention interventions for young people, and specialist interventions for young people already experiencing harms.\(^46\) The document outlines key principles that local areas might consider when developing plans for an integrated system, each followed by a series of prompts to help put them into practice. The four principles are:
  - Effective universal and targeted evidence-based interventions to prevent young people’s use of drugs, alcohol and tobacco are commissioned
  - A full range of specialist drug, alcohol and tobacco interventions are available
to young people in need
- Commissioning is integrated across prevention and specialist interventions and the wider children’s agenda
- A skilled workforce is in place to provide effective interventions

- NICE’s local government briefing on alcohol misuse prevention and treatment alcohol misuse prevention and treatment includes guidance pertaining to children and young people (see Box 6).

- NICE have produced guidance on assessing and managing people aged 14 years and over with coexisting severe mental illness (psychosis) and substance misuse (including alcohol misuse)\(^47\) and on how to improve services for the same cohort.\(^48\)

4.1.1(ii) Adults

- NICE guidance on the prevention and early identification of alcohol-use disorders among adults and adolescents was published in 2010.\(^2\) It sets out the need for a multi-pronged approach (see Box 7) and makes a number of recommendations for local authority and NHS commissioners, including:
  - mapping alcohol-related crime to inform licensing decisions
  - ensuring proactive steps are taken to prevent sales of alcohol to those underage or intoxicated
  - prioritising alcohol-use disorder prevention as an 'invest to save' measure
  - ensuring that plans include screening and brief interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers), including people from disadvantaged groups
  - include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up

- NICE guidance on identifying, assessing and managing alcohol-use disorders (harmful drinking and alcohol dependence) was published in 2011.\(^45\) It aims to reduce harms (such as liver disease, heart problems, depression and anxiety) from alcohol by improving assessment and setting goals for reducing alcohol consumption. This guideline includes recommendations on:
  - principles of care
  - identification and assessment
  - interventions for alcohol misuse

- NICE has also published quality standards covering adults on the topics of preventing and identifying alcohol problems in the community and the diagnosis and management of alcohol-use disorders (see Box 5).

- Public Health England has published a set of prompts for commissioners to guide them in planning for alcohol harm prevention, treatment and recovery in adults.\(^49\) The document outlines key principles that local areas might consider when developing plans for an integrated system, each followed by a series of prompts to help put them into practice. The five principles are:
Effective population-level actions to reduce alcohol-related harms
- Large-scale delivery of targeted brief advice
- Specialist alcohol care services for people in hospital
- Prompt access to effective alcohol treatment
- Commissioning effective alcohol and drug treatment services

- NICE’s local government briefing on alcohol misuse prevention and treatment alcohol misuse prevention and treatment includes guidance pertaining to adults (see Box 6).

- NICE have produced guidance on assessing and managing people with coexisting severe mental illness (psychosis) and substance misuse (including alcohol misuse)\(^{47}\) and on how to improve services for the same cohort.\(^{48}\)

**Box 5. NICE Quality Standards: Alcohol**

**Preventing harmful use in the community [QS83]\(^{50}\)**

- This quality standard covers preventing and identifying alcohol problems in the community. It includes policy and practice approaches to prevent harmful alcohol use in adults, young people and children. It is particularly relevant to local authorities, the police, and schools and colleges. It describes high-quality care in priority areas for improvement.

- Four quality statements are included in the document:
  - Local authorities use local crime and related trauma data to map the extent of alcohol-related problems, to inform the development or review of a statement of licensing policy.
  - Trading standards and the police identify and take action against premises that sell alcohol to people under 18.
  - Schools and colleges ensure that alcohol education is included in the curriculum.
  - Schools and colleges involve parents, carers, children and young people in initiatives to reduce alcohol use.

**Diagnosis and management [QS11]\(^{51}\)**

- This quality standard covers identifying and supporting adults and young people (aged 10 and over) who may have an alcohol problem, and caring for people with alcohol-related health problems, such as alcohol dependence or Wernicke's encephalopathy. It also covers support for their families and carers. It describes high-quality care in priority areas for improvement.

- Thirteen quality statements are included in the document:
  - Health and social care staff receive alcohol awareness training that promotes respectful, non-judgmental care of people who misuse alcohol.
  - Health and social care staff opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice.
  - People who may benefit from specialist assessment or treatment for alcohol
misuse are offered referral to specialist alcohol services and are able to access specialist alcohol treatment.

- People accessing specialist alcohol services receive assessments and interventions delivered by appropriately trained and competent specialist staff.
- Adults accessing specialist alcohol services for alcohol misuse receive a comprehensive assessment that includes the use of validated measures.
- Children and young people accessing specialist services for alcohol use receive a comprehensive assessment that includes the use of validated measures.
- Families and carers of people who misuse alcohol have their own needs identified, including those associated with risk of harm, and are offered information and support.
- People needing medically assisted alcohol withdrawal are offered treatment within the setting most appropriate to their age, the severity of alcohol dependence, their social support and the presence of any physical or psychiatric comorbidities.
- People needing medically assisted alcohol withdrawal receive medication using drug regimens appropriate to the setting in which the withdrawal is managed in accordance with NICE guidance.
- People with suspected, or at high risk of developing, Wernicke's encephalopathy are offered thiamine in accordance with NICE guidance.
- Adults who misuse alcohol are offered evidence-based psychological interventions, and those with alcohol dependence that is moderate or severe can in addition access relapse prevention medication in accordance with NICE guidance.
- Children and young people accessing specialist services for alcohol use are offered individual cognitive behavioural therapy, or if they have significant comorbidities or limited social support, a multicomponent programme of care including family or systems therapy.
- People receiving specialist treatment for alcohol misuse have regular treatment outcome reviews, which are used to plan subsequent care.

Box 6. NICE local government briefing on alcohol misuse prevention and treatment

- This briefing summarises NICE's recommendations for local authorities and their partner organisations on how to reduce the harm caused by alcohol. It supports local authorities in their duty to commission alcohol misuse prevention and treatment interventions.

- The briefing poses a range of questions which could be used as a guide when developing a comprehensive plan to help reduce the harm caused by alcohol.

- It describes the need for a local strategy, use of data to inform licensing decisions, involving families in initiatives to reduce alcohol use, alcohol screening, commissioning and evaluating interventions, and tackling under-age sales.
Box 7. Approaches to alcohol harm reduction

- A combination of interventions are needed to reduce alcohol-related harm.

- Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population’s risk of alcohol-related harm. They can help:
  - those who are not in regular contact with the relevant services
  - those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking.

- They can also help prevent people from drinking harmful or hazardous amounts in the first place.

- Interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if it is tackled early. In addition, an early intervention could prevent extensive damage.

4.1.2 Local services and approaches

4.1.2(i) Children and young people

- Hertfordshire’s Drugs and Alcohol Strategy and Delivery Plan, 2016-2019 (see Box 8) informs the provision of services and interventions for children and young people.

- Adolescent and Families Drug and Alcohol Service Hertfordshire (AFDASH), funded by Public Health, currently provides confidential advice, support and treatment for young people under the age of 18 with issues relating to use of drugs and alcohol as well as offering a whole family approach to help address households where there is substance misuse either in the parent or the young person (see Box 9).

- Data on the characteristics of young people in specialist substance misuse services are Hertfordshire is due to be released by the end of 2017 and will be incorporated into this report at the time.

- A new Hertfordshire integrated substance misuse service is being commissioned which will address drug and alcohol misuse in people of all ages (see Box 10).

Box 8. Hertfordshire’s Drugs and Alcohol Strategy and Delivery Plan, 2016-2019

- This strategy is produced on behalf of the Drugs & Alcohol Strategic Board for Hertfordshire. This Board has equal status to other county boards such as the Health & Wellbeing Board and the Criminal Justice Board.

- While accountability at the highest level in Hertfordshire lies with the Herts Leaders’ Group, the delivery of individual priorities is the responsibility of designated topic...
groups accountable to the Drugs & Alcohol Strategic Board.

- The strategy sets out four priority outcomes:
  - People choose not to misuse drugs and/or alcohol.
  - More people get the right help with their drugs and/or alcohol misuse.
  - Fewer children, young people and families are affected by drugs and/or alcohol misuse.
  - Fewer crimes are committed by those who misuse drugs and/or alcohol.

- Specific actions and indicators to measure progress for each priority outcome are set out in the document.

Box 9. Adolescent and Families Drug and Alcohol Service Hertfordshire (AFDASH)

- AFDASH provides specialist holistic assessment and treatment of young people who are misusing alcohol, drugs and volatile substances (excluding nicotine), including age appropriate structured one-to-one psychosocial interventions, structured group interventions and specialist pharmacological intervention.

- The service accepts self-referrals as well as referrals from a variety of different sources such as:
  - Families First Triage Panels
  - Youth Justice services
  - Children Looked After services
  - Targeted Youth Support Teams and Intensive Families First Teams
  - Schools and school partnerships
  - Mental Health Services, GPs and A&E departments
  - Sexual Health Services
  - Youth Connexions
  - Police
  - Voluntary sector organisations

- AFDASH is designed to support young people and their families in an integrated way with a commitment to partnership working; e.g. liaising closely with both Child & Adolescent Mental Health Services (CAMHS) and Adult Mental Health services to support young people and families where comorbid dual diagnosis is apparent and supporting young people in transition to adult drug and alcohol services where appropriate.

4.1.2(ii) Adults

- Local substance misuse services for adults largely address both drug and alcohol misuse. Provision of services and interventions is informed by Hertfordshire’s Drugs and Alcohol Strategy and Delivery Plan, 2016-2019 (see Box 8).52
Hertfordshire’s Health & Wellbeing Strategy 2016-2020 contains a specific objective to reduce the harm caused to health by alcohol and among working age adults (Hertfordshire’s Drugs and Alcohol Strategy and Delivery Plan provides the mechanism through which action to achieve this objective is delivered).  

- Public Health currently fund or commission a range of services, including the provision of adult substance misuse treatment services (including criminal justice), abstinence-based co-addiction provision, and the provision of a range of specialist accommodation support for adult substance misusers.

- Hertfordshire drug and alcohol services and interventions include:
  - **Spectrum Drug and Alcohol Service** – providing treatment provision and prevention:
    - Clinical interventions – provided from Hertford, Stevenage, Hatfield and Watford (including needle exchange services which are also provided at 28 participating pharmacies across the county)
    - Psychosocial interventions – provided from Hertford, Stevenage, Hatfield, Watford and community satellites in Waltham Cross, Letchworth, Borehamwood, St Albans and Hemel Hempstead (including group support for families, friends and carers)
    - Criminal justice – Alcohol Treatment Referrals (ATRs), Drug Rehabilitation Requirements (DRRs) and Test on Arrest – a countywide scheme (operational since April 2016) in which all detainees that are arrested (or charged) for a trigger offence (these are acquisitive crimes e.g. shoplifting, theft from motor vehicle, dwelling burglary) for the second time in a rolling 12-month period are required to undertake an oral swab test for Class A drugs (there are two testing centres, one in Hatfield and one in Stevenage)
    - A range of other support, including a rough sleeping intervention, peer mentor support and access to mutual aid (housing support, employment, education, training and volunteering, community aftercare)
  - **Future Living Hertford** – providing a range of interventions, including:
    - Daily psychosocial group therapy for clients who are abstinent and in recovery from all addictions but particularly drugs and alcohol.
    - Weekly psychosocial group therapy for female survivors of domestic abuse which embraces drugs and alcohol interventions
    - Weekly one-to-one counselling for one year for each client looking at root causes of their addiction
    - Weekly group therapy for those with loved ones who either misuse substances or are in recovery from them (commences September 2018).
    - Weekly music and art therapy group for 14-20 year olds who are abstinent from drugs or alcohol and have been victims of abuse (commences 13th September 2018).
    - A drop-in centre offering support and advice on all of the above projects plus signposting to other relevant services (scheduled to commence 6th September).
Opportunities for recovery clients to engage with a full personal development programme that embraces accredited training in the delivery of drugs and alcohol work.

- Opportunities for training for volunteering/paid for work
- A range of other holistic programmes

- **The Living Room Hertfordshire** – an abstinence-based, non-time limited day service, treating adults with any addiction and cross addictions. The service addresses the root causes of and triggers to break the cycle of addiction, providing strategies and tools for people to live life on life’s terms. Addictions supported include:
  - substances (alcohol and illicit and non-illicit drugs)
  - behavioural addictions (such as disordered eating; gambling; gaming; porn; destructive relationships; self-harming; shopping; sex; compulsions; excessive internet use or any addiction that has impacted lives in a negative way)

Working from two centres in Stevenage and St Albans and various outreach projects, The Living Room provides a free service to those suffering from addictions or their loved ones (self-referrals are welcome). Provision includes:

- group counselling
- psychoeducational workshops
- one-to-one counselling
- recovery toolkit and relapse prevention
- group counselling for families and friends affected by another person’s addictions
- outreach sessions in Watford (over 50s Alcohol addiction) and Hitchin (BME addiction support)
- complementary services (incl. art therapy)
- peer support and networking
- crèche for children under 11 (Stevenage only)
- work experience and volunteering opportunities
- Healthy Lifestyles Check
- mental health and wellbeing
- parenting courses and workshops

- **Resolve** – an adult, drug and alcohol structured day service, delivering a range of therapies aimed at helping people break the cycle of alcohol / substance misuse from centres in Welwyn Garden City, Hatfield and Hitchin, including:
  - one-to-one counselling
  - therapeutic group work
  - one-to-one key work support
  - life skills through drama therapy
  - cognitive behavioural therapy
  - relapse prevention group work
  - life coaching
  - families and carers support services
  - targeted outreach support/street workers targeting difficult to reach people engaged in drinking/substance misuse in public spaces
o **Carers in Hertfordshire** – running a project to provide support for Carers of people who misuse drugs or alcohol, working closely with treatment service providers across the county to assist them in identifying carers

o **Supporting Herts** – working with partners to offer housing-related support to drug and/or alcohol users within Hertfordshire, including:
  - one-to-one outreach support to people who are experiencing substance misuse and housing problems
  - short stay accommodation for those in stable recovery who are leaving prison, detox or rehab or who are homeless
  - a private rented sector scheme providing helping Supporting Herts service users to live in privately rented properties, with support for both landlords and tenants

o **Herts Alcohol Counselling Service** - offering face to face, telephone or online support and information to people who are concerned about their drinking or need help to reduce their drinking or to achieve abstinence, including:
  - counselling and group sessions to support families and carers who are affected by someone else’s drinking
  - recovery and equine facilitated psychotherapy groups focussing on learning new skills to sustain recovery

- Data on the characteristics of adults accessing alcohol treatment services in Hertfordshire in 2016-17 are due to be released by the end of 2017 and will be incorporated into this report at the time.

- A new Hertfordshire integrated substance misuse service is being commissioned which will address drug and alcohol misuse in people of all ages (see Box 10).

<table>
<thead>
<tr>
<th>Box 10. Procurement of all-age drug and alcohol treatment provision for Hertfordshire</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>• In spring 2019, the current contracts for both young people and adult substance misuse treatment services will end. The scope of new treatment services will be guided by The National Drug Strategy 2017 (two of its main focuses are prevention, particularly amongst young people, and building recovery) and by the Hertfordshire Drugs and Alcohol Strategy 2016-2019, which has four priority outcomes:</strong></td>
</tr>
<tr>
<td>o People choose not to misuse drugs and/or alcohol</td>
</tr>
<tr>
<td>o More people get the right help with their drugs and/or alcohol misuse</td>
</tr>
<tr>
<td>o Fewer children, young people and families are affected by drugs and/or alcohol misuse</td>
</tr>
<tr>
<td>o Fewer crimes are committed by those who misuse drugs and/or alcohol</td>
</tr>
<tr>
<td><strong>• The treatment service will provide harm reduction, brief interventions, structured treatment, secondary and tertiary prevention, recovery, and access to wrap-around support (including access to housing related support) to improve the health and well-being and quality of life of children, young people and adults (including older adults) in Hertfordshire with drug and/or alcohol misuse issues.</strong></td>
</tr>
<tr>
<td><strong>• A combination of signposting, advice and treatments will be provided based upon an assessment of individual’s needs, and co-ordination of care with wider services to</strong></td>
</tr>
</tbody>
</table>
support the housing, employment, mental and physical health of individuals and their families and carers.

- A single, integrated service will work across all age ranges and address all substances including:
  - Alcohol
  - Over the counter and prescribed medications, including analgesics & benzodiazepines
  - Opiates
  - Stimulants
  - Novel Psychoactive Substances
  - Cannabis
  - Addiction where substance misuse is strongly linked with other addictive behaviours
  - Tobacco use when it co-occurs with other substance misuse

- It is initially proposed that the service will:
  - target users that present the greatest risk, to themselves or to the community
  - deliver a range of interventions, including evidence based psycho-social interventions, pharmacological interventions, secondary and tertiary prevention, and harm reduction
  - enable service users to access all elements of the service at a range of locations
  - ensure that offenders in the community and those entering or leaving custody have access to specialist treatment interventions
  - protect children by supporting and treating their parents and carers to reduce/abstain from substance use
  - provide access to specialist support for carers who care for those with substance misuse issues
  - develop pathways and protocols with relevant partner organisations and agencies to ensure effective recovery outcomes
  - be made available at times and places where there is demand and supported by outreach
  - provide interventions and information in a variety of ways such as web based self-help tools
  - actively work jointly with services providing sexual health, mental health, smoking cessation, weight management and social care
  - ensure close working relationships and joint delivery arrangements with specialist mental health and learning disability services
  - provide interventions and support for those who are in acute hospital settings
  - have a presence in Accident and Emergency settings throughout the county, particularly at times when substance misuse generates increases in A&E attendance, which might be reduced by the provision of IBA, by signposting to another agency, or by providing an appointment for an assessment
  - support the development of emerging schemes that seek to reduce the impact of substance misuse on the wider health and care system
4.2 Drug misuse

4.2.1 What works?

4.2.1(i) Children and young people

- There is currently little high-quality evidence of ‘what works’ in preventing illegal drug use, although some good quality evidence is emerging. In schools, drug education alone is ineffective at changing behaviour, but programmes that aim to develop the skills required to support healthy decision making can be effective in preventing alcohol, tobacco and some types of illegal drug use.\(^{53}\)

- Mass media campaigns on their own are ineffective and at worst are associated with increased drug use. They should only be used as part of a wider strategy in combination with evidence based programmes, and embedded in research evaluation.\(^{53}\)

- NICE guidance covering children and young people on targeted interventions to prevent misuse of drugs, including illegal drugs, ‘legal highs’ and prescription-only medicines was published in 2017 (see Box 11).

- A NICE quality standard on drug misuse prevention is under development (expected to be published April 2018).

- NICE guidance on needle and syringe programmes for people who inject drugs published in 2014 covers those under 16 as well as adults.\(^{54}\)

- NICE’s local government briefing on tackling drug misuse includes guidance pertaining to children and young people (see Box 12).\(^9\)

- Public Health England has published a set of prompts for commissioners to guide them in commissioning universal and targeted drug, alcohol and tobacco prevention interventions for young people, and specialist interventions for young people already experiencing harms.\(^{46}\) See 4.1.1(i).

- NICE have produced guidance on assessing and managing people aged 14 years and over with coexisting severe mental illness (psychosis) and substance misuse\(^{47}\) and on how to improve services for the same cohort.\(^{48}\)

4.2.1(ii) Adults

- NICE has also published a quality standard on the treatment of adults (18+) who misuse opioids, cannabis, stimulants or other drugs in all settings in which care is received, in particular inpatient and specialist residential and community-based treatment settings. This includes related organisations such as prison services and the interface with other services, for example those provided by the voluntary sector.\(^{55}\)
• A NICE quality standard on drug misuse prevention is under development (expected to be published April 2018).

• NICE guidance on needle and syringe programmes for people who inject drugs was published in 2014.54

• Public Health England has published a set of prompts for commissioners to guide them in planning for drug prevention, treatment and recovery in adults. The document outlines key principles that local areas might consider when developing plans for an integrated system, each followed by a series of prompts to help put them into practice.56 The six principles are:
  o Drug misuse and dependence are prevented by early identification and interventions
  o Prompt access to effective treatment
  o Interventions to address the health harms of drug use
  o Treatment is recovery-orientated, effective, high-quality and protective
  o Treatment supports people to sustain their recovery
  o Commissioners work with partners to commission effective alcohol and drug services

• NICE’s local government briefing on tackling drug misuse includes guidance pertaining to adults (see Box 12).

• NICE have produced guidance on assessing and managing people with coexisting severe mental illness (psychosis) and substance misuse47 and on how to improve services for the same cohort.48

Box 11. NICE guidance on targeted prevention interventions41

• This guideline includes recommendations on:
  o delivering drug misuse prevention activities as part of existing services
  o assessing whether someone is vulnerable to drug misuse
  o providing skills training for children and young people who are vulnerable to drug misuse
  o providing information to adults who are vulnerable to drug misuse
  o providing information about drug use in settings that people who use drugs or are at risk of using drugs may attend

Box 12. NICE local government briefing on tackling drug misuse9

• This briefing summarises NICE’s recommendations for local authorities and partner organisations on tackling drug use. This includes preventing drug use, minimising the harm caused by drugs and helping people to stop taking them. It is particularly relevant to health and wellbeing boards, police and crime commissioners and community safety partnerships.

• The briefing contains a set of questions which could be asked when developing a
comprehensive plan to tackle drug use in the local population, drawn in part from the NICE quality standard for drug use disorders.\textsuperscript{55}

4.2.2 Local services and approaches

4.2.2(i) Children and young people

- See 4.1.2(i)

4.2.2(ii) Adults

- See 4.1.2(ii)

- Data on the characteristics of adults in drug treatment in Hertfordshire in 2016-17 are due to be released by the end of 2017 and will be incorporated into this report at the time.
5.0 Analysis

5.1 What the evidence tells us

- Although Hertfordshire’s drugs and alcohol harm statistics are generally better than those of England as a whole, the costs to public health and the demand on public services from harm caused by the misuse of drugs and alcohol are considerable.

- The worsening of some outcomes locally (such as the rate of hospital admission episodes for alcohol-specific conditions and hospital admissions due to substance misuse in people aged 15-24), the similarity between local figures for some key outcomes and the England average (such as the crude rate of alcohol related road traffic accidents and the percentage of adults drinking over 14 units of alcohol a week), and the rise in estimated prevalence of opiate use in the county demonstrate that tackling harm from drugs and alcohol should remain a Hertfordshire priority.

- There is notable variation across the county with regard to alcohol harm, with Watford and Stevenage generally experiencing worse outcomes – reflecting the relatively higher levels of deprivation and larger night-time economies of these districts. These areas should be a focus for intervention; however, alcohol misuse is a countywide problem which is not exclusively associated with the night-time economy.

- A broad range of factors increase the risk of someone misusing drugs and alcohol either as a young person or an adult, including environmental and social factors affecting the accessibility of drugs and alcohol and the acceptability of their misuse; childhood and adulthood experiences of stress and trauma; and individual characteristics, such as sex and ethnicity.

- Alcohol harm and drug misuse contribute to health inequalities. Some groups are particularly affected, including: military veterans, offenders, people with mental health problems and vulnerable young people. Alcohol harm and drug misuse are also important issues for addressing men’s health inequalities.

- Reducing drug misuse and alcohol harm at a population level requires a whole system approach, including prevention and treatment, which simultaneously tackles multiple aspects of this complex web of causes and risk factors with a combination of interventions aimed at the whole population and individuals.

- Approaches aimed at the whole population are important because they can help create an environment where lower-risk drinking behaviour is the norm. Such interventions benefit society as a whole. They also benefit people who are not in regular contact with the relevant services and those who have been specifically advised to reduce their alcohol intake.  

- Interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage.
• As well as increasing health and wellbeing of individuals and improving quality of life for communities, stopping people from misusing alcohol and drugs has the potential to save considerable amounts of money by:
  o reducing levels of associated crime (estimated to cost £445,000 over the lifetime of one drug user)\(^9\)
  o reducing the burden of associated health service usage (providing health services to someone who injects drugs costs an estimated £35,000+ over his/her lifetime)\(^9\)

• A wealth of national guidance is available to inform the delivery of effective substance misuse services for all ages and ensure that they meet the diverse needs of their target audience.

• Drugs and alcohol treatment services generally have better outcomes in Hertfordshire than in England as a whole and compare reasonably well with the county's statistical neighbours.

• Public Health England’s 2014/15 prevalence estimates for opiate and/or crack use suggest a substantial number of drug users in Hertfordshire are not known to treatment services; however, due to the large confidence intervals around these figures (i.e. their high degree of imprecision) they should be interpreted with caution.

• The commissioning of a new substance misuse service for Hertfordshire provides an opportunity to ensure the delivery of an integrated model for drug and alcohol treatment which is outcome focused and supports people to achieve and sustain recovery, providing effective and appropriate treatment for all stages of life, taking account of changing needs of the population, such as the estimated rising population of opiate users and the use of new psychoactive substances.

5.2 Limitations of this needs assessment

• This needs assessment provides a broad overview of the issues pertaining to harm from drugs and alcohol misuse in Hertfordshire; however, due to the complexity and breadth of the topic it has not been possible to explore many aspects in detail in this report for practical reasons, or to include all available related statistics.

• Crime data reflect recorded crime only. Actual crime related to drugs and alcohol will be greater as a proportion will go unrecorded.

• Only a proportion of those misusing drugs or alcohol will seek or be referred for treatment and only a proportion of those referred will enter treatment. Treatment data therefore reflect the demand for local services but not the full extent of the need for them.

• Self-reported data on drugs and alcohol usage may not represent a true picture as people may not have an accurate perception of their own alcohol usage, for example, or may not answer truthfully when asked about sensitive topics. Modelled estimates also have limitations and should not be interpreted with caution.
• For these reasons, it is difficult to achieve a true picture of the extent of harm caused by drugs and alcohol misuse locally.

• National NTDMS substance misuse statistics giving a current local profile of the characteristics of substance misuse treatment service users are restricted for publication at the time of writing. These are due to be released by the end of 2017 and will be incorporated into this report once the restriction is lifted (the updated JSNA report will be made available at herts.gov.uk/JSNA).
6.0 Recommendations

- A whole system approach should be applied to tackling alcohol harm and drug misuse across the life course – addressing the multiple causes and risk factors associated with substance misuse in childhood and adulthood, adopting both individual and population approaches to prevention and employing a multipronged approach to proactively identifying and referring those in need of treatment. Efforts to reduce or mitigate the effects of exposure to adverse childhood experiences should be considered a key element of a long-term prevention strategy.

- Addressing the increased levels of alcohol harm found in Watford and Stevenage should be a key element of efforts to reduce health inequalities across the county, while retaining a Hertfordshire-wide approach to reducing alcohol harm (with resources allocated proportionately).

- Efforts to prevent and mitigate the harm caused by the misuse of drugs and alcohol should be clearly informed by the comprehensive array of NICE guidance published on the various aspects of this field, including the forthcoming refresh of guidelines on school-based interventions to prevent and reduce alcohol use among children and young people, and the forthcoming NICE quality standard on drug misuse prevention.

- In light of the estimated increase in opiate users in Hertfordshire, relevant data and activity on the ground should be monitored to ensure that any real increase in need is identified and acted upon at the earliest opportunity.

- Commissioning of the new substance misuse service for Hertfordshire should be informed by Public Health England’s commissioning prompts for drugs and alcohol service planning. The service should meet the spectrum of local needs, recognising the varied nature of substance users and their circumstances and effectively reaching underserved groups (including carers, older people who are not accessing services, military veterans, offenders, vulnerable young people and the treatment naïve). It should be effectively joined up with other services to ensure that a whole-person approach is taken to meeting the needs of service users, particularly with regard to mental health.
References


22. Ipsos MORI. *Hertfordshire County Council Alcohol Consumption Survey Results.;* 2017.


41. NICE. *Drug Misuse Prevention: Targeted Interventions - NICE Guideline.*; 2017. nice.org.uk/guidance/ng64.


47. NICE. *Coexisting Severe Mental Illness (Psychosis) and Substance Misuse: Assessment and Management in Healthcare Settings*.; 2011. https://www.nice.org.uk/guidance/cg120.


## Part A: Protected characteristics

### Age

- Substance misuse (including drugs and alcohol) affects a broad age spectrum, from young people to older adults.

- Although young people aged 16-24 years in Great Britain are less likely to drink than any other age group, when they do drink, consumption on their heaviest drinking day tends to be higher than that of other age groups.\(^{12}\)

- A 2017 survey of Hertfordshire residents aged 50+ found that the overall frequency of alcohol consumption in this age group follows a similar pattern to that of the general adult population nationally. This age group were also found to be at lower risk of an alcohol use disorder (AUD) than the general adult population, although 10.5% were at ‘increasing’ or ‘higher’ risk for AUD.\(^{22}\)

- 8.4% of adults aged 16-59 in England and Wales in 2015/16 had taken an illicit drug in the last year compared with 18.0% of young adults aged 16-24 (both figures were significantly higher in 2005/06 - 10.5% and 25.2% respectively).\(^{37}\)

- Drug dependence decreases with age. Males in the 16-24 year old age group had the highest prevalence (11.8%) of drug dependence in England in 2014.\(^{37}\)

- The age profile of opiate users in treatment is older than that of only non-opiate users (excluding those receiving treatment for both non-opiates and alcohol). In 2015/16 in England, more opiate users in treatment were in the 35-39 year old age group than any other, whereas more non-opiate users in treatment were in the 25-29 year old age group than any other.\(^{37}\)

### Disability

- In 2016, there were 550 claimants of Incapacity Benefit/Severe Disablement Allowance or Employment and Support Allowance with alcohol misuse as the main disabling condition in Hertfordshire (76.5 per 100,000 population – a statistically significantly lower rate than England).

### Gender reassignment

- A US study found that compared to transgender-identified people, nontransgender-identified males
and females: have fewer heavy episodic drinking occasions (despite nontransgender-identified males having greater prevalence of heavy episodic drinking).  

- See also Sexual orientation

**Marriage and civil partnership**

- No specific issues identified through this needs assessment.

**Pregnancy and maternity**

- Drinking in pregnancy can lead to long-term harm to the baby - the more alcohol is consumed, the greater the risk. Drinking alcohol, especially in the first three months of pregnancy, increases the risk of miscarriage, premature birth and the baby having a low birth weight. Drinking heavily throughout pregnancy can cause the baby to develop a serious condition called foetal alcohol syndrome (FAS).

**Race**

- In Great Britain, drinking in the past week is more common among those who report being White (61.5%) relative to those who report being any other ethnicity (25.7%).

- The level of teetotalism is lower amongst those who are White (15.7%) compared with all other ethnicity groups (56.0%).

- Abstinence is high amongst South Asians, particularly those from Pakistani, Bangladeshi and Muslim backgrounds. But Pakistani and Muslim men who do drink do so more heavily than other non-white minority ethnic and religious groups.

- People from mixed ethnic backgrounds are less likely to abstain and more likely to drink heavily compared to other non-white minority ethnic groups.

- People from Indian, Chinese, Irish and Pakistani backgrounds on higher incomes tend to drink above recommended limits.

- Over time, generational differences may emerge:
  - Frequent and heavy drinking has increased for Indian women and Chinese men.
  - Drinking among Sikh girls has increased, whilst second generation Sikh men drink less than first generations.

- People from some ethnic groups are more at risk of alcohol-related harm:
  - Irish, Scottish, and Indian men, and Irish and Scottish women have higher than national average alcohol-related deaths in England and Wales.
  - Sikh men are overrepresented for liver cirrhosis.
  - People from minority ethnic groups have similar levels of alcohol dependence compared to the general population, despite drinking less.

- A study of older adults’ drinking habits in the UK published in 2015 found that, compared with older drinkers as a whole, older unsafe drinkers contained a higher proportion of white and Irish ethnic
groups and a lower proportion of Caribbean, African and Asian groups.\textsuperscript{19}  

- England data from 2014 showed that the highest proportion of young people who had tried cannabis came from the Mixed ethnic group while the lowest came from the Asian ethnic group.\textsuperscript{37}

- Based on age-standardised data, adults in the Black/Black British group in England in 2014 had the highest prevalence of drug dependency (7.5%). This may be explained by their higher rates of cannabis use, and could reflect reporting of daily use.\textsuperscript{37}

### Religion or belief

- In England, people with a religious understanding of life are less likely to be hazardous drinkers than those who are neither religious nor spiritual (OR = 0.81, 95% CI 0.69–0.96).\textsuperscript{29}

- In England, people with a religious understanding of life are less likely to have ever used drugs than those who are neither religious nor spiritual (OR = 0.73, 95% CI 0.60–0.88).\textsuperscript{29}

- Spiritual people are more likely than those who are neither religious nor spiritual to have ever used (OR = 1.24, 95% CI 1.02–1.49) or be dependent on drugs (OR = 1.77, 95% CI 1.20–2.61).\textsuperscript{29}

### Sex

- In the UK, girls aged 15–16 years report binge drinking and drunkenness more than boys. Girls are also more likely than boys to be admitted to hospital for alcohol related harm.\textsuperscript{11}

- In 2016, men were more likely to be drinkers than women - 62.8% of men drank in the previous week compared with 51.3% of women.\textsuperscript{12}

- Men are slightly more likely than women to binge drink (see Box 3). In 2016, 28.2% of males in Great Britain stated that they exceeded 8 units of alcohol on their heaviest day, whereas 25.3% of females stated that they exceeded 6 units of alcohol.\textsuperscript{12}

- A study of older adults’ drinking habits in the UK published in 2015 found that, compared with older drinkers as a whole, a higher proportion of older unsafe drinkers were men.\textsuperscript{19}

- Males accounted for 75% of hospital admissions with a primary diagnosis of drug-related mental and behavioural disorders in England in 2015/16.\textsuperscript{37}

- Males accounted for 54% of hospital admissions with a primary diagnosis of poisoning by illicit drugs in England in 2015/16.\textsuperscript{37}

- Males accounted for 74% of deaths related to drug misuse in England in 2015.\textsuperscript{37}

- Men aged 16-59 in England and Wales in 2015/16 were more than twice as likely to report using cannabis in the last year than women (9.1% of men compared with 3.8% of women). Men were almost three times more likely than women to take powder cocaine (3.3% compared with 1.2%) and ecstasy (2.2% compared with 0.8%) in the last year.\textsuperscript{37}

- 4.3% of males aged 16+ in England in 2014 had a drug dependency vs 1.9% of females.\textsuperscript{37}
**Sexual orientation**

- Lesbian, gay, bisexual, and transgender (LGBT) youth are at increased risk for alcohol misuse.\(^{17}\) There is significant heterogeneity in the etiological pathways that lead to alcohol use in LGBT youth and correlates of drinking are similar to those found in general populations.\(^{17}\)

- UK research evidence suggests that the 12 month relative risk of alcohol dependence is twice the rate in LGB people compared to control groups. It may be as high as four times the rate in lesbian and bisexual women.\(^{28}\)

- A systematic review of research evidence found an approximately 2.5 times higher risk of 12 month drug dependence in LGB people compared to controls.\(^{28}\)

- Research in Northern Ireland showed that 14.7% of same/both sex attracted students compared to 8.4% of opposite sex attracted students reported feeling pressurised to take illegal drugs.\(^{28}\)

**Part B: Other categories**

**Military personnel and armed forces veterans**

- A growing body of research indicates that harmful or hazardous alcohol misuse, alcohol-related problems and binge drinking are more prevalent in the military than the general population.\(^{34}\)

- A survey of serving and ex-serving members of the UK Armed Forces found that 13.0% overall reported alcohol misuse. Among those with probable post-traumatic stress disorder (PTSD), 44.9% reported alcohol misuse. 13.6% of those with alcohol misuse also met the criteria for PTSD.\(^{32}\)

- Evidence from the US has shown drug use disorder to be a major public health challenge among veterans.\(^{42}\)

- Research studies using diagnostic criteria to look at the prevalence of drug use disorders among veterans report higher prevalence than those using administrative criteria (20% vs. 5%).\(^{42}\)

- There is a well-established association between PTSD and substance misuse (including alcohol misuse).\(^{31,32}\)

- The importance of meeting the needs of those who have served in the military in the provision of drugs and alcohol treatment services is highlighted in the recommendations of this JSNA.

**Carers**

- A US study published in 2010 found that caregivers who experience social and emotional burden related to caregiving are at risk for problematic alcohol use.\(^{35}\)

- The importance of meeting the needs of carers in the provision of drugs and alcohol treatment services is highlighted in NICE guidance and in the recommendations of this JSNA.
Appendix B: Charts and tables

Alcohol harm

Children and young people

Fig. 1.1 Admission episodes for alcohol-specific conditions (under 18)

Admission episodes for alcohol-specific conditions,
Persons, <18 yrs

![Bar chart showing admission episodes for alcohol-specific conditions by year and area.]

Source: Local Alcohol Profiles for England (LAPE) PH.Intelligence@hertfordshire.gov.uk

Adults

Fig. 2.1 Years of life lost due to alcohol-related conditions (aged under 75)

Years of life lost due to alcohol-related conditions,
Persons, <75 yrs

![Bar chart showing years of life lost due to alcohol-related conditions by year and area.]

Source: Public Health Outcomes Framework (PHOF) PH.Intelligence@hertfordshire.gov.uk
Fig. 2.2 Alcohol-specific mortality (all ages)

Alcohol-specific mortality (directly age-standardised rate per 100,000), Persons, All ages

Source: Public Health Outcomes Framework (PHOF)

Fig. 2.3 Alcohol-related mortality (all ages)

Alcohol-related mortality (directly age-standardised rate per 100,000), Persons, All ages

Source: Local Alcohol Profiles for England (LAPE)
Fig. 2.4 Admission episodes for alcohol-specific conditions (all ages)

Admission episodes for alcohol-specific conditions, Persons, All ages

Source: Local Alcohol Profiles for England (LAPE)

Fig. 2.5 Admission episodes for alcohol-related unintentional injuries (Narrow) (all ages)

Admission episodes for alcohol-related unintentional injuries conditions (Narrow), Persons, All ages

Source: Local Alcohol Profiles for England (LAPE)
Fig. 2.6  Admission to hospital for mental and behavioural disorders due to alcohol (Narrow) (all ages)

Admission to hospital for mental and behavioural disorders due to alcohol (Narrow), Persons, All ages

Source: Local Alcohol Profiles for England (LAPE)  PHIntelligence@hertfordshire.gov.uk

Fig. 2.7  Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow) (all ages)

Admission episodes for intentional self-poisoning by and exposure to alcohol condition (Narrow), Persons, All ages

Source: Local Alcohol Profiles for England (LAPE)  PHIntelligence@hertfordshire.gov.uk
Fig. 2.8 Claimants of benefits due to alcoholism (Persons - Males 16-64; Females 16-61)

Claimants of benefits due to alcoholism, Persons, 16-64 yrs (M), 16-61 yrs (F)

![Figure 2.8: Claimants of benefits due to alcoholism](image)

Source: Local Alcohol Profiles for England (LAPE) PH.Intelligence@hertfordshire.gov.uk

Fig. 2.9 Alcohol-related road traffic accidents (aged 17+)

Alcohol Related Road Traffic Accidents, Persons, 17+ yrs

![Figure 2.9: Alcohol-related road traffic accidents](image)

Source: STATS19 data provided by the Department of Transport. PH.Intelligence@hertfordshire.gov.uk
Fig. 2.10  Successful completion of alcohol treatment (aged 18-75)

Successful completion of alcohol treatment, Persons, 18-75 yrs

Source: National Drug Treatment Monitoring System

Fig. 2.11  Proportion waiting more than 3 weeks for alcohol treatment (aged 18+)

Proportion waiting more than 3 weeks for alcohol treatment, Persons, 18+ yrs

Source: National Drug Treatment Monitoring System
Fig. 2.12  Percentage of adults drinking over 14 units of alcohol per week (aged 18+)

Percentage of adults drinking over 14 units of alcohol per week, Persons, 18+ yrs

Source: PHE Knowledge & Intelligence.

Fig. 2.13  Alcohol-related crime

Alcohol-related crime in Hertfordshire, rate per 1,000 population, 2015/16-2016/17

Source: Hertfordshire Police
Drug misuse

Children & young people

Fig. 3.1  Hospital admissions due to substance misuse (aged 15-24)

Hospital admissions due to substance misuse (15-24 years), Persons, 15-24 yrs

Source: Local Authority Child Health Profiles  PH.Intelligence@hertfordshire.gov.uk

Fig. 3.2  Percentage who have taken drugs (excluding cannabis) in the last month (aged 15)

Percentage who have taken drugs (excluding cannabis) in the last month, Persons, 15 yrs

Source: What About YOUth (WAY) survey 2014/15  PH.Intelligence@hertfordshire.gov.uk
**Fig. 4.1** Concurrent contact with mental health services and substance misuse services for drug misuse (aged 18+)

**Concurrent contact with mental health services and substance misuse services for drug misuse, Persons, 18+ yrs**

Source: National Drug Treatment Monitoring System

**Fig. 4.2** Adults with substance misuse treatment need, who successfully engage in community-based structured treatment following release from prison (aged 18+)

**Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison, Persons, 18+ yrs**

Source: NDTMS
Fig. 4.3  Deaths from drug misuse (all ages)

Deaths from drug misuse, Persons, All ages

![Bar chart showing deaths from drug misuse in different years and regions]

Source: Office for National Statistics (ONS)  PH.Intelligence@hertfordshire.gov.uk

Fig. 4.4  Proportion waiting more than 3 weeks for drug treatment (aged 18+)

Proportion waiting more than 3 weeks for drug treatment, Persons, 18+ yrs

![Bar chart showing proportion waiting more than 3 weeks for drug treatment in different years and regions]

Source: Office for National Statistics (ONS)  PH.Intelligence@hertfordshire.gov.uk
### Fig. 4.5 Classification of drugs

<table>
<thead>
<tr>
<th>Class A</th>
<th>Class B</th>
<th>Class C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crack cocaine, ecstasy (MDMA), heroin, LSD, magic mushrooms, methadone, methamphetamine (crystal meth)</td>
<td>Amphetamines, barbiturates, cannabis, codeine, ketamine, methylphenidate, barbiturates, cannabis, codeine, ketamine, methylphenidate (Ritalin), synthetic cannabinoids, synthetic cathinones (eg mephedrone, methosetamine)</td>
<td>Anabolic steroids, benzodiazepines (diazepam), gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP, khat)</td>
</tr>
</tbody>
</table>

### Fig. 4.6 Possession of drugs, numbers by class, 2014/15-2016/17

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Class A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broxbourne</td>
<td>50</td>
<td>348</td>
<td>0</td>
<td>398</td>
</tr>
<tr>
<td>Dacorum</td>
<td>69</td>
<td>499</td>
<td>0</td>
<td>568</td>
</tr>
<tr>
<td>East Hertfordshire</td>
<td>38</td>
<td>249</td>
<td>3</td>
<td>290</td>
</tr>
<tr>
<td>Hertsmere</td>
<td>21</td>
<td>234</td>
<td>2</td>
<td>257</td>
</tr>
<tr>
<td>North Hertfordshire</td>
<td>52</td>
<td>189</td>
<td>1</td>
<td>242</td>
</tr>
<tr>
<td>St Albans</td>
<td>55</td>
<td>238</td>
<td>1</td>
<td>291</td>
</tr>
<tr>
<td>Stevenage</td>
<td>66</td>
<td>220</td>
<td>3</td>
<td>289</td>
</tr>
<tr>
<td>Three Rivers</td>
<td>18</td>
<td>144</td>
<td>0</td>
<td>162</td>
</tr>
<tr>
<td>Watford</td>
<td>155</td>
<td>354</td>
<td>1</td>
<td>510</td>
</tr>
<tr>
<td>Welwyn/Hatfield</td>
<td>61</td>
<td>250</td>
<td>4</td>
<td>315</td>
</tr>
<tr>
<td><strong>Hertfordshire</strong></td>
<td>582</td>
<td>2725</td>
<td>15</td>
<td>3322</td>
</tr>
</tbody>
</table>

### Fig. 4.7 Possession of drugs, Class A, 2014/15-2016/17

Class A possession as a proportion of all drug possessions, 2014/15-2016/17

Source: Hertfordshire Police
Fig. 4.8  Possession of drugs, Class B, 2014/15-2016/17

Class B possession as a proportion of all drug possessions, 2014/15-2016/17

<table>
<thead>
<tr>
<th>Location</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broxbourne</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duxford</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Hertford</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hertford</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Hertford</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Albans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stevenage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thorpe Ranks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watford</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welwyn Hatfield</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hertfordshire</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Hertfordshire Police  
ph.intelligence@hertfordshire.gov.uk

Fig. 4.9  Test on Arrest in Hertfordshire, 2016/17

<table>
<thead>
<tr>
<th>Year 1 2016/17</th>
<th>Required Test</th>
<th>Refused</th>
<th>Tested</th>
<th>Positive</th>
<th>Negative</th>
<th>Disputed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1128</td>
<td>30</td>
<td>1098</td>
<td>864</td>
<td>234</td>
<td>33</td>
</tr>
</tbody>
</table>