From: Graham Gibbens, Cabinet Member for Adult Social Care and Public Health

Andrew Scott-Clark, Director of Public Health

To: Adult Social Care and Health Cabinet Committee – 12 July 2016

Subject: Proposed Kent Drug and Alcohol Strategy 2017-2022

Classification: Unrestricted

Past Pathway of Paper: This is the first committee to consider this report

Future Pathway of Paper: Kent Drug and Alcohol Partnership

Electoral Division: All

Summary:

The current Kent Alcohol Strategy ends in 2016. It is proposed that a five-year combined drug and alcohol strategy will replace this from 2017-22, jointly produced by Kent Police and Public Health on behalf of the Kent Drug and Alcohol Partnership.

This paper outlines the themes of the new strategy, which are: Resilience, Identification, Early Help and Harm Reduction, Recovery and Supply. A new strategy is required, as the complexity of drug use has increased. The paper proposes that the next steps are to draft a strategy, consult with our partners and the public in order to develop and implement the Kent Drug and Alcohol Strategy 2017-2022.

All partners will need to be more involved – particularly the NHS.

Recommendation:

Members of the Adult Social Care and Health Cabinet Committee are asked to:

COMMENT upon the proposal for the Kent Drug and Alcohol Strategy (2017-2022), specifically the main themes of the strategy and the timeline;

ENDORSE this approach and/or make alternative suggestions to the Cabinet Member for Adult Social Care and Public Health.

1. Introduction

This report presents an overview of the proposed Kent drug and alcohol strategy (2017-2022). This strategy will be a joined strategy led by Kent Police and Public Health on behalf of the Kent Drug and Alcohol Partnership, allied community groups and the public. The strategy will be developed throughout 2016-17 for launch in April 2017**.**

2. Rationale

2.1 Until recent years there was a clear picture of the types of drugs being misused and their associated harms. This is no longer the case. There are newer harms resulting from a range of drugs previously not seen by services, including steroids, psychoactive substances and prescription drugs – both legal and illicit.

2.2 This challenging landscape requires an integrated and co-ordinated approach by all partners. We require all agencies to be active participants in prevention in order to facilitate cultural and behaviour change towards alcohol and drug misuse.

2.3 There are early indications that young people have responded to preventative messages. There are now higher reported national rates of alcohol abstinence and fewer alcohol-related hospital admissions in Kent. The new strategic challenge is to see a change in the adult population. The combination of public sector austerity and increasingly complex drug and alcohol challenges mean that a new approach is needed that is shared with all partners – including the NHS.

2.4 All partners need to be part of tackling the growing complexities in drug and alcohol misuse, e.g. housing and employment are crucial to maintaining recovery. The NHS are needed to play their part in helping individuals manage their drug and alcohol issues as long-term conditions – just as diabetes and high blood pressure are managed.

2.5 There have been notable successes of alcohol strategy that we are keen to maintain. Each district in Kent has a collaborative local alcohol action plan. The progress on the current Alcohol Strategy for Kent is displayed in appendix 2 to this report.

2.6 The new Drug and Alcohol Strategy will build on this and also ensure treatment services become more focused on those with complex drug and alcohol issues. The recommissioning of the current treatment service in East Kent is to begin in autumn 2016**.**

2.7 The new strategy will tackle health inequalities and inequities. The recent needs assessments for drugs and alcohol have shown that there are higher alcohol-related harm rates in East Kent, particularly in Canterbury, Swale and Thanet. There are also higher rates of drug-related deaths in Swale, Canterbury and Maidstone. The needs assessment highlights issues of the offender population, homeless and leaving care population as the most vulnerable. The strategic themes in the strategy will tackle these issues in partnership.

3. Governance

3.1 The current Kent Alcohol Strategy reports to the Kent Drug and Alcohol Partnership Group. This strategy ends at the end of 2016. The new Kent Drug and Alcohol Strategy will report to the Kent Drug and Alcohol Partnership and also to the Health and Wellbeing Board and the Crime Partnership Board.

4. Themes

4.1 The priority areas and key themes forming the basis of the strategy are displayed in Table 1. These are applicable to both adults and children and are aligned to national evidence and locally-identified priorities.

Table 1 Drug and alcohol strategy themes

Theme	Main tasks – *example activity*
Resilience	• Maintain focus upon building resilience in individuals
Identification	• Increase workforce training and screening capacity in both statutory and non-statutory organisations • Public information and education
Early Help & Harm Reduction	• Drug and alcohol pathways • Increasing and earlier referrals to treatment services, especially for at-risk groups • Reduce preventable mortality and morbidity
Recovery	• Move from an acute (episodic) model of care to a sustained recovery model. • Improve support for sustained recovery
Supply	• Disrupt related criminal activities • Public health data contributing to the licensing process

4.2 There are no financial implications to the development of this strategy other than to make best use of available commissioning resources across the health and social care economy.

5 Next steps

5.1 A strategy development timeline, inclusive of a public consultation, has been issued (appendix 4). A working group drawn from partner organisations will facilitate and coordinate this work. The anticipated partners and allied interest organisations who will be involved are listed in appendix 3. The public consultation will take place over the summer and we will be seeking views on the strategy and proposed actions. We will also seek opinion on the evaluation criteria e.g. relevance, coherence, effectiveness, efficiency and value.

6. Recommendation

Members of the Adult Social Care and Health Cabinet Committee are asked to:

COMMENT upon the proposal for the Kent Drug and Alcohol Strategy (2017-2022), specifically the main themes of the strategy and the timeline;

ENDORSE this approach and/or make alternative suggestions to the Cabinet Member for Adult Social Care and Public Health.

7. Background Documents

7.1 None

8. Appendices

8.1 Appendix 1 Summary of Drug Misuse Needs Assessment for Kent

8.2 Appendix 2 Update of progress of Alcohol Strategy 2014-2016

8.3 Appendix 3 Briefing on Cannabis use in Kent

8.4 Appendix 4 list of Participants and Stakeholders

8.5 Appendix 5 Timeline: drug and alcohol strategy development

9. Contact details

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Appendix 1

Key Facts from Adults Drug Misuse Needs Assessment by Kent Public Health Team.

National

- Drug use is decreasing: Drug use is at its lowest since measurement began in 1996 with the use of any drug in the last year among 16 to 59 year olds falling from 8.9% in 2011/12 to 8.2% in 2012/13. Among young people aged 11 to 15, 12% reported having taken any drug in the last year in 2012, the latest drop in a downward trend from 20% in 2001
- Pattern of drug use is changing: Fewer Opiate and Crack and greater poly drug use, NPS (Legal Highs), prescribed drug misuse and dependent drinking.
- Attitudes to drugs are negative: The majority of adults think that drug-taking is unsafe: 98% of adults thought heroin was very unsafe; 97% view cocaine and ecstasy as unsafe (very or a bit unsafe); 79% of adults thought taking cannabis was unsafe compared with 3% who thought it was very safe; and 75% of adults viewed getting drunk as unsafe.
- Supply may be decreasing: In 2012/13, over 109 tonnes of Class A drugs were seized at home and abroad as a result of Serious Organised Crime Agency (SOCA) activity. The police and the UK Border Force made 193,980 drug seizures in England and Wales in 2012/13, an 8% decrease from 2011/12
- Treatment is getting more effective: Record numbers of people in England are completing their treatment free of dependence. The overall number of people who have successfully completed their treatment for any drug has gone up from around 11,000 in 2005/06 to just under 30,000 in 2011/12; and nearly one third of users in this period successfully completed their treatment and did not return, which compares favourably to international recovery rates
- Fewer Heroin and Crack Users. The number of heroin and crack cocaine users in England has fallen below 300,000 for the first time. The latest estimates show the number of heroin and crack users fell to 298,752 in 2010/11, from a peak of 332,090 in 2005/06

Local

- Treatment Providers may not be treating the most needy or vulnerable people Recent needs assessment on treatment data shows that while services are getting good outcomes for lower level substance misusers, there are far fewer clients in the most vulnerable category and vulnerable people are less likely to be recovering.

- Estimated number of 4616 Heroin and Crack Users in Kent (Glasgow Estimate).
- The data indicates that there is a significantly larger difference in treatment penetration between crack and opiate users in Kent. There are hypotheses as to the reason for this difference. It has been noted that treatment has historically been overwhelmingly focused on opiate users, with little attention paid to the growing numbers of crack and poly-drug users (Audit Commission, 2002)

- Vulnerable Groups: Prevalence statistics indicate that substance misuse among the LGB community is nearly 4 times greater than that of the overall population. Kent treatment data shows that LGB individuals were less likely to be in structured treatment in 2012/13 (0.1%) than the Kent population overall (0.3%).
- Drug Treatment is value for money. Using the PHE value for Money Tool it can be argued that in Kent, for every £1 spent on drug treatment, nearly £6 is gained in benefits.
- There are links between injecting drug use (including steroids) and HIV and Hep B & C.
- Lower rates in Kent for Drug related deaths but lots of variation. The 2012 figure was 2.5 in comparison to an average over the period of 2.7. There is notable variation between rates in districts. The highest rates are found in Thanet, Swale and Gravesham. The lowest rates are found in Ashford, Sevenoaks and Tonbridge & Malling. Dover has also had a very high rate over the period that has reduced in recent years.
- There has been an increase in mental health related drug hospital admissions in England and Kent. There were a total of 1157 admissions for drug-related mental health and behavioural disorders in Kent in 2012/13.
- Decrease in emergency detox in hospitals.
- Fewer people in structured treatment in Kent. 13% decrease from 2009. Mainly people are accessing for opiate and crack and 24% decrease in ‘other drug use’.

Alcohol (Adults): Progress on Current Alcohol Strategy

Pledge area	Aim	Achievement	Status/ DoT
1. Improve prevention and Identification	Screen 9% of the Kent population (18+) Target 106,389	11% of the target population; 128,542 (121%) .	Green 
2. Improve the Quality of Treatment	Increase number of referrals into treatment services by 15% by 2016[1].	Trend increasing.	Green 
3 Co-ordinate Enforcement and Responsibility *These elements of the plans are largely taken from the work of Kent Community Safety Partnerships.*	12 police operations per year will be completed e.g. CSP targeted activity within localities Support the work the development of Kent CAPs	Achieved in 2015. Ongoing in 2016. Achieved and ongoing	Green 
4 Tailor the plan to the local community	Each District will develop a local alcohol action plan.	Achieved	Green 
5. Target Vulnerable groups and Tackle Health Inequalities	Contained in District plans as locally identified priorities.	Ongoing. Evaluation at the end of the strategy	Green 
6 Protect Children and Young People	Reduce alcohol related hospital admissions for those aged under 18 years	The number of admissions is decreasing. Kent is better than the national and South East region	Green 

[1] Successful completions are a good indication of quality. Service Quality Assured by service monitoring of national reports on a range of service indicators and via quarterly KDAAP reports Service information available at: https://www.ndtms.net/default.aspx

Cannabis use in Kent

Summary

Data is limited due to the illegal nature of the drug. Data is presented from national surveys and Kent treatment services.

Cannabis is a Class B drug. It is the most commonly used illicit drug in UK and in Kent, with 29% of people claiming to have used the drug at least once in their lifetime. There is some evidence that there is more cannabis users in structured treatment in Kent then might be expected given national prevalence. However this does not mean that there are a higher proportion of drug users in Kent only that more people are referred and/or seek treatment. There is national evidence that the strength of Cannabis is increasing which may pose risks to user's mental and emotional health.

1.1 What is Cannabis?

Three products of the plant *Cannabis sativa* (also known as hemp) are commonly available in the UK[2]:

a) **Cannabis resin (hash),** which is prepared from the flowering and other parts of the cannabis plant that contain many glandular trichomes. The material is processed and compressed into hard blocks before importation into the UK, mainly from North Africa.

b) **Traditional herbal cannabis (marijuana),** which is a dried plant preparation of floral and folia material imported from the Caribbean, Africa or Asia. Like resin, it is either rolled with tobacco and smoked as a "joint" or vaporised in a smoking device.

c) **Sinsemilla (including skunk),** which is composed of the flowering tops of unfertilised female cannabis plants produced by intensive indoor cultivation methods. Although some is imported, much is now grown in the UK. As with other forms of cannabis, it is either rolled with tobacco or vaporised in a smoking device *(ACMD, 2008).*

- A study by the Home Office (2008) on cannabis potency found that the majority of cannabis seized across the UK was Sinsemilla.
- The potency of cannabis is measured according to its concentration of THC. THC (r9-tetrahydrocannabinol) is the dominant chemical component found in cannabis which stimulates cannaboid receptors in the brain to manipulate mood and cognition and give users a 'high'.
- Increasingly sophisticated cultivation of Sinsemilla has made cannabis stronger over the last 30 years
- Data from the Home Office study (2008) showed the percentage of THC in Sinsemilla ranged from 4.1% to 46.0%
- This study showed an increase in THC content from 5.8% in 1995 to 10.4% in 2007 and 16.1% in 2008, showing that more potent forms of cannabis are becoming more prevalent in the UK.
- Cannabis retains its Class B drug status due to a moderate risk and association with schizophrenia and psychosis.

[2] This is not to be confused with 'synthetic cannabis'; a psychoactive mix of herbs and chemicals commonly known as 'spice'.

1.2 Classification and Penalties

- Cannabis is controlled under Class B of the Misuse of Drugs Act (1971). In 2008, the Advisory Council on the Misuse of Drugs (ACMD) recommended in their report that cannabis remain a Class C drug, as a result of a review of the evidence on the harms posed by cannabis. However this was not accepted by the Government and it was upgraded to Class B., which has a number of implications for the way that police will deal with offences involving the drug (Drugscope, 2013)

- For possession of the drug: Up to 5 years prison, unlimited fine or both. For Supply Up to 14 years in prison, an unlimited fine or both.

- A person under 18: is found to be in possession of cannabis, they will be arrested and taken to a police station where they can receive a reprimand (first time), final warning (second time) or charge depending on the seriousness of the offence. This must be administered in the presence of an appropriate adult. After a final warning, the young offender must be referred to a Youth Offending Team to arrange a rehabilitation programme.

2. Nature and Extent of Use in UK:

Cannabis is by far the most commonly used drug according to the Crime Survey for England and Wales in 2015 (CSEW). In 2015 29% of people surveyed said they had used Cannabis sometime in their lives (Table 1).

Table 1 Reported drug use ever

Drug	Proportion
cannabis	29.2%
class A drug use	15.5%
amphetamines	10.3%
powder cocaine	9.7%
ecstasy	9.2%
amyl nitrite	8.5%

CSEW, 2015

Findings from the CSEW (2015) show that around 1 in 12 (8.2%) adults had taken an illicit drug (excluding mephedrone) *in the last year*, with cannabis being the most commonly used by **6.4%.** This is the lowest proportion since measurements began in 1996.

Cannabis was also the most commonly used drug amongst young people, with **13.5%** aged 16 to 24 *using it last year*. This is a decrease since 2011/12 (15.7%) and again is the lowest proportion since measurement began in 1996.

Data from the *Smoking, drinking and drug use amongst young people in England* survey (Fuller, 2012) shows that cannabis remains the most widely used drug among 11-15 year olds with **7.5%** of pupils reporting taking the drug in the last year.

Of those using Cannabis in the last year – around 40% report being regular users of Cannabis.

2.1. UK Treatment of Cannabis

Despite figures showing that the use of cannabis has declined since 2003, the number of treatment presentations for cannabis use nationally has substantially increased. However the increase in treatment presentations, which is mainly amongst young people aged under 20 years old, is likely to reflect the expansion of young people's treatment services (United Kingdom Drug Situation 2011). Data from the National Drug Treatment and Monitoring Service (NDTMS) showed that nationally, cannabis was the primary drug for **8%** of all clients receiving treatment.

National evidence points to the most effective treatment being any behavioural intervention (including cognitive behavioural therapy (CBT), motivational interviewing (MI) and contingency management) can help to reduce use and improve psychosocial functioning, both in adults and adolescents, at least in the short-term
Multidimensional family therapy helps reduce use and keep patients in treatment, especially in high-severity young patients.

2.2 Cannabis Use in Kent

The most recent needs assessment data in Kent shows that for 12% of people in Drug Treatment in Kent in 2014 had Cannabis as their primary drug. This is higher than the national average (Table 2).

More recent data from the local drug treatment services show that in 2015-2016, 21% of East Kent's clients accessing structured treatment cited Cannabis as either a primary, secondary or tertiary problem and in West Kent the proportion was 19%. However this data is not verified by the National data base so must be seen as indicative only at this stage. However data indicates a slight increase.

Overall treatment outcomes in Kent are good compared to National – with 54% of patients remaining abstinent 1 year after treatment.

Table 2 Treatment services: use by substance 2014

Drug	1st drug		2nd drug		3rd drug		Total
	n	%	n	%	n	%	n
Heroin	1813	68%	108	6%	18	2%	1939
Cannabis	*308*	*12%*	*461*	*25%*	*238*	*29%*	*1007*
Crack Cocaine	44	2%	534	29%	122	15%	700
Cocaine	111	4%	195	10%	58	7%	364
Other Opiates	144	5%	109	6%	52	6%	305
Methadone	69	3%	159	9%	69	8%	297
Benzodiazepines	28	1%	123	7%	113	14%	264
Amphetamines	66	2%	86	5%	53	6%	205
Prescription Drugs	37	1%	23	1%	26	3%	86
Other Drugs	14	1%	32	2%	28	3%	74
Ecstasy	7	0%	15	1%	21	3%	43
Hallucinogens	8	0%	14	1%	20	2%	42
NPS	4	0%	2	0%	4	0%	10
Solvents	1	0%	2	0%	2	0%	5

Source: KDAAT/NDTMS, 2014

Appendix 4

Strategy development: participants and Stakeholders

This list is not exhaustive and is subject to amendment.

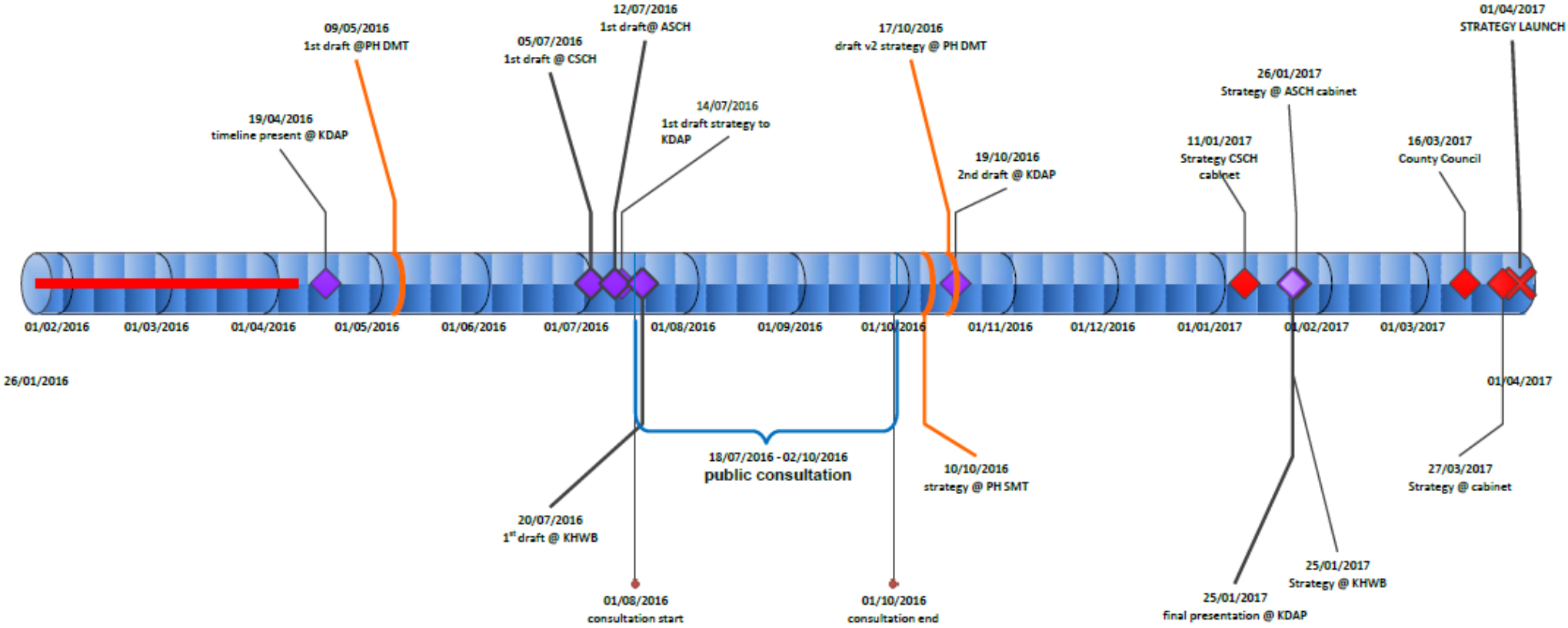
- Kent Police
- Community Safety Partnerships
- National Probation Service
- Community Rehabilitation Company (CRC)
- SEETEC
- Office of the Police and Crime Commissioner
- Coroner's office

Kent County Council: public health, housing, early help/preventative services
District Councils

- Kent and Medway NHS and Social Care Partnership Trust
- South East Coast Ambulance Service NHS Foundation Trust
- Kent NHS Hospitals:
    - William Harvey
    - Queen Elizabeth the Queen Mother
    - Kent and Canterbury
    - Maidstone
    - Tunbridge Wells
    - Medway Maritime
    - Darent Valley
- NHS England
- NHS Clinical Commissioning Groups
- NHS England Local Area Team Head of Health and Justice
- Kent Local Pharmaceutical Committee

- Kent and Medway Licensing Steering Group
- KCA
- Health watch
- Change, Grow, Live
- Turning Point
- RAPT
- Addaction
- Consultant / Specialist: drugs and alcohol (Chair)
- Head of Quality (Vice Chair)
- Commissioner: drugs and alcohol services
- Regional drug and alcohol representative
- Job Centre Plus
- Service user representation
- Kent Drug and Alcohol Partnership organisations
- Shelter
- Community, Voluntary an allied interest groups (TBA)

Appendix 5 Timeline: drug and alcohol strategy development



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