

Agenda Item:

Joint Public Health Board

11

Bournemouth, Poole and Dorset councils working together to improve and protect health

Date of Meeting	8 February 2016
Officer	Director for Public Health
Subject of Report	Drug and Alcohol Programme
Executive Summary	<p>This paper summarises progress with the drug and alcohol programme and in particular feedback on progress from the Pan-Dorset Drug and Alcohol Governance Board.</p> <p>It also summarises the process that underpinned the development of the Bournemouth, Poole and Dorset Alcohol and Drug Strategy and outlines the work to develop multi-agency action plans to support the implementation of the strategy.</p>
Impact Assessment: <i>Please refer to the protocol for writing reports.</i>	Equalities Impact Assessment: In relation to the Drug and Alcohol Strategy, an equalities impact assessment screening process has been completed and no concerns identified. Further assessment will be undertaken with the development of action plans.
	Use of Evidence: Both national and local evidence and information has been used in the production of the strategy as referenced within the strategy document.
	Budget: No budgetary implications

	<p>Risk Assessment:</p> <p>Having considered the risks associated with this decision using the County Council’s approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW</p>
	<p>Other Implications:</p> <p>The drug and alcohol agenda has implications on a broad range of other local authority strategic priority areas, as well as on the work of a range of other stakeholders. These implications are recognised within the strategy itself and will be considered in more detail through the development of action plans to support the implementation of the strategy.</p>
<p>Recommendation</p>	<p>Recommendation 1:</p> <p>The Joint Public Health Board is asked to note progress within the drug and alcohol programme.</p> <p>Recommendation 2:</p> <p>The Joint Public Health Board is asked to approve the Bournemouth, Poole and Dorset Alcohol and Drug Strategy.</p>
<p>Reason for Recommendation</p>	<p>The Pan-Dorset Drug and Alcohol Governance Board have agreed the proposed Drug and Alcohol Strategy.</p>
<p>Appendices</p>	<p>1. Bournemouth, Poole and Dorset Alcohol and Drug Strategy 2016-2020</p>
<p>Background Papers</p>	<p>Drug and Alcohol Commissioning in Bournemouth, Dorset and Poole</p>
<p>Report Originator and Contact</p>	<p>Name: Nicky Cleave, Assistant Director of Public Health Tel: 01305 225879 Email: n.cleave@dorsetcc.gov.uk</p>

1. Background

1.1 In February 2015, the Joint Public Health Board agreed proposals to rationalise commissioning arrangements for drug and alcohol services by:

- Extending the remit of Public Health Dorset to develop a more comprehensive central commissioning function, whilst integrating any remaining DAAT officer functions within broader local authority commissioning functions

- Replacing the local authority specific governance functions with a Pan-Dorset Drug and Alcohol Governance Board

1.2 This paper covers two areas:

- An update on progress within the drug and alcohol programme since the agreed changes were implemented – this includes the work of the Governance Board.
- A new Bournemouth, Poole and Dorset Alcohol and Drug Strategy for 2016-2020.

2. Progress within the Drug and Alcohol Programme

2.1 Good progress has been made with the implementation of the revised commissioning and governance arrangements.

2.2 The Governance Board is established and has met on three occasions. This Board is supported by the Lead Commissioners Group who has agreed a pan-Dorset work plan for 2015/16 and good progress has been made against this. The work plan includes:

- The development of a multi-agency pan-Dorset strategy as outlined below
- Work to consider the options to rationalise the existing data management systems
- Service review work to support the plans for re-commissioning of a number of services across Bournemouth, Dorset and Poole for 2017/18.

2.3 The transfer of some commissioning responsibilities to Public Health Dorset is currently being finalised, and there will be a full adjustment to associated budgets for 2016/17.

2.4 Public Health Dorset has recruited to the new posts which were agreed as part of the business case to support the centralised commissioning functions - this includes performance reporting, information analysis and service quality and standards work.

Recommendation 1:

The Joint Public Health Board is asked to note progress within the drug and alcohol programme.

3. Bournemouth, Poole and Dorset Alcohol and Drug Strategy

3.1 Public Health Dorset and local commissioners from Bournemouth and Poole have been coordinating the process of drafting a drug and alcohol strategy and processes for delivering on the outcomes specified within this. This paper outlines progress to date, and a timetable for action from this point. The members of the group are asked to comment on these processes and the draft provided as an appendix to this paper.

3.2 A stakeholder event to discuss the broader aims and principles was held in September 2015. This was well attended by a wide range of stakeholders.

3.3 From this initial feedback, three separate themes were identified for the strategy - Prevention, Treatment, and Safety – and the draft strategy is attached here.

3.4 At the stakeholder event discussion revealed that there is considerable overlap between the range of substances in terms of the target populations and wider stakeholders who would deliver and facilitate interventions for these individuals.

Therefore, a single strategy for both alcohol and other drugs has been recommended on the basis that separate strategies and/or action plans would lead to unnecessary duplication and inefficiency.

- 3.5 The draft strategy was circulated for consultation during December 2015, and the version presented here in appendix 1 has incorporated those comments. The strategy has been agreed with the Pan-Dorset Drugs and Alcohol Governance Board in January 2016.
- 3.6 It is proposed that there will be an action plan for each of the themes of Prevention, Treatment and Safety to deliver on the outcomes specified in the strategy.
- 3.7 Local commissioners are developing draft action plans during January and February prior to a small, focused stakeholder event on 23 February 2016.
- 3.8 Dedicated action groups with representation from relevant stakeholders for each theme will develop plans to deliver the outcomes identified in the strategy, and the Governance Board will be responsible for monitoring progress against the action plans.

Recommendation 2:

The Joint Public Health Board is asked to approve the Bournemouth, Poole and Dorset Alcohol and Drug Strategy.

**Dr David Phillips
Director of Public Health
February 2016**

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Foreword

Our relationship with alcohol and other drugs is complex, and the challenges posed cannot be addressed by any one agency or individual alone.

As of April 2015 we have come together through a new partnership: the Bournemouth, Poole and Dorset Drug and Alcohol Governance Board. This brings together a variety of perspectives and strengths to focus on delivering change across the whole area, as these problems don't respect geographical boundaries.

This strategy has been developed by the governance board to provide a framework for all of us to work together to improve the lives of the people in Bournemouth, Poole and Dorset in relation to alcohol and other drugs. We aim for everyone living in the area to have a balanced attitude to alcohol and other drugs, and we have an ambition for sustained recovery, reducing harm to individuals and the wider community.

We see this as being achieved through three themes of activity: prevention, treatment and safety. That is, we seek to improve people's wellbeing, increase their chances of recovery from substance misuse, and help ensure they are safe.

While the strategy offers a framework and set of principles, the details of how we will confront these issues will be contained within three action plans – one for each of the three themes.

Now is the right time to publish a new strategy, because it helps to address two key challenges.

Firstly, all agencies represented by this strategy will face financial pressures in the period 2016 to 2020. To tackle the significant issues in this context we will need to work together smarter.

Secondly, the issues people face today are not those of ten or twenty years ago. There are new substances, such as 'legal highs'; new supply routes, including the internet and 'head shops'; and new patterns of use and problems associated with more established substances, including problems with heroin and alcohol becoming more common among older people.

We need to respond to these challenges, and be aware that this area never stands still. We need a coordinated response to the problems caused by alcohol and other drugs in our local area, and we need this response to continue to develop as patterns of substance use and harm change.

This strategy is a key step towards having a constructive and responsive approach to alcohol and other drugs across Bournemouth, Poole and Dorset. We are happy to endorse it and we look forward to seeing it in action.

Bournemouth, Poole and Dorset Drug and Alcohol Governance Board

Executive summary

What is the problem?

Most of us drink alcohol within recommended guidelines, don't use illegal substances, and don't suffer any significant personal harm as a result.

Alcohol and other drugs can cause immediate and long term health damage. Misuse is associated with a range of wider problems including crime and disorder.

The effects of these substances are felt not only by the user, but by their family, including carers, friends and wider community. Children and young people may be particularly vulnerable – and may have a caring role themselves.

A number of organisations have a role to play in addressing these issues.

Current and future challenges

While levels of alcohol use have fallen over the past 10 years, admissions to hospital for alcohol-related illnesses have increased.

The harm resulting from misuse of alcohol and other drugs is not evenly distributed across the population, and is not concentrated in the groups that drink the most or are most likely to use illicit drugs.

More people are drinking at levels that may damage their health than are accessing support. There is a significant and increasing number of people who have been engaged in treatment for opiate use for a long period of time (six years or more) without completing their treatment successfully.

New psychoactive substances are available through new routes, including the internet and 'head shops'.

Next steps

We have set out our vision for tackling drug and alcohol issues:

We aim for everyone living in Bournemouth, Poole and Dorset to have a balanced attitude to alcohol and other drugs, and we have an ambition for sustained recovery, reducing harm to individuals and the wider community.

This vision is supported by three main outcomes. We will measure progress of these outcomes by key indicators for alcohol and other drugs, and achieved through identified objectives and actions.

Outcome one: prevention

“The wellbeing of communities and people affected by alcohol and other drugs is improved”

High level indicators:

- Reduce alcohol-related hospital admissions
- Reduce drug-related hospital admissions

Outcome two: treatment

“People achieve real sustained recovery from drug and alcohol misuse”

High level indicators:

- Increase proportion of alcohol users that exit treatment successfully
- Increase proportion of drug users that exit treatment successfully

Outcome 3: Safety

“Communities and people affected by alcohol and other drugs are safer”

High level indicators:

- Reduce alcohol-related crime
- Reduce drug-related crime

The governance board will monitor progress against these outcomes. We will deliver work through action plans developed for each of the three themes of prevention, treatment and safety.

Principles

As we work to make this vision a reality, all partners have agreed to the following four principles:

- Build services around the need of the service user, their families and the wider community
- Focus on areas of demographic and geographic need
- Work in partnership to make the best use of all resources in our communities
- Share appropriate information for the benefit of service design and service user support

Introduction

The misuse of alcohol and other drugs continues to cause considerable harm to families and communities in Bournemouth, Poole and Dorset.

Most of us drink safe amounts of alcohol, but we are concerned with two main issues for alcohol. The first is related to people who drink and cause harm to others. The second is related to people who drink above safe limits – harming themselves, often without knowing it.

While the vast majority of us do not use street drugs or new psychoactive substances, commonly known as ‘legal highs’, we face a significant challenge locally through the increase of opiate users who have remained in treatment services for more than six years. With an ultimate ambition for these people to lead drug-free lives independent of services, it is important we have a common goal for how we tackle such a complex matter.

Now is the right time to build on our achievements by developing existing work and delivering innovations to address current and future challenges.

This strategy sets out to build a clear approach to dealing with drug and alcohol misuse in our local population; establishing outcomes that will make a difference to people’s lives, with annual action plans that hold accountable partners to the strategy.

Having a clear joint vision, along with agreed actions is a core principle of this strategy and crucial given the financial pressures and challenges that all public sector organisations are facing during the next four years. As we look to deliver public services more efficiently, it is important that organisations work together to develop policies and practices.

Partners from Bournemouth, Poole and Dorset came together in September 2015 to share their views and experiences as part of the development of this strategy. This feedback has been cross referenced with HM Government’s alcohol (2012) and drug (2010) strategies and the latest evidence and best practice guidelines.

The alcohol and drug strategy for Bournemouth, Poole and Dorset sets out the following:

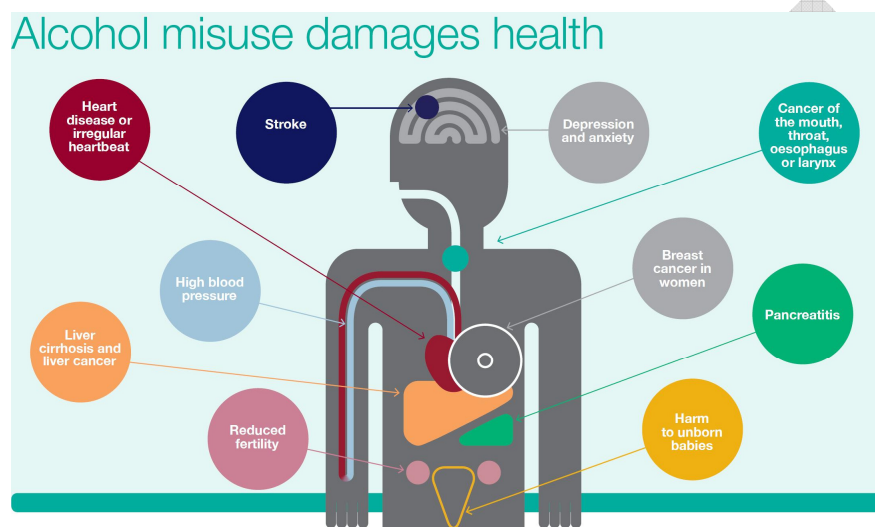
- **A background to the key local issues**
- **Vision and aims of the strategy**
- **Principles**
- **Next steps to deliver the strategy outcomes**

What is the problem?

Alcohol

Our relationship with alcohol is complex. There are many people who choose not to drink, and, for the majority of people who drink in our local area, alcohol is an accepted and pleasurable part of life.

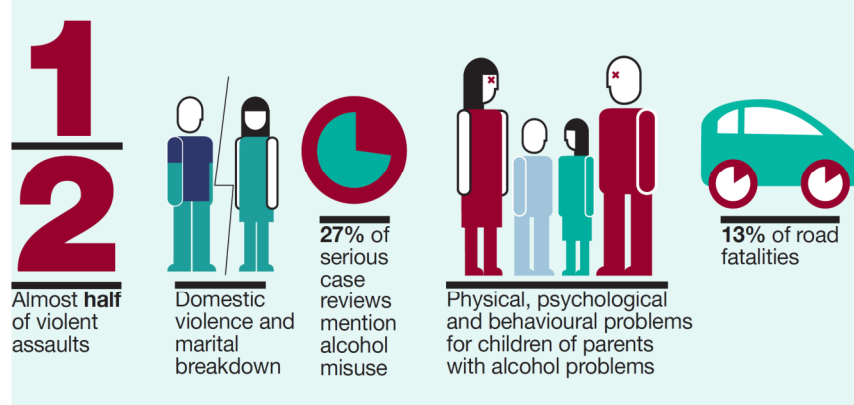
Alcohol has a place in our local community and economy, not only through bars and pubs in town centres but also the range of licensed premises from rural pubs to urban restaurants. Dorset has a range of brands of alcoholic products that have a local and national profile and are available through various retailers in Dorset and across the country.



Source: Public Health England.

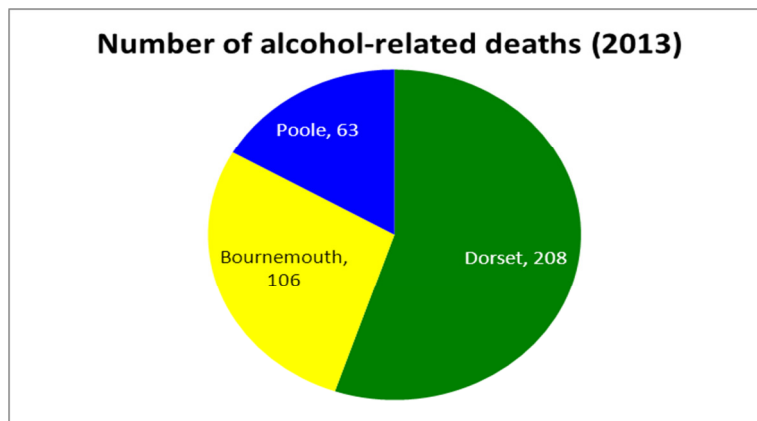
But the use of alcohol also carries significant risk. Alcohol contributes to a wide range of health problems, relationship breakdown and crime and disorder. These issues also create wider social costs to public services and affect productivity and earnings.

Alcohol misuse harms families and communities



Source: National data, taken from Public Health England.

Locally, in a year, about 3,300 recorded crimes, 240 traffic collisions and more than 8,000 hospital admissions are related to alcohol.



Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates. Available from <http://fingertips.phe.org.uk/>

Health problems from drinking do not just affect people who are dependent on alcohol, or who drink to get drunk. Drinking above low-risk guidelines (see Box one below) can cause many harmful effects, including liver problems, reduced fertility, high blood pressure, increased risk of various cancers and heart attack. These harms usually only emerge after a number of years. By then, serious health problems could have developed. This is particularly likely when the person faces other risk factors from issues such as smoking, exercise or diet. This means some groups are more vulnerable to harm than others.

Box one: What is risky drinking?

The Chief Medical Officers' guideline for both men and women is that:

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level.
- If you do drink as much as 14 units per week, it is best to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries.
- The risk of developing a range of illnesses (including, for example, cancers of the mouth, throat and breast) increases with any amount you drink on a regular basis.
- If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week.

Taken from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489795/summary.pdf

Box 2: What is a unit of alcohol?

<p>1.5 units</p>  <p>Small glass red/white/rose wine (125ml, ABV 12%)</p>	<p>2.1 units</p>  <p>Standard glass red/white/rose wine (175ml, ABV 12%)</p>
<p>3 units</p>  <p>Large glass red/white/rose wine (250ml, ABV 12%)</p>	<p>2 units</p>  <p>Pint of lower-strength lager/beer/cider (ABV 3.6%)</p>
<p>3 units</p>  <p>Pint of higher-strength lager/beer/cider (ABV 5.2%)</p>	<p>1.7 units</p>  <p>Bottle of lager/beer/cider (330ml, ABV 5%)</p>
<p>2 units</p>  <p>Can of lager/beer/cider (440ml, ABV 4.5%)</p>	<p>1.5 units</p>  <p>Alcopop (275ml, ABV 5.5%)</p>
<p>1 unit</p>  <p>Single small shot of spirits* (25ml, ABV 40%)</p>	

Taken from: <http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx>

Drugs other than alcohol

Most people in Bournemouth, Poole and Dorset do not use drugs other than alcohol, but those who do can cause high levels of harm to themselves, others around them and the wider community. This includes the use of street (illicit) drugs, new psychoactive substances ('legal highs') and misuse of, or dependence on, prescribed drugs.

Almost 4,000 people are estimated to be using crack cocaine, heroin or other opiate drugs across the area. Although this represents less than one per cent the population, there are considerable harms associated with the use and supply of these substances.

Across Bournemouth, Poole and Dorset, there are likely to be around 40 drug related deaths in a year, 700 hospital admissions and during the same time period more than 1,500 crimes linked to drug offences.

Parental drug use is a risk factor in many serious case reviews, which are undertaken when a child dies (including suicide), and abuse or neglect is known or suspected to be a factor in the death. Heroin and crack use causes crime and disrupts community safety – a typical heroin user spends about £1,400 a month on drugs, which is unsustainable for most people without debt and crime funding their habit.

Drug misuse harms families and communities



Source: National data, taken from Public Health England.

Given that 86% of people locally drink some amount of alcohol, and nationally 35% of people report using another drug at some point in their livesⁱⁱ, we know that not everyone goes on to develop problems. Issues around alcohol and other drugs cannot be separated from wider aspects of people's lives. There are many factors that influence people's life course, whether environmental, social, economic or psychological. Different public services have a role to play in tackling these issues, and each has their own unique contribution to make.

What have we achieved?

Locally as well as nationally, work has been done by a number of partners to deal with substance misuse and related issues. This has had a clear impact on the lives of people living in Bournemouth, Poole and Dorset.

This work can be separated into three themes:

- **Prevention** work seeks to reduce problematic use of substances and tries to ensure that when people do use substances they do so with the minimum of risk.
- **Treatment** services offer support to those who do use substances and have developed some form of dependency, helping them to change their patterns of behaviour.
- **Safety** initiatives aim to reduce the crime and disorder sometimes associated with substance misuse, for example through policing interventions and licensing policies.

Here, we highlight just a few key examples of work that has been carried out locally.

Prevention

- 1) The Purbeck Pledge is a new health and wellbeing campaign implemented by Purbeck District Council, the Purbeck Locality CCG, Dorset Community Action and LiveWell Dorset between June and November 2015. The campaign aimed to raise alcohol awareness and revolved around encouraging people to ‘take a pledge’ to abstain or reduce their drinking during the month of October. Pledgers were supported with awareness raising resources, including a website, five Tips, Tastes and Tales newsletters and a Directory of Local Groups and Services. 257 people signed up to take the Pledge by the end of the Pledge month, and 36 local bodies formally signed up as Supporting Organisations. 75% of participants know more about alcohol as a result of the campaign, 87% reduced alcohol consumption during October, and 83% intend to watch or reduce their drinking in future.
- 2) Bournemouth Borough Council, in partnership with Public Health Dorset and LiveWell Dorset has developed the pilot #MyHappyHour campaign, which encourages people to take up a healthy, social activity in place of time focused around alcohol. The campaign used social media to encourage people to share photos and videos of their alternative activity. This challenged people to come up with their own answer to the common view that drinking is the default social activity. The campaign received about people submitted about 230 challenges.

Treatment

- 1) Across Bournemouth, Poole and Dorset, 75% of those estimated to use opiates or crack cocaine have used treatment services at some point. This high level of engagement is an achievement as it helps to reduce transmission of blood borne viruses such as HIV and Hepatitis, and helps reduce crime – particularly theft and robbery.ⁱⁱⁱ The patterns are encouraging for the future, as fewer people aged 15 to 34 use heroin than in the past.^{iv}
- 2) In partnership with local substance misuse commissioners and the relevant localities of the CCG, Poole Hospital developed a seven day multi-agency, multi-

disciplinary alcohol care & treatment service (ACTS) made up of specialist addiction nurses, an addiction care coordinator, brief intervention workers and assertive outreach alcohol workers. Since the service started, it has had a significant impact on alcohol attributable admissions, emergency department attendances and ambulance journeys. This has saved the trust a substantial amount of money and, more importantly, improved the health and social wellbeing of patients under the care of ACTS. The service's success has resulted in national recognition as finalists in this year's Health Service Journal award for innovation in an acute trust.

Safety

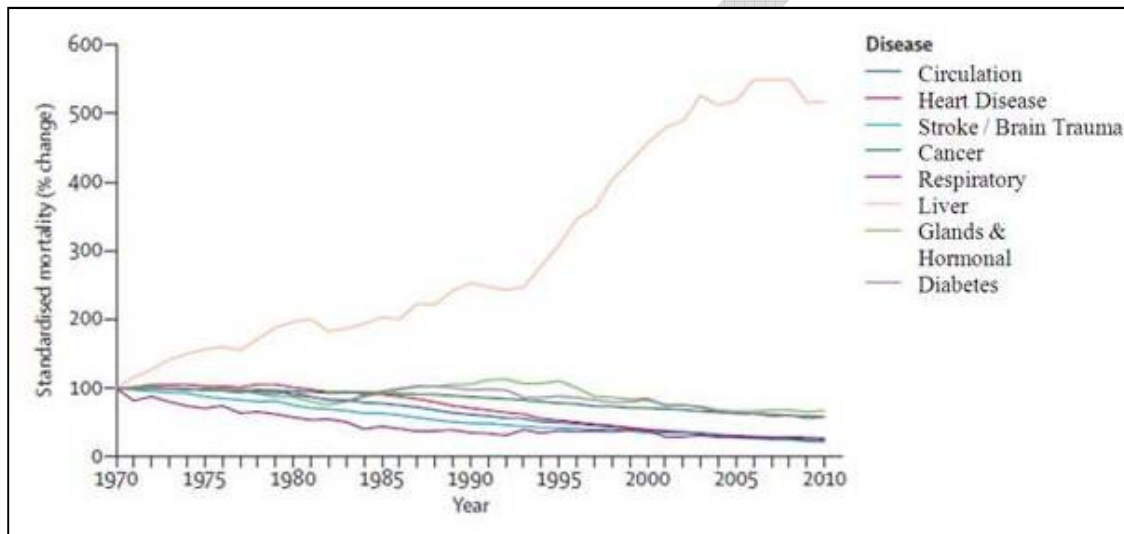
- 1) Horseshoe Common in Bournemouth town centre has undergone a major redevelopment, and now boasts a modern street layout, fresh open space and new street furniture, completely revitalising this part of town which is a key part of the town's night-time economy. The new layout uses high-quality urban design and is based on a 'shared space' approach, which is already working well in thriving towns and cities across the UK. It aims to safely integrate all road users and encourage everyone to take additional care, as there may be some uncertainty as to who has priority. Providing an open space for pedestrians to enjoy the area in a safe manner is a key part of the scheme. A new seating area in the Common offers people the comfort to relax in the green open space, while providing a great area for events. The redevelopment has been awarded 'Small Project of the Year' by the Institute of Highway Engineers South West Branch (IHESW).
- 2) Dorset Police has worked with the charity Druglink to implement the Alcohol Diversion Scheme across the area. Under this scheme, people who have been issued with a penalty notice for disorder related to alcohol can choose to pay £45 to attend a one-day educational course rather than paying the full £90 fine. The fees received from attendees cover the costs of the programme, which has been run in Bournemouth, Poole and Weymouth. After the first year, there had been 14 courses run with a total of 78 people attending. Those attending the course have, on average, reduced their alcohol consumption and issues associated with this. There is also evidence that offending behaviour was addressed through the programme. At the time of evaluation, under 18% of those who had gone through the programme had reoffended, compared to national figures of 29% for those who have received a fine.^v

Current and future challenges

Alcohol

There are particular emerging challenges both nationally and locally. The graph below shows the rise in liver disease in the UK over the past 40 years. Liver disease kills more people than diabetes and road deaths combined, but is largely preventable.

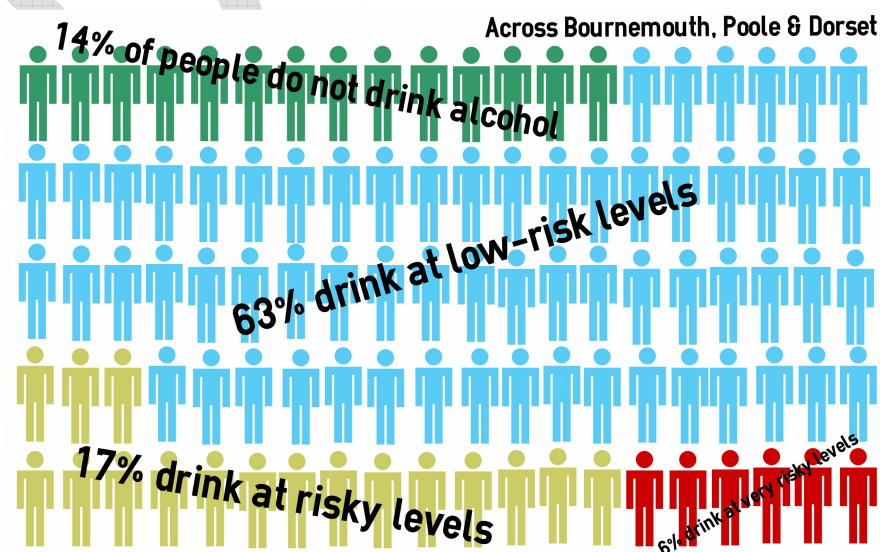
While about five per cent of liver disease is attributable to autoimmune disorders, most liver disease is due to three main risk factors: alcohol, obesity and viral hepatitis. But most people at risk of developing serious liver disease, or who have early liver damage, are not aware of this.



Graph

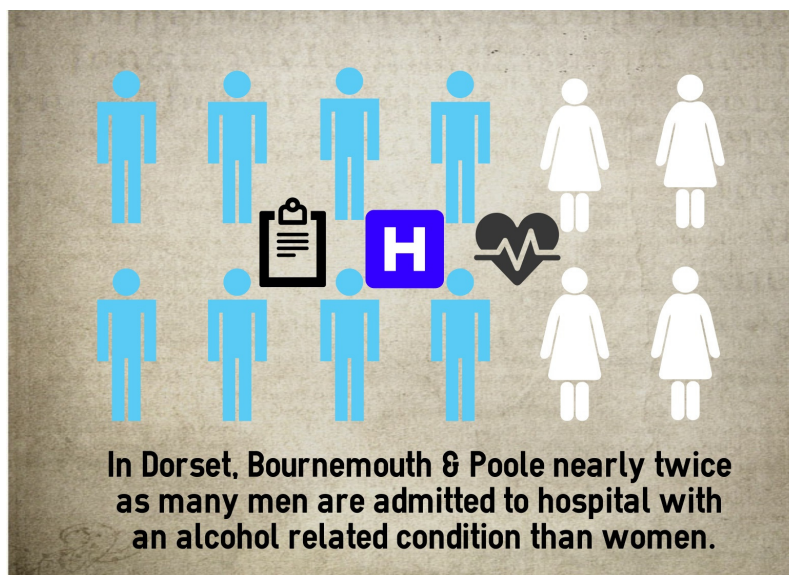
from the Lancet Liver Campaign report: Addressing liver disease in the UK. Data are from the WHO-HFA database, normalised to 100 in 1970, and were analysed by Nick Sheron September, 2013.

Alcohol-related liver disease deaths in Britain have increased more than four fold since 1970. In 2010-12, 7.5 people in every 100,000 died early from alcohol-related liver disease, which was about 922 deaths.^{vi}



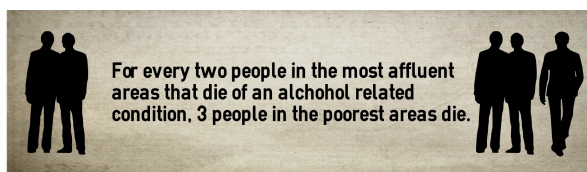
Across Bournemouth, Poole and Dorset about 6% of people aged 16 or over are drinking at higher risk levels; a total of over 37,000 people. Encouraging everyone who drinks in the area to do so in a safe and social way is a significant challenge.

Drinking patterns are different across Bournemouth, Poole and Dorset and research has shown that the harm from drinking is not evenly distributed across the population, and is closely tied to other factors of health and social inequality. Any action we take locally will need to be targeted to make sure that services are accessible to, and used by, those who need them the most, and looks at the needs of the whole person, not simply their alcohol use in isolation.



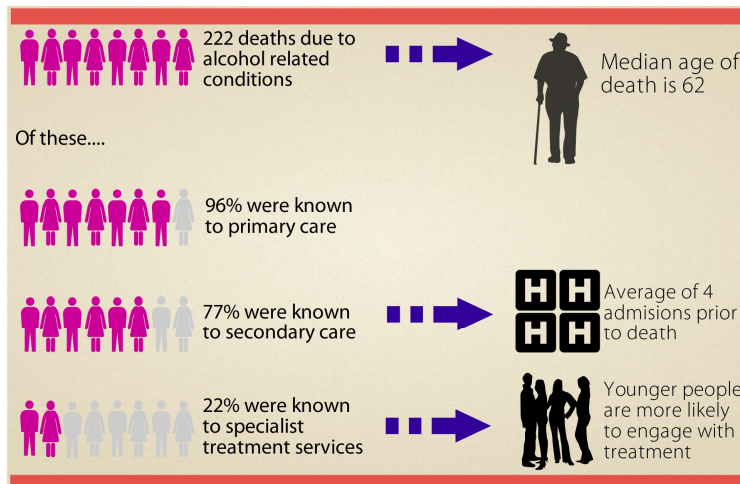
Local data that allows us to split our population into groups with similar characteristics based on where they live, along with government and commercial information, suggests that:

- levels of drinking among young people have dropped over the past 10 years, but some areas locally have relatively high levels of use compared to the England average.
- people who are older and economically well off tend to drink the most in our society; but this group also has the overall best health outcomes. They are also less likely to access the local commissioned drug and alcohol treatment services.
- although as a group they drink less, all age groups in areas of social and economic deprivation have a greater complexity of need and are much more likely to use services. People in the most deprived 20% of the population are 4.9 times more likely to die from alcohol-related liver disease than those in the least deprived 20%.^{vii}



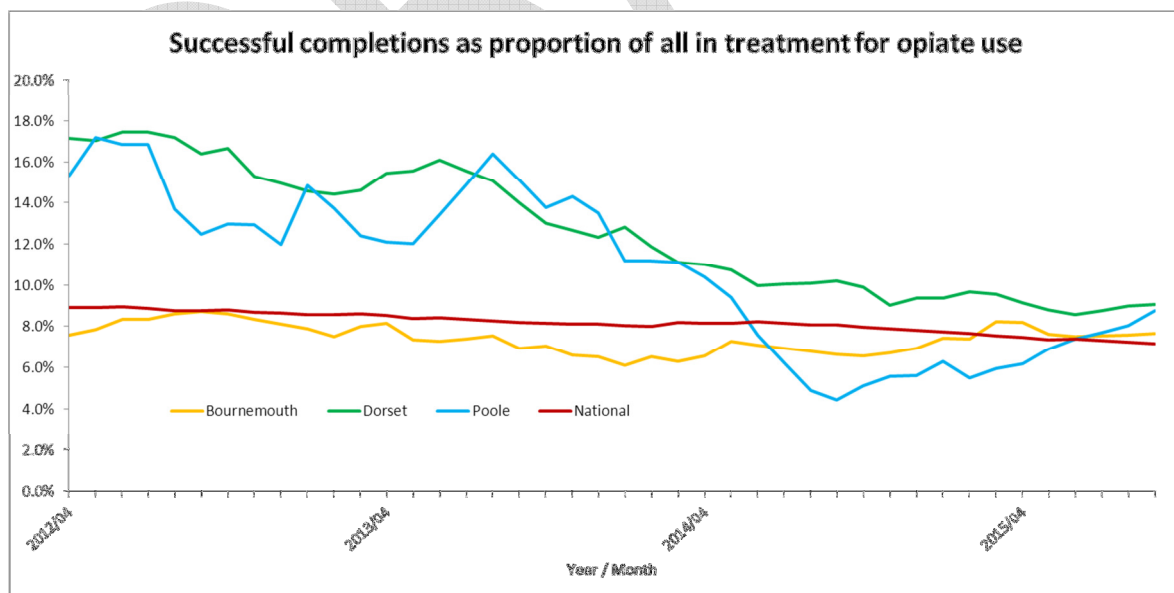
When people engage with local support services, successful outcomes of treatment are comparable to England averages. But there are many people drinking at high risk levels who do not currently access support.

This is a challenge for areas across the country as patterns of substance use change. In 2015, more people entered local treatment services for support with their alcohol use than for any other drug. This has changed significantly from 10 years ago when the main drug to present to services was heroin. While this is a positive development, showing that services are responsive to changes in need, further progress can be made, including adapting service design.^{viii}



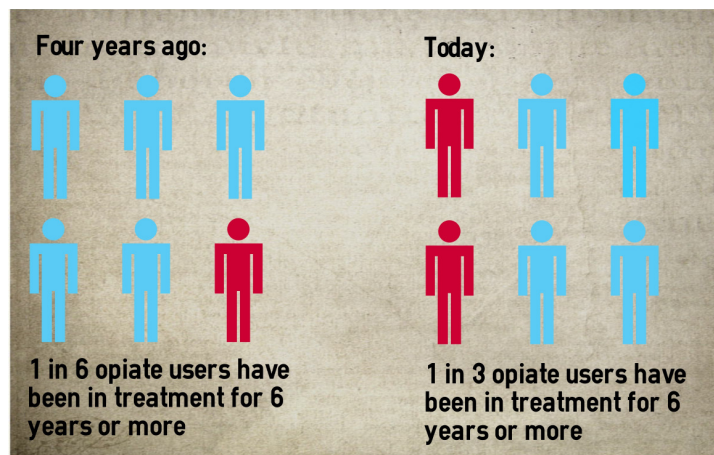
Heroin and crack cocaine

A higher proportion of opiate users complete treatment successfully in Bournemouth, Poole and Dorset than in England in general. But there are challenges regarding a group of older, long-term users.



Four years ago, just one in six opiate users had been in treatment for six years or longer. Today, although the overall number of clients has not changed, as many as one in three of these have been in treatment for 6 years or more. These local figures reflect a national trend, and it should be acknowledged that long-term treatment can provide substantial

benefits to the service user and wider community. This development poses definite challenges for all those involved in supporting opiate users locally.



There is evidence that these long-term users, as well as having lower chances of completing treatment successfully, are likely to be facing wider health and social challenges that are not being addressed through treatment. Almost half of injecting drug users who have Hepatitis C are unaware they are infected^{ix} and therefore cannot access treatment, and smoking causes many more deaths among service users than heroin or alcohol.^x

Other established drugs

Although there are significant issues associated with the use of heroin and crack, most people who use illicit drugs tend not to use these substances. Compared to the 0.82% of people who use opiates or crack locally, national estimates suggest 8.8% of adults aged 16-59 have taken an illicit drug in last year.

The most commonly used illicit substance is cannabis, with 6.6% of adults reporting some use in the past year. There are also notable numbers of users of other substances, with 2.4% reporting use of powder cocaine and 1.6% ecstasy. While these substances are relatively familiar to professionals and users alike, relatively few people who use them will require treatment to manage their drug use, unlike those who use opiates.

Many individuals access support services locally. In 2014-15, 591 people reporting use of a non-opiate drug accessed a structured programme of support across Bournemouth, Poole and Dorset. But we must ensure that all those who might benefit from support for their substance misuse can access the services they need.

Emerging substances

The number of young people taking illicit substances continues to drop, but there is some concern that individuals using emerging substances are unaware of associated risks and are not accessing the support available to them.

New psychoactive substances (NPS), over-the-counter and prescription drugs, and image and performance enhancing drugs (IPEDs) have challenged established approaches to enforcement and, to a lesser extent, treatment.

New psychoactive substances, also known as 'legal highs', tend to mimic the effects of illegal drugs such as ecstasy, cocaine and cannabis, but many are not currently controlled under the UK's Misuse of Drugs Act 1971. Their effects on humans are often unknown, and there

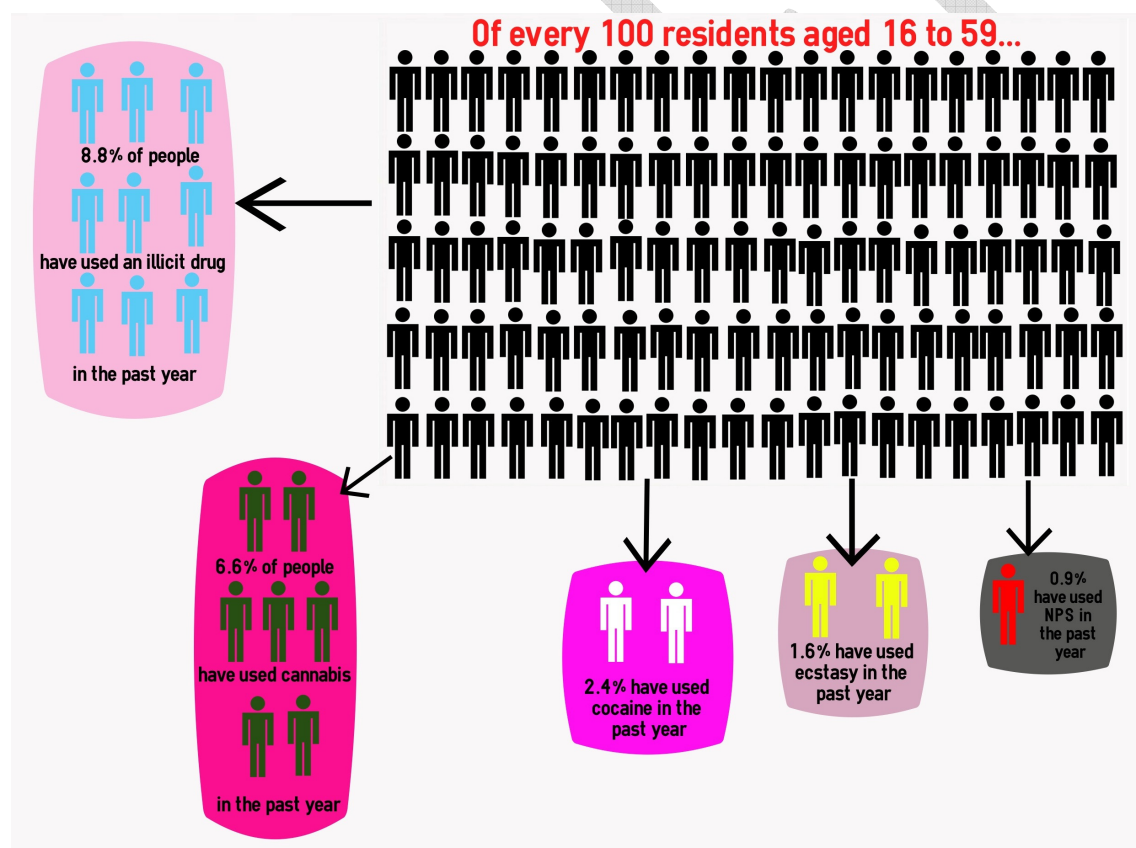
have been reports of cases causing paranoia, psychosis, seizures, hospitalisation and even death after ingestion.

These substances are generally sold online or on the high street in ‘head shops’, and there are some reports of them being sold in outlets such as newsagents, petrol stations, sex shops and market stalls.

The issues relating to both supply of and demand for these substances involve a range of partner agencies including some that have not generally dealt with drug policy in the past, such as local council regulatory services departments.

These drugs reflect a change in patterns of drug supply and use, but they are not currently used as much as alcohol, cannabis, cocaine or opiates. Under one per cent of adults aged 16 to 59 report using NPS in the past year. There is considerable overlap between users of NPS and more established drugs, with 83% of NPS users reporting use of an illicit substance in the past year.

Although the guidance for addressing problematic use of such substances does not differ considerably from that for more established issues, we must ensure that the support available is accessible and viewed positively by all those who could potentially benefit.



Numbers of people accessing local treatment systems for new psychoactive substances are relatively low, though there are people using such substances who do not currently access support, particularly as there are specific sub-groups where use is more common. For example, four per cent of young men between 16 and 24 report using NPS in the past year, and HM Inspectorate of Prisons has referred to NPS use amongst prisoners as a significant growing problem.^{xi} Use of needle exchange facilities by steroid users, for example, is increasing, but these people do not currently access structured support.

The illicit trade in substances produces crime in local neighbourhoods and international organised crime with wide-reaching effects. In a year across Bournemouth, Poole and Dorset about 1,600 recorded crimes were drug possession or supply offences, with implications for a range of public services from the police, probation services and prisons through to treatment services.

Only a small number of users with addictions to prescription drugs are accessing support services; but anecdotal evidence suggests that drugs such as oramorph – a prescribed opiate painkiller – are increasingly implicated in drug-related deaths locally. Therefore, monitoring patterns in prescribing and harm related to these drugs remains vitally important to ensure we are providing the support that is needed.

Drug misuse features significantly in Child Sex Exploitation (CSE) and where there are issues regarding the safeguarding of children and vulnerable adults, including incidents of domestic abuse. National data suggest that parental drug use is a factor in 29% of all serious case reviews and alcohol is involved in half of violent assaults. One of the priorities for this strategy is to make sure that effective pathways of treatment and evidence-based therapies are available to those adults and young people adversely affected by substance misuse.

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Next steps

The key to making sure this strategy has a real impact on improving people’s lives is to have an action plan that accurately reflects the aims and principles of the strategy.

Specific actions will be developed through conversations with relevant partners to make sure there is full agreement from those who are responsible for delivery.

These actions will then be incorporated into a single document that will be updated to reflect progress across three key themes of prevention, treatment and safety.

This joint action plan will be monitored by a steering group comprising all partners, and progress on the actions will be monitored by the Bournemouth, Poole and Dorset Drug and Alcohol Governance Board.

The vision

The vision for this strategy is:

We aim for everyone living in Bournemouth, Poole and Dorset to have a balanced attitude to alcohol and other drugs, and we have an ambition for sustained recovery, reducing harm to individuals and the wider community.

This vision is supported by three high level outcomes. Key indicators for alcohol and other drugs will measure progress towards these outcomes. These will be achieved through identified objectives and actions.

Outcome one: prevention

“The wellbeing of communities and people affected by alcohol and other drugs is improved”

4 Key prevention objectives

- Young people and adults have a better understanding of the risks of using alcohol and other drugs.
- For those who do use alcohol and other drugs, they do so in a way that reduces risks of immediate or long term health damage, including death.
- Young people and adults at risk are identified through the use of appropriate screening tools by frontline workers in all relevant settings.
- Where young people and adults are identified as being at risk, appropriate interventions and onward referrals are made to ensure the individual and those around them, including family and carers, receive the support they need.

Examples of high level indicators:

- *Reduce alcohol-related hospital admissions*
- *Reduce drug-related hospital admissions*

Outcome two: treatment

“People achieve real sustained recovery from drug and alcohol misuse”

4 Key treatment objectives

- Ensure people are able to access appropriate treatment and harm reduction interventions at times and places appropriate for their needs.
- People move through the full range of local services smoothly as appropriate for their changing age and needs.
- Improve treatment outcomes, particularly amongst those who have been engaged for 2 or more years.
- Establish recovery as a hope and ambition for people to be both free of dependence on substances and living lives independent from support services.

Examples of high level indicators:

- *Increase proportion of alcohol users that exit treatment successfully*
- *Increase proportion of drug users that exit treatment successfully*

Outcome three: safety

“Communities and people affected by alcohol and other drugs are safer”

4 Key safety objectives

- Any adult or child who is vulnerable through their own or others’ substance use is assessed, prioritised and managed through appropriate safeguarding procedures in line with established local guidelines.
- There is a coordinated and consistent approach to licensing and other forms of local regulation across the area regarding alcohol.
- There is a clear and consistent approach to addressing supply of emerging substances
- Activity is coordinated to ensure that enforcement actions are effective in reducing substance misuse and related crime and disorder.

Examples of high level indicators:

- *Reduce alcohol-related crime*
- *Reduce drug-related crime*

Principles

As we work to make this vision a reality, all partners have agreed to the following four principles.

Build services around the need of the service user, their families and the wider community

This strategy aims to deliver outcomes that will make a real difference to people's quality of life, and so any activity related to alcohol and other drugs should have at its heart the individuals affected by use of alcohol and other drugs.

The service provided to an individual should be determined on the basis of their specific needs, not by boundaries of responsibility – whether geographical or based on organisational scope.

We commit to ensuring that policies and practices apply equitably across the whole area of Bournemouth, Poole and Dorset.

Focus on areas of demographic and geographic need

Just as individuals should be supported according to their individual needs, so services and policies should be tailored to the requirements of different areas and communities.

Such a tailored approach also serves to ensure that the organisations represented by this strategy make the best possible use of public time and money.

We will identify the geographical and demographic areas of greatest need and prioritise these.

Work in partnership to make the best use of all resources in our communities

Given the cross-cutting nature of this subject, organisations must work together. **We commit to investigating how organisations can better integrate the work they do, to ensure people receive the most effective and efficient service possible.** This includes linking with voluntary and community groups such as the fellowship groups (such as Alcoholics Anonymous).

In order to ensure this effectiveness and efficiency, we can draw on the strong and constantly developing body of evidence available in the field of substance use.

We commit to ensuring that all our activities are based on the latest evidence on effectiveness and guidelines for best practice as outlined by organisations such as Public Health England (PHE), the National Institute of Health and Clinical Excellence (NICE), the Local Government Association (LGA) and relevant government departments such as the Home Office.

Where there is a gap in the evidence, we will work to improve this by **committing to accompany any intervention by a full evaluation to assess its local effectiveness.**

Share appropriate information for the benefit of service design and service user support

Whether planning a package of care for an individual engaged with a range of services, or making sure that partner services integrate without duplication, those planning and delivering services have access to the best information available.

We commit to share information in an appropriate and proportionate way.

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Notes

ⁱ Deaths from alcohol-related conditions based on underlying cause of death (and all cause of deaths fields for the conditions: ethanol poisoning, methanol poisoning, toxic effect of alcohol) registered in the calendar year for all ages. This includes a proportion of deaths where alcohol is implicated in the condition.

ⁱⁱ Source: [Crime Survey for England & Wales 2014-15](#). 'Any drug' comprises powder cocaine, crack cocaine, ecstasy, LSD, magic mushrooms, ketamine, heroin, methadone, amphetamines, methamphetamine, cannabis, tranquillisers, anabolic steroids, amyl nitrite, any other pills/powders/drugs smoked plus mephedrone since 2012/13 interviews.

ⁱⁱⁱ Nick Morgan (2014) [The heroin epidemic of the 1980s and 1990s and its effect on crime trends – then and now: Technical Report](#).

^{iv} Gordon Hay, Anderson Rael dos Santos, Joanne Worsley (2014) [Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8: Summary Report](#).

^v Data for Dorset Police taken from Druglink 12 month evaluation; national data from [Proven reoffending tables: January to December 2013](#)

^{vi} This refers to the age-standardised premature mortality rate for alcohol-related liver disease, estimated at 10.4 per 100,000 for males and 4.7 per 100,000 for females. Source: PHE (2015) [Liver Disease in the South West: A health needs assessment](#).

^{vii} Source: PHE (2015) [Liver Disease in the South West: A health needs assessment](#).

^{viii} Data available on request from Public Health Dorset.

^{ix} PHE (2015) [Shooting Up Infections among people who inject drugs in the UK: An update](#).

^x Hurt et al. (1996) Mortality following inpatient addictions treatment. *Journal of the American Medical Association: JAMA*, 275:pp.1097-1103,

^{xi} HM Inspectorate of Prisons (2015) [Changing patterns of substance misuse in adult prisons and service responses](#).

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- CRI
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Foundation Trust
- Dorset Clinical Commissioning
Group
- Dorset County Council
- Dorset County Hospital Foundation
Trust
- Dorset Fire and Rescue
- Dorset Local Pharmaceutical
Committee
- Dorset Police
- Dorset Police and Crime
Commissioner
- Dorset Service User Forum
- EDP
- Essential Drug and Alcohol Services
(EDAS)
- Fellowships
- FERIA Urbanism
- Job Centre Plus
- National Probation Service
- North Dorset District Council
- NHS England
- Poole Borough Council
- Poole General Hospital
- Providence Community Addiction
Service
- Public Health Dorset
- Purbeck District Council
- Royal Bournemouth and
Christchurch Hospital Foundation
Trust
- South West Ambulance Services
Trust
- Steven James Counselling
- Turning Point
- West Dorset District Council
- Weymouth and Portland Borough
Council

Appendix 1: Glossary of terms

Amphetamine: A synthetic stimulant drug that affects the central nervous system and speeds up the messages going from the brain to the body.

Blood borne virus: A virus that is carried in the blood. Blood borne viruses (BBVs) can be transmitted sexually or by direct exposure to infected blood, such as sharing drug injecting equipment. BBVs include hepatitis B, hepatitis C and HIV.

Cannabis: A depressant that comes from the hemp plant, Cannabis sativa. When taken at high doses it can have hallucinogenic properties.

Cocaine: A powerful central nervous system stimulant used to produce euphoria. Commonly comes in the form of a white, powder called "cocaine hydrochloride".

Crack: A very pure form of cocaine obtained by heating cocaine powder combined with baking soda (freebasing) and sold in the form of small crystals or rocks.

Depressant: A drug that causes the body to slow down and relax. Depressant drugs can also cause drowsiness, and slowed breathing and heart rate.

Ecstasy: Ecstasy is a street term for a range of drugs that are similar in structure to the synthetic stimulant MDMA (methylenedioxymethamphetamine).

Harm reduction: Aims to reduce the impact of drug-related harm within society.

Hepatitis: Inflammation of the liver caused by viruses A, B, C, D and E.

Heroin: One of a group of drugs called opiates; derived from the opium poppy.

HIV: Human immunodeficiency virus is the blood borne virus that causes AIDS. HIV can be contracted by having intercourse with an infected person without using a condom, or by sharing needles and other drug injecting equipment.

Image and performance enhancing drug: A drug, such as an anabolic steroid, growth hormone, reproductive hormone or peptide, that can increase muscle strength, increase endurance, influence body shape and psychologically improve self-esteem.

Ketamine: A hallucinogenic dissociative anaesthetic that is used in surgery and veterinary medicine. It causes amnesia (memory loss) and analgesia (pain-relief).

Legal high: A general term for substances designed to mimic or produce similar effects to common illicit drugs. They may also be known as NEDs (new and emerging drugs) or NPSs (new psychoactive substances).

Mephedrone: A powerful stimulant drug which affects mood, it is also known as 'miaowmiaow', 4-methylmethcathinone or 4-MMC.

Methadone: A synthetic opiate often used to treat heroin dependence. When given in an adequate dose tends to reduce desire to use heroin and other opiates, eliminates withdrawal, and blocks the euphoric effects of other opiate drugs.

Methamphetamine: A stimulant drug, also called speed or amphetamine. Most commonly it is found as a colourless crystalline solid, sold under a variety of names, such as crystal meth, crystal or "ice".

Needle exchange: Supply of needles to people who use drugs intravenously; aims to reduce the transmission of infectious diseases by the use and sharing of needles.

New psychoactive substances: New psychoactive substances (NPS) are a range of drugs that have been designed to mimic established illicit drugs

Opiate: One of a group of alkaloids derived from the opium poppy or manufactured synthetically with the ability to induce analgesia, euphoria, and, in higher doses, stupor and respiratory depression.

Steroid: One of a group of naturally occurring or synthetic hormones that affect the chemical processes in the body, growth and sexual and other physiological functions

Stimulant: A drug that acts to stimulate certain chemicals in the brain.