

# **Substance Misuse Needs Assessment: Bolton Salford Trafford**

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## Technical Notes

- 1.1 A number of technical notes apply to this needs assessment.
- 1.2 Where data is provided in this main report only for the Bolton, Salford and Trafford cluster, a breakdown is available by each area within the appendices.
- 1.3 Some data, when combined for the three areas, is not necessarily directly comparable. Where this is the case, this is stated in the footnotes (as well as reasons why).
- 1.4 Where presenting data relating to current treatment services, any numbers under 5 have been redacted.
- 1.5 Percentages vary. For example, some are calculated based on total numbers in treatment, and some on new presentations to treatment. Footnotes identify variations.
- 1.6 This report utilises the best available sources and amalgamates data to attempt to provide a comprehensive, but non-exhaustive, picture of need.
- 1.7 Data is benchmarked against GM and/or England, where provided. However, it is acknowledged that benchmarking against statistical neighbours is also useful. This report does not cover statistical neighbours due to the combination of three areas.
- 1.8 Readers should refer to footnotes for specific technical notes.

## Glossary

|        |  |
|--------|--|
| BBVs   | Blood Borne Viruses  |
| BME    | Black & Minority Ethnic  |
| BST    | Bolton, Salford & Trafford   |
| CRC    | Community Rehabilitation Company                                       |
| CSEW   | Crime Survey for England and Wales                                     |
| DWP    | Department for Work and Pensions                                       |
| ESA    | Employment Support Allowance   |
| ETE    | Education, Training & Employment                                       |
| GM     | Greater Manchester   |
| GMCA   | Greater Manchester Combined Authority                                  |
| GMP    | Greater Manchester Police  |
| HIV    | Human Immunodeficiency Virus   |
| IB/SDA | Incapacity Benefit / Severe Disablement Allowance                      |
| ICO    | Intensive Community Order  |
| LAPE   | Local Alcohol Profiles for England                                     |
| LGBT   | Lesbian, Gay, Bisexual & Transgender                                   |
| MoJ    | Ministry of Justice  |
| MSM    | Men who have Sex with Men  |
| NDTMS  | National Drug Treatment Monitoring System                              |
| NPS    | New Psychoactive Substances OR National Probation Service <sup>1</sup> |
| OASys  | Offender Assessment System   |
| OCU    | Opiate and Crack Use   |
| PHE    | Public Health England  |
| PSR    | Public Service Reform  |
| UNODC  | UN Office for Drugs and Crime  |

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<sup>1</sup> Depending on context. See footnotes

## Key Context: Introduction

- a) The nature of substance misuse is complex, and it is changing. This expresses itself in various ways. We know that:
- increasing numbers of people are damaging their health through excessive drinking, and there has been an associated rise in the prevalence of alcohol-related conditions. Meanwhile, a move away from drinking in a public setting to drinking at home means that many individuals and families manage their problems without service support;
  - new types of drug users are emerging; they are younger, likely to be poly-drug users, more diverse, more likely to buy drugs online and more willing to try unknown substances;
  - specific behaviours and issues are arising – for example, the increase in prescription/over-the-counter drug misuse, and a surge in the use of new psychoactive substances in particular – are common and recognised challenges, and yet our system response is yet to fully evolve and respond; and
  - there continues to be a presence of an ageing cohort of users, mostly OCU, who have been in treatment for a long time. These users are costly, complex and are likely to continue in treatment for some time.

## Key Context: Progress to Date

- b) In autumn 2015, New Economy and the Public Service Reform (PSR) team supported work between the 10 substance misuse commissioner leads in GM to facilitate the production of the report 'The Case for Change – Substance Misuse in Greater Manchester'.
- c) The case for change document:
- traces through some of the key changes in patterns of substance misuse, reflecting on the latest developments and how the service offer in GM has evolved and responded;
  - draws together our clearest GM evidence base on how substance misuse interconnects with other issues – from mental health and domestic abuse, to worklessness / productivity and child safeguarding challenges; and
  - sets a level of ambition for future collaboration, by re-stating the case for working together on a set of common commissioning standards, and priming a practical discussion on how we can do more to collectively commissioning at the appropriate spatial level.



Appendix 1 Case for  
Change.docx

- d) This paper was produced on behalf of the AGMA Wider Leadership Team to engage commissioning leads for substance misuse services in each of the ten GM authorities on future collaboration opportunities.
- e) Since November 2015, the GM commissioners have been working collaboratively through a series of workshops. This work will develop a common set of standards for service provision in GM (across a range of topics, themes and priorities), and identify options for collaboration at a GM and cluster level. An early output from this work is the following shared vision for GM substance misuse commissioning:

*GM Partners will work collaboratively to ensure that local systems of substance misuse intervention and treatment are commissioned and provided in accordance with common principles and standards, so that individuals and families affected by all forms of substance misuse, including alcohol, are supported to achieve recovery and live independently.*

*We will achieve more for less by:*

- Recognising that substance use is diverse and complex, and collectively responding to changing patterns of substance use and behaviour to provide the most effective route to recovery from all types of substance misuse.*
  - Rooting our approach in prevention and early intervention, anticipating future cost and escalating demand on services, and ensuring responses are appropriate to levels of need and health risk.*
  - Basing our approach to treatment and harm reduction on a growing evidence base, and a shared understanding of challenges, opportunities and changing circumstances - ensuring that we share learning, expertise and resources.*
  - Using asset-based approaches to enable long-term and sustained recovery from all types of substance misuse.*
  - Adopting a whole-person approach to working with complex families and individuals, and integrating provision with wider delivery models tackling Complex Dependency.*
- f) The local authorities of Bolton, Salford and Trafford are working to action the vision statement and commitments made in the workshops by engaging in a joint commissioning exercise for their substance misuse treatment systems. It will act as a pilot in action for the collaborative work, and the service hopes to implement some of the 'common standards' developed through this process.
- g) New Economy has worked with Bolton, Salford and Trafford to co-produce this needs assessment, which should inform the development of future Substance Misuse Services in the three areas.

- h) This needs assessment is structured differently to many traditional substance misuse needs assessments. It is designed to reflect need based on key data and information sources. Where possible, breakdowns for the three areas are provided.
- i) Data and information on need is mostly contained within chapters 3, 4 and 5. It is important to note that the information contained within these chapters should not be considered mutually exclusive. Many of the same topics and themes are discussed in these chapters, and are strongly correlated. Data that appears in different chapters, particularly when covering similar themes, should not be considered in isolation.
- j) The structure provides a simple way of understanding and comparing need seen in the general population to the needs of current and previous service users in the treatment population.

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# 1 Demographics Overview

1.1

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## 2 Policy Context

### 2.1 POLICIES

2.2 Every £1 invested in drug treatment services saves £2.50 in costs to society (NTA, 2013). When modelled for Bolton, Salford and Trafford collectively, the figure is £3.32 for every £1 invested (NDTMS, 2015)<sup>2</sup>. However, this is only for costs and savings associated with OCU.

2.3 The number of alcohol-related hospital admissions in England is about one million per year and has been steadily rising (PHE, 2014a). Modelled for GM, this is a total cost of £167m per year (Alcohol Concern, 2014).<sup>3</sup>

2.4 As highlighted in the GMCA Alcohol Strategy, the combination of crime, health, worklessness and social care costs to Greater Manchester arising from alcohol are estimated at £1.2billion per year – around £436 per resident. Considering the combined costs arising in respect of Bolton, Salford and Trafford residents, the estimated cost of alcohol is calculated at around £300,000 per year, and £409 per person. The NHS and social care cost estimates for Salford are the highest of any of the GM districts, and the overall cost of alcohol per resident in Salford is second only to Manchester. Table 2.1 shows the differences across cluster area. Fuller details are supplied in the appendix to this report. (PHE, 2014)

| <b>Table 2.1: Cost of Alcohol Harm, Per Head of Population (2014 prices)</b> |            |              |                  |                        |               |
|--|------------|--------------|------------------|------------------------|---------------|
| <b>Area</b>  | <b>NHS</b> | <b>Crime</b> | <b>Workplace</b> | <b>Social Services</b> | <b>Total*</b> |
| Bolton   | £77        | £132         | £152             | £31                    | <b>£386</b>   |
| Salford  | £106       | £140         | £173             | £46                    | <b>£459</b>   |
| Trafford   | £82        | £89          | £191             | £25                    | <b>£384</b>   |
| Cluster  | £88        | £121         | £170             | £34                    | <b>£409</b>   |
| Greater Manchester   | £89        | £142         | £175             | £36                    | <b>£436</b>   |

\*Total is slightly less than the sum of constituent theme costs, given a small element of double counting across categories.

2.5 The use of ‘traditional’ drugs, including opiates and crack, is declining. A new group of drug users is emerging; they are younger, likely to be poly-drug users, more diverse, more likely to buy drugs online and more willing to try unknown substances. The use of cocaine, ecstasy, LSD and ketamine is increasing, alongside New Psychoactive Substances (NPS) (Home Office, 2014). Significantly, these users are much less

<sup>2</sup> Figure is correct for June 2013 (the most up to date).

<sup>3</sup> Comprised of A&E attendances, inpatient admissions and outpatient attendances

likely to enter treatment for their drug use. Those particularly at risk of significant harm are younger adults who would formerly have been experimenting with traditional drugs, including young people involved with the criminal justice system and displaying early characteristics of complex dependency (see chapter 4).

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## 3 General Population Needs Profile

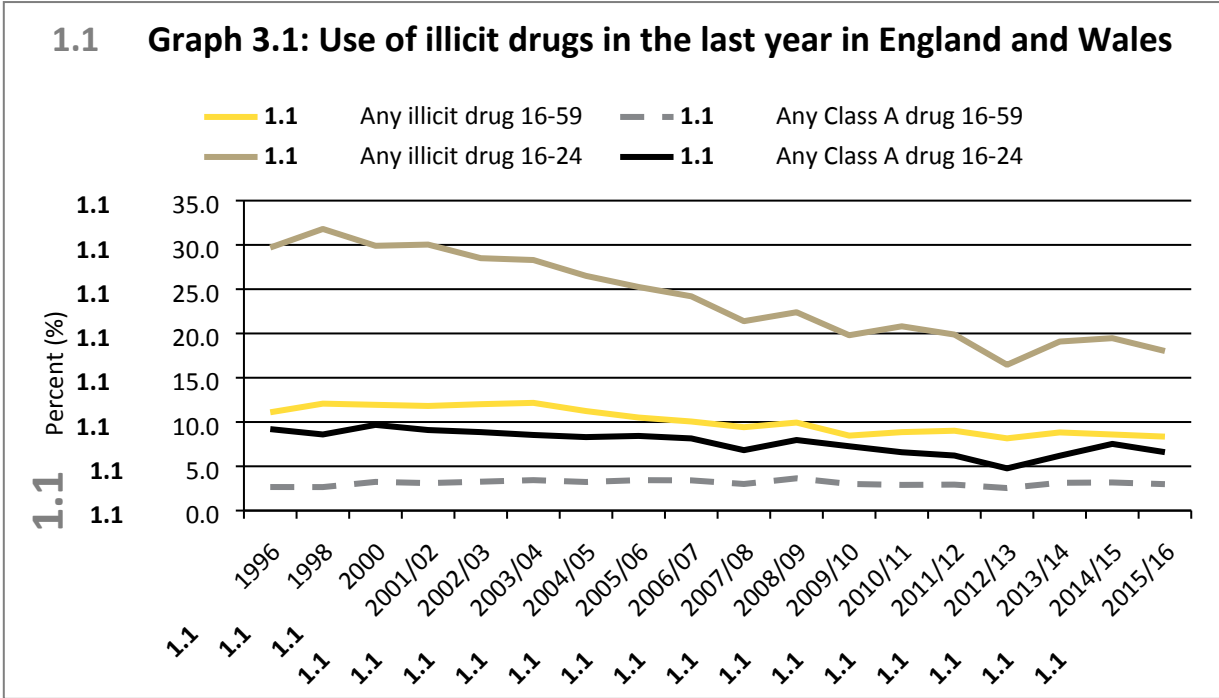
- 3.1 This chapter is designed to provide a summary of need found in the general population. This will undoubtedly include both those who already access substance misuse treatment services, as well as those who are not currently accessing but display particular levels of need.
- 3.2 Topics covered in this section include:
- Drug use in the general (adult) population
  - Alcohol use in the general (adult) population
  - Young people's drug use
  - Young people's alcohol and tobacco use
  - New and emerging drug trends
  - Marginalised and vulnerable communities' substance use
- 3.3 This section should not be read in isolation from subsequent chapters (4 and 5). Some information on general population use is also contained in Chapter 4 (Complex Dependency), and is grouped thematically. Many of the same topics and themes are discussed in these chapters.
- 3.4 Please see appendices for further data.

### Drug Use

- 3.5 According to the 2015/16 CSEW<sup>4</sup>, nationally, around 8.4% of adults aged 16-59 have taken an illicit drug in the last year. This equates to 37,314 people across the three areas (Bolton 13,487; Salford 12,631; Trafford 11,196). This is statistically significantly different from a decade ago, at 10.5% in 2005/6, but has been stable for the past seven years.
- 3.6 Illicit drug use is more common in younger adults, with 18.0% of those aged 16-24 having taken a drug in the last year. This proportion is more than double that of the wider age group, and equates to 15,124 younger adults across the three areas (Bolton 5,685; Salford 5,534; Trafford 3,905). This level of drug use is similar to 2014/15 (19.5%), but statistically significantly lower than a decade ago (25.2% in 2005/6). Graph 3.1 shows the use of illicit drugs over the past twenty years in England and Wales.

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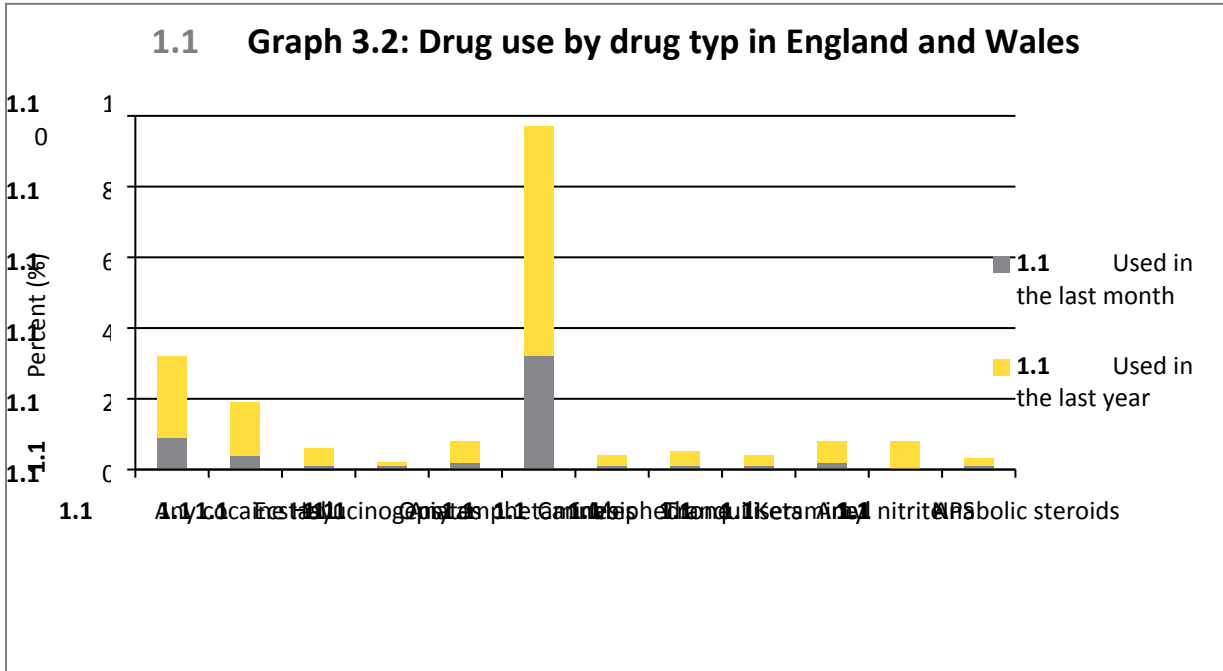
<sup>4</sup> The CSEW is recognised as a robust measure of recreational drug use for the drug types it covers. However, it may not provide as good a coverage of problematic drug users as they may not necessarily be a part of the household resident population, or they may be concentrated in specific and relatively small subgroups of the population.



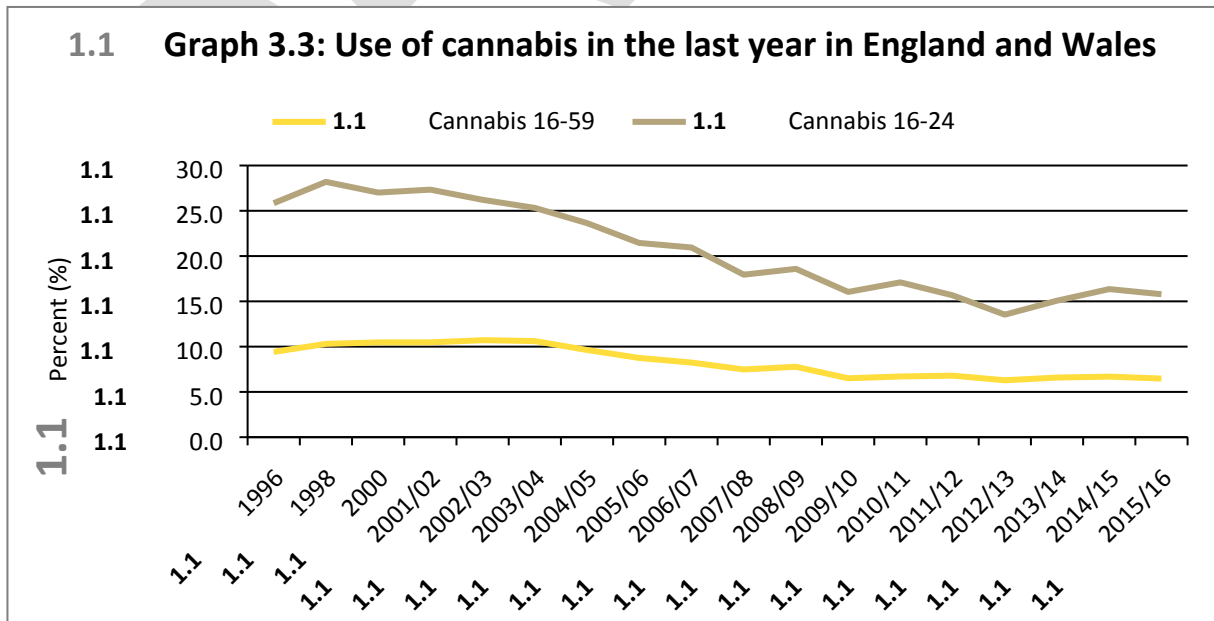
3.7 Estimates show that 3.3% of adults aged 16-59 are frequent drug users (having taken any illicit drug more than once a month on average in the last year). This equates to 14,659 people across the three areas (Bolton 5,298; Salford 4,962, Trafford 4,399). Younger adults are more likely to be frequent drug users, with a comparable proportion of 4.7% (3,949) 16-24 year olds across the three areas (Bolton 1,484; Salford 1,445; Trafford 1,020). 8.0% of all adults who had used drugs in the last year say that they have used drugs every day.

**Drug Use by Type of Drug**

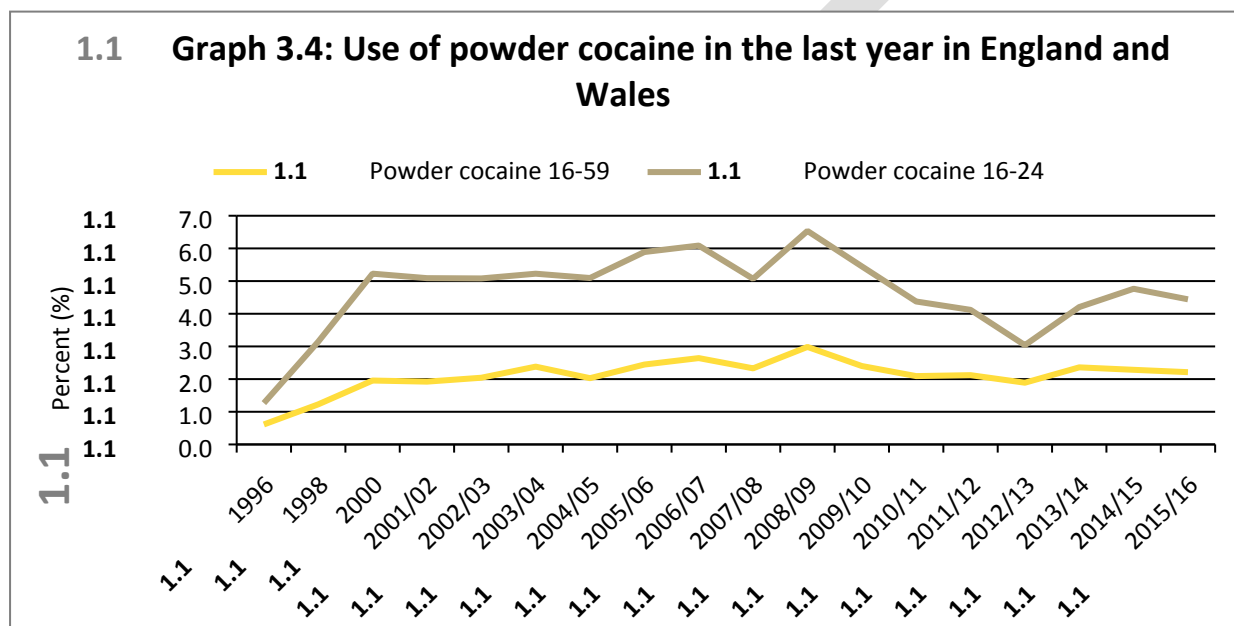
3.8 According to CSEW, cannabis is the most commonly used drug, with 6.5% of adults aged 16-59 having used it in the last year, equating to 28,874 people in Bolton (10,436), Salford (9,774) and Trafford (8,664). This is a similar proportion to the previous survey (2014/15) but has reduced significantly over the last ten years (from 8.7%, and from 9.4% in 1996). Graph 3.2 shows drug use by drug type in England and Wales.



3.9 Cannabis use is notably higher in younger adults, with 15.8% of those aged 16-24 having used the drug over the last year. This equates to 13,275 16-24 year olds in Bolton (4,990), Salford (4,857) and Trafford (3,428). This is similar to the 2014/15 estimate (16.4%), but represents a statistically significant reduction over the last decade (from 21.4%) and the 1996 survey year, when a quarter of younger adults used cannabis (25.8%). Graph 3.3 shows cannabis use trends over the last twenty years in England and Wales.

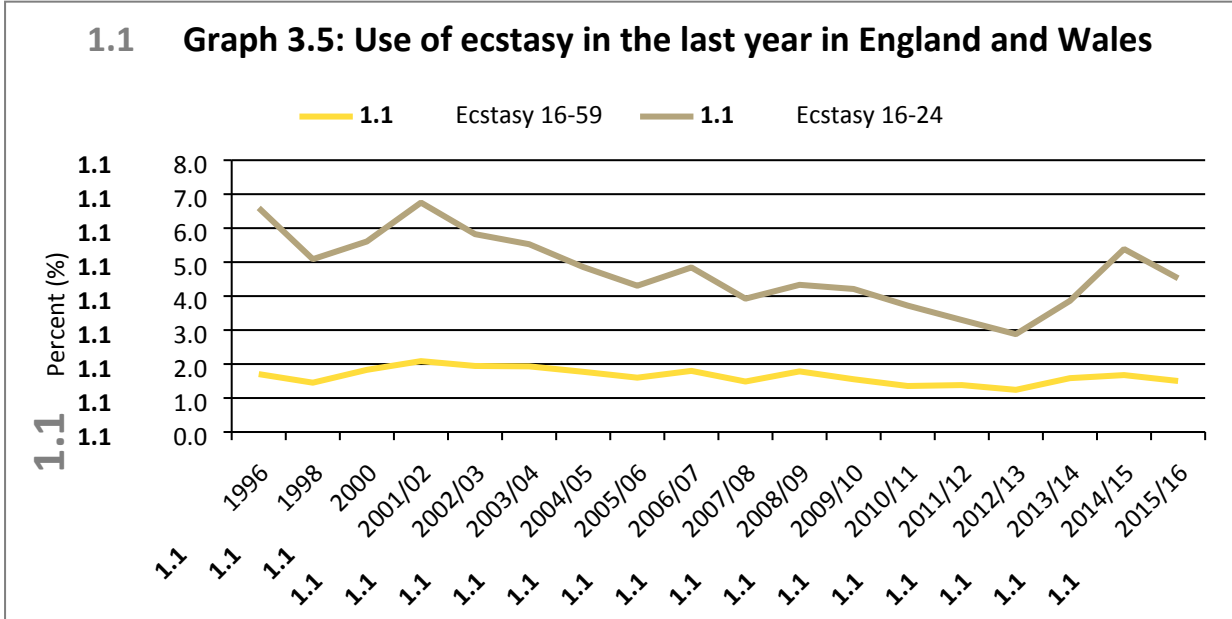


- 3.10 The next most commonly used drug (after cannabis) among 16-59 year olds is powder cocaine, at 2.2%, equating to 9,773 people in Bolton (3,532), Salford (3,308) and Trafford (2,932). In contrast, powder cocaine is the third most commonly used drug among young adults aged 16-24, at 4.4% after cannabis and ecstasy.
- 3.11 Graph 3.4 shows that among younger adults the trend for use of powder cocaine has fluctuated for a number of years in England and Wales, making it difficult to assess its overall direction. However, the overall trend for 16-24 year olds is likely to be flat over the last six years, and so similar to the trend for the wider age group.



- 3.12 Levels of ecstasy use by adults aged 16-59 in the 2015/16 survey (1.5%, or 6,663 people across the three areas) is similar to the previous year (1.7%) and to that seen in the 1996 survey year (also 1.7%). Generally, the proportion of people using ecstasy has been relatively flat throughout the lifetime of the survey, fluctuating between 1-2% since measurement began in 1996.
- 3.13 Use is higher in younger adults with 4.5% of 16-24 year olds having taken ecstasy in the last year. This equates to 3,781 younger adults across the three areas. The trend in ecstasy use among young adults was generally downward until the 2012/13 survey year.<sup>5</sup> Estimates in the last three years have been higher than previously, with last year's ecstasy use reaching back to the level seen ten years ago (4.3%). As such, it appears that use is rising from its downward trend in England and Wales.

<sup>5</sup>Although estimates in this survey year appear to be out of line with recent results for many drug types and may be a result of sampling variation, but upward trends are not unique to this survey year.



**Alcohol Misuse**

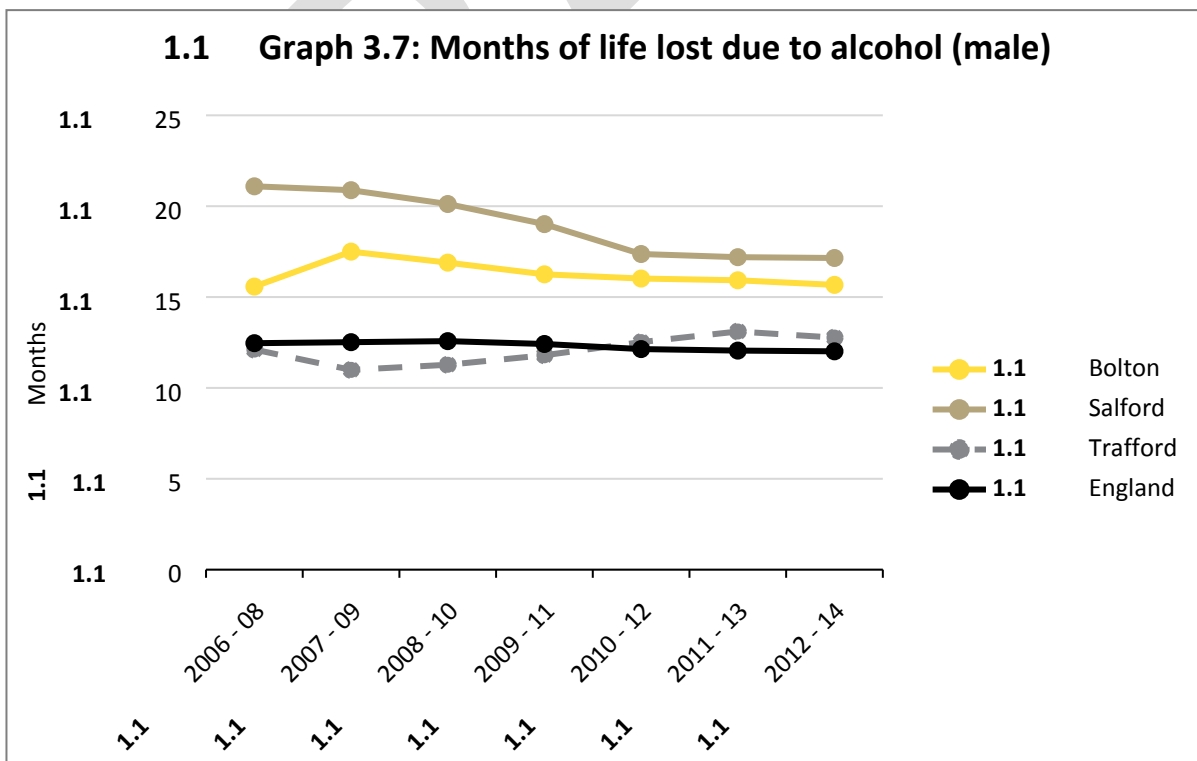
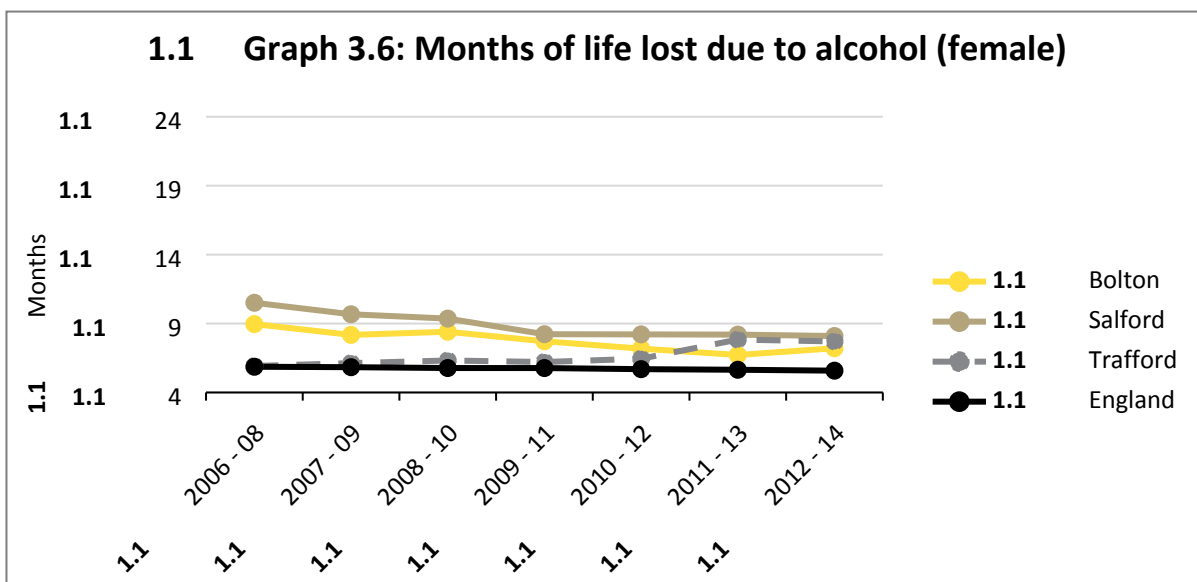
- 3.14 Alcohol misuse is England’s second biggest cause of premature deaths, and the leading risk factor for deaths among men and women aged 35-44 years in the UK (Global Burden of Disease, 2010). 34% of men and 28% of women in the UK exceed current consumption guidelines on at least one day per week.
- 3.15 The NHS estimates that around 9% of men and 4% women show signs of alcohol dependence. According to Public Health England, 94% of dependent drinkers are not engaged with treatment at any one time.
- 3.16 A small sub-group within this cohort are both treatment resistant and placing a huge burden on public services; Alcohol Concern estimates these individuals cost at least £2.5 billion nationally each year (2015).
- 3.17 Data from the Local Alcohol Profiles for England (LAPE)<sup>6</sup> indicates that alcohol-related harm is increasing in all three areas.<sup>7</sup> However, the extent to which this is present and varies is dependent on measures used.

**Mortality**

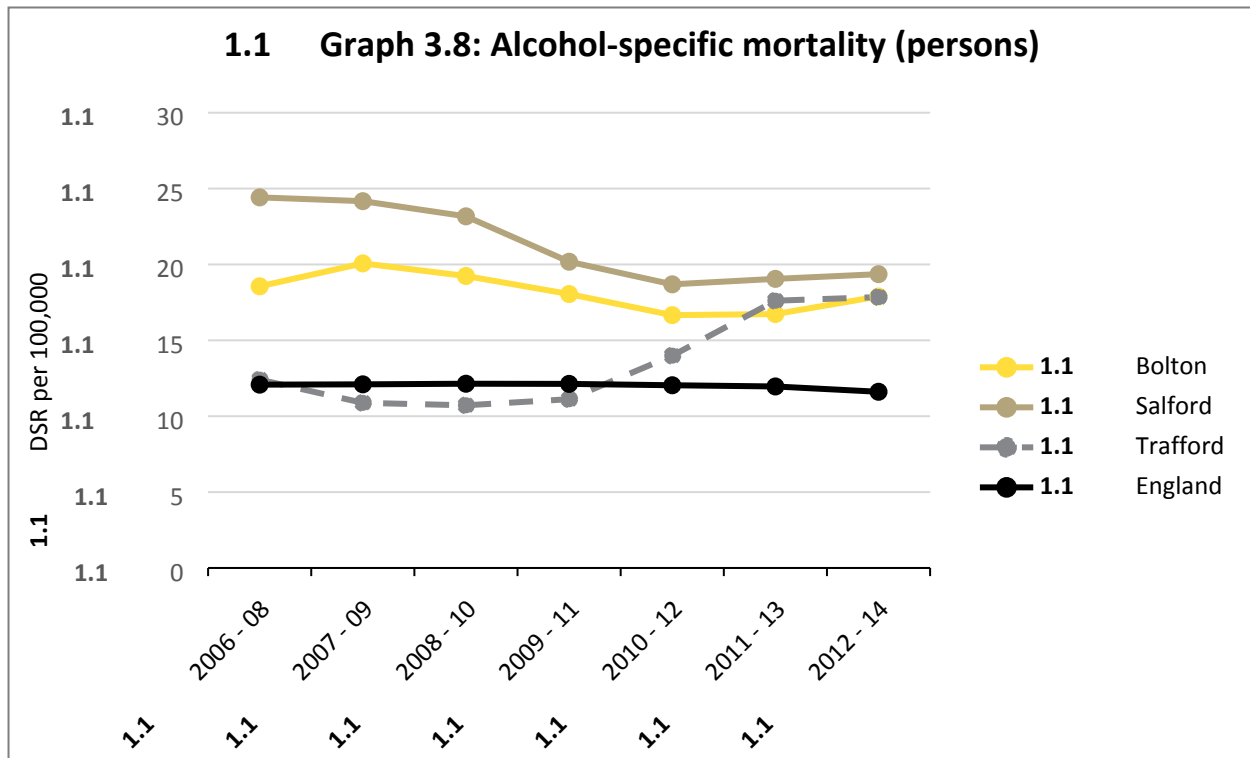
<sup>6</sup> Unless otherwise stated, all LAPE data is taken from <http://fingertips.phe.org.uk/local-alcohol-profiles>  
<sup>7</sup> Be aware that data from LAPE operates on a different timescale to other data used in this report. Some time points are two year periods as this is the way in which the data is provided. Where this occurs, the graphs are labelled as such. This means it is not necessarily directly comparable to data provided for financial years.



3.18 The number of months of life lost due to alcohol has decreased over the latest three time periods measured (2010-12 to 2012-14) in both Bolton and Salford, and increased in Trafford, for both males and females. However, as the graphs show, Bolton and Salford's starting points are higher. Months of life lost due to alcohol are considerably higher amongst men than women.



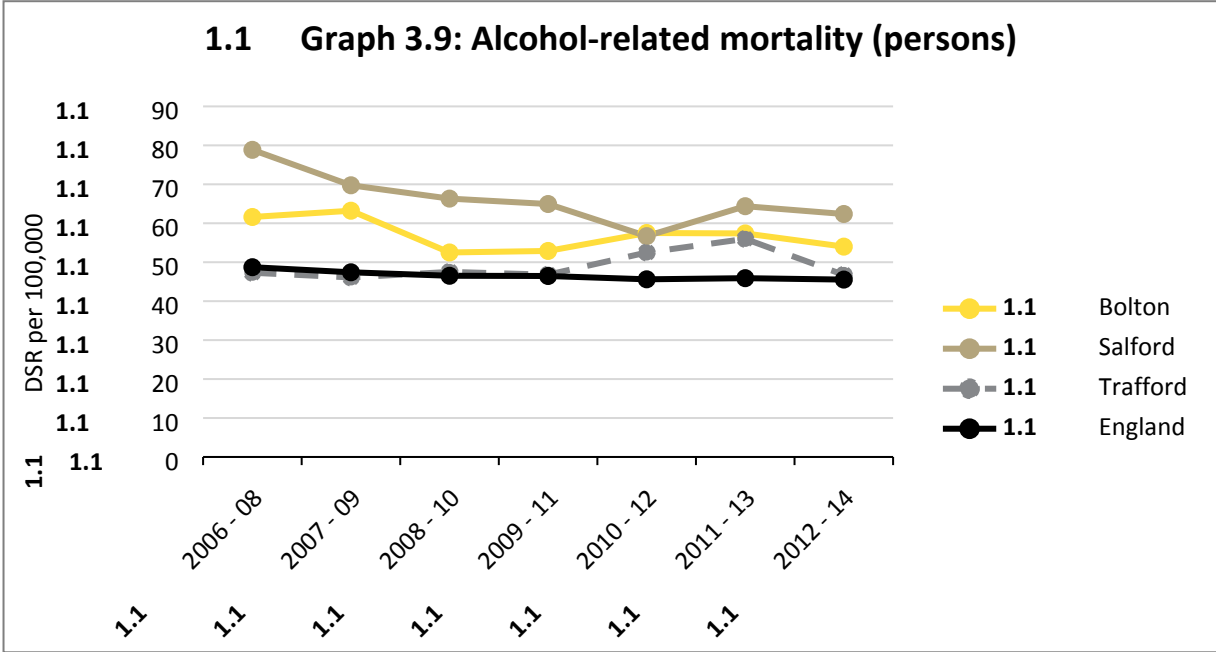
3.19 Alcohol-specific mortality<sup>8</sup> increased in all three areas over the latest three time periods (2010-12 to 2012-14). However, there are variations in these increases, ranging from 28% in Trafford to 7% and 4% in Bolton and Salford respectively. In addition, as can be seen from the graph, Trafford had a much lower starting point compared to the other two areas, with its increase simply bringing it in line with the other two areas. All three areas are significantly higher than the England average.



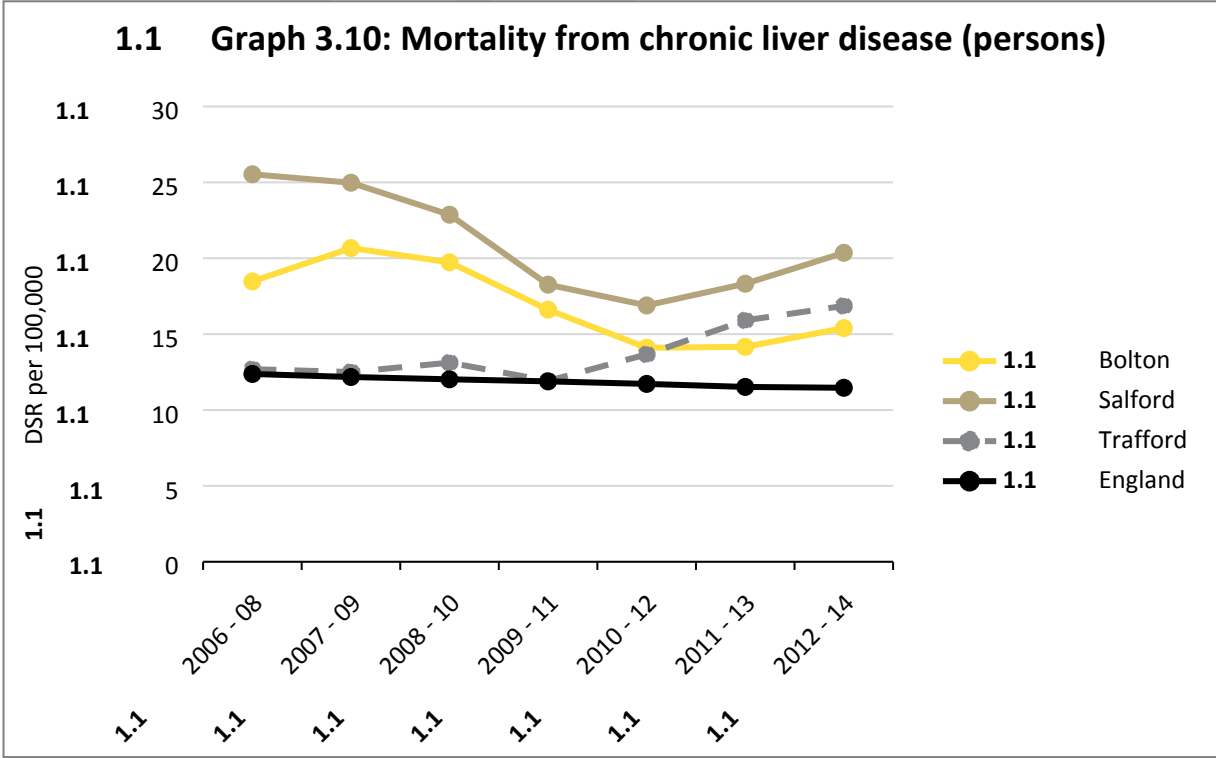
3.20 Alcohol-related<sup>9</sup> mortality increased in Salford (+10%), and decreased in Trafford (-11%) and Bolton (-4%) over the last three time periods (2010-12 to 2012-14). All three remain higher than the England average (though Trafford is only slightly so).

<sup>8</sup> Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis.

<sup>9</sup> Alcohol-related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls.



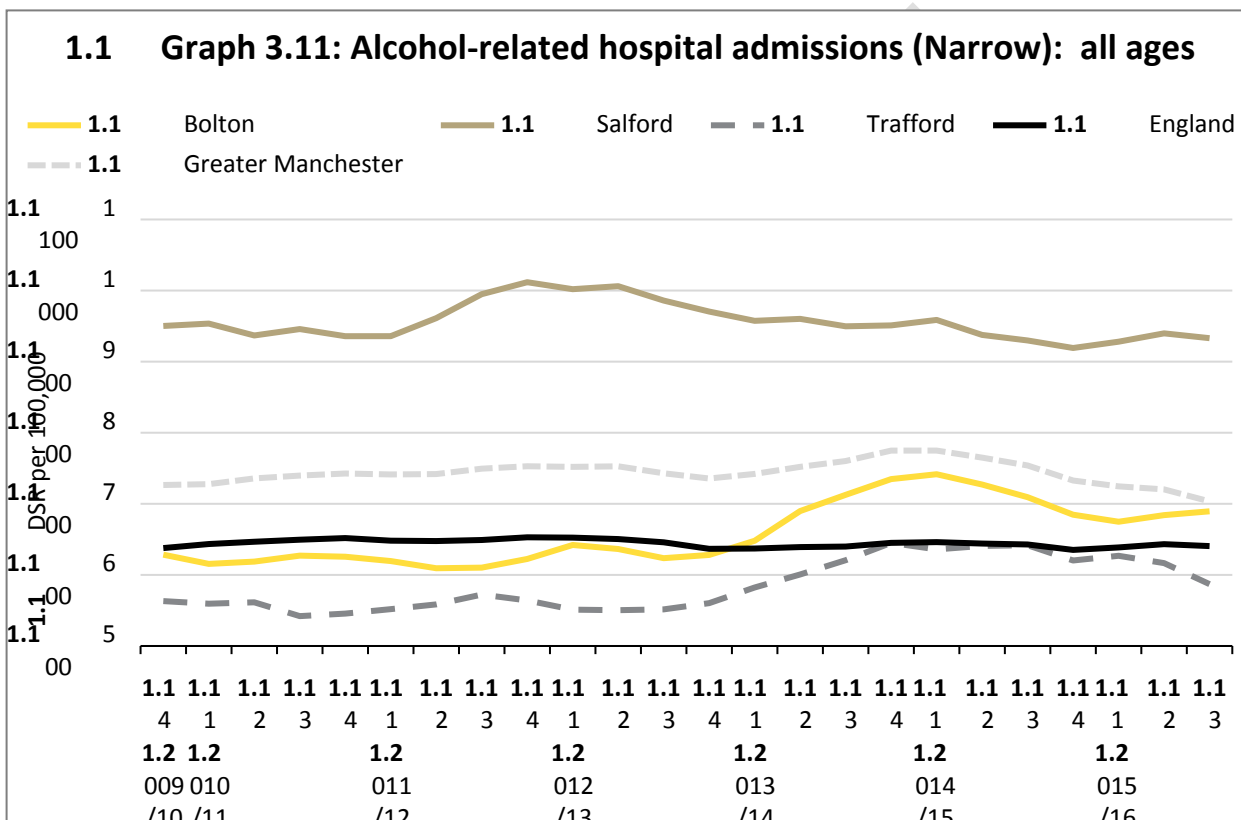
3.21 Both Trafford (23%) and Salford (21%) have seen sharp rises in chronic mortality liver disease over recent years (2010-12 to 2012-14). There has also been a rise in Bolton



(9%) over the same time periods, albeit smaller.

### Hospital Admissions

3.22 During the three year time period from 2012/13 to 2014/15<sup>10</sup>, hospital admissions for alcohol-related conditions (Narrow<sup>11</sup>) increased slightly in Bolton and Trafford, and decreased slightly in Salford. However, Salford's rate of admissions is significantly higher than Bolton's and Trafford's, and the England and GM averages. Generally, over a five year period admissions seem relatively stable, with some peaks.



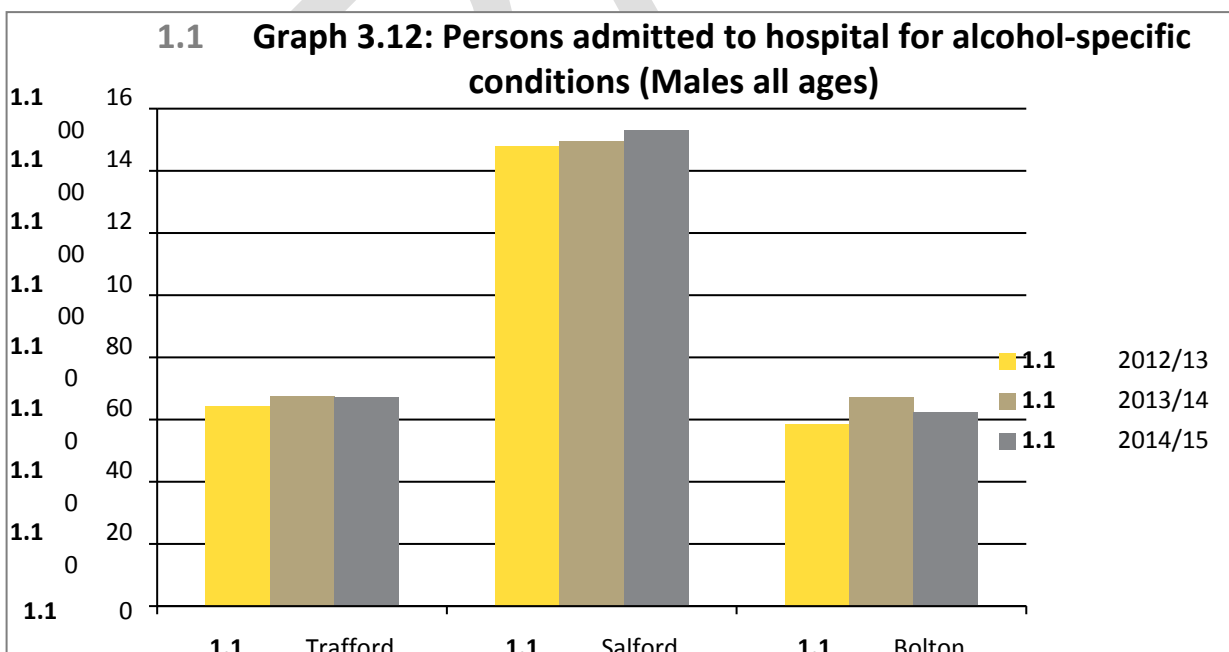
3.23 Table 3.1 provides some interesting breakdowns of percentage changes in the graph above. For example, we can see large increases in admissions for female over 65s in Trafford, and female under 40s in Bolton.

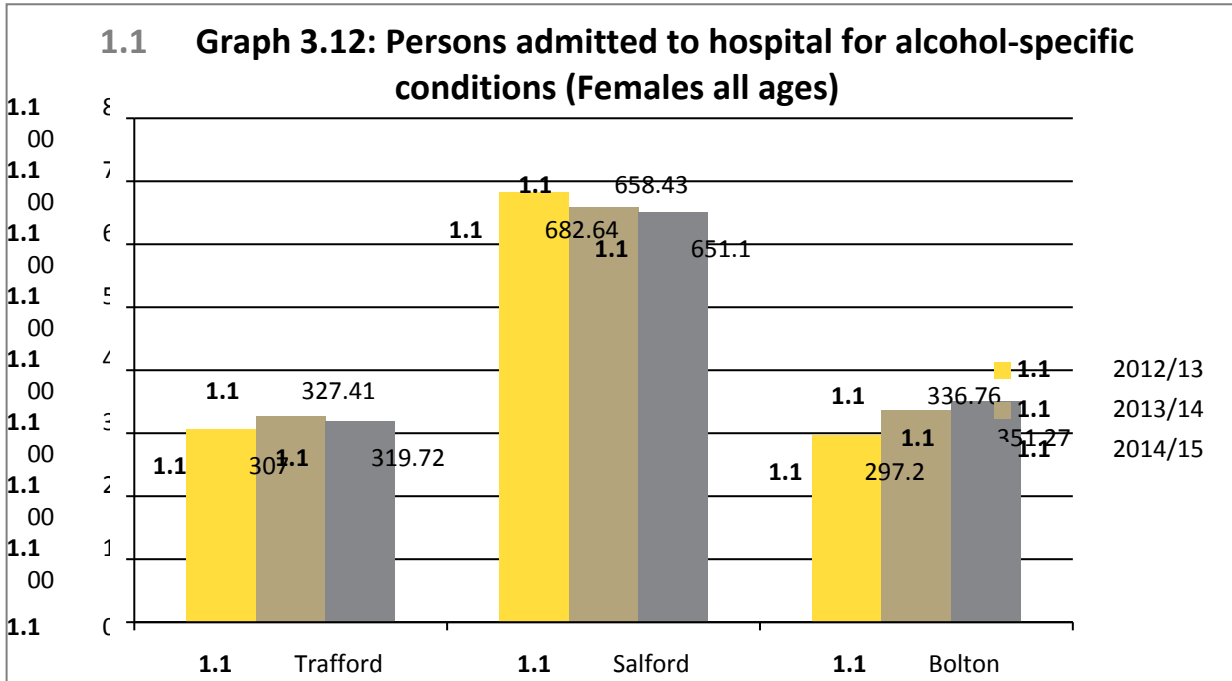
<sup>10</sup> Data for 2015/16 is estimated

<sup>11</sup> This needs assessment will only consider the Narrow measure alcohol-related hospital admissions. For further guidance on Narrow and Broad measures, please see LAPE guidance: [http://www.lape.org.uk/downloads/LAPE%20User%20Guide\\_Final.pdf](http://www.lape.org.uk/downloads/LAPE%20User%20Guide_Final.pdf) pp. 23/24

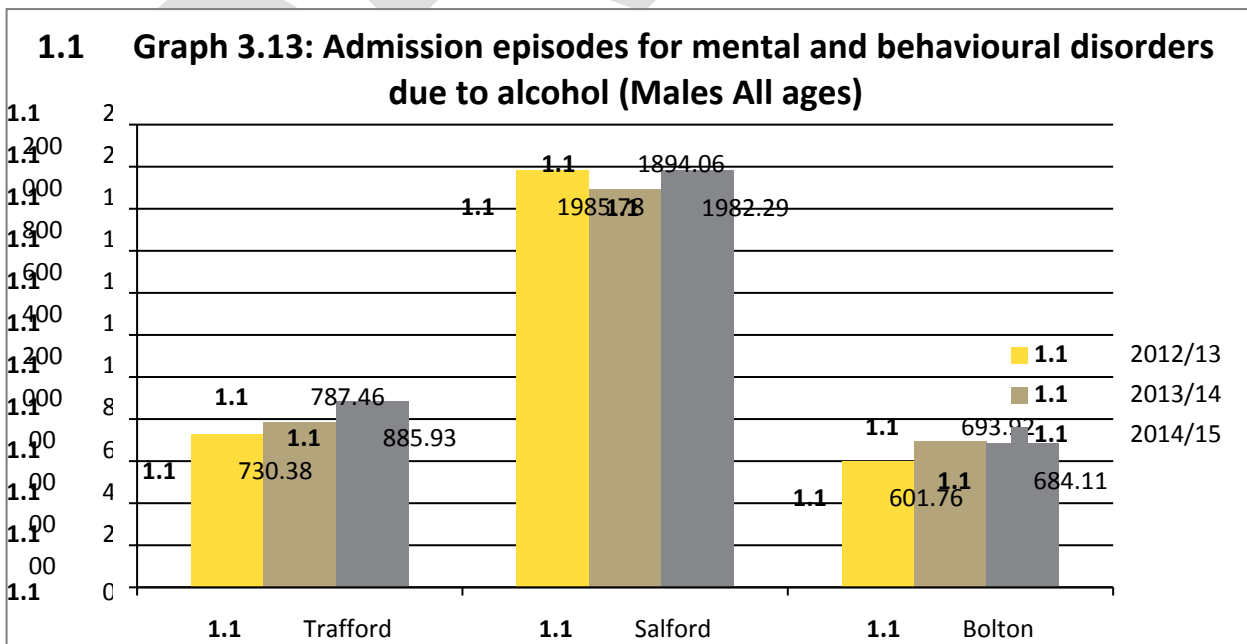
| Table 3.1: Percentage changes in alcohol-specific hospital admission episodes (Narrow), 2012/13 to 2014/15 by age and gender |             |        |
|--|-------------|--------|
|  | <40 years   |        |
|  | Male        | Female |
| <b>Bolton</b>  | +16%        | +32%   |
| <b>Salford</b>   | -10%        | +6%    |
| <b>Trafford</b>  | -2%         | -5%    |
|  | 40-65 years |        |
|  | Male        | Female |
| <b>Bolton</b>  | +8%         | +4%    |
| <b>Salford</b>   | -4%         | +3%    |
| <b>Trafford</b>  | +18%        | +13%   |
|  | 65+ years   |        |
|  | Male        | Female |
| <b>Bolton</b>  | +8%         | +1%    |
| <b>Salford</b>   | -5%         | -11%   |
| <b>Trafford</b>  | +12%        | +25%   |

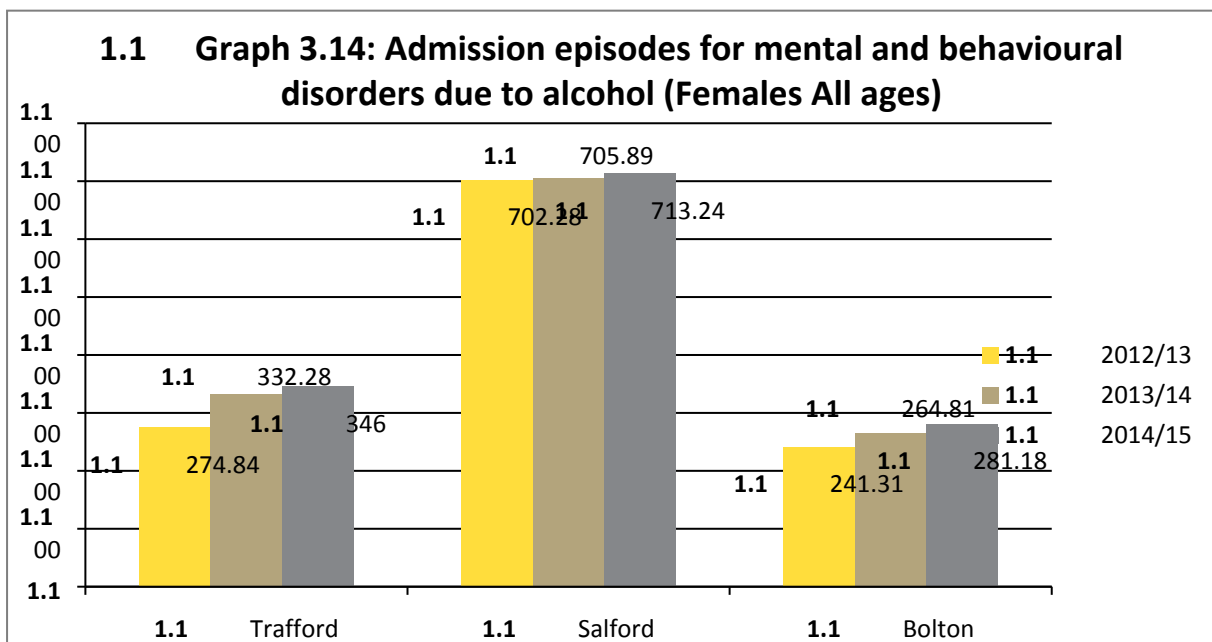
3.24 Across all three areas, alcohol-specific hospital admissions have been broadly consistent over the past three years. Alcohol-specific admissions remain much higher for men than for women. Salford's rates are significantly higher than other areas.





**3.25** There have been fairly significant increases in admissions for mental and behavioural disorders due to alcohol in Bolton (15%) and Trafford (22%), with a steady rate in Salford. There is little gender variation in these trends, but men have much higher rates of admission for mental and behavioural disorders due to alcohol than women. Salford has much higher rates of admission than either Trafford or Bolton.





3.26 It is important to be aware that these statistics do not provide us with a complete or nuanced picture of how people are affected by alcohol harm. Evidence demonstrates that alcohol harm is a fundamental component of health inequalities, and a key driver of large gaps in (healthy) life expectancy in GM. For example, in 2013/14, those with an alcohol specific condition living in the most deprived areas had rates of admission to hospital more than twice those living in the least deprived areas (PHE, 2015).

### Young People’s Drug Use

3.27 Nationally, reported drug use amongst secondary school age children has halved since 2001. The latest data shows that the percentage of 11-15 year olds who say they have ever taken drugs has fallen from 29% in 2001 to 15% in 2014. 6% have used in the last month. Use increases with age, with 15 year olds four times more likely to have taken drugs than 11 year olds (24% compared to 6%). Use amongst boys (16%) is higher than girls (13%) (Fuller, 2015).

3.28 Amongst those young people who have used drugs in the last year the most commonly used drugs are cannabis (65%), solvents (28%), stimulants (20%) and psychedelics (13%). One in five of those who had used drugs in the last year used a Class A drug (cocaine accounted for half of Class A use).

3.29 The percentage of secondary age children reporting the use of drugs within the last year is highest in the North West region. Reported prevalence was around 80% higher than other regions. This would give a rate somewhere in the range of 10% to 28% of 11-15 year olds, but likely to be closer to 17%, compared to 10% nationally.

3.30 Local data on drug use prevalence amongst children and young people has always been difficult to come by. It is often a hidden activity occurring outside the law with

negative consequences for users, making accurate prevalence estimates challenging to determine. The best current source is the WAY survey of young people (Ipsos MORI, 2015).

- 3.31** Taking a weighted average across the three areas, 9.5% of 15 year olds report using cannabis in the last year. Cannabis use was more common in Salford (10.2%) and Bolton (9.6%) with Trafford (8.9%) having a similar prevalence to the national average (8.9%).
- 3.32** Weighted across the three areas, only 3.0% of 15 year olds say they have ever tried drugs other than cannabis. Trafford has a higher prevalence for other drug use, at 4.3% which compares to 3.4% in Salford, 1.7% in Bolton and an England average of 2.5%.
- 3.33** There is little difference by gender for the three areas taken as a whole for other drug use (boys 2.8%; girls 3.2%) but girls in Salford (4.6%) and Trafford (4.1%) do differ notably from the prevalence seen in girls in Bolton (1.5%).

### Young People's Alcohol and Tobacco Use

- 3.34** As well as posing a need themselves, smoking and drinking in young people are also good predictors of drug use. Young people who are regular smokers are at least eight times<sup>12</sup> as likely as non-smokers to report using drugs in the last year. Young people who drink (even infrequently) are at least three times<sup>13</sup> as likely as non-drinkers to report having used drugs in the last year.
- 3.35** Trading Standards North West conducts a biennial survey of 14-17 year old pupils on alcohol and tobacco use (Mustard/TSNW, 2015). The latest survey was conducted in 2015.<sup>14</sup>
- 3.36** The three areas have relatively similar proportions of children and young people reporting that they never drink (44% in Salford, 48% in Trafford, and 35% in Bolton<sup>15</sup>). Regular drinking (at least once a week) was also similar (9% in Salford, 10% in Trafford, and 18% in Bolton<sup>16</sup>). Slight variations in Bolton are to be expected given the different timelines (see footnotes).

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<sup>12</sup> The odds ratio (OR) for having taken drugs in the last year for regular smokers aged 11-15 compared to non-smokers is 13.69 (95% CI: 7.98 – 21.81)

<sup>13</sup> The OR for having taken drugs in the last year for 11-15 year olds who have drunk alcohol but not in the last week compared to those who have never drunk alcohol is 4.69 (95% CI: 3.29 – 6.69) for those who have drunk alcohol in the last week the OR is 8.73 (95%CI: 5.62 – 13.55)

<sup>14</sup> Bolton did not take part in the 2015 survey. As a result, data from 2013 are presented here for Bolton.

<sup>15</sup> However, the regional average was also lower in the 2013 survey

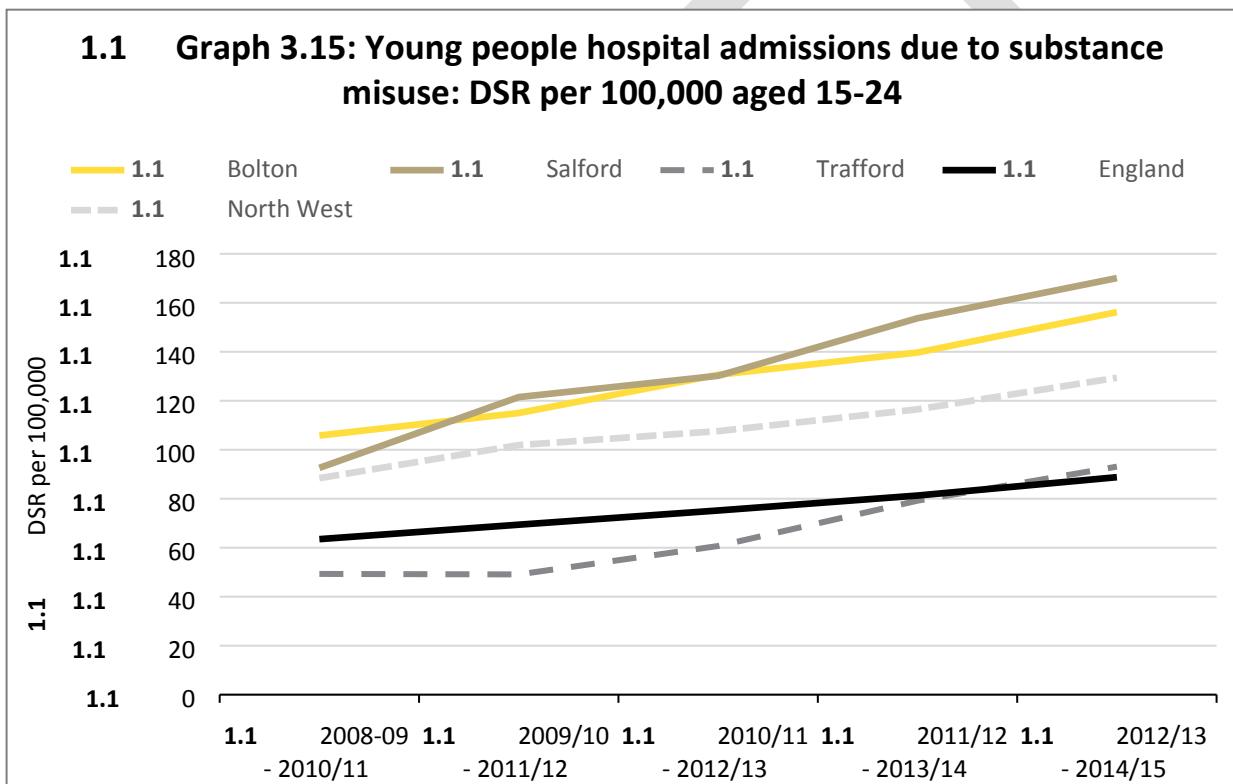
<sup>16</sup> However, the regional average was higher in the 2013 survey.



3.37 In all three areas and the region overall, smoking prevalence in children and young people has reduced in every survey since 2009. Currently, self-reported smoking rates are 10% in Salford, 7% in Trafford, and 9% in Bolton.

### Young People’s Hospital Admissions

3.38 Interestingly, graph 3.15 shows higher admission rates in Salford (170.1) and Bolton (156.2) compared to Trafford (93.1) but an increasing trend in all three areas, the North West region, and England as a whole. These figures equate to 58 admissions in Salford each year, 56 in Bolton each year, and 23 in Trafford each year. Across the three areas this means 2.6 children and/or young people can be expected to be admitted to hospital for substance misuse each week and looking at the direction of travel this number will likely increase over coming years.<sup>17</sup>



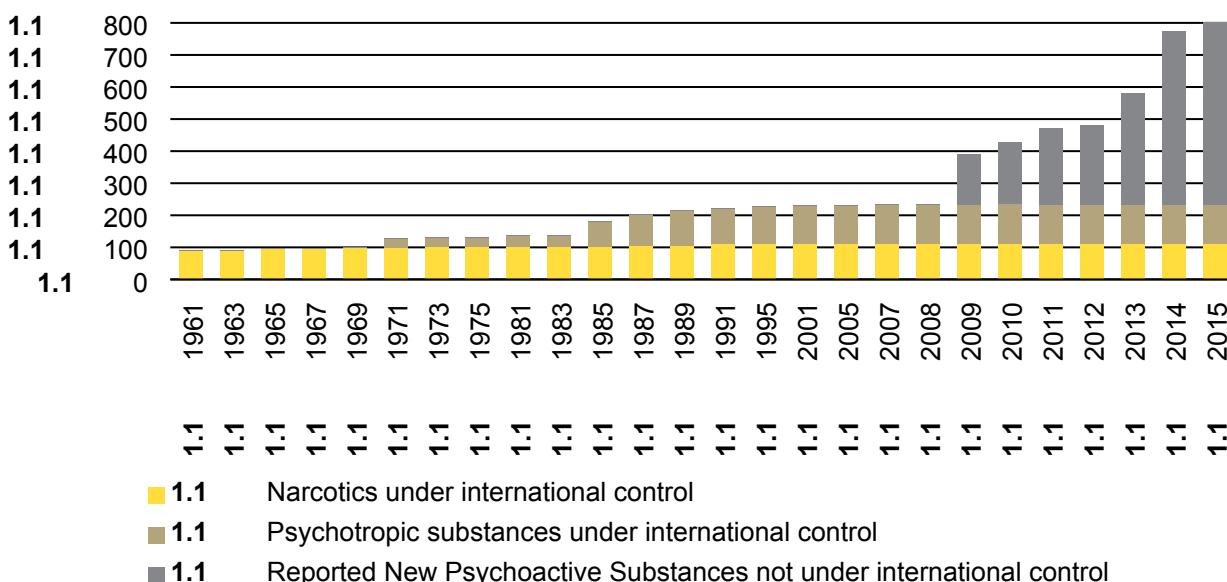
3.39 This is in contrast to evidence above that indicates that use of all substances is, across the general population of young people, declining. This confirms that the most high risk young people are still likely to present with high needs (see chapter 5).

<sup>17</sup> Data from Child Health Profiles, available: <http://fingertips.phe.org.uk/profile/child-health-profiles>

### New and Emerging Drug Trends

3.40 The speed at which New Psychoactive Substances (NPS)<sup>18</sup> are being introduced to the market is unprecedented, and continues to rise. Towards the end of 2015, 75 new substances had been reported to the UN Office for Drugs and Crime (UNODC) for the first time. In 2014, the figure was 66. Towards the end of 2015<sup>19</sup>, a total of 616 NPS not under international control had been reported to UNODC. In 2013, the figure was 348. None were reported before 2009 (UNODC, 2016).

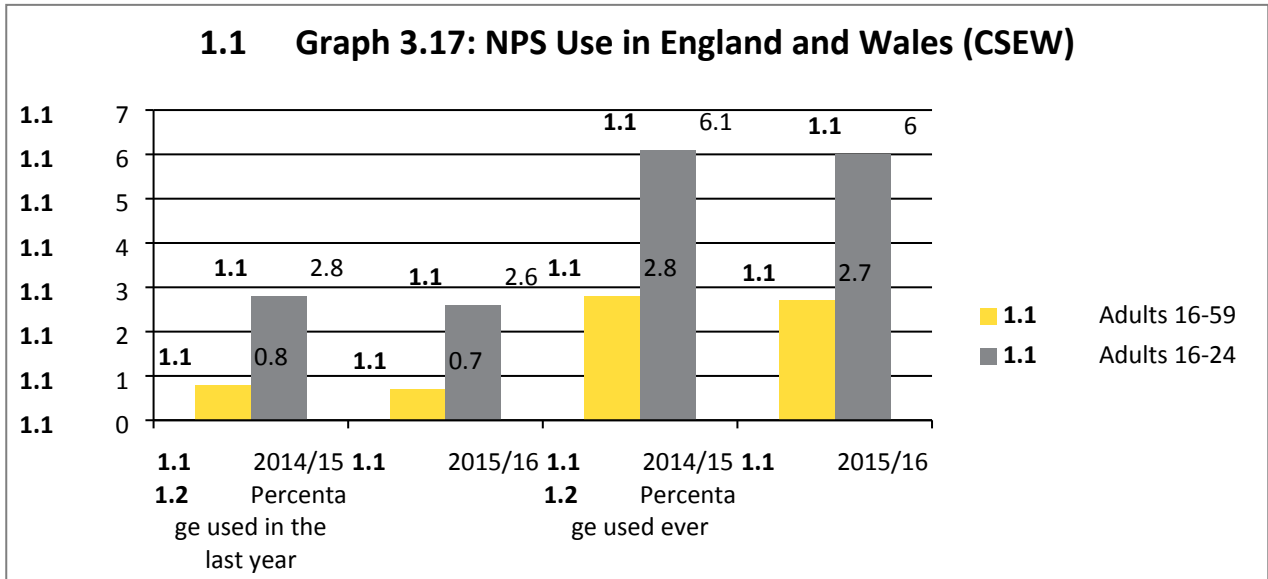
1.1 Graph 3.16: Number of NPS not under international control, and substances controlled under the international drug conventions (1961-2013)



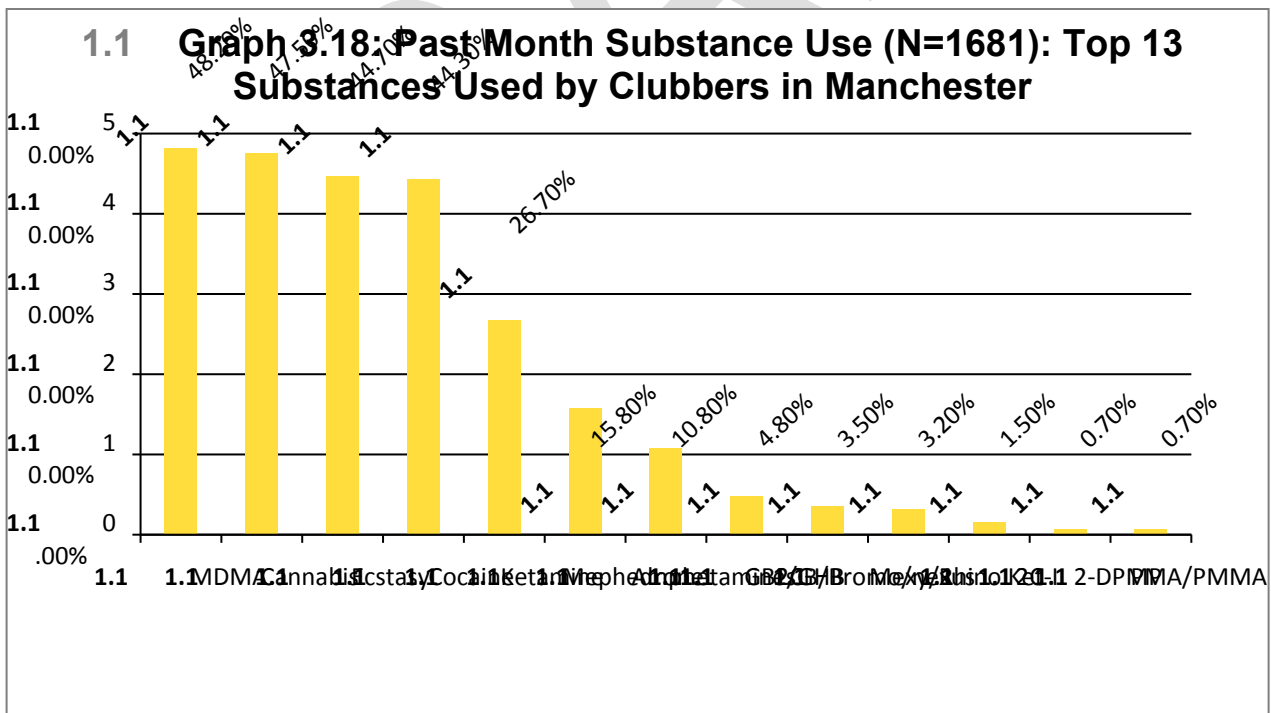
3.41 According to CSEW 2015/16, use of NPS is concentrated among young adults aged 16-24. Around 2.6% young adults took an NPS in the last year – a proportion more than three times higher than the general population. This equates to around 2,185 young people across the three areas. Use of NPS in the last year was concentrated among young men aged 16-24, of whom 3.6% had used a NPS in the last year compared to 1.6% of women.

<sup>18</sup> The UNODC defines a new psychoactive substance as “substances of abuse, either in a pure form or a preparation, that are not controlled by the 1961 Single Convention on Narcotic Drugs or the 1971 Convention on Psychotropic Substances, but which may pose a public health threat” (UNODC, 2015). This term encompasses those substances that have recently been banned under the Psychoactive Substances Act 2016 and that were often colloquially referred to as ‘legal highs’. It should also be noted that some of these drugs are not actually ‘new’. However, their availability and forms are.

<sup>19</sup> UNODC 2016 World Drug Report was released with this figure before the final number was available. This number may go up but will not go down.



3.42 Research from Manchester Metropolitan University analysing drug use in clubs in Manchester found that 79% (n=1,698) of people had 'ever used drugs'. 46% of these had used "legal highs" (Ralphs, 2013).



- 3.43 Whilst this research is based in the City of Manchester, patterns of night-time economy travel mean that the individuals within this study will not live only within Manchester, but across the boroughs.
- 3.44 26.9% of those surveyed reported bad experiences with “legal highs”, ranging from confusion and memory loss to hallucinations, panic attacks and collapsing. Despite this, just 10% of the sample wanted more information and advice about drugs. This reflects wider evidence indicating that users of non-traditional drugs are reluctant to access treatment from services they view as for alcohol, heroin and crack users (RCPsych, 2014).
- 3.45 In 2015/16, 36 adults in treatment in Bolton, Salford and Trafford used NPS. In 2014/15, this figure was 6. In 2015/16, 24 young people in treatment in Bolton, Salford and Trafford used NPS. In 2014/15, this figure was 7.
- 3.46 These issues are not confined to GM. A 2014 Home Office report outlines barriers to treatment and intervention with people using NPS. These include a lack of knowledge on NPS and their harms, very little systematic recording of NPS prevalence and effects across health services, a limited evidence base relating to treatment, users being new and unknown to services, and challenges in sharing learning (Home Office, 2014). As the Royal College of Psychiatrists has summarised: there is a growing national recognition that “*our health services are not equipped to address the serious harms that NPS and club drug users are now reporting and were instead designed to deal with the drugs and dangers of the past decade.*” (RCPsych, 2014)
- 3.47 In addition, there have been particular and growing problems in prisons and the custody suite relating to synthetic cannabinoids (‘Spice’). These are outlined in Section 4.

## Marginalised and Vulnerable Communities

- 3.48 People from marginalised and vulnerable groups (including but not limited to people with ‘protected characteristics’<sup>20</sup>) often have particular needs relating to substance misuse. These groups are more likely to experience discrimination and marginalisation in their daily lives, making them more vulnerable to substance use, poor mental health and isolation.
- 3.49 Whilst not homogeneous, groups of people and communities who share certain characteristics can also often experience a range of barriers to engaging with substance misuse treatment services. These include, but are not limited to:
- BME and minority religious communities
  - People with English as a second language (or no English)

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<sup>20</sup> Protected characteristics are defined in the Equalities Act of 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

- LGBT (lesbian, gay, bisexual and transgender) people and MSM (men who have sex with men, regardless of their identified sexual orientation)
  - People with disabilities (including physical and sensory disabilities, such as deafness and/or blindness, learning difficulties and physical and/or mobility impairments)
  - People with mental health problems (aside from dual diagnosis)
  - People who have experienced (or are experiencing) domestic and/or sexual violence
  - Older people
  - Other minority communities, e.g. Travellers, Gypsies and Roma people
  - People with non-traditional drug use (e.g. club drugs, NPS, over-the-counter and prescription drugs)
- 3.50** These groups experience particular, and sometimes high, needs relating to drug and alcohol use and accessing treatment. Intersectionality between these groups is also important, and they are not mutually exclusive (e.g. someone may identify as LGBT and have a physical disability). Intersectionality has further impacts on substance misuse and treatment.
- 3.51** Given the hidden nature of substance misuse in these communities, data and evidence are not always available. This means we often cannot provide robust evidence of need, but anecdotal information, patterns of behaviour and a history of discrimination mean that we can be reasonably sure that unmet need exists in these communities. An absence of data should not be taken as a sign of unimportance or low levels of need.

### **BME and minority religious communities**

- 3.52** The evidence around BME drug and alcohol use is scarce and often local. It is an oft-neglected area that requires more research.
- 3.53** Substance misuse in BME communities, particularly South Asian, is regularly masked due to overall patterns of lower use amongst these communities and higher levels of associated stigma. However, this means that problematic use, when it occurs, is often hidden. *“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.”* (JRF, 2010). In particular, alcohol consumption amongst second-generation BME people has increased and is beginning to converge with overall consumption patterns. This is not just limited to young men but patterns of increasing use are being seen amongst younger women, too.
- 3.54** There are indications that use amongst Asian people is increasing. Data from CSEW indicates that from 2008/9 to 2015/16, the number of Asian people who had used drugs in the last year increased from 2.6% to 3.8%, a 46% rise. However, evidence

indicates that drug use in Asian communities is almost certainly under-reported in statistics. People of mixed heritage were the most likely to say that they had used drugs, at 15%.

**Table 3.2: Respondents to CSEW 2015/16, by ethnicity (percentages)**

| Ethnicity              | Any Class A drug | Any stimulant drug | Any drug |
|------------------------|------------------|--------------------|----------|
| White                  | 3.3              | 3.6                | 8.9      |
| Non-white              | 1.4              | 1.4                | 5.0      |
| Mixed                  | 6.4              | 6.4                | 15.2     |
| Asian or Asian British | 1.2              | 1.0                | 3.8      |
| Black or Black British | 0.4              | 0.6                | 4.6      |
| Chinese or other       | 0.0              | 0.3                | 2.1      |

- 3.55** It is likely that this rise in drug use can be mainly attributed to cocaine and cannabis use. This is combined with a corresponding increase in alcohol consumption. For example, anecdotal information from Bolton indicates that young Asian males often test positive for alcohol and cocaine use (through Test on Arrest), reporting hazardous behaviour alongside these. Such patterns often escalate at key times such as Eid al-Fitr.
- 3.56** Substance misuse amongst Eastern European communities is less hidden, but more common. Bolton in particular has a growing Eastern European population. **More? Bolton and Salford in particular have growing numbers of... LINK TO DEMOGRAPHICS SECTION when have it**
- 3.57** Despite patterns of need, BME and minority religious communities have traditionally been under-represented in service provision. In **2015/16**, 89.25% of adults in treatment across all three areas were White British. Adults in treatment from an Asian background represented 1.87%. Adults in treatment from an African, Caribbean or other Black background represented 1.09% and those of mixed heritage represented 2.15%.
- 3.58** Young people from an Asian background represented 1.22% of those in treatment. Young people in treatment from an African, Caribbean or other Black background represented 0.63% and young people of mixed heritage represented 5.60%. When compared to the evidence above, it appears that representation in services is not as ethnically representative as it could be.<sup>21</sup>

**Table 3.3: Ethnicity of clients in treatment, 2015/16, across all three areas**

| Ethnicity | Adults |            | Young People |            |
|-----------|--------|------------|--------------|------------|
|           | Number | Percentage | Number       | Percentage |
|           |        |            |              |            |

<sup>21</sup> For example, compare the 15.2% prevalence in drug use amongst people of mixed heritage to their representation in services, at 2.15%.

|                         |      |        |     |        |
|-------------------------|------|--------|-----|--------|
| White British           | 4640 | 89.25% | 556 | 88.69% |
| White Irish             | 65   | 1.25%  | 6   | 0.96%  |
| Other White             | 107  | 2.06%  | 6   | 0.95%  |
| White & Black Caribbean | 50   | 0.96%  | 14  | 2.18%  |
| White & Black African   | 13   | 0.25%  | 5   | 0.80%  |
| White & Asian           | 21   | 0.4%   | 10  | 1.64%  |
| Other Mixed             | 28   | 0.54%  | 6   | 0.98%  |
| Indian                  | 30   | 0.58%  | 0   | 0%     |
| Pakistani               | 22   | 0.42%  | -   | -      |
| Bangladeshi             | -    | -      | -   | -      |
| Other Asian             | 41   | 0.79%  | -   | -      |
| Caribbean               | 26   | 0.5%   | -   | -      |
| African                 | 8    | 0.15%  | 0   | 0%     |
| Other Black             | 23   | 0.44%  | -   | -      |
| Chinese                 | 0    | 0%     | 0   | 0%     |
| Other                   | 21   | 0.4%   | -   | -      |
| Not stated              | 96   | 1.85%  | 7   | 1.15%  |
| Missing                 | -    | -      | -   | -      |

### LGBT people and MSM

- 3.59** Estimates of the number of LGBT people in the population vary. The Gender Identity Research and Education Society (GIRES) estimates that around 1% of the UK population experiences some degree of gender variance. PHE estimate that gay, bisexual and other MSM make up 5.5% of the male population in the UK (PHE, 2014). The most reliable estimates indicate that LGB people represent between 5-7% of the population.
- 3.60** LGBT people are overwhelmingly more likely to use drugs compared to the general population (NEPTUNE, 2016). The LGBT foundation estimate that drug use amongst LGB people is 7 times higher than in the general population. Data from CSEW indicates that gay and bisexual men are more likely to have used drugs than heterosexual men. LGBT people are particularly more likely to use 'club drugs' than other groups. Binge drinking is twice as high amongst LGB people (of both sexes) than in the general population. However, the difference in alcohol use seems less apparent than the difference in drug use levels.
- 3.61** In a study by the LGBT Foundation in GM, "*over a fifth of the sample scored as dependent on a substance, and a further quarter showed at least one indicator of dependency. This included 16% of all alcohol users in the sample, and between 4 to 13% of users of the most commonly used drugs.*" (LGBT Foundation, 2014, p.4) Poly

LGB drug users are more likely to display signs of dependency. This means that not only are LGB people more likely to use drugs and alcohol more frequently and more problematically, they are also more likely to show signs of dependency to these substances.

- 3.62 Whilst drug use is generally higher amongst LGBT people than heterosexual people, it is important to distinguish between and within this group when considering need. There are varying patterns of use between genders, but evidence is contradicting in terms of need pattern, though most evidence tends to indicate that gay and bisexual men have greater use than women. Studies generally indicate that patterns of drug use by people who identify as bisexual are higher than homosexual men and women.
- 3.63 This group often has worse broader health outcomes than their heterosexual counterparts. MSM in the UK are most affected by HIV and are at greater risk of other BBVs such as Hepatitis C.
- 3.64 Despite an indication towards higher patterns of need, LGBT people and MSM are less likely than the general population to seek treatment or support from mainstream services for health-related issues. Sexual orientation monitoring of those in treatment across the three areas appears to indicate that LGB people continue to be under-represented compared to their needs profile.<sup>22</sup>

**Table 3.4: Sexual Orientation (adults in treatment), 1 Apr – 31 Mar 2016**

| Identifying as: | Bolton <sup>23</sup> |                          | Salford <sup>24</sup> |                          | Trafford <sup>25</sup> |                          |
|-----------------|----------------------|--------------------------|-----------------------|--------------------------|------------------------|--------------------------|
|                 | Number               | Percentage <sup>26</sup> | Number                | Percentage <sup>27</sup> | Number                 | Percentage <sup>28</sup> |
| Bi-sexual       | 5                    | 0.63%                    | 16                    | 1.06%                    | 5                      | 1.07%                    |
| Gay or Lesbian  | 25                   | 3.17%                    | 49                    | 3.23%                    | 20                     | 4.30%                    |
| Heterosexual    | 759                  | 96.2%                    | 1450                  | 95.71%                   | 439                    | 94.40%                   |
| Other           | 0                    | 0%                       | 0                     | 0%                       | -                      | -                        |
| Not provided    | 138                  | -                        | 221                   | -                        | 8                      | -                        |
| Total           | 927                  | -                        | 1736                  | -                        | 473                    | -                        |

- 3.65 Minority gender identity status is not currently monitored in treatment services.

<sup>22</sup> As this has only recently started being reported to NDTMS, data from the three areas is not necessarily comparable, as data may be for slightly different time periods and/or classifications (e.g. numbers in treatment vs. new presentations). This is why no overall average is provided. Footnotes indicate differences. However, the data can be taken as a reliable number for which it is labelled.

<sup>23</sup> Entrants to service

<sup>24</sup> Total numbers in treatment

<sup>25</sup> Starting structured treatment

<sup>26</sup> Percentages calculated out of the total number who disclosed (789) not total overall

<sup>27</sup> Percentages calculated out of the total number who disclosed (1515) not total overall

<sup>28</sup> Percentages calculated out of the total number who disclosed (465) not total overall



### Older People

- 3.66** The Royal College of Psychiatrists estimates that 1 in 5 older men and 1 in 10 older women are drinking enough to harm themselves, figures that have increased by 40% in men and 100% in women over the past 20 years. This is likely to be a combination of those who only started drinking heavily as they aged, and those whose health problems from long-term drinking start to materialise as they become older. A number of risk factors for excess alcohol consumption materialise as people age, including bereavement, poor health and financial stress.
- 3.67** The cohort of people in treatment is also ageing. In England, nearly half (48%) of those in substance misuse treatment services are aged 40 or over, this figure reaches 68% among those being treated for alcohol alone. These figures are consistent with the pattern in GM and in Bolton, Salford and Trafford, with Trafford seeing slightly higher percentages.

**Table 3.5: In treatment by age group, 1 Apr 2015 – 31 Mar 2016 (all drugs)**

| Age                | Bolton | Salford | Trafford |
|--------------------|--------|---------|----------|
| 40-44              | 423    | 370     | 150      |
| 45-49              | 320    | 302     | 196      |
| 50-54              | 161    | 187     | 137      |
| 55-59              | 95     | 98      | 60       |
| 60-64              | 44     | 43      | 39       |
| 65-74              | 20     | 32      | 31       |
| 75-84              | -      | -       | -        |
| Total over 50      | 322    | 364     | 269      |
| Total all ages     | 2,169  | 1,904   | 1,126    |
| Percentage over 40 | 49%    | 54%     | 55%      |
| Percentage over 50 | 15%    | 19%     | 24%      |

**Table 3.6: In treatment by age group, 1 Apr 2015 – 31 Mar 2016 (alcohol only)**

| Age                | Bolton | Salford | Trafford |
|--------------------|--------|---------|----------|
| 40-44              | 72     | 95      | 62       |
| 45-49              | 84     | 107     | 68       |
| 50-54              | 87     | 103     | 65       |
| 55-59              | 62     | 66      | 41       |
| 60-64              | 30     | 34      | 31       |
| 65-74              | 18     | 30      | 26       |
| 75-84              | -      | -       | -        |
| Total over 50      | 199    | 237     | 165      |
| Total all ages     | 560    | 648     | 415      |
| Percentage over 40 | 63%    | 68%     | 71%      |

|                    |     |     |     |
|--------------------|-----|-----|-----|
| Percentage over 50 | 36% | 37% | 40% |
|--------------------|-----|-----|-----|

3.68 In 2014/15, there were 194 hospital admissions for alcohol related conditions (narrow) amongst over 65s for every 100,000 people in GM. This is worse than the England average of 190 (LAPE, 2016). This is an 11% increase from 2008/9, when there were an average 175 per 100,000 admissions amongst over 65s for every 100,000 people in GM, (and the England average was 174.8).

| <b>Table 3.7: Admission episodes for alcohol-related conditions (Narrow) over 65s per 100,000 people</b> |                |                |                |
|--|----------------|----------------|----------------|
| <b>Area</b>  | <b>2012/13</b> | <b>2013/14</b> | <b>2014/15</b> |
| Bolton   | 164.6          | 176.4          | 174.7          |
| Salford  | 227.7          | 209.7          | 212.7          |
| Trafford   | 152.4          | 172.8          | 177.8          |
| England  | 185.7          | 184.5          | 190.5          |

3.69 It can often be difficult to engage certain types of older people in treatment, such as those in care homes and people with cognitive difficulties. Alcohol use in such cases exacerbates these cognitive and other health problems, but is often hidden.

3.70 There are a range of other people sharing common characteristics amongst whom substance use is highly prevalent. However, there are problems relating to reliable data for these people. For example, travellers, gypsies and Roma people often report high levels of drug and alcohol use. However, drug use still remains a taboo in many traveller communities and so high levels of use are hidden. An absence of data for these communities should not be viewed as an absence of need.

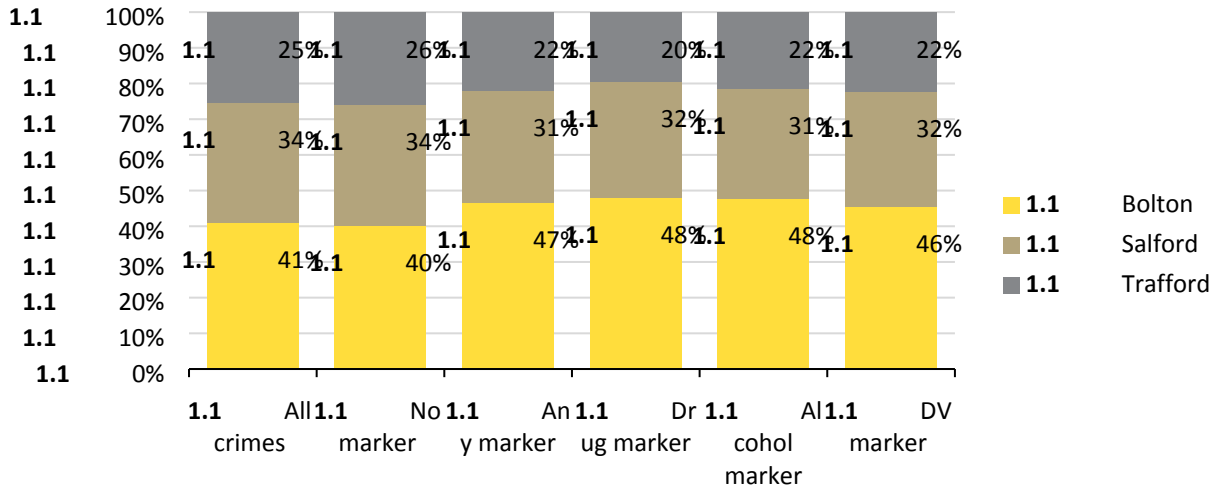
### Offending

3.71 A wealth of data is available in relation to offending, domestic violence and substance use. Over the three year period from April 2013 to March 2016 there were 147,681 crimes recorded across Bolton, Salford and Trafford. When crimes are recorded, Greater Manchester Police (GMP) can flag whether the offence was influenced by drugs or alcohol or whether domestic violence was a factor through the use of 'markers'. Around one-in-seven of all crimes recorded in this period had a drugs, alcohol and/or domestic violence marker.<sup>29</sup>

3.72 The use of the markers has not changed significantly over the past three years and, whilst Bolton, Salford and Trafford vary in the number of offences, there is little difference across the three areas in the proportion of crimes using each marker, as shown below. For this reason data presented is for the three areas combined.

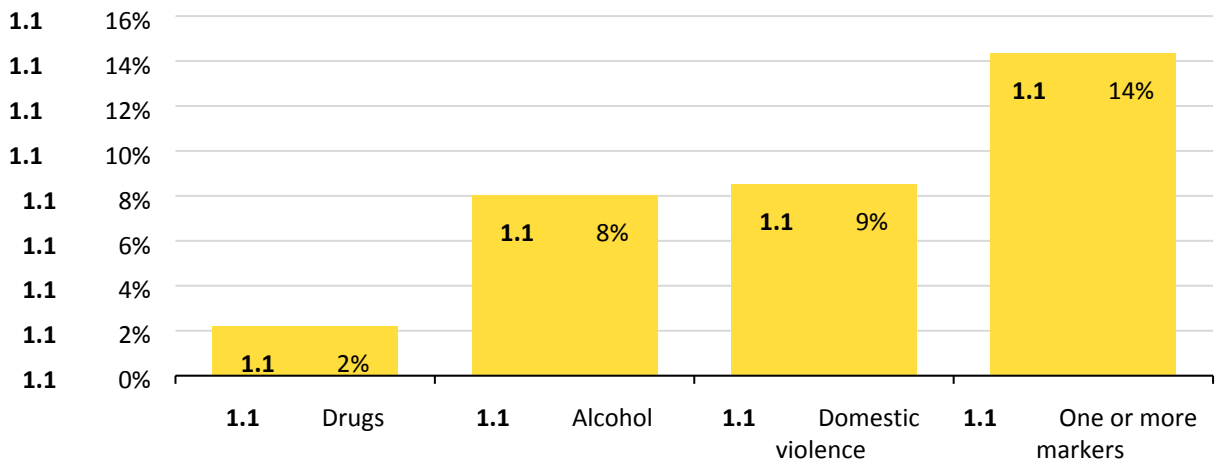
<sup>29</sup> Some crimes had more than one relevant marker attached. All had at least one out of alcohol, drugs or domestic violence.

**1.1 Graph 3.19: Share of crimes by markers and District in Bolton, Salford and Trafford, 2013/14 - 2015/16**



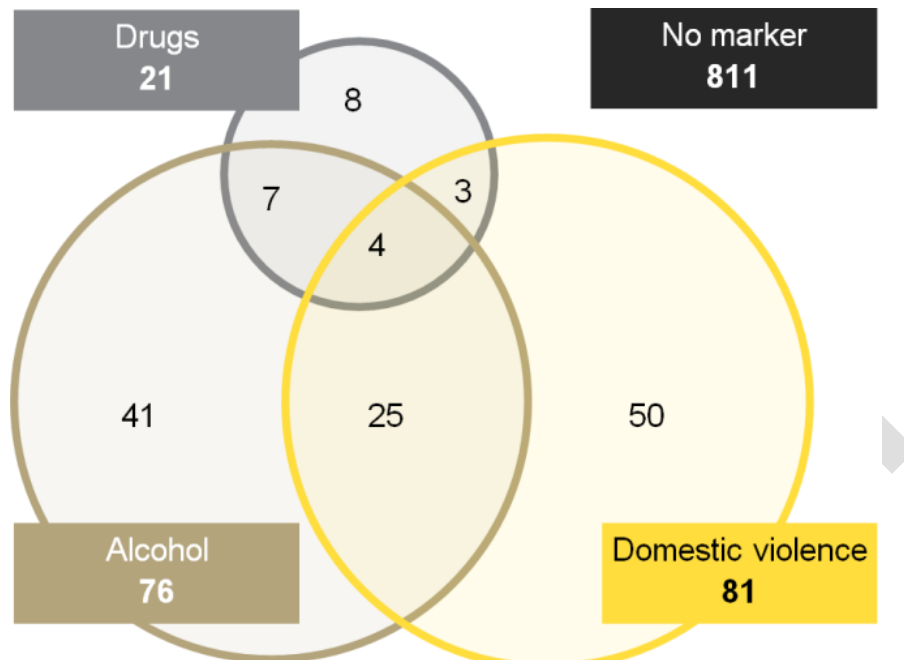
3.73 One-in-twelve crimes were flagged as involving alcohol, with a similar proportion involving domestic violence and far fewer, around one-in-fifty, involved drugs.<sup>30</sup> Some crimes have more than one of these markers. The chart below shows the frequency of use of the different markers.

**1.1 Graph 3.20: Frequency of crime markers in Bolton, Salford and Trafford, 2013/14 - 2015/16**



<sup>30</sup> This frequency is lower because these are where each crime had only one marker attached (i.e. only involving alcohol, only involving drugs or only involving domestic violence)

3.74 The crossover between the use of the markers is shown in the chart below. The figures shown relate to the number of offences using the markers within an average week across all three areas<sup>31</sup>.

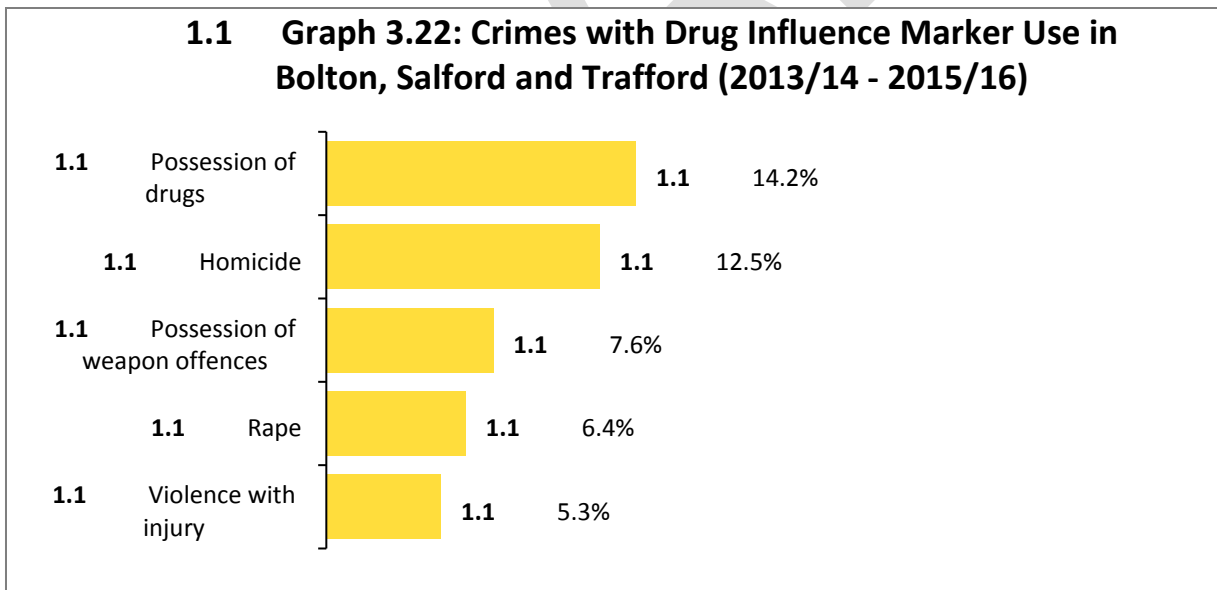
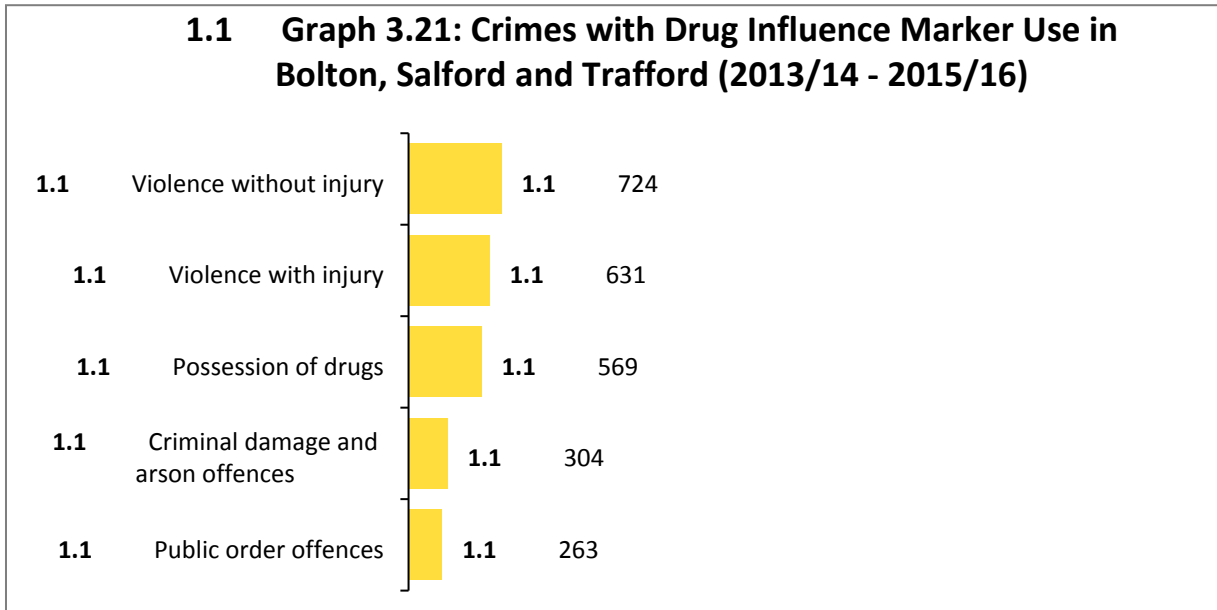


3.75 Crimes are grouped together using a 'crime tree', which has four levels. The first level has the broadest categories of crimes; these are then subdivided into narrower groupings at each subsequent level. Below are three charts showing the number and percentage of offences that use the three markers at this first level. Victim-based crimes have the highest number of crimes with each of the three markers. However, for crimes flagged as having drug or alcohol involvement the percentage was higher for non-victim based crimes.

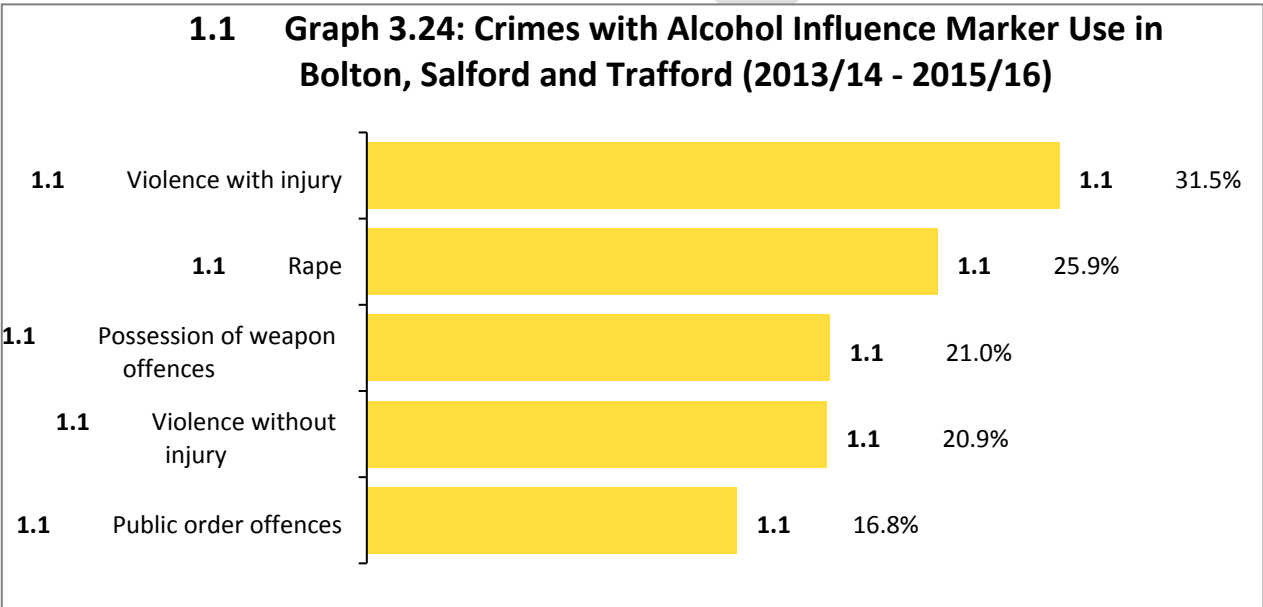
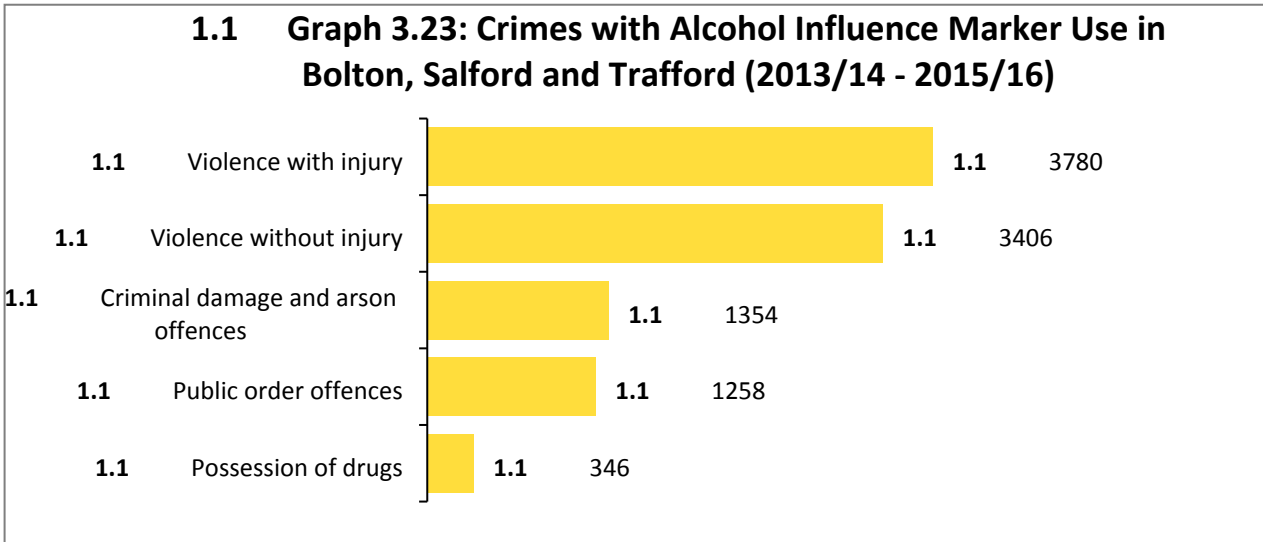
3.76 Further sub-divisions give more detail on the types of offences that are most associated with drugs, alcohol or domestic violence. The charts below show the top five crime types for each marker in terms of number of offences and percentage of offences that have a marker.

3.77 The drugs influence marker is used less than the other two. *Violent crimes* have the highest number of offences but, unsurprisingly, *Possession of drugs* has the highest proportion. *Homicide* is second highest but numbers are very low.

<sup>31</sup> Figures may not sum to totals due to rounding



**3.78** *Violent crime* also accounts for the highest number of alcohol influenced crimes; almost a third of all *Violence with injury* crimes have an alcohol influence. Around a quarter of *Rape* offences are influenced by alcohol.



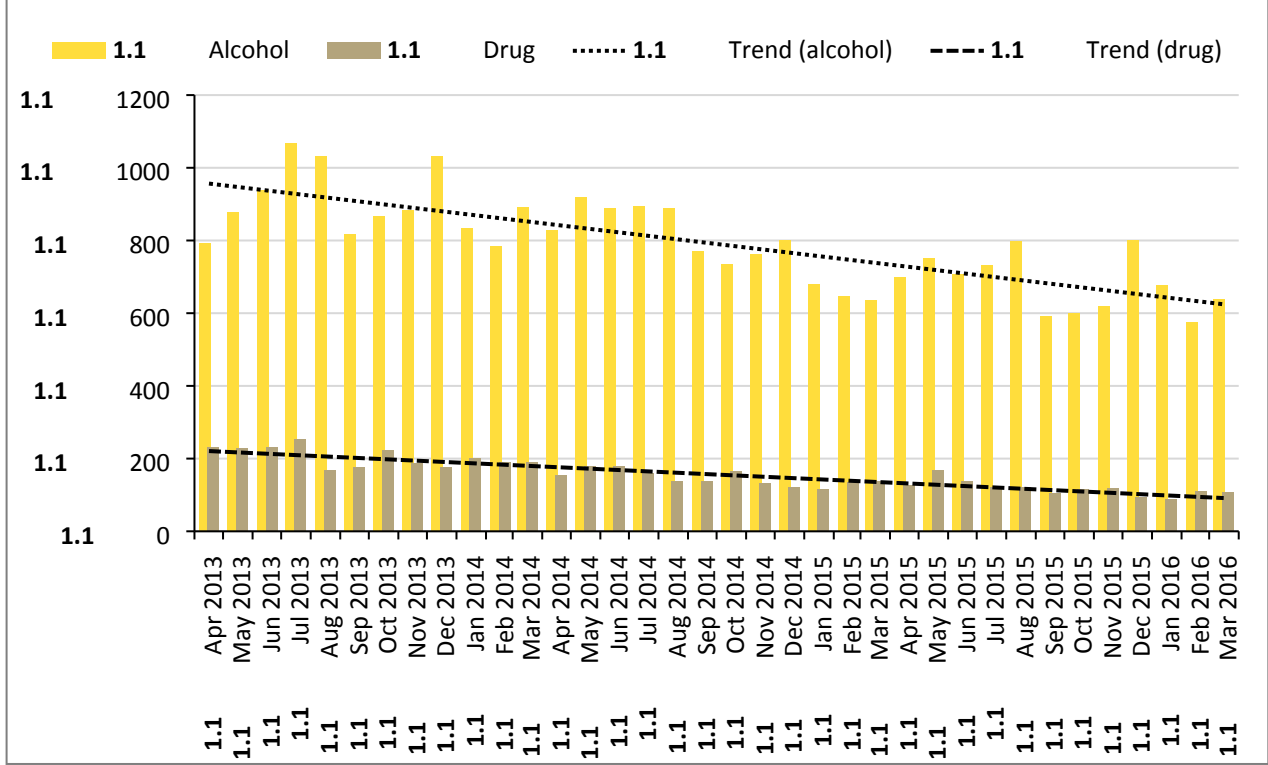
**3.79** An alternative way of reviewing policing evidence is to consider the degree to which drugs and alcohol are mentioned in the GMP call handling system data – i.e. the records of the initial call from the public to the police. Not all incidents become recorded crimes, so this provides a wider breadth of policing activity that also covers antisocial behaviour, public safety & welfare related incidents, and other calls for service.

**3.80** Data on incidents in Bolton, Trafford and Salford logged by GMP call handlers show a falling number of reports relating to drugs and alcohol between April 2013 and March 2016. There has been an annual fall of 24% in recorded drug related incidents over

three years and a smaller (13%) fall in recorded alcohol related incidents. During this period the overall number of incidents logged fell by 5% per year.

3.81 There is a discernible seasonal effect from the data on alcohol related incidents with peaks in the summer months and in December.

**1.1 Graph 3.25: Drug and Alcohol Related Incidents, Bolton, Salford And Trafford (2013/14 - 2015/16)**



## 4 Complex Dependency

- 4.1 Drug and alcohol misuse are often intertwined with a range of mental health and social problems, including: depression and anxiety; domestic abuse; loss; trauma; housing needs; unemployment; debt; offending; and severe mental disorders such as schizophrenia.
- 4.2 Tackling complex dependency is a key reform priority for GM. The evidence base that has been generated through the strands of our reform programme working with complex cohorts makes it clear that substance misuse can often be a root cause, or symptom, of other complex needs experience by families or individuals. People presenting to various different services will overlap, so providing an effective response to substance misuse as a part of an integrated, holistic intervention for a person or family in their context is a central element of our shared complex dependency challenge in GM.
- 4.3 This chapter discusses some of these complexities that are often seen alongside substance misuse. It is designed to place an emphasis on these complexities and highlight these patterns. The individuals with these needs can be found both in and out of treatment. This includes a focus on:
- (Un)employment
  - Justice and Rehabilitation
  - Families, Children and Safeguarding
  - Housing and Homelessness
  - Mental Health
- 4.4 This chapter should not be read in isolation from either the preceding (3) or subsequent (5) chapters. Many of the same topics and themes are discussed in these chapters, and are strongly correlated. Data that appears in different chapters, particularly when covering similar themes, should not be considered in isolation.
- 4.5 A report by Lankelly Chase (2015) found that the numbers of people with a substance misuse need alone, particularly OCUs, was decreasing. The numbers of people with a substance misuse need and a homelessness and/or offending need, is increasing. This suggests, particularly for those long-term opiate users still in treatment after long periods of time, that some clients are becoming more complex.



## **(Un)employment and Substance Misuse**

- 4.6 Data from the GM Working Well programme indicates that in 2015, 17.5%<sup>32</sup> of clients stated that substance misuse is a barrier to work. When isolated for Bolton (14.4%) and Salford (18.4%) and Trafford (17.2%), the figure is 16.6%.
- 4.7 National DWP analysis on IB/SDA and ESA claimants has indicated that, across England, 1 in 15 working-age benefit claimants are dependent on drugs (primarily heroin and/or crack cocaine), and that 1 in 25 are suffering from alcohol dependency.
- 4.8 PHE benchmarking data on the number of claimants of IB/SDA and ESA with alcohol as the main disabling condition suggests that there are over 4,000 claimants across GM, and over 1,000 claimants across Bolton, Salford and Trafford. The crude claimant rate per 100,000 residents in GM is 77% higher than the England average (the Bolton, Salford and Trafford combined rate, similarly, is 70% higher). Viewed in a ranked list of 150 local authority areas, the claimant rate places Salford 7<sup>th</sup> and Bolton 17<sup>th</sup> on a national scale (Trafford is ranked 70<sup>th</sup>, close to the national average on this measure) (PHE, 2015.)

| <b>Table 4.1: Claimants of Incapacity Benefit/Severe Disablement Allowance or Employment and Support Allowance, whose main medical reason is alcoholism<sup>33</sup></b> |                              |                             |
|--|------------------------------|-----------------------------|
| <b>Area</b>  | <b>2015 Rate per 100,000</b> | <b>2015 Count (Rounded)</b> |
| Bolton   | 252                          | 430                         |
| Salford  | 295                          | 460                         |
| Trafford   | 141                          | 200                         |
| BST Cluster  | 233                          | 1,090                       |
| Greater Manchester   | 243                          | 4,170                       |
| England  | 137                          | 45,950                      |

## **Justice and Rehabilitation**

- 4.9 Criminal justice has been a central element of the Greater Manchester programme of public service reform for over five years, stemming back to GM's role as one of four original community budgets pilot, and a parallel designation as a Ministry of Justice 'Justice Re-investment' local pilot area. Work over recent years has culminated in a justice devolution deal that gives further freedom and flexibility to Greater Manchester

<sup>32</sup> Percentages calculated out of the total numbers who answered the question. A rating scale of 0-6, where 0 is no impact and 6 is severe impact, is used to rate substance misuse (and other issues) as a barrier to work. To arrive at this percentage we have assumed a cut off of 3 (all those who said 3, 4, 5 or 6 in the scale. If we change the figure to identify anyone who said substance misuse had some impact, then the percentage changes to 22% for GM, 17.9% for Bolton, 23.9% for Salford and 22.5% for Trafford (average 21.4%).

<sup>33</sup> Working age persons (males aged 16-64 years, females aged 16-61 years)

Combined Authority (GMCA) and the Mayor/Police and Crime Commissioner around criminal justice and offender management.

- 4.10 The Lankelly Chase Foundation estimates that for every 1,000 working age people in the cluster area, 4.3 people will have a history of offending and a substance misuse need (Bolton, 4.6; Salford, 6.0; and Trafford, 2.4).<sup>34</sup> The Salford figure is the highest in GM. This equates to an estimated population of 2,050 people across the three areas. An additional 1,000 people are estimated to have a combination of needs that also includes homelessness. There is evidence to suggest that this relates to persistent, low-level offenders serving short-term prison or community sentences, i.e. those people who constitute regular and costly individuals.

**Table 4.2: Estimated numbers of people experiencing complex dependencies<sup>35</sup>**

| Area        | Homelessness only | Offending only | Substance misuse only | Offending & substance misuse |
|-------------|-------------------|----------------|-----------------------|------------------------------|
| Bolton      | 700               | 990            | 1,330                 | 800                          |
| Salford     | 540               | 980            | 1,240                 | 910                          |
| Trafford    | 190               | 390            | 660                   | 340                          |
| BST cluster | 1,430             | 2,360          | 3,230                 | 2,050                        |
| GM          | 4,550             | 8,690          | 13,860                | 7,830                        |

- 4.11 The development of priority themes and priority cohorts in respect of Justice and Rehabilitation means that there is now more evidence than ever before on the make-up and needs of GM offenders. A headline summary is provided here, and fuller details are available in the relevant Appendices.

### In Police Custody

- 4.12 A recent dedicated health needs assessment considering GM custody suites found that nearly half of all detainees (44%) were identified during initial screening as requiring a further intervention from the custody healthcare provider. A physical health need was identified in 59% of cases, but only 15% of these were registered with a GP. Greater Manchester is currently in the process of awarding a contract that will put in place a new integrated service in police custody, covering custody healthcare services and wider liaison and diversion functions. This is the first integrated contract of its kind, and it will be vital for clear pathways to be established between custody suites and the local substance misuse treatment offer in Bolton, Salford and Trafford.

<sup>34</sup> This data is based only on the numbers of people accessing services for their requisite need. The scale of need in the population may be higher.

<sup>35</sup> Estimated for each area using prevalence rates above

4.13 The custody health needs assessment undertook bespoke analysis on the presenting needs of detainees, and found that 12% of sampled cases were alcohol dependent, 35% had a history of alcohol misuse, 23% had a history of illicit drug use, and 18% had recently used drugs (including prescription drugs) (Claire Cairns Associates, 2015). The evidence also suggests that alcohol is a stronger feature of the local GM profile of female detainees in custody than it is for males.

**Offenders serving a community sentence or post-custody licence under CRC supervision**

4.14 Some of the richest evidence available on the links between substance misuse and offending within Greater Manchester is available specifically in relation to individuals who have been convicted of an offence and are currently serving either a community sentence or period of post-licence supervision under the management of the Greater Manchester Community Rehabilitation Company. Sample data<sup>36</sup> has been provided that describes the criminogenic risk factors identified by CRC staff when undertaking Offender Assessment System (OASys) assessments on offenders resident in GM.

4.15 CRC assessments judge that, across the cluster as a whole, drug misuse is a criminogenic risk factor for 27.7% of offenders, whilst alcohol misuse is linked to offending behaviour in 41.1% of all cases. The association is recorded more frequently for Bolton offenders, particularly in relation to alcohol misuse.<sup>37</sup>

| <b>Table 4.3: Community Rehabilitation Company – Profile of Live Caseload (Aug 2016) Offender Assessment System (OASys) risk assessment ratings, % of offenders where drug / alcohol misuse is linked to the risk of reoffending</b> |                                      |   |
|--|--------------------------------------|---|
| <b>Area</b>  | <b>Drug misuse (section 8 OASys)</b> | <b>Alcohol misuse (section 9 OASys)</b> |
| Bolton <sup>38</sup>   | 28.7%                                | 46.0%                                   |
| Salford <sup>39</sup>  | 29.0%                                | 38.0%                                   |
| Trafford <sup>40</sup>   | 23.5%                                | 38.1%                                   |
| BST Cluster  | 27.7%                                | 41.1%                                   |
| GM <sup>41</sup>   | 28.2%                                | 38.7%                                   |

<sup>36</sup> Data provides a snapshot picture relating to the total 'live' CRC caseload at the point of extraction (August 2016). Not every case under CRC management has a full OASys assessment (e.g. standalone risk assessment is made in some instances, for example in respect of offenders sentenced to 'standalone' unpaid work or curfew orders. In addition, some offenders on the 'live' caseload will not have hit their 'target' date for full OASys assessment at the point the dataset was compiled.

<sup>37</sup> CRC colleagues advise that – for reasons explained in ft 36 – this only relates to instances where an OASys is available and data has been captured. Around 30-35% of CRC cases are estimated to potentially have some kind of substance misuse issue that is not captured in OASys.

<sup>38</sup> N=466

<sup>39</sup> N=457

<sup>40</sup> N=247

<sup>41</sup> N=4,772

4.16 The appendices provide a full visualisation of assessed risk factors for the Bolton, Salford and Trafford cohorts, as compared to the overall GM profile for all criminogenic risk factors. This shows a range of complex needs, and highlights in particular:

- the markedly high numbers of offenders in Bolton for whom accommodation is judged to be directly associated with risk of reoffending;
- the relatively high levels of risk associated with financial / income issues for Salford offenders; and
- the general pattern of elevated risk for Bolton & Salford offenders as compared to Trafford offenders (also this is less notable for some risk areas than others).

### Offenders serving a community sentence or post-custody licence under NPS supervision

4.17 Equivalent OASys data to that described above has also been supplied by the National Probation Service in relation to criminogenic risk factors. Somewhat unsurprisingly, given the remit of NPS to manage higher-risk offenders, the OASys profile suggests a higher prevalence of risk relating to substance misuse. NPS data suggests that drug misuse is a risk factor for 49.5% of all offenders in Bolton (52.2%), Salford (45.2%) and Trafford (52.2%). Alcohol misuse is judged as a risk factor linked to reoffending for 55.9% of cases in Bolton (60.1%), Salford (51.4%) and Trafford (55.1%). The association of alcohol misuse and reoffending for Bolton offenders is therefore marked both in the NPS and the CRC profile.

### Community Sentences and Licences

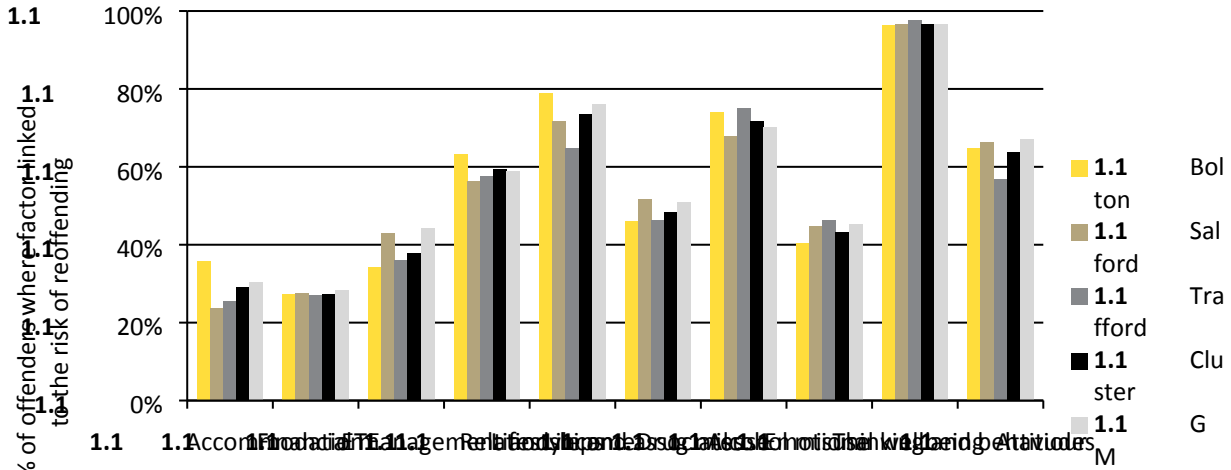
4.18 A sub-set of caseload data (both in relation to NPS<sup>42</sup> and CRC caseloads) was analysed to look specifically and in isolation at offenders for whom the OASys has flagged a drug or alcohol misuse issue contributing to the risk of reoffending. The CRC data provided a sample of 2,631 offenders across GM, and 670 offenders in the Bolton/Salford/Trafford cluster). The NPS data provided a slightly larger sample of 3,233 offenders across GM, and 861 offenders in the Bolton/Salford/Trafford cluster).

4.19 The picture of multiple complex needs is presented below:

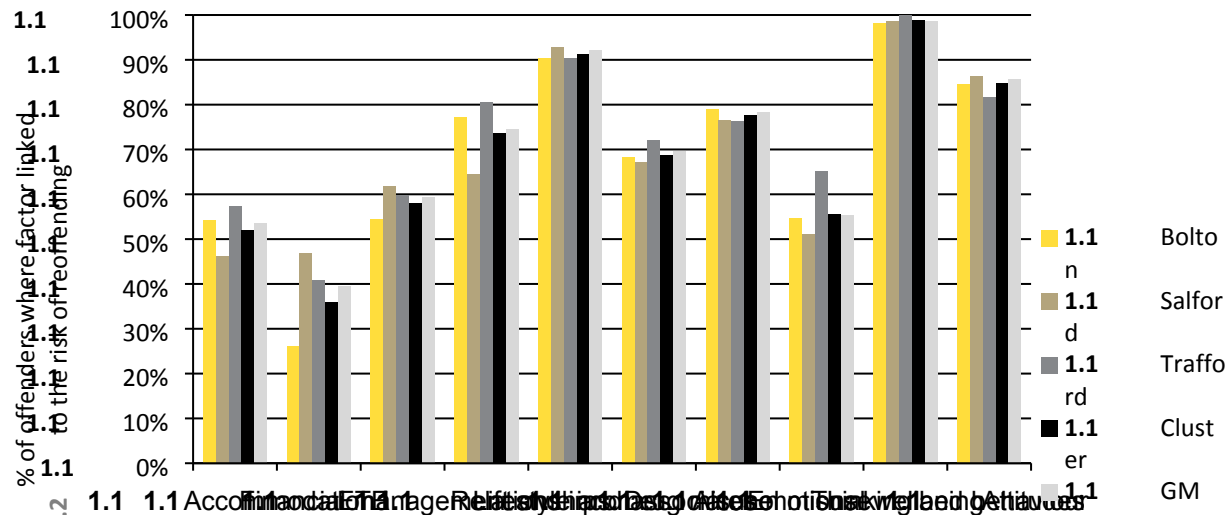
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<sup>42</sup> National Probation Service

1.1 Graph 4.1: Profile of CRC Live Caseload, August 2016 - Sample (Drug / Alcohol Issues = Yes) OASys risk assessment ratings



1.1 Graph 4.2: Profile of NPS NW Live Caseload (GM resident offenders) - Sample (Drug / Alcohol Issues = Yes) OASys risk assessment ratings



**ICO: Young, adult males (18-25) at risk of short-term custody**

4.20 One important sub-cohort under CRC supervision is cohort of young, adult males at risk of short-term custody who are made the subject of an “Intensive Community Order” (ICO) – a community order for GM resident offenders aged 18-25 who would otherwise have been sentenced to a prison sentence of less than twelve months. Snapshot data was provided by the CRC in respect of 214 GM-resident offenders with a ‘live’ ICO order, 41 of whom are residents of Bolton, Salford and Trafford. Taking into account the small sample sizes involved, the insight this provides relates to the seemingly disproportionate prevalence of drug misuse amongst offenders residents within the cluster area that are currently subject to ICO (nearly two thirds of the 41 cases).

**Table 4.4: CRC Profile of ICO Caseload (Aug 2016): OASys risk assessment ratings, % of offenders where drug / alcohol misuse is linked to the risk of reoffending**

| Area                      | Drug misuse | Alcohol misuse |
|---------------------------|-------------|----------------|
| GM ICO <sup>43</sup>      | 46.7%       | 36.9%          |
| BST Cluster <sup>44</sup> | 63.4%       | 41.5%          |

**Whole System Approach to Women Offenders**

- 4.21 In 2014, a programme of work commenced to develop a consistent and common ‘whole system approach’ for women offenders across GM, building on the emergent ‘women’s centres’ models in Bolton (Eve’s Space project), Salford (Together Women project) and Manchester (Women Matta project). The whole system approach has developed a gender-specific common offer to support large numbers of vulnerable women across GM, and helping to reduce reoffending by tackling underlying needs, including substance misuse.
- 4.22 Bespoke data provided for this needs assessment helps to provide a clear profile of the varied needs of women who have accessed the local systems in Bolton, Salford and Trafford.<sup>45</sup> This is taken from a licensed Outcomes Star™ monitoring tool which measures presenting needs on a 1-10 scale across 12 pathways.<sup>46</sup>
- 4.23 The high proportions of Bolton women that are identified with support needs is notable, given comparisons to the other areas and to GM. 67.1% women offenders from Bolton are judged to have a substance misuse related need, compared to 41.5%

<sup>43</sup> N=214

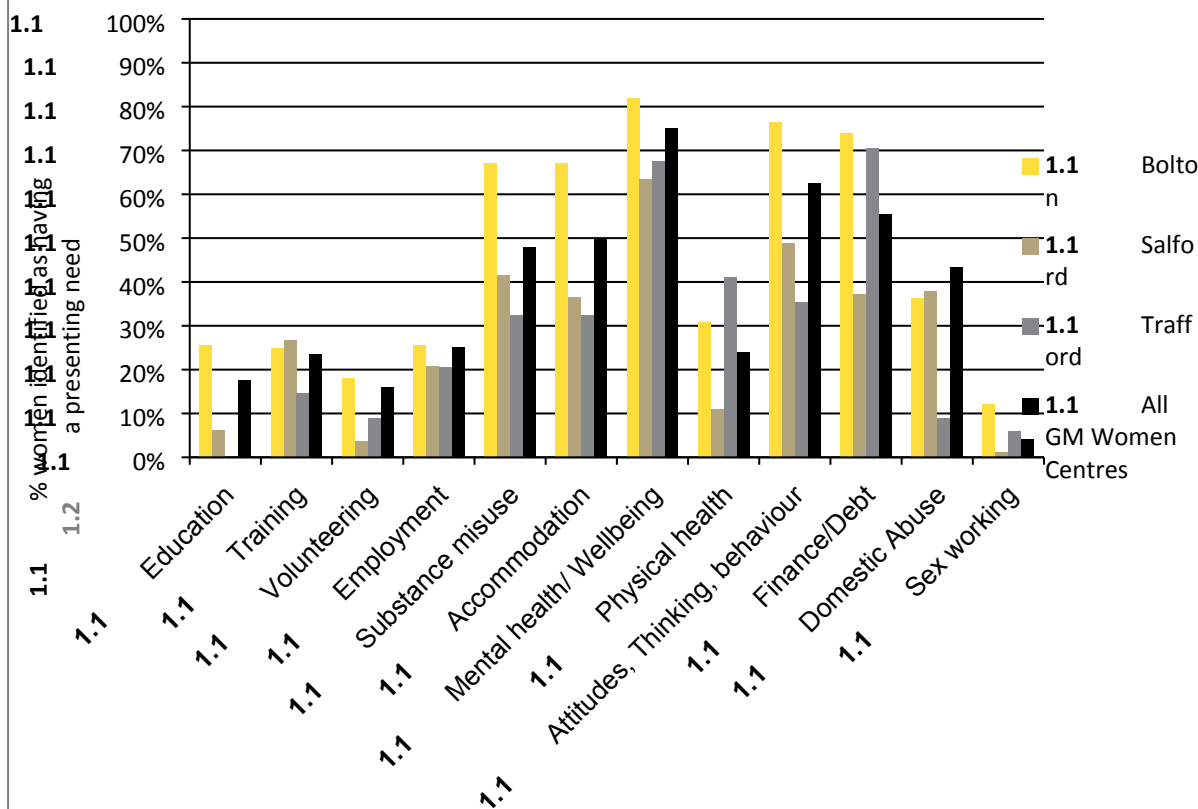
<sup>44</sup> N=41

<sup>45</sup> Care should be taken when interpreting the results for Trafford women offenders, given the small sample that applies.

<sup>46</sup> Needs pertaining to substance misuse are screened. This is not separated into drug and alcohol misuse-related needs.

in Salford, 32.4% in Trafford and 48.2% across GM. Accommodation-related needs are also higher in Bolton.

**1.1 Graph 4.3: Whole system approach to women offenders: Profile of women assessed to March 2016**



**Table 4.5: Whole system approach to women offenders: Profile of women assessed to March 2016**

| Pathway                  | Bolton <sup>47</sup> | Salford <sup>48</sup> | Trafford <sup>49</sup> | All GM women centres <sup>50</sup> |
|--------------------------|----------------------|-----------------------|------------------------|------------------------------------|
| Education                | 25.5%                | 6.1%                  | 0.0%                   | 17.6%                              |
| Training                 | 24.8%                | 26.8%                 | 14.7%                  | 23.4%                              |
| Volunteering             | 18.1%                | 3.7%                  | 8.8%                   | 16.1%                              |
| Employment               | 25.5%                | 20.7%                 | 20.6%                  | 25.0%                              |
| Substance misuse         | 67.1%                | 41.5%                 | 32.4%                  | 48.0%                              |
| Accommodation            | 67.1%                | 36.6%                 | 32.4%                  | 49.9%                              |
| Mental health/ Wellbeing | 81.9%                | 63.4%                 | 67.6%                  | 75.1%                              |
| Physical health          | 30.9%                | 11.0%                 | 41.2%                  | 24.0%                              |

<sup>47</sup> N=149  
<sup>48</sup> N=164  
<sup>49</sup> N=34  
<sup>50</sup> N=1,074

|                                       |       |       |       |              |
|---------------------------------------|-------|-------|-------|--------------|
| <b>Attitudes, Thinking, behaviour</b> | 76.5% | 48.8% | 35.3% | <b>62.5%</b> |
| <b>Finance/Debt</b>                   | 73.8% | 37.2% | 70.6% | <b>55.5%</b> |
| <b>Domestic Abuse</b>                 | 36.2% | 37.8% | 8.8%  | <b>43.3%</b> |
| <b>Sex working</b>                    | 12.1% | 1.2%  | 5.9%  | <b>4.2%</b>  |

4.24 Data comparing the needs of women with and without substance misuse needs shows that substance misusing women offenders are twice as likely to have accommodation needs, a third more likely to have a mental health/wellbeing need, and a third more likely to have debt/finance issues.

**Table 4.6: Whole system approach to women offenders: Profile of women assessed in 2015/16, all cluster, comparing needs of substance misusing women and non-substance misusing women**

| <b>Pathway</b>                 | <b>Women Offenders with substance misuse need<sup>51</sup></b> | <b>Women Offenders without substance misuse need<sup>52</sup></b> |
|--------------------------------|--|---|
| Education                      | 13.4%  | 9.7%  |
| Training                       | 23.5%  | 26.2%   |
| Volunteering                   | 11.2%  | 9.5%  |
| Employment                     | 22.9%  | 22.6%   |
| Accommodation                  | 62.0%  | 35.7%   |
| Mental health/ Wellbeing       | 82.7%  | 60.1%   |
| Physical health                | 31.3%  | 13.1%   |
| Attitudes, Thinking, behaviour | 74.9%  | 42.8%   |
| Finance/Debt                   | 64.8%  | 47.0%   |
| Domestic Abuse                 | 39.1%  | 29.2%   |
| Sex working                    | 12.3%  | 0.0%  |

### Offenders in Prison

4.25 The majority, 38%, of adult males in treatment in GM prisons are in treatment for heroin use. For women, the rate is much higher, at 52%. Alcohol is the second highest treatment requirement for both groups, at 19% and 29% for men and women respectively (NDTMS, 2015e).

4.26 Seizures of synthetic cannabinoids (spice) in English and Welsh prisons increased from 15 in 2010 to 430 in 2014 (PRT, 2015). HMI Prisons states that synthetic cannabinoids were identified as a concern in 37% of men's prisons inspected in 2013/14, and 64% in 2014/15 (HMI Prisons, 2015). A report from HMP Buckley Hall in 2015 indicated that just over half of ambulance call outs were as a result of prisoners taking NPS (IMB, 2015).<sup>53</sup>

<sup>51</sup> N=179

<sup>52</sup> N=168

<sup>53</sup> The same period also witnessed a large increase in the number of ambulance call outs as a result of this. The report also stated that official statistics significantly under-report the prevalence of Spice in prisons.



## Families, Children and Safeguarding

- 4.27 Tackling substance misuse is an integral element of the Troubled Families programme. Analysis of national profiling data in 2014 suggested that 14% of families within the national programme to date included an adult dependent on alcohol and 13% had an adult dependent on drugs<sup>54</sup> (DCLG, 2014).
- 4.28 Over time, the government's commitment to a five-year national study looking at the impact of the family key-work approach (the National Impact Study, NIS) will help to further develop the troubled families evidence base. This will provide benefit both for national insight and local decision making; a common set of Family Progress Data (FPN) will include standardised data at the Local Authority level specifically in relation to alcohol and drug dependence. However, at the time of writing this needs assessment, robust local data for the whole of GM is not yet available, and so excerpts from bespoke local data analysis have been compiled as follows:
- **Trafford** – Trafford Council have undertaken an analysis of substance use amongst their first and second Troubled Families Cohorts. The latest analysis, in September 2016, covered 448 families and 932 individuals. 28%<sup>55</sup> of families and 16%<sup>56</sup> of individuals were identified as having drug and/or alcohol problems for which they were receiving treatment. In 2015<sup>57</sup>, these figures were 17%<sup>58</sup> and 10%<sup>59</sup> respectively. In the 15/16 financial year, 13% of individuals in treatment in Trafford were part of the Troubled Families cohort, rising to 44% of those in treatment for non-opiate substances only.
  - **Salford** – In 2014/15, the national Troubled Families worked intensively with seven 'exemplar' areas to build up a detailed picture of the costs and fiscal benefits resulting from their local delivery of the programme. Salford, one of the seven exemplars, identified financial benefits from their local programme to health services in the order of £1,700 per family on average, attributed in significant part to *"a nearly 60% reduction in alcohol misuse and a 50% reduction in drug misuse in the 12 months following intervention."*<sup>60</sup>
- 4.29 Data from NDTMS indicates that 23.9% (667) of people starting on a new treatment journey in Bolton, Salford and Trafford in 2015/16 lived with children (with only limited differences in this percentage between areas). A further 39.2% are noted as having children but not living with them.

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<sup>54</sup> Identified through a combination of clinical diagnosis and key worker assessment

<sup>55</sup> 125 families

<sup>56</sup> 147 individuals

<sup>57</sup> Troubled Families Cohort 1

<sup>58</sup> 72 families

<sup>59</sup> 83 individuals

<sup>60</sup> *The Benefits of the Troubled Families Programme to the Taxpayer* (DCLG, 2015)

- 4.30 Furthermore, 2.2% of women starting on a new treatment journey in Bolton (2.9%), Salford (2.0%) and Trafford (1.4%) in 2015/16 disclosed that they were pregnant.
- 4.31 There is strong evidence to suggest that many patterns of behaviour outlined above are formed in, or strongly affected by, childhood and young adulthood. For example, in the Troubled Families data, 23% of families with an adult drug user in this sample also had a child with a substance misuse problem, compared to 13% where there was no adult drug user. And 20% of families with an adult with an alcohol misuse problem had a child with a substance misuse problem, compared to 13% families where there was no adult misusing alcohol (DCLG, 2014).
- 4.32 In addition, 31.94% of young people in treatment in Bolton (28.47%), Salford (42.53) and Trafford (24.83%) are affected by other peoples' substance use.
- 4.33 It is highly likely that some of our most vulnerable young people using NPS and club, over-the-counter and prescription drugs will at some point require treatment, and this is most effective when provided before use has escalated. A blended approach that combines an 'early help' offer with a focus on complex dependency provides a means through which to prevent escalation, and to focus on high risk, high cost and high-need individuals and families.

## Housing and Homelessness

- 4.34 Lankelly Chase estimates that in Bolton (1.9), Salford (1.8) and Trafford (0.9), for every 1,000 working age people, approximately 1.5 will be homeless and have a substance misuse problem. This equates to an estimated population of 750 individuals across Bolton, Salford and Trafford.<sup>61</sup>

**Table 4.7: Estimated numbers of people experiencing complex dependencies<sup>62</sup>**

| Area        | Homelessness only | Offending only | Substance misuse only | Homelessness & substance misuse |
|-------------|-------------------|----------------|-----------------------|---------------------------------|
| Bolton      | 700               | 990            | 1,330                 | 340                             |
| Salford     | 540               | 980            | 1,240                 | 280                             |
| Trafford    | 190               | 390            | 660                   | 130                             |
| BST cluster | 1,430             | 2,360          | 3,230                 | 750                             |
| GM          | 4,550             | 8,690          | 13,860                | 3,080                           |

## Mental Health

- 4.35 20.2% of people starting on a new treatment journey in Bolton (21.5%), Salford (20.6%) and Trafford (16.9%) in 2015/16 had a dual diagnosis. However, poor mental

<sup>61</sup> See appendices for full tables

<sup>62</sup> Estimated for each area using prevalence rates above

health needs to be taken into consideration as a factor in its own right, aside from dual diagnosis.

- 4.36 There is a lack of robust data in this area. One of the best indicative measures of co-existing mental health problems in the drug/alcohol treatment population is captured within NDTMS and tracked in PHE's 'Co-existing substance misuse and mental health issues' Fingertips Tool.<sup>63</sup>
- 4.37 The latest 2014/15 data shows that in Bolton, Salford and Trafford 14.8% of people, when assessed for drug treatment, were receiving treatment from mental health services for reasons other than substance misuse. This is marginally lower than the 2013/14 figure. The cluster figure is lower than the GM equivalent proportion (21.9%), in part because the percentage figure for people in Trafford is markedly lower, and because of disproportionately higher figures for Manchester and Rochdale.<sup>64</sup>
- 4.38 The 2014/15 data shows that in Bolton, Salford and Trafford 13.1% of people were receiving treatment from mental health services at the time of their alcohol treatment assessment. This is an increase on the 2013/14 figure (11.7%). The GM equivalent figures are substantially higher (19.6% in 2014/15; 22.6% in the previous year). However, the GM percentage is skewed by disproportionately high figures for Manchester and Rochdale.

**Table 4.8: Percentages receiving treatment for mental health alongside alcohol and/or drug treatment**

| Area        | 2013/14 |       | 2014/15 |       |
|-------------|---------|-------|---------|-------|
|             | Alcohol | Drugs | Alcohol | Drugs |
| Bolton      | 16.7    | 16.1  | 17.2    | 17.0  |
| Salford     | 12.6    | 16.9  | 16.0    | 18.7  |
| Trafford    | 4.6     | 12.9  | 5.7     | 7.0   |
| BST Cluster | 11.7    | 15.5  | 13.1    | 14.8  |
| GM          | 22.6    | 20.1  | 19.6    | 21.9  |

<sup>63</sup> The PHE guidance highlights: 'The measure is indicative of levels of co-existing mental health problems in the drug treatment population. However, it should not be regarded as a comprehensive measure of dual diagnosis as it only captures whether a person is receiving mental health treatment at a given point in time.'

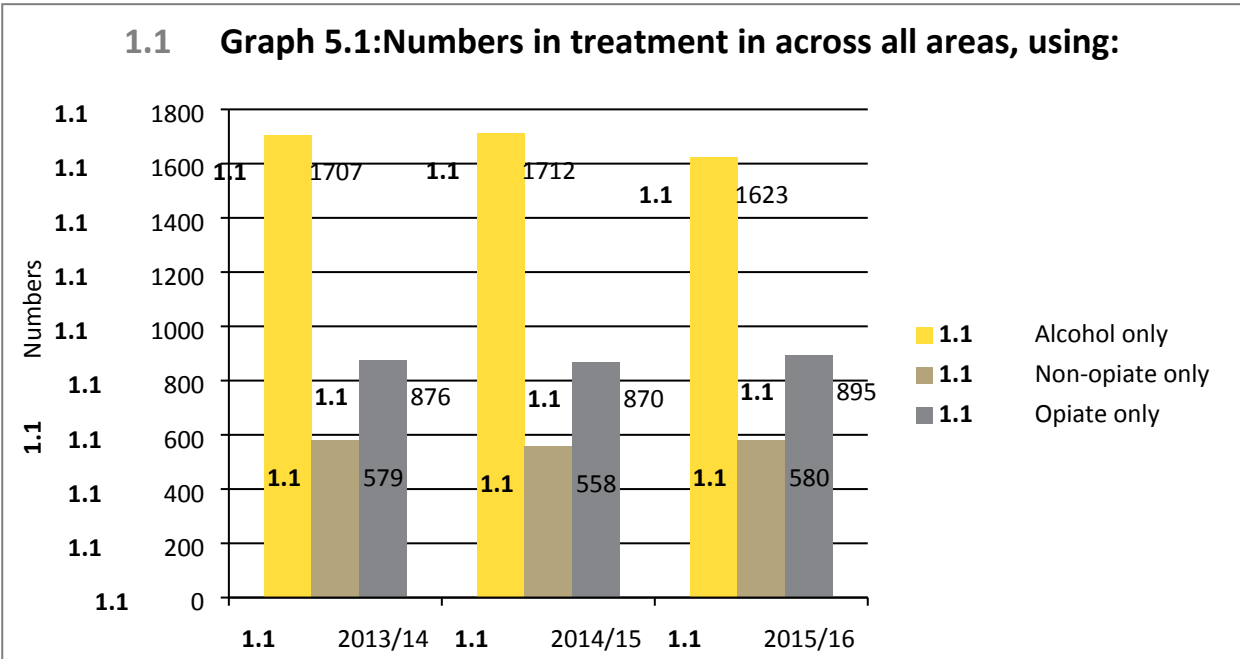
<sup>64</sup> See appendices for full data, including for other areas in GM

## 5 Treatment Population Needs Profile

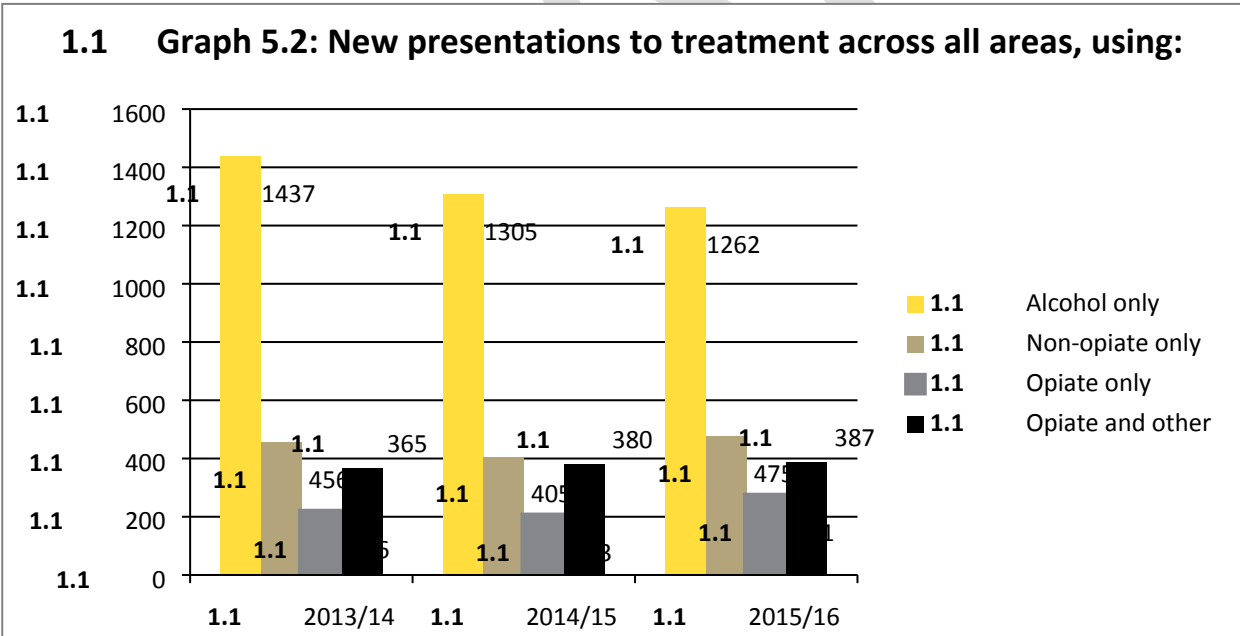
- 5.1 This chapter provides an overview of the needs of service users in treatment in Bolton, Salford and Trafford.
- 5.2 This chapter should not be read in isolation from the preceding two (3 and 4) chapters. It is recommended that comparisons are made between the former and current chapters to consider the extent to which need in the general population is being met by the current treatment systems, where gaps arise, and where further work is required.
- 5.3 This chapter covers:
- Numbers in treatment;
  - Substance use by substance type;
  - New presentations to treatment;
  - Other presenting needs, including housing and employment; and
  - Young people in treatment (presenting needs and substance types)

### Substance Use

- 5.4 In 2015/16, there were 5,199 adults in treatment across the three areas. This is made up of 2,169 in Bolton, 1,904 in Salford and 1,126 in Trafford. There were 2,809 new presentations to treatment in this year: 1,014 in Bolton, 1,160 in Salford and 635 in Trafford.
- 5.5 In 2015/16, 17.2% of the treatment population used opiates only. However, this varied largely across the three areas, ranging from 21.3% (Bolton), 15.4% (Salford) and 12.3% (Trafford).
- 5.6 In 2015/16, 11.2% of the treatment population used non-opiate drugs (excluding alcohol) only. This is fairly consistent across the three areas, ranging from 7.9% (Bolton), 13% (Salford) and 14.2% (Trafford). This has increased from 10.8% in 2013/14 and 10.7% in 2014/15.
- 5.7 In 2015/16, 31.2% of the treatment population used alcohol only. This is fairly similar in Salford (34%) and Trafford (36.8%), but lower in Bolton at 25.8%.



5.8 When considering new presentations to treatment, the picture is fairly similar.



5.9 Since 2006/7, there has been a 66% decrease in the numbers of people using Opiates and Crack in the treatment system across the three areas. There has been a 48% increase in people in treatment for non-opiate drug use in the same time period across the three areas.

**Table 5.1: Substances used (in treatment) across all three areas<sup>65</sup>**

| Substance         | 2006/7 | 2015/16 | Percentage change |
|-------------------|--------|---------|-------------------|
| Opiates           | 2111   | 1713    | -18.9%            |
| Opiates and Crack | 2157   | 739     | -65.7%            |
| Crack             | 532    | 43      | -91.9%            |
| Benzodiazepines   | 254    | 382     | +50.4%            |
| Amphetamines      | 212    | 350     | +65.0%            |
| Cocaine           | 181    | 529     | +192.3%           |
| Cannabis          | 431    | 977     | +126.7%           |

5.10 Between 2013/14 and 2015/16 there was a significant increase in numbers in treatment using NPS across the three areas, from 1 to 36 (split fairly evenly over the three). However, they still represent a minority.

**Table 5.2: Successful Completions (No Representations<sup>66</sup>)**

| Area     | All drugs |       | Opiates |       |
|----------|-----------|-------|---------|-------|
|          | 13/14     | 14/15 | 13/14   | 14/15 |
| Bolton   | 12.7%     | 12.7% | 4.8%    | 6.3%  |
| Salford  | 20.4%     | 21.3% | 10.2%   | 9.1%  |
| Trafford | 20.9%     | 20.8% | 9.9%    | 6.5%  |
| Cluster  | 18.0%     | 18.3% | 8.3%    | 7.3%  |
| GM       | 15.0%     | 15.2% | 7.2%    | 7.2%  |

## Other needs

5.11 In 2015/16, 15.76% of people starting on a new treatment journey across all three areas had some identified housing need on entry to treatment. Slightly higher proportions of people in Salford appear to have housing needs compared to the other two areas.

**Table 5.3: Accommodation need at entry (new treatment journey/episode)**

|                              | Bolton | Salford | Trafford | All    |                          |
|------------------------------|--------|---------|----------|--------|--------------------------|
|                              |        |         |          | Number | Percentage <sup>67</sup> |
| NFA - urgent housing problem | 23     | 54      | 13       | 90     | 3.46%                    |
| Housing problem              | 119    | 144     | 57       | 320    | 12.3%                    |
| No housing problem           | 870    | 869     | 453      | 2,192  | 84.24%                   |

<sup>65</sup> Based on number of substances used not numbers of people; an individual may use more than one substance. Note some substances are excluded as they are not directly comparable as more detail on substances used is now collected (e.g. NPS and Prescription Drugs). Figures have been relatively stable between 2013/14-2015/16. See appendices for breakdown by area.

<sup>66</sup> Within six months

<sup>67</sup> Percentage is based on total number of people who answered the question (2,602), not total number overall.

|                        |       |       |     |     |       |
|------------------------|-------|-------|-----|-----|-------|
| Other/not answered     | -     | 93    | 112 | 207 | -     |
| Total number of people | 1,014 | 1,160 | 635 | -   | 2,602 |

**5.12** In Bolton, 21% of clients who did not report working at the start of treatment reported doing so at exit from treatment (2015/16). The figures are 7% in Salford and 17% in Trafford. This compares to a GM average of 23% and a national average of 27%.

## Young People

**5.13** In 2015/16, there were 627 young people<sup>68</sup> in substance misuse treatment services in Bolton (205), Salford (205) and Trafford (217). There were 452 new presentations to treatment in Bolton (129), Salford (174) and Trafford (149) in 2015/16.

**5.14** 191 (30.73%) were female and 436 (69.27%) were male.

**5.15** The most commonly used substance by young people in treatment is overwhelmingly cannabis, followed by alcohol.<sup>69</sup> Cannabis is consistently in the majority, but ranges from being used 92.07% of times in Bolton, to 78.05% in Salford and 66.36% in Trafford. There appears to be a greater diversity in substances used in Trafford compared to the two other areas.

**Table 5.4: Substances used, 2015/16<sup>70</sup>**

| Drug type    | Bolton |                 | Salford |        | Trafford |        |
|--------------|--------|-----------------|---------|--------|----------|--------|
|              | No.    | % <sup>71</sup> | No.     | %      | No.      | %      |
| Cannabis     | 189    | 92.07%          | 160     | 78.05% | 144      | 66.36% |
| Alcohol      | 114    | 56.30%          | 79      | 38.54% | 94       | 43.32% |
| Amphetamines | 4      | 2.03%           | 8       | 3.90%  | 5        | 2.30%  |
| Cocaine      | 14     | 6.71%           | 55      | 26.83% | 57       | 26.27% |
| Ecstasy      | 25     | 13.01%          | 18      | 8.78%  | 24       | 11.06% |
| Solvents     | 1      | 0.61%           | 3       | 1.46%  | 1        | 0.46%  |
| Opiates      | 0      | -               | 3       | 1.46%  | 8        | 3.69%  |
| Crack        | 0      | -               | 3       | 1.46%  | 2        | 0.92%  |
| NPS          | 7      | 1.41%           | 2       | 0.98%  | 15       | 6.91%  |
| Nicotine     | 20     | 9.35%           | 10      | 4.88%  | 1        | 0.46%  |

<sup>68</sup> For the purposes of this report, 'Young People' covers those aged up to 25, or all of those people who are or have been in treatment with Young People's Services, regardless of age.

<sup>69</sup> Note that Figures are of YP in specialist substance misuse community services year to date. Substances cited are from any episode for the young person in the year (any citation in drug 1, 2 or 3). Individuals may have cited more than one problematic substance so percentages may sum to more than 100%.

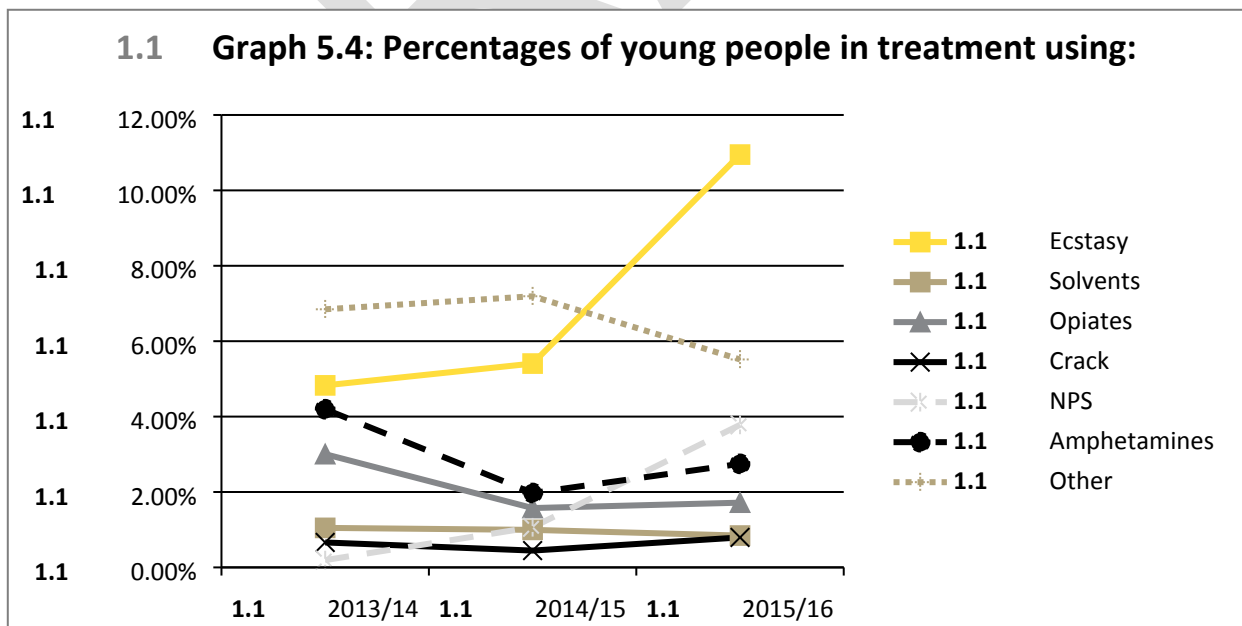
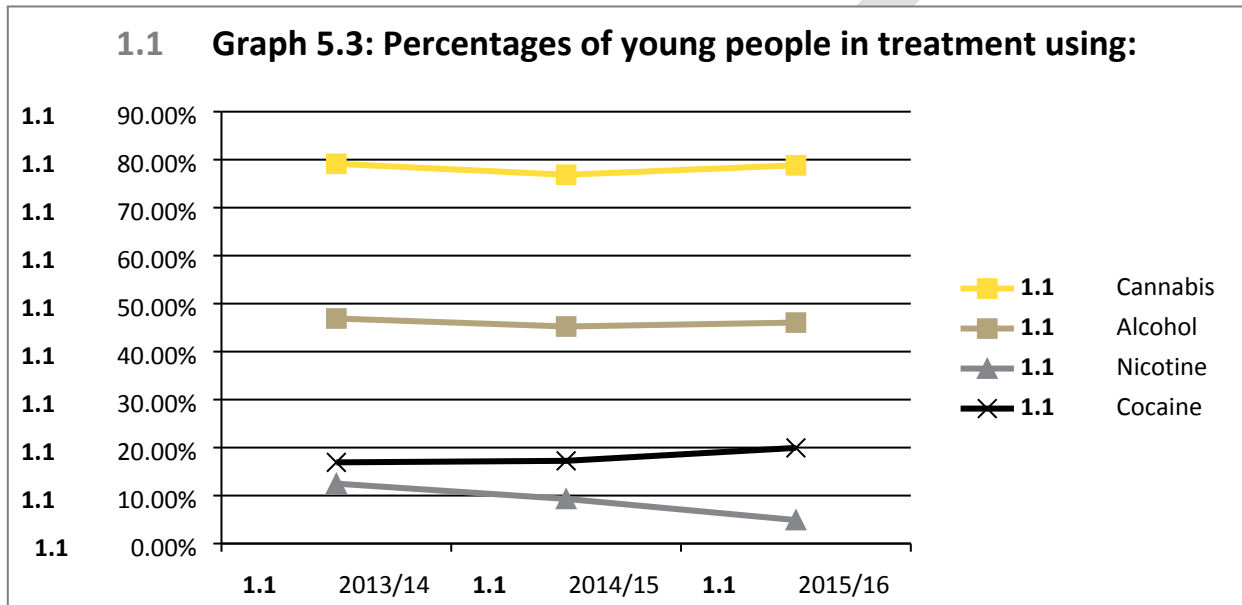
<sup>70</sup> Substances not individuals

<sup>71</sup> Percentages are calculated from total new presentations to treatment, not total number in treatment over the year

|       |   |       |    |       |    |       |
|-------|---|-------|----|-------|----|-------|
| Other | 2 | 1.02% | 12 | 5.85% | 21 | 9.68% |
|-------|---|-------|----|-------|----|-------|

5.16 There are some notable trends when looking at substances used over a three year period.

5.17 The percentage of young people in treatment using Nicotine has reduced by 60.7% (From 12.5% to 4.9%). The percentage of young people in treatment using Ecstasy has more than doubled, from 4.8% to 11%.





5.18 Young people in treatment present with a number of substance-use related complexities.

| Table 5.5: Substance use related vulnerabilities, 2015/16 |        |                    |         |        |          |        |
|---|--------|--------------------|---------|--------|----------|--------|
| Characteristic  | Bolton |                    | Salford |        | Trafford |        |
|   | No.    | % <sup>72 73</sup> | No.     | %      | No.      | %      |
| Early onset   | 122    | 94.37%             | 174     | 100%   | 115      | 77.18% |
| Injecting   | 0      | 0%                 | 6       | 3.45%  | 7        | 4.70%  |
| High risk alcohol user                                    | 12     | 8.23%              | 28      | 16.09% | 20       | 13.14% |
| Opiate or crack user                                      | 0      | 0%                 | 5       | 2.87%  | 6        | 4.03%  |
| Poly drug user  | 86     | 66.52%             | 101     | 58.05% | 105      | 70.47% |

5.19 The majority of young people in treatment in Bolton (59.61%), Salford (64.34%) and Trafford (50.59%) in 2015/16 had a planned exit.<sup>74</sup> However, this is compared to a national average of 77.34%.

5.20 In addition, young people in treatment present with a number of complex vulnerabilities and needs that are seen in combination with substance use.

| Table 5.6: Presenting vulnerabilities at treatment start, 2015/16 <sup>75</sup> |        |                 |         |        |          |        |
|---|--------|-----------------|---------|--------|----------|--------|
| Vulnerability   | Bolton |                 | Salford |        | Trafford |        |
|   | No.    | % <sup>76</sup> | No.     | %      | No.      | %      |
| Looked after child  | 22     | 17.96%          | 23      | 13.22% | 5        | 3.36%  |
| Child in need   | 8      | 5.34%           | 8       | 4.60%  | 6        | 4.03%  |
| Domestic abuse  | 28     | 22.52%          | 68      | 39.08% | 19       | 12.75% |
| Mental health problem   | 33     | 25.57%          | 85      | 48.85% | 72       | 48.32% |
| Sexual exploitation   | 19     | 14.31%          | 5       | 2.87%  | -        | -      |
| Self-harm   | 37     | 28.92%          | 23      | 13.22% | 18       | 12.08% |
| NEET <sup>77</sup>  | 9      | 6.85%           | 81      | 46.55% | 51       | 34.23% |
| Housing problems <sup>78</sup>  | -      | -               | 5       | 2.87%  | 15       | 10.07% |
| Parent/pregnant   | -      | -               | 22      | 12.64% | 22       | 14.77% |
| Child Protection Plan   | 10     | 7.92%           | 27      | 15.52% | -        | -      |

<sup>72</sup> Percentages refer to percentage of people with that characteristic. Individuals may display more than one.

<sup>73</sup> Percentages are calculated from total new presentations to treatment, not total number in treatment over the year

<sup>74</sup> Treatment exits are calculated differently at partnership/centre level and at provider level so are not comparable.

<sup>75</sup> Percentages refer to percentage of people with that vulnerability. Individuals may have more than one.

<sup>76</sup> Percentages are calculated from total new presentations to treatment, not total number in treatment over the year

<sup>77</sup> For a further breakdown, see appendices

<sup>78</sup> For a further breakdown, see appendices

|   |    |        |    |        |    |        |
|---|----|--------|----|--------|----|--------|
| Anti-social behaviour/<br>criminal acts | 23 | 25.57% | 81 | 46.55% | 36 | 24.16% |
| Affected by others'<br>substance use    | 37 | 28.47% | 74 | 42.53% | 37 | 24.83% |
| Practicing unsafe sex                   | 31 | 24.03% | 28 | 16.09% | 11 | 7.38%  |

**5.21** Whilst there are some variations between local areas, this data gives us a good picture of the complex and intertwined needs that young people using substances have. Many of these will act as barriers to recovery, and are strongly linked to themes explored in the previous sections (relating to both young people and adults).

DRAFT