Contents
1. Executive Summary ........................................................................................................... 4
   1.1. Commissioning Planning ................................................................................................. 4
   1.2. Changes to services ........................................................................................................ 4
   1.3. Treatment ....................................................................................................................... 4
   1.4. Prevention ..................................................................................................................... 4
   1.5. Brief interventions ......................................................................................................... 4
   1.6. Care Quality Commission Review .................................................................................. 4
   1.7. Drug related deaths (DRDs) ........................................................................................... 5
   1.8. Inequalities .................................................................................................................... 5
   1.9. Changing population demographics .............................................................................. 5
   1.10. Changing drug profiles ................................................................................................. 5
   1.11. New opiate presentations .............................................................................................. 5
   1.12. Prison releases .............................................................................................................. 5
   1.13. Inpatient admissions for detox and residential rehab placements ................................ 5
   1.14. Young people ............................................................................................................... 5
   1.15. Alcohol related Hospital admissions ............................................................................ 6
   1.16. Blood Borne Viruses .................................................................................................... 6
   1.17. Criminal Justice ........................................................................................................... 6
   1.18. Needle exchange .......................................................................................................... 6
   1.19. Employment, Training and Education ........................................................................ 6
   1.20. Service User consultation, mentoring and mutual aid ................................................... 6
   1.21. Housing and Homelessness .......................................................................................... 6
   1.22. Dual Diagnosis ............................................................................................................ 7
   1.23. Smoking Cessation ....................................................................................................... 7
   1.24. Licensing ...................................................................................................................... 7
   1.25. Local Alcohol Action Area (LAAA) ........................................................................... 7
2. Introduction .......................................................................................................................... 7
   1.1. Scope ............................................................................................................................. 7
   1.2. Purpose .......................................................................................................................... 7
   1.3. Local Context ................................................................................................................. 8
3. Background and national policy ........................................................................................... 9
4. Swindon population profile .................................................................................................................. 12
  4.1. About Swindon................................................................................................................................. 12
  4.2. Population and area.......................................................................................................................... 13
  4.3. Employment, income and benefits .................................................................................................. 16
  4.4. Deprivation ......................................................................................................................................... 16
  4.5. Housing and homelessness ............................................................................................................. 18
  4.6. Education and skills ....................................................................................................................... 19
  4.7. Health ................................................................................................................................................ 21
  4.8. Crime ................................................................................................................................................ 24
5. Substance misuse in Swindon – where are we now .......................................................... 26
  5.1. Universal prevention campaigns .................................................................................................... 26
  5.2. Young People Substance misuse .................................................................................................... 26
    5.2.1. National and local trends ........................................................................................................... 27
    5.2.2. Targeted prevention and risk groups .......................................................................................... 31
    5.2.3. Young people treatment system ............................................................................................... 32
    5.2.4. Safeguarding Children ............................................................................................................. 36
  5.3. Drug misuse - adults ...................................................................................................................... 38
    5.3.1. The costs of drug addiction ....................................................................................................... 38
    5.3.2. National and local trends ........................................................................................................... 39
    5.3.3. Drug treatment system overview ............................................................................................. 44
    5.3.4. Harm Reduction ......................................................................................................................... 54
    5.3.5. Drug related deaths .................................................................................................................... 60
  5.4. Alcohol misuse adults .................................................................................................................. 64
    5.4.1. Economic review ......................................................................................................................... 64
    5.4.2. Inequalities and the harms of alcohol misuse ........................................................................... 67
    5.4.3. Impact of alcohol misuse on ill-health ....................................................................................... 70
    5.4.4. Licencing and alcohol misuse ................................................................................................... 86
    5.4.5. Alcohol treatment system ......................................................................................................... 90
    5.4.6. Residential treatment provision ............................................................................................... 99
    5.4.7. Ambulance Service ................................................................................................................... 101
    5.4.8. Alcohol projects in Swindon ................................................................................................... 102
  5.5. Crime and Criminal Justice ........................................................................................................ 103
    5.5.1. Alcohol and crime ..................................................................................................................... 103
    5.5.2. Drugs and crime ....................................................................................................................... 105
5.5.3. Criminal Justice provision ................................................................. 107
5.5.4. Prison releases .................................................................................. 107
5.5.5. Probation ......................................................................................... 107
5.5.6. Cell intervention ............................................................................. 108
5.5.7. Modern Crime Prevention Strategy – a local response ....................... 109
6. Supporting recovery .................................................................................. 111
  6.1. Access to Employment, Training and Education ...................................... 111
  6.2. Housing ............................................................................................ 112
  6.3. Peer support ...................................................................................... 113
7. Recommendations ...................................................................................... 114
  7.1. Priority One: Early intervention with young people and their families .......... 114
  7.2. Priority Two: Prevention of substance related harms for adults ................. 114
  7.3. Priority Three: Treatment services deliver effective harm reduction and sustained recovery 115
  7.4. Priority Four: Reduce substance misuse related crime and anti-social behaviour .... 116
1. Executive Summary

1.1. Commissioning Planning
This joint strategic needs assessment along with a new substance misuse strategy for Swindon will inform our commissioning processes for next year. Our aim is to deliver a more integrated, cost effective and efficient model of service that will deliver a high quality, evidence based service to our identified vulnerable groups whilst making best use of resources. We are currently exploring options for cross boundary commissioning and further joint working with neighbouring authorities.

1.2. Changes to services
The past year has been one of significant change for drug and alcohol services. Both services are now delivered by one provider, Change, Grow, Live (CGL). All services have moved from their previous three sites into one newly refurbished premise in Temple Street. This allows for improved joint working along with improved access and facilities for service users. The service has also undertaken a thorough systems review. This has delivered a new service model allowing a more efficient and recovery orientated offer to our service users.

1.3. Treatment
The adult drug service is meeting client demand with 744 clients being effectively treated over the past 12 months (planned capacity 580 – 600 clients). National performance has maintained with Swindon Opiate performance in the top quartile of comparator local authorities. The young people’s substance misuse service (U-Turn) continues to perform well against local indicators. Due to the change in the service delivery there has been a recent drop in alcohol service performance, notably alcohol treatment completions, which is being addressed with increased contract scrutiny and review.

1.4. Prevention
Prevention campaigns should be balanced between drug and alcohol issues. Consideration needs to be given to a review of online and digital awareness raising tools. The Street Drinker’s Outreach Project has been launched this year and has successfully targeted this highly vulnerable group. Drug and alcohol education campaigns should be targeted effectively for both children, young people and adults.

1.5. Brief interventions
A review of our current prevention strategy against NICE guidelines and PHE Clear Review has highlighted the need for increased focus on brief interventions to further strengthen prevention messages. Best use should be made of making Every Contact Count. Brief interventions and advice can have a significant impact on drinking behaviours for hazardous and harmful drinkers. A coordinated approach to increasing capacity within mainstream partner agencies is required to enable the specialist substance misuse service to focus on those more complex harmful and dependent drinkers. However, spend on campaigns should be minimal as evidence shows that they are not necessarily cost effective in long term behaviour change.

1.6. Care Quality Commission Review
Both drug and alcohol services have recently been subject to a full CQC inspection. This is the first year that substance misuse services have been subject to these reviews. The initial feedback on the
Swindon visit was very positive but we are awaiting the full report. We will act on all findings of the review.

1.7. Drug related deaths (DRDs)
Swindon’s DRD levels compare favourably with national and regional levels. There is a robust review process for substance misuse related deaths. However age of death is slightly younger than that observed nationally. A process for further multi agency review for those identified as being of imminent risk of drug related death needs to be implemented.

1.8. Inequalities
There is a need to improve the number of women in treatment as estimates indicate that Swindon’s services are failing to engage with women misusing substances. Of further concern is the accessibility to services and barriers for pregnant women. Alcohol treatment services have a narrower age profile than would be expected with fewer older and younger clients. There are also fewer clients from ethnicities other than white British presenting to alcohol and drug services.

1.9. Changing population demographics
Swindon has a projected marked increase in older people. A review of what are we doing to support and engage this older cohort in substance misuse interventions along with how we meet complex needs such as end of life care needs to be undertaken.

1.10. Changing drug profiles
Swindon, in line with the national picture, has a rapidly changing drug profile. Reviews of the use of New Psychoactive Substances, prescription drugs and Steroid use are all necessary.

1.11. New opiate presentations
The new presentations to treatment are mainly opiate (heroin using) clients which have increased by 8% from last year. As Opiate clients are more lengthy and costly to treat, continuation of this trend has serious consequences on funding for this service. A full review of this cohort is to be undertaken.

1.12. Prison releases
Increasing level of offenders released from prison who are not previously known to the area, possibly linking to county lines and dangerous drug networks. Again, a full review of this cohort is to be undertaken.

1.13. Inpatient admissions for detox and residential rehab placements
An Increasing awareness of complexity across the wider partnership( i.e. poly drug use, dual diagnosis, prison release, sex working cohort and both adult and safeguarding panel referrals) have led to increasing demand for residential placements. This increasing demand needs to be reviewed against existing resource. Access to community detox needs to be reviewed as an alternative to inpatient admission were clinically indicated.

1.14. Young people
There is a further need to review the increase in hospital admissions for 15-24 year olds from 2010/11 to 2014/15. A review of the work across the wider partnership needs to be undertaken to implement strategic screening of young people engaged by YOT, CAMHS, Children looked after, and
those educated outside of mainstream schools to ensure early identification and prevention. There is also a need to see that effective transition policies are in place to ensure no unplanned exits as young people move into adult services. There needs to be a focus on prevention, education and early intervention effectively targeting all and proactively intervening with those at risk of substance misuse.

1.15. Alcohol related hospital admissions
Hospital admissions (narrow measure) for females under 40 have increased by 66% since 2013/14. Males over 65 have also experienced a significant increase in admissions. Swindon is also seeing higher admission rates for both drug poisoning and alcohol poisoning than seen nationally. This may reflect the inequalities for those accessing services as mentioned above. There is a need to consider a substance misuse rather than an alcohol only hospital based liaison service.

1.16. Blood Borne Viruses
We will continue to work with the service provider to improve the uptake of Blood Bourne Virus testing and immunisation.

1.17. Criminal Justice
In responding to the local delivery of the Modern Crime Strategy we are committed in working in close partnership with Police colleagues. Responding to the effects of Dangerous Drug Networks along with the increased needs of sex workers, victims of domestic violence and other vulnerable groups are key priorities. There is identified need for increased provision for cell interventions at Gablecross. There is a need to undertake a further cost/benefit analysis of spend on substance misuse services against delivery of criminal justice outcomes.

1.18. Needle exchange
We have seen a significant increase in demand for this service. We need to review the causes of this increase, the content of packs on offer against best practice advice and current resource.

1.19. Employment, Training and Education
Improving access to ETE is a priority as evidence shows that clients who are working, or engaging in meaningful activities are more likely to find sustained, long term Recovery from substance misuse. Improved links with Job Centre team and further developing joint working with Learn Direct are priorities. A computer suite will soon be available for clients to use on site to do job searches and CV writing supported by volunteers and peer mentors.

1.20. Service User, mentoring and mutual aid
Swindon substance misuse services have a well-established service user and peer mentoring service (SUST). This service sits alongside Smart Recovery, SWADS, fellowship support groups and HEPC+ in the town. There is a need to further map and review the offers of support from these groups and how they sit with the main commissioned service to deliver an integrated offer to our client group to further support their recovery journey.

1.21. Housing and Homelessness
Housing need has been highlighted for those who are currently unable to maintain abstinence who may find themselves homeless and having to wait 6 weeks to be assessed. Housing is also a
particular issue for those with dual diagnosis. A project has been identified to address housing solutions for the sex worker cohort

1.22. Dual Diagnosis
Much work has been undertaken on linking substance misuse and mental health services. A pathway for referral and support together with regular joint training and case reviews sessions have been developed. However dual diagnosis remains a key issue as it increases the risk for individual clients.

1.23. Smoking Cessation
Current smoking rates are high amongst substance misusing clients. This needs addressing through the development of a stop smoking pathway for drug and alcohol service users. Work is underway to set up stop smoking clinics based at CGL for clients, carers and family members to access.

1.24. Licensing
More joint work is required with SBC Licensing to review options to reduce the harm caused by alcohol.

1.25. Local Alcohol Action Area (LAAA)
A multi-agency plan has been developed to deliver improved joint working regarding the night time economy and to facilitate more effective cross agency data sharing.

2. Introduction

1.1. Scope
The scope of this needs assessment includes misuse of all substances but focuses on alcohol and illicit substances include Novel Psychoactive substances for all age residents of Swindon Borough Council. It includes prevention and harm reduction, treatment, health, criminal justice and licencing.

1.2. Purpose
The purpose of this document is to:

- Review national and local policy and best practice
- Assess current demand and provision of substance misuse service in Swindon
- Assess the impact of substance misuse in Swindon including the impact on health and other inequalities
- Review the impact of licencing policy
- Make recommendations about the best use of reducing resources with regard to future substance misuse commissioning, partnership working and strategic direction in Swindon.

Swindon Council is responsible for reducing the harm caused by substance misuse. As such it is important to review the needs of drug and alcohol users and assess the impact their substance misuse is having on themselves, their families and their communities. This information is used to inform the commissioning of a range of services that aim to impact on substance misuse.

The council intends to undertake a procurement process to re-commission services for a revised treatment system to be in place by April 2018 onwards. This needs assessment is a key part of that process.
This report draws on a number of data sources (including self-reports, hospital admissions and service level data). Other data sources include, Joint Strategic Needs Assessment support packs for drugs and alcohol, DOMES data, PHE activity reports and Public Health Outcomes Framework statistics.

The needs assessment provides a series of recommendations for consideration by commissioners. How Swindon chooses to respond to these recommendations and shapes services to meet these needs will be detailed within the Commissioning Strategy which is the next stage of the process and will involve wider stakeholder consultation.

The substance misuse services aim to reduce addiction and assist service users to re-integrate into the community. Addressing the needs of our clients can be effective in tackling health inequalities, addressing social determinants of health, preventing wider damage to the community and instilling community confidence in Swindon as a great area in which to live and work.

Substance misuse is a key issue across a range of Public Health, Criminal Justice and Social Care concerns. This needs assessment can be reviewed alongside across a range of other locally produced documents. These include

- Swindon Joint Strategic Assessment for Crime and Disorder 2014/2015
- Priority Neighbourhoods Action Plans
- Children & Young People’s Plan 2012 – 2016
- Reducing Re-offending Strategy
- Health and Wellbeing Strategy 2013 – 2017
- Clinical Commissioning Group (CCG) Priorities 2016/17
- Child Poverty Strategy 2015

Whilst a wealth of information is available on clients who engage in services it is harder to assess the needs of people who, for a number of reasons, are underrepresented in current service provision. Addressing these gaps will be a specific focus in the wider consultation and will be factored in to any future commissioning decisions.

1.3. Local Context

Swindon has an estimated 1147 opiate and/or crack users. This equates to approximately 8 of every thousand young people and adults (15 – 64 years) in Swindon using opiates/crack. Of these about 525 are estimated to be injecting drug users. This is a slightly higher rate than the South West but lower than the national average. Whilst the proportion of Swindon residents using drugs is relatively small the impact can be extensive.

According to the North West Public Health Observatory (NWPHO) alcohol profiles and the Department of Health’s Alcohol Learning Centre (ALC), Swindon has an estimated 31,000 hazardous drinkers, 7500 harmful drinkers, 4046 dependent drinkers and 25,000 binge drinkers. Not all of
these individuals will require treatment however, as of November 2016 there were only 158 clients in treatment.

Substance Misuse is one of Swindon Public Health’s priority work areas. Recognizing the contribution this work area makes to improving and protecting the health and wellbeing of people in Swindon, and to reduce health inequalities within this population.

3. Background and national policy

Successive UK Governments over 2 decades have sought to minimise the impact of drug use, and more latterly alcohol use, on those who use them, their families and communities and on society. 1998 heralded Tackling Drugs to Build a Better Britain, a cross-government approach aimed at coordinating national and hence local responses to better ensure that a partnership approach would yield integrated pathways in terms of prevention, diversion and treatment, for adults and young people. This partnership needed, as a minimum to include local authorities, criminal justice and health partners.

The advent of Models of Care (2000) and the National Treatment Agency (NTA) a year later shone a spotlight on the evidence-base for treatment, and measured its impact through detailed analysis of client pathways. Its work diversified the approach beyond medical interventions such as substitute prescribing, to early intervention, psycho-social interventions alongside or instead of medication, harm reduction and blood-borne virus control, and a recovery and social integration focus. NTA’s subsequent integration into Public Health England in 2012 saw a renewed emphasis on the evidence-base to drive commissioning and delivery, the necessity for a ‘whole system’ approach, the introduction of alcohol as well as drugs and a reframing of the national alcohol and drugs strategy as necessarily a matter of public health. Within this there are 3 clear, and connected, strands or themes:

- **Prevention**
- **Treatment**
- **Recovery**

The Government 2010 Drug Strategy, ‘Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug-free Life’, has been a drive to respond to emerging drug threats and to tackle drug dependence. In particular, the strategy makes references to ‘dependence on all drugs, including prescription medicines’ and ‘local responses to drug misuse and dependence.’

This also runs parallel to Building Recovery in Communities 2011, which enshrines the value of working with people who wish to take proactive steps in tackling their dependency on substance misuse, and offers an exit strategy through recovery.

Effective clinical governance policies and practices are at the core of our services and we plan to continue to develop and maintain the areas of work that comply NICE guidance, the 2007 Guidelines on the Clinical Management of Substance Misuse, Building Recovery in Communities Framework, Medications in Recovery, Drug Misuse and Dependence: UK Guidelines on Clinical Management, and any other relevant national guidance.
Alcohol is leading risk factor for deaths among men and women aged 15 – 49 years\(^1\). In the UK and the harm from alcohol impacts on a range of other public health outcomes. In England, over nine million people, 22% of the population drink at level that increase the risk of harm to their health\(^2\). Of these over 1.6 million adults show some signs of alcohol dependence\(^3\).

Alcohol has been identified as a causal factor in more than 60 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression\(^4\). Even those drinking just above the government guidelines are at significantly increase risk of these conditions and the risk increases with the amount of alcohol consumed\(^5\). Binge drinking can lead to injuries, anti-social behaviour and other societal harms. Alcohol is also implicated in half of all violent assaults, 27% of all serious case reviews and 13% of all road fatalities.

*Figure 1: Alcohol misuse damages health*\(^6\)

Alcohol related harms fall disproportionately on the poorest in society. According to the local alcohol profiles for England (LAPE) for the most deprived tenth of the population hospital admissions, where the main reason for admission was alcohol, are 55% higher and alcohol-related

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\(^2\) General Household Survey 2009 & mid-2009 population estimates (ONS, 2009)

\(^3\) Adult psychiatric morbidity in England, 2007, Result of a household survey (NHS Information Centre, 2007)


deaths 53% higher, than the least deprived tenth of the population\textsuperscript{7}. People with mental health problem are more likely to misuse alcohol.

Public Health England has identified 7 key priorities to be achieved by 2020 one of which is reducing harmful drinking and alcohol related hospital admissions. Public Health England highlight that alcohol accounts for 4.2% of disability adjusted life year in the UK\textsuperscript{8}.

The Government’s Alcohol Strategy (2012) focuses on irresponsible drinking, closer working with the drinks industry and support for individuals to make informed choices about responsible drinking and reducing the numbers of people drinking to excess.

In January 2016 the government revised the alcohol guidelines\textsuperscript{9}. The key findings were:

- The evidence of the protective effect of drinking (compared to not drinking at all) is now weaker than previously thought and there is no justification for recommending drinking on health grounds.
- Alcohol consumption in pregnancy even at low levels of 1-2 units a day can increase the risk of low birth weight, preterm birth and being small for gestational age. The report recommends precautionary guidance that it is safest to avoid drinking in pregnancy.
- The overall health risk are similar for men and women, with short term risk being greater for men and long term risks being greater for women on average.
- The report recommends that for men and women who drink regularly or frequently i.e. most weeks, they should not consume more than 14 units a week. This is a reduction from previous guidelines for men which set the limit from men at 21 units.
- The report also highlights that there are short term health risks of alcohol related to any single drinking occasion such as accidents, injuries (which may or may not lead to death) for anyone drinking to levels that cause intoxication. This can arise from drinking too much or too quickly but the report did not set an additional guideline level for low risk drinking on any one occasion.
- No level of drinking is completely safe.

The report also recommends the adoption of alcohol free days as a useful way for drinkers to moderate their consumption.

The Modern Crime Prevention Strategy (2016) updates the way we think about crime prevention, aiming to build on the successes of the past while making the most of new research, techniques and technology. The strategy sets out the evidence on the 6 drivers of crime: opportunity, character, effectiveness of the criminal justice system, profit, drugs and alcohol.

A new national drug strategy was due in 2016, and is being awaited. However, we know that Drug misuse is widespread, with over 2.7m adults using an illegal drug in the last year.

There are an estimated 294,000 heroin and crack users in England, whose dependence impacts 1.2m people, mostly in deprived communities. Heroin users are 10 times more likely to die than the general population, with deaths relating to new drugs and prescription medications rising. With 40%


\textsuperscript{8} From Evidence into Action: opportunities to protect and improve the nation’s health Public Health England October 2014

\textsuperscript{9} Alcohol Guidelines Review – Report from the Guidelines development groups to the UK Chief Medical officers January 2016 DoHI
of prisoners having used heroin, it, and crack use, significantly fuel crime, notably acquisitive crime: without treatment an average of £26,074 worth of crime is committed each year, by each user. Parental drug use is implicated in 29% of serious case reviews.

An effective, joined up response is required locally, to secure the best alcohol and drugs prevention, treatment and recovery initiatives and services for adults and young people.

Substance misuse has serious health implications and treatment is proven to reduce the strain on local health services. Having reviewed the Public Health Outcomes Framework it is evident that the impact of substance misuse is far reaching and contributes to 92 of the 224 indicators and sub-indicators currently reported through the Public Health Outcomes Framework.

The following list gives an indication of the wide ranging impact substance misuse has on public health outcomes:

- Deaths from drug misuse
- Successful completion of alcohol treatment
- Blood borne virus vaccinations
- Hospital admissions/readmissions
- Employment rates, Sickness absence
- Injuries due to falls, Hip fractures
- Injuries in children
- Low birth weight babies
- Smoking at the time of delivery
- Pupil absence
- Child poverty
- Entrants to the youth justice system
- Life expectancy
- Mortality rates
- Smoking prevalence
- Mental illness
- Social Isolation
- Suicide rates
- Stable and appropriate accommodation
- Statutory homelessness
- Domestic abuse
- Violent crime
- Perceptions of community safety
- Re-offending levels

4. Swindon population profile

4.1. About Swindon

Swindon has its origin as a small market town, used mainly for barter trade until the mid-1800s. The original Swindon is now known as Old Town. With the arrival of the Great Western Railway in 1840 a whole new town was created between the new railway works and Swindon Hill. Today this is Swindon’s Town Centre.
Whilst Swindon might be an urban centre, two-thirds of the borough is rural and within its boundaries are many historic towns and villages. The largest settlement in the surrounding area is the country town of Highworth, which lies about 6 miles to the north east of Swindon. It has a population of about 8,200.

The borough of Swindon occupies an area in the north east corner of Wiltshire and is bordered by two other counties, Gloucestershire (to the north) and Oxfordshire (to the east). It has two junctions (15 and 16) onto the M4 motorway and is on the GWR main line to London Paddington and Bristol.

Swindon is governed by a unitary authority; its area is also covered by Swindon Clinical Commissioning Group and Wiltshire Police. The Council has 20 wards served by 57 elected members. There are two parliamentary constituencies in Swindon.

On behalf of Swindon Borough Council, Forward Swindon is leading a £750 million regeneration programme. This has already delivered the Swindon Designer Outlet and the Regent Circus shopping and leisure centre. Current projects include refurbishing the Oasis Leisure Centre and developing a larger leisure zone; upgrading Swindon’s station forecourt; and regenerating Kimmerfields (formerly Union Square), Swindon’s central business district.

There are currently 26 GP practices in Swindon. The Great Western Hospital is located just off junction 15 of the M4 on the edge of the Swindon urban area while a walk in centre is based in Carfax Street in the town centre.

The following summary offers a snapshot of some of the most important economic, social and environmental factors in Swindon.

### 4.2. Population and area

Until the industrial revolution Swindon was a small market town. The industrial revolution saw an increase in population, initially due to trade from the Wiltshire and Berkshire Canal and North Wiltshire Canal, then later due to the establishment of the Great Western Railway works. By the start of the 20th Century Swindon had become the largest town in Wiltshire. In 1952 Swindon was designated as an overspill town and around 14,000 people relocated, mainly from London, over the next 10 years. Swindon has continued to expand to this day, firstly mainly through housing developments to the west and north and now to the south and east of the town. The 2015 population was estimated to be 217,160 people, an increase of 27,476 people compared to 2005. It is estimated that by 2025 the population of Swindon will be 250,978 people.

The average age of people living in Swindon is 39.3 years which is similar to that of England as a whole; 39.8 year. The population pyramid for the Swindon shows that the largest age group are those aged between 40 and 50 years old.
There has been a marked change in the ethnic diversity of Swindon’s population in the 21st century. In 2011, the black and ethnic minority (BME) population comprised 11.2% of the population of Swindon up from 4.8% in 2001. It is likely that the BME has grown further since 2011 and local data suggests that 18% of the under 5 population in Swindon is from a BME background.

Note: The pyramid contains data for ages 0 to 89 inclusive. Age 90 comprises data for ages 90 and above and is omitted from the chart.

ONS, 2015 mid-year estimates
Figure 3: Ethnicity in Swindon, Census 2011

<table>
<thead>
<tr>
<th>Broad ethnic group</th>
<th>Census 2011</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Swindon UA</td>
<td>South West</td>
</tr>
<tr>
<td>White</td>
<td>187,898</td>
<td>5,046,429</td>
<td>45,281,142</td>
</tr>
<tr>
<td>Asian/Asian British</td>
<td>13,365</td>
<td>105,537</td>
<td>4,143,403</td>
</tr>
<tr>
<td>Mixed/multiple ethnic group</td>
<td>4,226</td>
<td>71,884</td>
<td>1,192,879</td>
</tr>
<tr>
<td>Black/Black British</td>
<td>2,861</td>
<td>49,476</td>
<td>1,846,614</td>
</tr>
<tr>
<td>Other ethnic group</td>
<td>806</td>
<td>15,609</td>
<td>548,418</td>
</tr>
<tr>
<td>Total population</td>
<td>209,156</td>
<td>5,288,935</td>
<td>53,012,456</td>
</tr>
</tbody>
</table>

There is no reliable local data regarding alcohol misuse on the basis of ethnicity or by/within any identifiable racial community in Swindon. Swindon’s BME communities may be underestimated in the population profile and consequently significantly under-represented in service use. Community understanding and on-going health interventions suggest established Somali and Nepalese communities and a growing Goan population (community estimates are of between 12,000 and 20,000 Goan people, disproportionately male, many in Houses of Multiple Occupation (HMOs) on low income and under the age of 60). These groups may be under-represented in current service use.

It is difficult to estimate arrivals from specific countries, however the School Census in Swindon identified that there was an increase in the proportion of pupils who speak English as a second language, rising from 7.3% in 2006 to 16.0% in 2015 for primary school children and from 7.6% to 13.4% for secondary school children over the same period.¹¹

Figure 4: Most common languages in Swindon schools¹²

<table>
<thead>
<tr>
<th>First language</th>
<th>Number of pupils</th>
<th>First language</th>
<th>Number of pupils</th>
<th>First language</th>
<th>Number of pupils</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>25,794</td>
<td>Nepali</td>
<td>207</td>
<td>Turkish</td>
<td>87</td>
</tr>
<tr>
<td>Konkani</td>
<td>893</td>
<td>Bengali</td>
<td>200</td>
<td>Italian</td>
<td>82</td>
</tr>
<tr>
<td>Polish</td>
<td>470</td>
<td>Urdu</td>
<td>162</td>
<td>Other</td>
<td>2,020</td>
</tr>
<tr>
<td>Portuguese</td>
<td>247</td>
<td>Panjabi</td>
<td>118</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹¹ LAIT tool (01/06/2016)
¹² Swindon Schools Census 2014
4.3. Employment, income and benefits

Swindon is a hard-working economy with at or near full employment amongst residents (out with recessionary periods) for the last 20 years. However, Swindon did experience negative growth in employment between 2010 and 2014, following the recession. Even so, the number of businesses continued to grow. This growth could be partially explained by residents taking up self-employment following redundancy. In 2014 and 2015, both employment and the number of businesses grew indicating a strongly expanding economy. Swindon has created 5,000 jobs in the last 2 years but needs to create another 8,000 to return to the workforce employment levels of 2009.

Manufacturing is important to the Borough’s economy, and the automotive, electrical engineering, pharmaceutical, banking, insurance and professional sectors are high value sectors in which Swindon has a key strength. The motor manufacturing is particularly prominent with Honda and BMW plants located in the Borough. Swindon residents are less likely to be employed in professional and managerial occupations than other areas in the country. However, they are more likely to be employed elementary occupations such as factory and plant assembly jobs and technical occupations such as civil engineering and IT technician roles.

In 2011, 75% of residents work in the borough, compared to 83% in 2001. Workforce wages are slightly higher than resident wages in Swindon suggesting people are commuting in for the better paid jobs.

Since 2013, the claimant count for out of work benefits has fallen in Swindon and in similar areas. However, in Swindon, there has been a persistently high proportion of claimants are aged 16 to 24. In March 2016, they made up 22% of the claimants, 430 persons. Long term unemployment in Swindon has historically been less than the national average and in March 2015 had fallen to 0.4% across Swindon as a whole. This suggests that Swindon does not have any significant unemployment issues, but this masks pockets of deprivation at ward level. Worklessness varies from 23.5% in Penhill to 2% in Ridgeway. There are over 3,500 people out of work in the four wards with the highest worklessness rates.

4.4. Deprivation

The English Indices of Deprivation 2015 (ID 2015) were published on 30 September 2015 and provide data on relative deprivation for small areas (LSOAs) in Swindon and nationally.

Swindon is ranked as the 108th most deprived area out of 152 Upper Tier Local Authorities (UTLAs), i.e. there are 107 more deprived UTLAs and 44 less deprived. This places Swindon in the second least deprived quintile in England.

Swindon’s relative deprivation is most severe in the education, skills and training domain where it is 47th most deprived out of 152 UTLAs. The driver appears to be children and young people’s indicators, i.e. Key Stage 2 and Key Stage 4 exam results, secondary school absence rates, young people staying in education post 16 and young people entering higher education.

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13 LSOAs contain around 1,500 people and are standard geographical units created and used by the Government and Office for National Statistics (ONS). There are 132 LSOAs in Swindon.
While Swindon is considered to be relatively prosperous, there are pockets of deprivation that are often hidden in official statistics. The ID 2015 goes some way in identifying where deprivation exists in Swindon and in measuring its severity.

In 2015, there are eight Swindon LSOAs in the most deprived 10% nationally (compared to nine in 2010).

*Figure 5: Swindon LSOAs by National Deprivation Decile, IMD 2015*

Three of the eight LSOAs in Swindon which are in the 10% most severely deprived LSOAs in England are found in Penhill and Upper Stratton ward, a further three are found in Walcot and Park North ward and the remaining two in Gorsehill and Pinehurst ward.

Area deprivation is a persistent phenomenon and many LSOAs remain relatively similarly deprived over long periods of time. 92.3% of LSOAs which were in the most 20% deprived areas of Swindon in 2010 were still there in 2015.
4.5. Housing and homelessness

The average (median) Swindon house price in Sep – Dec 2015 was £180,000, compared to £215,000 for the South West region and £212,000 nationally\textsuperscript{14}. Average prices in Swindon have doubled since 2001.

Affordability in comparison with the South West and England as a whole is less of an issue in Swindon. However, around 35% of first-time buyers are priced out of the market for flats and this rises to 50% for terraced housing and 60% for semi-detached properties\textsuperscript{15}.

The number of possession orders granted to mortgagors rose to a peak of 435 in 2008 at the height of the recession, but have since fallen back to pre-recessionary levels (164 in 2013).

Single person households are set to increase by 15% between 2011 and 2021, and lone parent households are set to increase by 32%.

163 households were accepted as homeless in 2014/15 and on 31/03/2015 there were 273 households in temporary accommodation.

The main reasons for homelessness in Swindon are parental exclusion and terminations of Assured Shorthold Tenancies by private landlords.

The Rough Sleeper Estimate for Swindon has been approximately 10 for the past 3 years, and this in 2015 increased above 20. This may be due to issues such as welfare reform, and reduced availability of affordable housing. However, it is the view of practitioners that the complexity of the support needs of rough-sleepers is increasing. Analysis of individuals tells us that many of those rough-sleeping in Swindon have been stuck in a revolving door of homelessness for a number of years.

\textbf{4.6. Education and skills}

In the ID 2015 the most prominent domain of deprivation in Swindon is in Education, Skills and Training. Qualifications have a direct impact on labour market opportunity and pay and hence on child poverty. Additionally in Swindon, there is a strong relationship between low levels of attainment for children and poor qualification levels of adults.

In Swindon, 28.8% of people of working age (16-64) are qualified to NVQ4 (degree level) or above compared to 37.1% in Great Britain as a whole\textsuperscript{16}. Women in Swindon are more likely to be qualified to NVQ levels 1 – 3, and men more likely to be qualified to level 4 or above, limiting women’s employment opportunities\textsuperscript{17}.

\begin{footnotesize}
\textsuperscript{15} Swindon Strategic Housing Market update, 2014: http://swindonjsna.co.uk/dna/housing-market-and-housing-need
\textsuperscript{16} Nomis Local Authority Labour Market profile (accessed 8/7/16): https://www.nomisweb.co.uk/reports/lmp/la/1946157355/report.aspx
\textsuperscript{17} 2011 Census (DC5102EW - Highest level of qualification by sex by age)
\end{footnotesize}
Figure 7: Qualification levels, 2015

<table>
<thead>
<tr>
<th>Level</th>
<th>Swindon number</th>
<th>Swindon %</th>
<th>South West %</th>
<th>Great Britain %</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ4 and above</td>
<td>40,600</td>
<td>28.8%</td>
<td>37.3%</td>
<td>37.1%</td>
</tr>
<tr>
<td>NVQ3 and above</td>
<td>69,100</td>
<td>49.1%</td>
<td>60.4%</td>
<td>57.4%</td>
</tr>
<tr>
<td>NVQ2 and above</td>
<td>97,000</td>
<td>68.9%</td>
<td>77.6%</td>
<td>73.6%</td>
</tr>
<tr>
<td>NVQ1 and above</td>
<td>121,800</td>
<td>86.5%</td>
<td>89.7%</td>
<td>84.9%</td>
</tr>
<tr>
<td>Other qualifications</td>
<td>9,800</td>
<td>7.0%</td>
<td>4.8%</td>
<td>6.5%</td>
</tr>
<tr>
<td>No qualifications</td>
<td>9,200</td>
<td>6.5%</td>
<td>5.5%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

Note: Numbers and % are for those aged 16-64; % is a proportion of resident population of area aged 16-64.

Qualification levels in deprived wards in Swindon are lower than in the rest of the Borough. In the 2011 Census 39% of residents (aged 16 and over) of Penhill (2011 ward) stated that they had no qualifications [NVQ1 or above]. This contrasts with the Swindon rate of 20.5%. The picture for higher-level qualifications is equally contrasting, with less than 10% of those in Parks and Penhill (2011 wards) having degree level or above qualifications compared with 23% in Swindon overall.

Key Stage 4 results across Swindon Secondary schools saw improvement from 2007/08 to 2012/13 before a dip in 2013/14. In 2014/15, the calculation of this national indicator was changed and cannot be compared to earlier time periods. In 2014/15, 54.1% of pupils in Swindon achieved 5 or more A*-C GCSEs (including English and Maths). Swindon’s figure was statistically significantly below the England value of 57.3% and South West value of 57.9% and also lower than local authorities experiencing similar levels of deprivation (59.8%). Attainment at GCSE was lowest in the Swindon wards that experience the highest levels of deprivation.

Primary level results are generally in line with or slightly higher than the national average. Key Stage 1 results for 2015 show the percentage of Swindon pupils reaching expected levels is the same as England in each subject (apart from science where it is higher) and has increased since 2014 (apart from Maths where it is the same as 2014). Key Stage 2 results for Swindon generally exceeded the England levels. Achievement in reading, writing and maths at Key Stage 2 was 17% points lower in those eligible for free school meals in Swindon compared to those who were not eligible.

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18 Nomis Local Authority Labour Market profile (accessed 8/7/16): https://www.nomisweb.co.uk/reports/lmp/la/1946157355/report.aspx
19 2011 Census (DCS102EW - Highest level of qualification by sex by age)
In Swindon, in 2014/15, 67.6% of pupils reached a good level of development at the Early Years Foundation Stage (academic year a child turns 5). This is much improved since 2013 and in line with the national average. However, there is a 13% point gap between the Swindon figure for children eligible for free school meals and those not eligible.

Swindon rates of young people (aged 16 to 18) who are Not in Education Employment or Training (NEET) have fallen from 6% in 2011 to 4% in 2015. NEET levels in the most deprived Swindon wards are 50% to 100% higher than the Swindon average.

### 4.7. Health

Average life expectancy (at birth) in Swindon is 79.5 years for men and 83.0 years for women. This is similar to the national average. Deprivation related inequalities exist in Swindon, as elsewhere. There is a difference in life expectancy as measured by the Slope Index of Inequality (SII), of 9.7 years between the most and least deprived males in Swindon. This gap is 4.0 years for Swindon females. This gap for males is greater than most other areas in the South West and is widening over time.

Swindon’s infant mortality rates are lower than England’s as shown in Figure 9 below. In 2014/15, in Swindon 12.7% of women smoked at the time of delivery which was significantly higher than the

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21 Public Health Outcomes Framework, overarching indicators, based on 2012-14 data.
England value of 11.4%. Rates of breastfeeding and obesity in children in Swindon are similar to the national averages.

Figure 9: Infant mortality and low birthweight

People in Swindon have similar lifestyles to people nationally as figure 9 shows. A slightly lower percentage of people in Swindon smoke but there are more adults of excess weight and physical activity levels are lower.

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22 Swindon Joint Strategic Needs Assessment Summary 2015/16: [http://swindonjsna.co.uk/pictures](http://swindonjsna.co.uk/pictures)
Many people in Swindon are admitted to hospital for injuries, both unintentional and self-inflicted, see figure 11 below. Swindon has significantly higher admission rates for self-harm than England for

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23 Swindon Joint Strategic Needs Assessment Summary 2015/16: [http://swindonjsna.co.uk/pictures](http://swindonjsna.co.uk/pictures)
young people and adults. In 2014/15, 776 people were admitted which equated to 352 per 100,000 compared to 191 per 100,000 in England overall\textsuperscript{24}.

Mental illness in parents means a family is more likely to be in poverty. Living in poverty leads to mental health problems, such as depression in parents. Maternal depression during pregnancy or infancy has an adverse effect on health, behaviour and learning and development outcomes for children. Children growing up in poverty are more likely to suffer a range of behavioural and emotional problems. Disorders such as ADHD have particularly high social differences and bedwetting and self-harming behaviour also have strong social patterns. Hospital admissions in 10-24 year olds as a result of self-harm have risen by 60% in Swindon between 2012/13 and 2014/15 compared to only a small rise nationally over the same period. Swindon’s rates are significantly higher than the England and South West rates.

\textit{Figure 11: Injuries}\textsuperscript{25}

4.8. Crime

Crime is an important feature of deprivation that has major effects on individuals and communities. The Crime domain of the IMD 2015 shows that 14 Swindon Lower Super Output Areas (LSOAs)\textsuperscript{26} are the 10% most deprived LSOAs nationally. The majority of these are in deprived wards (four are in Central ward, four in Gorsehill and Pinehurst and three in Penhill and Upper Stratton).

The Wiltshire Police and Crime Plan for 2015-17\textsuperscript{27} outlines four priorities to keep Wiltshire and Swindon one of the safe places in the country.

\textsuperscript{24} Health Profiles: \url{http://fingertips.phe.org.uk/profile/health-profiles/data#page/4?gid/1938132695/pat/6/par/E12000009/ati/101/are/E06000030/iid/21001/age/1/sex/4}

\textsuperscript{25} Swindon Joint Strategic Needs Assessment Summary 2015/16: \url{http://swindonjsna.co.uk/pictures}

\textsuperscript{26} LSOAs contain around 1,500 people and are standard geographical units created and used by the Government and Office for National Statistics (ONS). There are 132 LSOAs in Swindon.

\textsuperscript{27} \url{http://www.wiltshire-pcc.gov.uk/About-Us/PoliceandCrimePlan2015-2017.aspx}
Figure 12: Police and crime priorities

Recorded crime statistics show significant reductions in overall crime (in Wiltshire and Swindon) with 885 fewer crimes, a reduction of 2.7% and a 4.2% decrease in antisocial behaviour incidents28.

However, comparisons between September to October 2013/14 and 2014/15 show that violent crime increased by 28% in Swindon to 15.3 offences per 1,000. This was significantly higher than England’s rate of 13.5 per 1,000 and the South West rate of 11.6 per 1,00029.

Alcohol is a common factor across many violence issues so measures to reduce the contribution alcohol makes to violence in communities and to provide effective support services to victims and offenders is a key focus for both public and private space violence. Alcohol makes victims more vulnerable particularly to robbery and sexual offences.

Reporting of domestic abuse in Swindon is increasing, enabling more effective harm reduction interventions. However, given its hidden nature the levels could be much higher than currently reported.

The hidden harm of abuse within the home significantly impacts the health and wellbeing of children witnessing violent acts; on the mental health of victims; risk of suicide; and substance misuse issues, including smoking.

The number of first time entrants to the youth justice system has fallen in Swindon from 289 in 2010 to 115 in 2014. However, this equates to a rate of 581 per 100,000 which is still significantly higher than the England rate of 409 per 100,000 and also the South West rate of 428 per 100,00030.

The highest incidences of drug-related crime, supply and drug-related nuisance occur in the communities that suffer most from social deprivation. Drug users tend not to travel far from their sites of distribution and purchase of drugs in committing offences. Mapping of their offending shows it to be usually close to where they buy and or sell drugs. This means that the poorest

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29 Swindon Joint Strategic Needs Assessment Summary 2015/16: http://swindonjsna.co.uk/summaries/community-safety
communities where drugs are most commonly sold also attract a disproportionate amount of burglaries. This in turn can lead to a cycle of abandonment and area decline.

5. Substance misuse in Swindon – where are we now

5.1. Universal prevention campaigns
Local awareness and behaviour change campaigns on alcohol and drugs tend to be undertaken on an annual basis and are coordinated via the Drug and Alcohol team within Public Health with our treatment provider and Public Health England. This includes attendance at local events e.g. Mela, Christmas Campaign, Fresher’s Week at the colleges but also supporting national campaigns. Campaigns and awareness raising events during 2015 and 2016 include:

- Dry January – 2016
- Alcohol Awareness Week – Knowing the risks – November 15
- World Hepatitis Day - 28th July 2016
- Swindon Pride - 20th August 2016
- International Overdose Awareness Day - 31st August 2016
- Swindon College Fresher’s Fayre - 7th September 2016
- New College Fresher’s Fayre - 7th September 2016
- World Suicide Prevention Day - 10th September 2016
- World Mental Health Day - 10th October 2016
- Domestic Violence Week - 25th November 2016

It has been recognised that there has been more focus on alcohol rather than drug awareness, which may indicate a need to redress that in the future. There may also be a need to raise awareness about prescription medication dependence/risks. A review should be undertaken of the availability of digital/online support to raise awareness, educate, advise. Making every contact count (MECC) is also another opportunity to raise awareness of both drugs and alcohol.

5.2. Young People Substance misuse
While the majority of young people do not use drugs, and most of those that do are not dependent, drug and alcohol misuse can have a major impact on young people’s education, their health, their families and their long-term chances in life.

Public Health England state that intervening when a young people has a substance misuse issue works and saves money. Young people’s drugs and alcohol interventions result in £4.3 million health savings and £100 million crime savings per year. Drugs and alcohol interventions can help young people get into education, employment and training and bring a total lifetime benefit of up to £159
million. For every £1 spend on young people’s drugs and alcohol interventions brings a benefit of £5.831.

Swindon Borough Council commissions U-turn to provide specialist interventions for substance misuse, this is one strand of a varied provision which protects young people by preventing or delaying the onset of substance use. U-turn provides good quality education and advice to Young People and their parents; targeted support to prevent drug or alcohol misuse and early interventions to avoid escalation of risk and harm when problems first arise.

Evidence suggests32 that effective specialist substance misuse interventions contribute to improved health and wellbeing, better educational attainment, reductions in the numbers of young people not in education, employment or training (NEET) and reduced risk taking behaviour, such as offending.

Specialist interventions for young people’s substance misuse are effective and provide value for money. A Department for Education cost-benefit analysis found that every £1 invested saved £1.93 within two years and up to £8.38 in the long term. Specialist services engage young people quickly, the majority of whom leave in a planned way and do not return to treatment services.

This indicates that investing in specialist interventions is a cost effective way of securing long-term outcomes, reducing future demand on health, social care, youth justice and mental health services, and supporting the Troubled Families agenda and Life Chances strategy33.

This section focuses on those aged under 18 accessing substance misuse services but will also examine the 15 – 24 year old cohort which is observed in the hospital episode data and those in contact with Swindon Children’s’ services.

5.2.1. National and local trends

Evidence from multiple sources shows that risk taking behaviour among young people is declining at a population level. Teenagers are less likely to take drugs, to smoke, to drink alcohol or to become pregnant than the generation before them34. Local data from the schools social norms study showed that in 2016 95% of year 9s don’t use cannabis and 88% never or rarely drink alcohol.

However, levels of alcohol consumption among United Kingdom (UK) youth are higher than the European average and there are groups of young people who are taking risks and experiencing harm. A recent UK study suggests that pre-teen drinking behaviours are particularly important; while many 11 year old children are yet to explore alcohol, examining the situations in which children drink (how they obtain alcohol, who they drink with, where, when, what they drink) could help inform effective policy and alcohol harm prevention strategies to alleviate the risk associated with

33 Swindon Joint Strategic Needs Assessment Young People Support pack 2017/18
34 Data Intelligence summary: alcohol consumption and harm among under 18 year olds August 2016 PHE gateway number 2016173
drinking in youth. Furthermore, drinking before the age of 15 has a strong association with future problematic drinking and drug use.\(^{35}\)

The Smoking, Drinking and Drug Use among Young People in England (SDD) survey is the primary source of data on alcohol consumption among young people. This survey is conducted in secondary schools with pupils aged between 11 and 15 year via self-completion questionnaire. Over the past decade, there has been a strong downward trend in drinking behaviour among 11 to 15 year old boys and girls, however the most recent years data suggests that, for girls, this decline may be starting to level off (see below).

Figure 13: Proportion of pupils aged 11 to 15 years who have ever had an alcoholic drink.\(^{36}\)

In 2014 a survey of 15 year olds was undertaken in England. The What About YOUth Survey (WAY)\(^{37}\) provides further insight into drinking behaviour among teenagers and, unlike the SDD survey, can provide a robust sub-national breakdown (local authority level) as well as further demographic breakdowns (eg by age, gender and deprivation level).

Results of the WAY 2014 survey in England revealed that 62% of respondents had drunk an alcoholic drink, with 6% being classified as regular (weekly) drinkers. Fifteen percent of respondents said that they had been drunk in the previous four weeks. Girls were more likely than boys to have had a drink (65% and 60% respectively) and to have been drunk in the past month (girls 18%; boys 12%) but were slightly less likely to be regular drinkers (girls 7%; boys 6%). Young White people were much

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\(^{35}\) Data intelligence summary: alcohol consumption and harm among under 18 year olds August 2016 PHE gateway number 2016173

\(^{36}\) Smoking, Drinking and Drug Use among Young People in England Survey, 2014

more likely to have had an alcoholic drink than those from a Black and Minority Ethnic group background (72% compared with 27%).

Patterns of drinking also varied by deprivation group with young people in the least deprived areas being more likely to have had an alcoholic drink (66%) and to be regular drinkers (8%) than those in the most deprived areas (44% and 4% respectively). This is similar to the pattern observed for adult drinkers.

Figure 14: Current drinking and smoking status of 15 year olds by deprivation group England, 201438.

At a local authority level, the WAY survey showed a positive picture of substance use overall with lower levels of regular smokers and drinkers compared within the region and nationally and similar levels for other indicators.

38 What About Youth? Survey 2014
The survey presents a broadly similar position to the rest of England, this is further supported by Swindon also experiencing similar levels of hospital admission for alcohol specific conditions (under 18's) to the England average as seen in Figure 16 below.

While the outlook for alcohol consumption among those under 18 yrs appears to be in decline, hospital admissions due to substance misuse for 15 – 24 year olds are increasing.

39 http://fingertips.phe.org.uk/profile/what-about-youth/data#page/1/gid/1938132874/pat/6/par/E12000009/ati/102/are/E06000030
40 https://fingertips.phe.org.uk/search/under%2018#page/4/gid/1/pat/6/par/E12000009/ati/102/are/E06000030/iid/90856/age/173/sex/4
Figure 17: Swindon - Public Health Profiles Hospital admissions due to substance misuse (15 - 24 years)⁴¹.

When Public Health has full access to the Hospital Episode Statistics further work can be done to identify the specific ages of these hospital admissions and find more detail about the substances involved.

Analysis of local hospital data analysed Swindon hospital admissions in under 19’s over period 2013/14. This found 162 admissions for 124 individuals where 60 individuals were admitted due to Intentional self-poisoning by and exposure to non-opioid analgesics, antipyretics and anti-rheumatics (X60) such as ibuprofen, paracetamol and aspirin. These substances are not included in the child health profile measure, but do provide broader insights into the possible links with self-harm and mental health needs in a hospital setting.

5.2.2. Targeted prevention and risk groups

U-turn substance misuse service delivered by Swindon Borough Council provide a universal service for 11 – 17 year olds and their families in Swindon and targeted support and treatment to those at risk or involved in substance misuse.

Many young people receiving specialist interventions for substance misuse have a range of vulnerabilities. Examples of the types of vulnerabilities / risks young people report having at the start of treatment, and the ways U-turn provides targeted prevention work, include:

⁴¹https://fingertips.phe.org.uk/search/substance%20misuse#page/4/gid/1/pat/6/par/E12000009/ati/102/are/E06000030/iid/90808/age/156/sex/4
Not in education, employment or training (NEET) | U-turn supports all staff across Children’s Services to identify young people not seeking treatment, but who may be at risk of substance misuse problems. U-turn staff and volunteers invest up to 10% of their time training and raising awareness to Children’s Services (incl. Education) through talks, presentations, information and guidance.

In contact with the youth justice system | U-turn is currently co-located with the Youth Offending Team, joint care planning is provided as routine and we continue to see a higher level of referral into treatment services than seen nationally.

Experience of domestic abuse and sexual exploitation | U-turn regularly attends a multi-agency risk panel (MARP) on a monthly basis. This group discusses vulnerable young people who are flagged using a risk matrix and includes social workers, their managers, CAMHS, Wiltshire police, child sexual exploitation and missing children’s teams.

**Alcohol and drug use**, for example, is associated with early sexual initiation and other risky sexual behaviours⁴². A sexual health nurse is appointed within the Youth Offending Team (YOT), which U-turn can access, to support young people.

U-turn provides a universal service for those aged 11 – 17 and their families with drug and alcohol related problems in Swindon. U-turn has also been working alongside “the Dock” a website designed, created and used by young people to find out about services for them in Swindon. Future development of the website will be based on importance placed on items by young people, which the U-turn and Public Health will respond to.

Pathways have long been established between agencies who are most likely to be in contact with young people who disclose vulnerabilities listed above. U-turns co-location with the YOT continues to support a higher level of referral into treatment services than seen nationally. Pathways with GWH have been established in principal, and have become active in the last six months with GWH now alerting U-turn if a young person presents with a substance misuse related admission. U-turn is also embedded with working practice in Children’s services and provides advice to schools and any third sector organisations concerned about substance misuse in young people.

### 5.2.3. Young people treatment system

Specialist services are provided to those whose use has escalated and/or is causing them harm. There are effective pathways between specialist services and children’s social care for those young people and age appropriate care is available for all young people in specialist services.

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U-turn is currently staffed with 2 full time recovery workers who are managed by a portion of a YOT manager post. With this limited resource, U-turn endeavour to spread training and knowledge on substance misuse to any adults in Swindon working closely with Young People and regularly organise training and events to facilitate this.

5.2.3.1. Number in treatment

The year 2015-16 saw an increase in the number of young people being treated by U-turn to 78 clients, however this is more due to cycling staffing capacity within service rather than a true change in demand. Typically there is a 18 month cycle of waxing and waning client numbers, associated in part with drops in demand over longer school holiday periods, this is usual for U-turn.

*Figure 18: Number of young people in treatment service*

No young people were transferred from secure estates back into community treatment, and historically these have been low this will become part of the transitions policy review.

5.2.3.2. Referral sources

Due to its co-location within the Youth offending team, the young people’s substance misuse service has a higher proportion of referrals from this source than seen nationally, there is also a higher proportion from self, family and friends.

A lower proportion are seen from education services, although referrals from children and family services are higher, suggesting that more referrals are received from services targeted at young people with specific identified vulnerabilities.

*Figure 19: Referral sources for young people substance misuse treatment*

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43 Swindon young people Joint Strategic Needs Assessment support pack 2017/18
44 Swindon young people Joint Strategic Needs Assessment support pack 2017/18
5.2.3.3. Profile of young people in service

As referrals are being received from agencies which are targeting young people with vulnerabilities, the clients who are in treatment tend to be using more substances, and using these from a younger age than seen nationally.

Young people also have wider vulnerabilities with higher proportions of looked after children, child in need, involvement in self harm, not in education employment or training, involved in offending/antisocial behaviour and being affected by others’ substance misuse than seen nationally.

Figure 20: Identified vulnerabilities and risks for young people in treatment services

5.2.3.4. Substance use

The main substances Swindon young people seek treatment for are cannabis and alcohol use. Although information on tobacco use is captured, U-turn does not provide a stop smoking service, these young people are referred on to the YOT specialist nurse.

There has been increased reporting on the number of clients reporting Novel Psychoactive substance use and < 5 young people seeking treatment for heroin and/or crack use.

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45 Swindon young people Joint Strategic Needs Assessment support pack 2017/18
5.2.3.5. Treatment length

Swindon young people tend to spend shorter periods of time in treatment, with predominately psychosocial interventions taking place. Given the types of problem substances being disclosed and treated, the majority do not tend to require a pharmacological substitution therapy or lengthy time in treatment.

Figure 22: Swindon young people time in treatment

<table>
<thead>
<tr>
<th>Length of time in services</th>
<th>Local</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (zero) to 12 weeks</td>
<td>39</td>
<td>41%</td>
</tr>
<tr>
<td>13 to 26 weeks</td>
<td>22</td>
<td>32%</td>
</tr>
<tr>
<td>27 to 52 weeks</td>
<td>6</td>
<td>19%</td>
</tr>
<tr>
<td>Longer than 52 weeks</td>
<td>0</td>
<td>8%</td>
</tr>
</tbody>
</table>

5.2.3.6. Treatment exit and representation

The proportion of young people leaving treatment in a planned way has dropped from previous years. U-turn work proactively to re-engage clients into treatment, however the wide range of vulnerabilities identified with this cohort of young people may mean that these are more difficult to engage on a long term basis. U-turn also have a slightly higher proportion of re-presentation than seen nationally.

Figure 23: Swindon young people planned treatment exits

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46 Swindon young people Joint Strategic Needs Assessment support pack 2017/18
47 Swindon young people Joint Strategic Needs Assessment support pack 2017/18
48 Swindon young people Joint Strategic Needs Assessment support pack 2017/18
5.2.3.7. Transitions

Currently transitions between the young people’s specialist service and adult services are very low. The transitions policy is being reviewed by CGL in conjunction with U-turn to insure that clients are transitioned appropriately between the two services.

While the number of young people detained in secure settings is low, these often have complex health needs including substance misuse – these clients are not being seen in the young peoples’ service, but the transitions policy will need to include transitions between Youth Offending Team/secure estate and treatment services as appropriate.

U-turn has a lower proportion of 18 – 24 year olds than seen nationally, with slightly higher proportions in younger age groups.

5.2.4. Safeguarding Children

Around 31,000 (33%) of adults in alcohol treatment are parents with childcare responsibilities. A further 20% are parents whose child lives elsewhere.

In 2010 Alcohol Concern and The Children’s Society produced a report49 which estimated that 2.6 million children in the UK are living with parents who are drinking hazardously and 705,000 are living with dependent drinkers. The report also cites evidence of parental substance misuse in 57% of serious case reviews (of serious or fatal child abuse) and also the impact of parental alcohol misuse on youth offending and domestic violence. The report calls for improvements in training regarding alcohol and drug misuse for social workers.

In Swindon adult drug and alcohol treatment there were 270 clients who were living with children under the age of 18 from the 1006 clients presenting to treatment in a 12 month period between October 2015 and September 2016.

Figure 24: Proportion of clients in treatment who live with children under 18 period October 2015 - Sep 201650

CGL arranges home visits with any clients identified as parents or carers of children in their own home, with priority being given to children under the age of five. CGL also has established safeguarding adult’s and children’s procedures which are reviewed in line with CQC and local policies and regularly contributes to safeguarding proceedings.

50 National Drug Treatment Monitoring System Swindon Diagnostic Outcomes Monitoring Executive Summary Quarter 2 2016-17
The number of pregnant service users and those with children under five are closely monitored in contract review and joint work has been undertaken with the NSPCC to support programmes such as parents under pressure.

Within U-turn, a wide range of vulnerabilities in addition to substance misuse are worked with and supported by the service.

With regard to the substance misuse harms which come to light through involvement with Swindon children’s services, the table below shows that the number of children with a Child Protection Plan has remained relatively consistent over the last three years. Of 245 children in 2015/16 with a child protection plan 6 children misused alcohol and this has remained relatively consistent between 2013/14 and 15/16. The number of parents of children on a children protection plan who misuse alcohol has varied over the three year period but increased from 39 in 13/14 to 70 in 14/15 and has since gone down again to 48 in 15/16. This equates to between 16 – 20% in 15/16. A further 44 children with a plan had a parent who misused drugs.

![Figure 25: Swindon Children’s Service Child Protection Plans – Substance use](https://example.com/image1)

<table>
<thead>
<tr>
<th>Child Protection Plan</th>
<th>Child alcohol misuse</th>
<th>Parental alcohol misuse</th>
<th>Child drug abuse</th>
<th>Parental drug abuse</th>
<th>Total starting in the year</th>
<th>Total at year end</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>&lt;5</td>
<td>39</td>
<td>11</td>
<td>40</td>
<td>290</td>
<td>214</td>
</tr>
<tr>
<td>2014/15</td>
<td>5</td>
<td>70</td>
<td>12</td>
<td>48</td>
<td>266</td>
<td>213</td>
</tr>
<tr>
<td>2015/16</td>
<td>6</td>
<td>48</td>
<td>&lt;5</td>
<td>44</td>
<td>289</td>
<td>245</td>
</tr>
</tbody>
</table>

The table below shows that between 2013/14 and 2015/16 there were an additional 45 Children Looked After in Swindon. In 2015/16, 17 or (9%) of those children had a parent who misused alcohol and 8 (or 4.3%) of the children themselves misused alcohol. 35 (or 12%) had a parent who misused drugs.

![Figure 26: Swindon Children’s Services Child Looked after – substance use](https://example.com/image2)

<table>
<thead>
<tr>
<th>Child Looked After</th>
<th>Child alcohol misuse</th>
<th>Parental alcohol misuse</th>
<th>Child drug abuse</th>
<th>Parental drug abuse</th>
<th>Total starting in the year</th>
<th>Total at year end</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>6</td>
<td>9</td>
<td>10</td>
<td>9</td>
<td>138</td>
<td>252</td>
</tr>
<tr>
<td>2014/15</td>
<td>7</td>
<td>20</td>
<td>6</td>
<td>28</td>
<td>139</td>
<td>252</td>
</tr>
</tbody>
</table>

---

51 Swindon children’s services  
52 Swindon children’s services
Further work will need to be undertaken to establish how individuals are screened for substance misuse issues and are subsequently linked in with appropriate substance misuse treatment services.

5.3. Drug misuse - adults

5.3.1. The costs of drug addiction

The annual cost of drug addiction in England has been estimated at £15.4 billion. These costs include cost to criminal justice, the health service and social care. These costs do not include the wider costs to society and the individual.

Figure 27: Infographic annual cost of drug addiction

Public Health England estimate that every £1 spent on drug treatment saves £2.50 cost to society. This includes the estimated prevention of 4.9 million crimes £960m in costs to the public, businesses, criminal justice and the NHS.

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5.3.2. National and local trends

5.3.2.1. Prevalence estimates

While published statistics provide information on the numbers of people accessing treatment for drug dependency, they do not give an indication on the levels of need for drug treatment or the prevalence of drug use.

The Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2011/12: Sweep 8 Summary Report from Liverpool John Moores University\(^{55}\) estimated a national rate of opiate and Crack use of 8.40 per 1,000 population in England. With the highest prevalence rates seen in Yorkshire and the Humber region at 10.44 with the South West region amongst the lowest at 7.69 persons per 1,000 population aged between 15-64.

The report used indirect techniques to produce the best possible estimates of an important and very hard to reach group. It showed that there has been a decrease in the national estimate of problem drug use between 2010/11 and 2011/12, but this decrease was not statistically significant. There were statistically significant decreases in the younger (15 to 24) and middle (25 to 34) age group, but a statistically significant increase in the older (35 to 64) age group. The highest prevalence rate in opiate and crack use is in the 25-34 age group, this is consistent across all regions in England.

Within Swindon, there has been no significant change in the modelled estimate numbers of Opiate and crack use between 2009 and 2012 which is the most recent year of modelling. However as seen

in the rates table below, Swindon does have an estimated higher rate of Opiate and Injecting users than the South West but lower than the England average.

In 2015/2016, it is estimated that there are 1,147 Opiate and Crack users in the local area, which is equivalent to eight in 1,000 people. 53% of the estimated number of OCUs in Swindon were engaged in structured treatment, which is 2% lower than the national average of 55%. 217160

Figure 29: Prevalence Estimates by Region including Swindon, South West and England

<table>
<thead>
<tr>
<th>Region</th>
<th>15-64 population estimate 2011/12</th>
<th>Opiate/Crack users</th>
<th>Opiate users</th>
<th>Crack users</th>
<th>Injecting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swindon</td>
<td>141,800</td>
<td>1,147</td>
<td>974</td>
<td>1,398</td>
<td>1,068</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,068</td>
<td>906</td>
<td>1,329</td>
<td>846</td>
</tr>
<tr>
<td></td>
<td></td>
<td>607</td>
<td>467</td>
<td>525</td>
<td>423</td>
</tr>
<tr>
<td>South West</td>
<td>3,389,400</td>
<td>26,051</td>
<td>25,034</td>
<td>23,082</td>
<td>12,145</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12,145</td>
<td>10,134</td>
<td>9,474</td>
<td>705</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>34,991,400</td>
<td>293,879</td>
<td>202,146</td>
<td>253,751</td>
<td>166,640</td>
</tr>
<tr>
<td></td>
<td></td>
<td>161,621</td>
<td>90,353</td>
<td>90,353</td>
<td>10,958</td>
</tr>
</tbody>
</table>

When looking at whether the estimated numbers of users are reflected in numbers engaging in treatment services, Swindon appears to be performing broadly in line with the national picture. However, services appear to appeal more for male client than female, with the latter being under represented in services compared with nationally.

Swindon’s treatment penetration for male users is 59% against a national figure of 51%. Of concern is the female treatment penetration which shows 42% against a national figure of 65%. This is particularly important as drug using women are more likely to experience poor mental health, domestic abuse and be a main care giver than males in treatment services – therefore service delivery must reflect their different needs.

Swindon’s treatment system has a good track record for engaging with OCUs. Collectively, this cohort of service users has a significant impact on crime, unemployment, safeguarding children, and long-term benefit reliance for the local area.

For engagement with opiate clients, our local treatment service records a 56% rate against the national average of 61%.

For engagement with crack users, the local area recorded 53% treatment uptake compared to 40% nationally, whilst the local area recorded 49% of engagement with injecting cohort, compared to 56% nationally. Swindon drug treatment penetration compared with national picture

A source of prevalence information is the report Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales (CSEW)\(^5^9\), while this report only covers information at a national level, it provides the following key findings;

- Around 1 in 12 (8.6%) adults aged 16 to 59 had taken an illicit drug in the last year. This equated to around 2.8 million people. This level of drug use was similar to the 2013/14 survey (8.8%), but significantly lower than a decade ago (11.2% in the 2004/05 survey).

- Around 1 in 5 (19.4%) young adults aged 16 to 24 had taken an illicit drug in the last year. This proportion was more than double that of the wider age group, and equated to around 1.2

\(^{57}\) Joint Strategic Needs Assessment Support Pack 2016/17

\(^{58}\) Excerpt from Joint Strategic Needs Assessment Support Pack 2016/17 data

million people. This level of drug use was similar to the 2013/14 survey (19.0%), but significantly lower compared with a decade ago (26.5% in the 2004/05 survey).

- The use of ecstasy in the last year increased among 16 to 24 year olds between the 2013/14 and 2014/15 surveys, from 3.9 per cent to 5.4 per cent. This is an increase of approximately 95,000 people.

- Last year use of khat among 16 to 59 year olds has fallen to 0.04 per cent. This is a significant fall compared with the 2011/12 estimate of 0.2 per cent, when khat use was last measured by the CSEW. Khat was legal prior to June 2014, when it became controlled as a Class C drug.

- Around 1 in 20 (4.7%) adults aged 16 to 59 had taken an illicit drug in the last month, while one in ten (10.2%) young adults aged 16 to 24 had done so. Neither proportion has changed significantly compared with the 2011/12 survey, when the questions on last month use were last asked.

- Just over one-third (34.7%) of adults aged 16 to 59 had taken drugs at some point during their lifetime. This is similar to the 2013/14 survey estimate (35.7%).

While drug use appears to be widespread amongst the population, there is no indication from this survey of the level of clinical need for treatment or whether this use is otherwise problematic.

5.3.2.2. New opiate users

Between September 2015 and August 2016 there were 165 clients presenting with opiate and/or crack use which has increased by 8% from last year. As Opiate clients are more lengthy and costly to treat, continuation of this trend has serious consequences on funding for this service. The South West region saw a slight increase of 2.5% and nationally there was a 2.25% decrease from last year.

As the previous year had seen an increase in prison release to Swindon having no fixed abode, there was a concern that this vulnerable cohort was continuing to increase in volume. During the latest period, of the 165 entering treatment, 11 were not previously known to Swindon – all of which were prison releases. Of the 165 entering treatment, 11 had never entered drug treatment before and 28 have ongoing contact with another agency (28 with probation and 1 with social services).

The client cohort entering treatment were more diverse in terms of ethnicity and sexuality than seen in previous years, though this could be due to improved reporting. A quarter of those presenting to treatment were female – this is slightly lower than the 27% seen in drug treatment services.

In line with national profile the age of clients accessing treatment is rising. Over half of those entering treatment with CGL in Swindon were over 35 years of age. 27 clients reported that their problematic drug use had started before the age of 18. Many of these clients have long term health problems as well as their addiction issues.

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60 CGL T3 Opiate and Crack new presentations ClientBDRecoveryDrugs2016111111 September 2015 – August 2016
61 Swindon Adult Drug Joint Strategic Needs Assessment support pack 2017/18
5.3.2.3. Novel Psychoactive Substances (NPS) – Emergence of Legal Highs

Since 2006 there has been a growing interest in, and availability of, a new generation of drugs collectively known as Novel Psychoactive Substances (NPS) or more colloquially, 'legal highs' and less frequently 'research chemicals.'

The arrival of NPS has been something of a 'game-changer' in that traditional models of drug diffusion and supply (e.g. for heroin or cocaine) have been joined by the internet as a new route of wholesale and retail supply, distribution and information exchange.

From 2006 until 2016, many of these substances have been legally available on the high street, both from 'head shops' and a range of other retail outlets. However, the Psychoactive Substances Act which came into effect on 26th May 2016 banning the manufacture, sale and distribution of any and all psychoactive substances accompanied by a list of exemptions including tobacco and alcohol.

The main group of drugs are the synthetic cannabinoid receptor agonists (SCRAs), including Spice, which are currently presenting serious problems in prisons and young offender institutions, among the homeless and existing service users. Relatively few people are coming forward to treatment services in the community citing an NPS as their primary drug problem in 2016. Workers see more of the problem out in the community with clients who are not accessing treatment, for example homeless and rough sleepers. A&E, Ambulance Service and Supported Housing colleagues have reported varying changes to patterns of NPS use as a response to the change in legislation.

The Swindon Drug and Alcohol Service have recently appointed an NPS lead in response to the presenting need. They are holding specialist NPS caseload and coordinating prevention initiatives with other stakeholders including U-Turn and police colleagues.

Figure 32: Initial assessment at CGL, number of clients by primary substance

<table>
<thead>
<tr>
<th>Primary substance clients seeking treatment for at initial assessment</th>
<th>Number of clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis (herbal, skunk and unspecified)</td>
<td>55</td>
</tr>
<tr>
<td>NPS (all types, sedative, opioid, cannabinoid, stimulant)</td>
<td>13</td>
</tr>
<tr>
<td>Codeine (Linctus and tablets)</td>
<td>9</td>
</tr>
<tr>
<td>Amphetamines Unspecified</td>
<td>7</td>
</tr>
<tr>
<td>Benzodiazepines Unspecified</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Mephedrone</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Gas Butane/Propane</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Ketamine</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Nicotine</td>
<td>&lt;5</td>
</tr>
<tr>
<td><strong>Total non-opiate initial assessments</strong></td>
<td><strong>92</strong></td>
</tr>
</tbody>
</table>

62 CGL Swindon drug service STARS project summary report August 2015 – September 2016
5.3.3. Drug treatment system overview

5.3.3.1. Treatment service performance against national measures

There are two national Public Health Framework indicators specifically for drug treatment;

- 2.15i – Successful completion of drug treatment – opiate users
- 2.15ii – Successful completion of drug treatment – non-opiate users

Swindon’s performance against these indicators has strongly improved over the course of the re-commissioning cycle with Swindon currently achieving top quartile performance for successful opiate treatment.

Figure 33: Quarter 1 2016/17 Drug treatment national performance monitoring

5.3.3.2. Current service provision

The current substance misuse treatment services provided in Swindon are listed as follows;

- New premises for both alcohol and drug treatment services
- Change from a key worker model to more efficient care co-ordination group work model
- Clinical provision within service
- Alcohol liaison nurses at GWH
- Criminal justice workers
- Street drinkers outreach
- Shared care – GP practices
- Needle Exchange Pharmacies, specialist provision (including image and performance enhancing drugs) available at Temple Street.
- Naloxone widely available
- Tele Health online support
- Hep C positive support group

63 National Drug Treatment and monitoring System DOMES report Q1 2016/17
- U-turn - young people’s treatment
- Prevention campaigns
- SUST – Service User representatives
- Non-commissioned services – 9 mutual aid services, viewable on MyCare MySupport
- Families and carer support group – Time4Us and CGL
- Residential Rehabilitation
- Liaison with midwifery, NSPCC (support for parents)
- Dual diagnosis
- Licensing and trading services

5.3.3.3. Treatment entry

Drug users need prompt help if they are to recover from dependency, simple access to specialised services and short waiting times facilitates the recovery process in the local community.

In Swindon, CGL currently operates a zero waits policy for alcohol and drugs clients. Clients are triaged at first contact with the service and appointments booked for Tier 2 information and advice up to other structured interventions as appropriate.

This rapid recruitment into treatment has resulted in a higher proportion of opiate or crack users accessing the service with an estimated 53% of active drug users coming into contact with the service over a 12 month period compared with 51% seen nationally.

Early access and engagement into treatment means earlier safeguarding assessments, blood borne virus testing, harm reduction advice such as safer injecting and provision of naloxone pens. All of these interventions are intrinsic to the health and wellbeing of the client and their families as they move through recovery.

However, particular barriers exist for certain marginalised groups, this is covered in more detail in the service user demographics section of the needs assessment.

In 2016, 100% of waiting times to start structured treatment were under 3 weeks for both drug and alcohol treatment in Swindon, this compares favourably with national figures which show 96% of drugs clients and 98% of alcohol clients being seen in less than three weeks nationally.

For the year 2015-16, 268 clients were referred into drug treatment the main source being self-referral. In Swindon the referrals principally come from Self or Criminal Justice system referrals with fewer referrals from General Practices.
Figure 34: Routes into Swindon Drug Treatment

Looking at the 792 referrals for all those in drug treatment between September 2015 and August 2016 shows a similar picture.

Figure 35: Local referrals to drug treatment

5.3.3.4. Clients in treatment

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing early unplanned exits and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. The information below shows the proportion of adults entering treatment in

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64 Swindon Adult Drugs Joint Strategic Needs Assessment Support pack 2017-18
65 CGL STARS Project Summary report August 2016, all drug clients.
Swindon in 2015-16 who left treatment in an unplanned way before 12 weeks, commonly referred to as early drop outs is well below what is seen nationally.

*Figure 36: Early unplanned exits from Swindon drug treatment*

Between September 2015 and August 2016 CGL had engaged 1,250 clients in drug or alcohol treatment.

*Figure 37: Clients in Swindon Treatment by problematic substance*

The drug treatment service has exceeded its planned capacity and CGL has re-structured in response to this and reductions in funding. Despite these pressures drug and alcohol treatment retention and representations to treatment after a planned exit are excellent. Swindon Opiate treatment services have been in the top quartile performance in the country, however co-location in a single premises with the ending of sub-contracting arrangements with SWADS and service re-design have meant more recent performance has started to decline.

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66 Swindon Adult Drugs Joint Strategic Needs Assessment Support pack 2017-18
67 CGL STARS and SOLAR Project Summary report August 2016, all drug clients, all alcohol clients.
Figure 38: Numbers of clients locally reported in treatment against target

<table>
<thead>
<tr>
<th>Swindon number of clients in effective treatment - Rolling 12 month total</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Q1 - 2016/17</th>
<th>Swindon in treatment target range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opiate clients</td>
<td>597</td>
<td>594</td>
<td>600</td>
<td>580 - 600</td>
</tr>
<tr>
<td>Non-opiate</td>
<td>71</td>
<td>86</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>Non-opiate and alcohol</td>
<td>89</td>
<td>84</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>404</td>
<td>321</td>
<td>333</td>
<td>292 - 600</td>
</tr>
</tbody>
</table>

Swindon remains an opiate centric service with 56% of clients seeking treatment for mainly opiate based drugs (principally heroin), 28% for alcohol and 16% for non-opiate drugs such as crack cocaine. The high proportion of opiate drug clients who are using non-opiate drugs alongside are noteworthy for being particularly difficult to treat. There are few pharmacological tools to assist with cocaine/Crack use, therefore the emphasis is placed on psychosocial interventions and group work – engagement with which can fluctuate with client motivation. In December 2016, throughout the treatment population of 671 drug and alcohol clients, 656 clients attended psychosocial interventions, 423 clients were on a script and 314 clients attended a group pod. CGL aim to reduce the amount of scripting and increase participation in group pods which will support in clients journey to recovery.

Clients approaching service for help with Novel Psychoactive Substance (NPS) use has been closely monitored, however uptake is disproportionally low, with 24 clients reporting NPS use compared with reports of endemic use from partner agencies, particularly prisons. This is also being mirrored throughout the country with clients using NPS not being present in the drug treatment population in large numbers. Work is ongoing with the CGL NPS lead to ensure the treatment offer is appealing to these clients.

Clients that have been in treatment for long periods of time (six years or over for opiate clients and over two years for non-opiate clients) are most likely to be entrenched users who will find it harder to successfully complete treatment. Current data shows that opiate clients who successfully complete within two years of first starting treatment have a higher likelihood of achieving sustained recovery. With drug services also reaching capacity, there is pressure to move clients through the treatment service to free enough capacity to treat incoming clients. The proportion of Swindon drug clients who have been in treatment for longer than 6 years is similar to the national average, this is cohort is predicted to increase in the coming year.

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68 Swindon Borough Council Performance Management Review AppE and App H Q1 2016/17
For non-opiate clients the movement through treatment system is far swifter with the proportion of clients in treatment for two years or more currently 1% compared with 3% nationally.

While there is pressure regarding volumes of clients within service, those clients are also becoming increasingly complex. Poly drug use, dual diagnosis, prison release, sex working cohort, mother and baby placements and Risk Enablement Panel (REP) referrals (adult safeguarding risk) have led to increasing demand for residential placements. These are the most costly interventions which are used when community detox and treatment facilities cannot meet the needs of the client.

Clients are also entering treatment having experienced long drug using careers. Behaviours associated with drug use can become entrenched with a greater chance of broken ties in family relationships. Swindon has a greater proportion of clients with careers spanning over 21 years which can be more challenging to engage and engender a growth mind set with.

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69 Swindon Adult Drugs Joint Strategic Needs Assessment Support pack 2017-18

70 Swindon Adult Drugs Joint Strategic Needs Assessment Support pack 2016-17
5.3.3.5. Service user demographics

Due to the hidden nature of drugs misuse, it may never be possible to know whether Swindon has a treatment population truly representative of its drug using population. While we know an approximate number of problematic drug users, knowing further details about them such as their gender, ethnicity and sexuality is difficult due to limited research being undertaken.

Understanding these discrete populations in an already marginalised group of people is crucial as these are more likely to experience poor health outcomes as a result of lack of understanding of their specific needs.

The Swindon drug treatment service is becoming more gender balanced and seeing wider diversity in terms of ethnicity and sexuality. Although these are still not fully representative of the broader population of Swindon, the differences in patterns of drug use between these sub groups could account for some of the discrepancies.

A new core data set is being introduced in 2017 which will monitor diversity in greater detail across drug and alcohol treatment providers. We will monitor these reports to ensure clients are able to access treatment services, this will include those with physical and learning impairments.

The gender and sexual orientation of clients accessing Swindon treatment services are in line with what is seen in treatment services nationally, and the proportion of female clients has increased by 2% since last review. However prevalence estimates suggest that 23% of female clients are missing from Swindon’s treatment services, highlighting that though this may be typical among treatment services, outreach work should have a focus on diversity and that work should continue to focus on at risk groups.

Figure 41: Gender of clients in drug treatment Sep 2015 - Aug 2016

The age profile of those in treatment is aging, this is partly as a consequence of the 80’s heroin epidemic cohort now reaching the life stage where ill health and the consequences of long term injecting mean that continuing the same pattern of opiate use is no longer an option. This aging population has serious consequences for the treatment system as this longer lived, poorer health cohort are the least likely to complete drug treatment successfully.

\[71 \text{ CGL STARS Project Summary report August 2016}\]
A characteristic of a more prevention centric substance misuse treatment system, would be a shift in the age of cohort entering treatment. By attracting clients earlier in their drug using career, this increases the likelihood they will complete treatment and manage the risk that they develop into a long term entrenched drug user. A metric for this could be establishing that over 50% of the treatment cohort be under 35 years of age, currently this stands at 41%.

Figure 42: Age profile of clients in drug treatment Sep 2015 - Aug 2016

There has been a substantial improvement in reporting of ethnicity as previously 98% of clients in drug treatment services identified as White, which now stands at 92%, with the general Swindon population in the 2011 census being 89.8% White. While this is positive, further information is needed about;

- the variation in drug use within specific ethnic communities to identify the role and relative importance of other factors – personal, social, economic, cultural, geographical – that may increase risk of or provide protection against drug use;
- the different patterns of drug use (types of drugs, mode of administration, length of use) between different ethnic groups and the contexts in which drug use occurs;
- the variation in drug use within the White ethnic group, for example among the new communities from Eastern European countries.

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72 CGL STARS Project Summary report August 2016
5.3.3.6. Clients exiting treatment

The data below shows the proportion of drug users who successfully complete treatment free of dependence, and do not relapse and re-enter treatment. Helping people to overcome drug dependence is a core function of any local drug treatment system. Although many individuals will require a number of separate treatment episodes spread over many years, most individuals who complete successfully do so within two years of treatment entry.

In Swindon, the number of successful completions of treatment for Opiate and Non-opiate drug use is above the national average, with treatment for Opiate use being in the top quartile for performance in the country. The proportion of successful completions for Non-Opiate and alcohol use is lower than the national average, highlighting the need for more joined up work between alcohol and drugs services.

Figure 44: Swindon successful completions of drug treatment

Those clients, who after completing a minimum 12 week treatment programme, then re-present to treatment services within a six month period, are no longer considered a successful completion and are instead known as a re-presentation.

Representation to service can be a positive step, drug addiction is a chronic lifelong condition and a client seeking additional treatment and support following relapse can indicate an easily accessible service that is able to meet client need. It can also be an indicator of a service releasing a client too

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74 CGL STARS Project Summary report May 2016
75 Swindon Adult Drugs Joint Strategic Needs Assessment Support pack 2017-18
early when sustained recovery is unlikely, this is particularly risky following a rapid detoxification without the necessary psychosocial interventions also being followed.

Representations in Swindon are in line with national performance which is a positive indication of service efficacy. Representations among non-opiate and alcohol treatment are slightly higher, again highlighting the need for joint working with this client group.

*Figure 45: Swindon drug treatment representations*76

<table>
<thead>
<tr>
<th>Local</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opate</td>
<td>79.7%</td>
</tr>
<tr>
<td>Non-opiate</td>
<td>95.1%</td>
</tr>
<tr>
<td>Non-opiate and alcohol</td>
<td>94.4%</td>
</tr>
<tr>
<td>All</td>
<td>87.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trend in performance 2013-14 to 2015-16</td>
<td></td>
</tr>
<tr>
<td>Opiate</td>
<td>Opiate</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

5.3.3.7. **Shared care**

In Swindon part of our substance misuse service is provided by GP practices in conjunction with CGL substance misuse service. The GPs are responsible for the prescribing and medical checks on clients and CGL are responsible for the psychosocial support. In essence both parties together with the client work to achieve recovery. The GPs are responsible for the physical health of the patients together with any harm reduction advice particularly around blood borne viruses.

In Swindon, historically there have been 9 practices providing shared care. At present there are 7 practices actively providing this service. Since the CGL (formerly CRI) took over the service in April 2014 there has been a decrease in the numbers of clients in Shared Care. This decrease was partly due to changes in the Substance Misuse providers clinical working practice. Since quarter 4 2015-16 there has been a slight increase in numbers in shared care treatment.

*Figure 46: Number of clients accessing shared care in Swindon April 2014 - September 2015*77

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients in shared care treatment</td>
<td>274</td>
<td>174</td>
<td>94 **</td>
</tr>
</tbody>
</table>

The advantages of shared are that it normalises substance misuse treatment and engages clients back into using mainstream services. For clients with an already established relationship with their

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76 Swindon Adult Drugs Joint Strategic Needs Assessment Support pack 2017-18
77 Swindon Borough Council shared care payments
GP the on-going support they receive is helpful both during and after treatment. It also provides an alternative resource should clients, for whatever reason, disengage with the substance misuse service. The GP can often work together with the substance misuse service to re-engage the client. Having a shared care provision also provides additional clinical capacity for substance misuse within Swindon.

All GPs providing shared care should have achieved a RCGP Certificate in the Management of Drug Misuse Part 1 or 2 or equivalent training.

5.3.4. Harm Reduction

5.3.4.1. Needle Exchange

A Blood Borne Virus (BBV) is transmitted when blood from an infected person gets into the bloodstream of another. It has been shown that Injecting Drug Users (IDUs) are at increased risk from BBVs due to the risks associated with their injecting behaviour such as sharing needles and injecting paraphernalia, frequency of injection, repeated injecting with used needles and inadequate cleaning of injecting paraphernalia.

There are 13 pharmacies that are currently delivering Needle Exchange services across Swindon. Over the last 3 years, the number of interactions at needle exchanges has increased. In December 2014 the type of syringe supplied in packs was changed due to the line being discontinued. Following consultation from both the pack provider and CGL, a suitable alternative was identified with the additional benefits of the new syringe being a low dead space product. Clients reported back to CGL that the new syringes blunted more quickly, as the product is designed for single use this is not considered a defect and supports the safer injecting message of “one hit, one syringe”. This appears to have changed client behaviour, after an initial drop in needle provision between February and April 2015, the number of visits to needle exchange has increased as well as the number of needles distributed.

Figure 47: Swindon community pharmacy needle exchange interactions April 2013 - December 2016

78 PharmOutcomes Needles Exchange Standard report full service delivery Dec 2016
As the personal information provided at pharmacies is anonymous, we are not able to say with certainty whether this is due to more clients presenting to needle exchange, or more frequent visits.

123,210 syringes were distributed through 9,682 visits to pharmacy needle exchanges in between 1st January 2016 to 31st December 2016.

Figure 48: Pharmacy Needle exchange visits Jan - Dec 2016

<table>
<thead>
<tr>
<th>Pharmacy Name</th>
<th>Number of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boots Pharmacy (Branch: 0264 - Brunel)</td>
<td>3723</td>
</tr>
<tr>
<td>Lloyds Pharmacy (Branch: 0559 - Park South)</td>
<td>1799</td>
</tr>
<tr>
<td>Rowlands Pharmacy (Branch: 1297 - Sussex Square)</td>
<td>1258</td>
</tr>
<tr>
<td>Boots Pharmacy (Branch: 1419 - Penhill)</td>
<td>774</td>
</tr>
<tr>
<td>Rowlands Pharmacy (Toothill)</td>
<td>731</td>
</tr>
<tr>
<td>Rowlands Pharmacy (Branch: 1298 - Kingswood)</td>
<td>508</td>
</tr>
<tr>
<td>Boots Pharmacy (Branch: 6525 - Orbital)</td>
<td>350</td>
</tr>
<tr>
<td>Rowlands Pharmacy (Rodbourne)</td>
<td>193</td>
</tr>
<tr>
<td>Tesco Instore Pharmacy (Ocotal Way)</td>
<td>164</td>
</tr>
<tr>
<td>Lawn Pharmacy</td>
<td>112</td>
</tr>
<tr>
<td>Sparcells Pharmacy</td>
<td>62</td>
</tr>
<tr>
<td>Lloyds Pharmacy (Branch: 6495 - Victoria Road)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>9682</strong></td>
</tr>
</tbody>
</table>

Boots Brunel in the town centre is consistently the pharmacy facilitating the greatest number of interactions. It is also the main provider of supervised consumption suggesting its town centre location is convenient for clients. Park South, Penhill and Sussex Square are also the most common providers of needle exchange services and they have also seen substantial increases in interactions.

The ethnic diversity remained unchanged since consistent recording began from April 2013. Over 98% of those attending needle exchange identified as White British. While there are a range of other ethnicities identified, the small proportions makes it difficult to any conclusions or trends from this.

Gender has also remained consistent with 90% of interaction with needle exchange pharmacies being males and the remaining 10% being females. This is inconsistent with the prevalence of females in opiate treatment being around 25%. This may be due to females being more reliant on secondary distribution than males, or that the face to face nature of a local community pharmacy is off putting for females.

The age profile of clients is of increasing importance in monitoring client cohort change in opiate use. The expectation has been that 1980’s heroin epidemic clients are now aging and accessing treatment services, therefore the age of those accessing needle exchange should be older and the need decreasing. As the recent needle exchanges have increased in volume and the data is looking

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79 PharmOutcomes Needles Exchange Standard report 01012016 - 31122016
at visits rather than tracking individuals, changes could be down to more frequent visits rather than a change in cohort.

Reporting on sexuality has remained low as over 95% of interactions had left this field blank. There is a slight increase in those interactions as identifying as homosexual, but the small volumes make it difficult to gain any insights.

In order to facilitate availability in syringes at times and places convenient to clients, a broad range of opening times is thought to be beneficial. The main needle exchange provider at Boots Brunel (39% of interactions) does have Sunday opening hours. However Lloyds Park South, Rowlands Sussex Square, Boots Penhill and Rowlands Pharmacy Toothill, providing 52% of needle exchange interactions, are all closed on Sunday.

CGL offer a broader range of safer injecting materials which are not included in community pharmacy provision including water ampoules and foil. Between September 2015 and October 2016 146 clients visited the CGL needle exchange 17% of which were female compared with the 10% female seen in community pharmacy exchanges. Work is ongoing to appropriately identify and record the substance being injected and this will be used to inform needle exchange pack contents.

The changing needs and challenges of the Needle Exchange Service are:

- Increase in uptake of needles being due to change in behaviour or change in cohort size.
- Increase in cost associated with increased demand
- Unknown need for image and performance enhancing drug injectors
- Needs of NPS users who inject
- Lack of returns of the used needles
- Increase in participating pharmacies particularly in areas of currently poor coverage and ensuring 7 day a week availability.

5.3.4.2. Blood-borne Viruses

Risky injecting behaviour, such as sharing needles & other paraphernalia, among vulnerable drug users puts them at an increased risk of getting HIV, hepatitis C (HCV), hepatitis B (HBV) and other infections. Injecting drug use is a declining feature of most areas in the UK, however the Southwest region continues to have increased prevalence of injecting drug use leading to higher risk factors for the transmission of HCV. As part of health protection interventions, provisions of methadone and sterile injecting equipment, benefit the users and the communities through long-term health savings.

This underlines the need to ensure the treatment system maintains the ability to identify, and make use of, the opportunities for regularly offering tests to those at risk. Dry Blood Spot Testing for hepatitis C (HCV) and hepatitis B (HBV) is available for all clients who are identified as at-risk of blood-borne viruses.

In Swindon the number of people tested for Hepatitis C has tended to be low in comparison to national and regional rates. However, in the last year this has been addressed and in Sept 2016 the number of opiate clients who have not got a record of Hepatitis C Virus testing as a proportion of all clients in treatment who were eligible to receive one was 9.6% compared to 17.9% nationally.
However, the number of clients offered and received a hepatitis B vaccination is low in comparison to national figures. The percentage of clients who have no record of a Hepatitis B vaccination course completed as a proportion of all clients in treatment who were eligible to receive it was 81.7% compared to 71.9% nationally.

Approximately 11% of those in treatment for opiate or crack use have a positive diagnosis of hepatitis C and a similar proportion in treatment for alcohol are also Hepatitis C positive. This equates to about 74 clients.

### 5.3.4.3. Opiate Overdose and Naloxone

The provision of naloxone to at-risk service users is thought to have a positive effect on limiting the number of overdose deaths. Naloxone, the overdose antidote, can potentially prevent an overdose from being fatal. Due to the success of the intervention, continuing the provision of naloxone will need to be part of a continued strategy to reduce drug related deaths.

In 2015/16 104 Naloxone pens were issued. 103 to service users and 1 to another family member. 29 pens were reissued. 1 because the kit had expired, 16 because the kit was lost, and 12 were used.

Information received from the South Western Ambulance Service highlights the number of occurrences of opiate overdose where naloxone is administered to a patient. However, as SWAS is transitioning the methods by which it records patient care information from August 2016, no trend information can be reliably informed at present.

The data does show some clustering of naloxone administration, with the April 2016 cluster aligning with a drug alert for high heroin purity circulated in the same period. Further work should be undertaken to inform the drug alert system with information available from the ambulance service.

### 5.3.4.4. Emerging drug trends

#### Prescription only medication

The proportion of the treatment population who were seeking treatment for prescription only (POM) or over the counter (OTC) medication has reduced from 122 clients in the previous year to 101 in 2015/16, this remains broadly in line with the national picture.

No prevalence estimates for POM or OTC exist, however data from the National Treatment Agency suggests that 49.7% of those leaving treatment reported problems with POM or OTC medicines alone, this suggests the impact of POM/OTC on successful treatment should be considered as a factor.

#### Image and Performance Enhancing Drug (IPED) use

Current provision in pharmacy needle exchange has been based around principally an intravenous opiate using client base. Steroid injectors require different equipment and advice in order to facilitate harm reduction and safer injecting practice. Nice Guidance PH52 recommends that syringes and specialist advice is available for those who inject image and performance enhancing drugs (IPED), but acknowledge that there is a lack of evidence about the number of people who inject
these drugs, how this group uses needle and syringe programmes and the effectiveness and cost effectiveness of providing programmes to these groups.\(^{80}\)

In response to this, Swindon CGL provided an extended range of equipment at Temple Street and gave specialist IPED advice as part of a pilot project to soft market test need in Swindon. This ascertained the types of advice individuals were seeking, the types of equipment which were in demand and to start making contacts with those who were actively using steroids. At the end of the pilot, 6 clients were in treatment with steroids recorded as a problem drug (though not the primary drug of problem substance). All of the clients were males between the ages of 35 – 44, 4 disclosed their sexuality as heterosexual while 2 preferred not to say. In all, 8,739 needle exchange items were given out between 26th September 2015 and 26th September 2016 associated with steroid use, however due to the paper based recording systems we cannot automatically discern the number of clients who were steroid injectors.

**Chemsex**

“Chemsex” is used in the United Kingdom to describe intentional sex under the influence of psychoactive drugs, mostly among men who have sex with men. It refers particularly to the use of mephedrone, γ-hydroxybutyrate (GHB), γ-butyrolactone (GBL), and crystallised methamphetamine. These drugs are often used in combination to facilitate sexual sessions lasting several hours or days with multiple sexual partners.\(^{81}\)

This has been highlighted as a public health concern, not only due to the risks taking these substances pose, but also enhanced risk of blood borne virus transmission and sexually transmitted disease. The client group who attend extended sex sessions can be an ultra-high risk group of males as the risk of HIV, Hepatitis, Gonorrhoea and Syphilis is high combined with higher numbers of sexual partners who are interacted with.

This year equality leads have highlighted concerns that chemsex activities are easy to dismiss, as they occur in relatively small populations and can appear distasteful as a subject to some. While there is awareness within the LGBT community of the destructive force of these activities, equality leads had concerns around lack of knowledge of locally accessible services. While the community may be small presently, Swindon has the aspiration to become a small city with a diverse population, there are a variety of needs which accompany this.

The Terrance Higgins Trust in its joint work with the GWH has witnessed an increase in problems associated with chemsex, there is now a referral pathway from the sexual health clinic at GWH to drug treatment services.

With a small Lesbian Gay Bi-Sexual Transgender (LGBT) scene publically present in a small number of venues, opportunities to publically engage are limited- events such as PRIDE need to be capitalised upon. There are anecdotes to suggest a growing BDSM (bondage, discipline, dominance, submission,

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\(^{81}\) McCall H et al What is Chemsex and why does it matter? (2015) BMJ [http://www.bmj.com/content/351/bmj.h5790](http://www.bmj.com/content/351/bmj.h5790)
sadism, masochism) scene in Swindon, this tends to occur in private residences but may also occur in public places if frontline staff were able to gain good quality intelligence.

Anecdotal observations are that chemsex clients tend to be males, aged 24-35, professionally employed, routine travel fairly widely i.e. London for weekends, able to privately fund for harm reduction methods such as PREP (not currently funded publically). However we have no insight of any inequalities within groups engaged in chemsex. Terrance Higgins trust has undertaken work with independent venues within Swindon in order to access these difficult to reach groups.

Very low numbers reporting their sexuality in needle exchange services in Pharmacies (17 of 12,509 exchanges over 18 month period reported sexuality of bi-sexual or other, none recorded homosexual). While this is self-reported and is not an accurate reflection of uptake, pharmacy needle exchange is designed for Opiate injectors. More diverse clients are being seen in Needle Exchange Services at Sanford Street (now Temple Street) as the Never Share range has proved effective for harm reduction in chemsex sessions involving multiple partners.

Work is on-going to monitor diversity in services likely to be accessed by chemsex clients, and also to establish links between drug treatment services and the Sexual Assault Referral Centre (SARC).

5.3.4.5. Smoking cessation
CGL have approximately 400 clients on their caseload who are self-reported smokers. Their caseload includes pregnant women, parents with children, clients diagnosed with chronic obstructive pulmonary disease and clients with serious mental health conditions.

Of these 400 clients approximately 40-50 clients are reported as being engaged and motivated to quit smoking. Work is currently being undertaken to scope how the most convenient and effective stop smoking support can be made available for clients of CGL who wish to quit.

The plan is to develop a stop smoking pathway for drug and alcohol service users. We are working towards setting up stop smoking clinics based at CGL for clients, carers and family members to access.

5.3.4.6. Dual Diagnosis
A significant proportion of problem drinkers will also have mental health problems. This combination is associated with high levels of suicide, self-harm and violence to others and can make clients difficult to engage in services or treat effectively.

Dual diagnosis has now become a standing agenda item on the Harm Reduction Drug Related Deaths Group. The aim is to ensure that strategies, policies and procedures are developed, implemented and fit for purpose. A dual diagnosis pathway and network has been developed.

An operational multi-agency group has also been established to monitor implementation of strategies and policy and review individual cases. AWP will take the lead as provider of services for those with dual diagnosis and will work with other provider key workers to provide optimal support to individuals. Regular joint training sessions between the community mental health and Substance Misuse Teams take place. In addition AWP hold a multi-agency learning meeting where individual cases can be brought and reviewed where there are concerns.
CGL, Swindon’s local substance misuse treatment service, report that just over 13% of their current clients have been identified as having a significant mental health problem, while the higher number are within the drug treatment service (113 clients, 13% of drug treatment population) a slightly higher proportion with a dual diagnosis are within the alcohol service (56 clients, 16% of alcohol treatment population). A third of clients across drug and alcohol treatment services with dual diagnosis are female, with a higher proportion of these accessing drug treatment. The age distribution of dual diagnosis also mirrors the general age profile of services with the drug service treating a greater proportion of younger clients compared with the alcohol service.

An audit undertaken by AWP six years ago found that 30% of those in inpatient services, 15% of those under the intensive team and 40% of those under the care of the early intervention team had a dual diagnosis. The most common co-existing substances are alcohol and cannabis.

5.3.5. Drug related deaths
Nationally recorded rates of drug-related deaths (DRDs) have shown marked increases in recent years. This high number of DRDs partly reflects the fact that the population of injecting drug users in England since the ‘epidemic’ of the 1980s is growing older. People with long histories of drug dependency are more likely to be in poor health and to engage in dangerous injecting behaviour, and are at greater risk of dying from overdose. Deaths often involve a combination of drugs as well as opioids, with alcohol and stimulants frequently mentioned on death certificates. Deaths involving novel psychoactive substances (sometimes referred to as ‘legal highs’) have also increased nationally in recent years.

The definition of a drug related death we use locally is very broad and includes:

- Deaths immediately following drug misuse: due to toxicity or dose, resulting in respiratory failure, cardiac arrest, blockage of airways, acute respiratory distress etc.
- Death following soon after and as a consequence of drug misuse but where the cause of death is not the drug itself but drug misuse is a complicating factor. This could include kidney failure, hyperthermia, liver failure, stroke, septicaemia, endocardia and respiratory distress.
- Death as a consequence of the influence of drugs e.g. risky behaviour, attempt to obtain drugs, accidents etc.
- Deaths as a delayed consequence of drug misuse, e.g. HIV, hepatitis brain damage, gangrene etc.

Substances consider relevant in this definition:

- Heroin, methadone, other opioids
- Cocaine, crack, amphetamine, ecstasy
- LSD, other hallucinogens
- Volatile substances
- Cannabis
- Benzodiazepines – where they are used illicitly or with alcohol
- Alcohol
- Novel Psychoactive substances

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82 CGL Project summary report October 2016
What we do to prevent drug related deaths

Many drug overdose deaths are preventable. We seek to ensure that appropriate practices are in place, along with the policies and protocols to support them, to prevent overdoses and subsequent fatalities.

- Treatment engagement along with continuity of treatment between services and relapse prevention interventions can reduce the risk of overdose.
- Services, including needle and syringe programmes, provide service users with information and advice on the risk of overdose. Services offer steps to reduce that risk, including support for safer injecting practices and to stop injecting.
- Staff in services have a good understanding of high-risk practices, high-risk groups and high-risk stages (e.g. prison release). Practitioners pay attention to the elevated risk for those in treatment who are using on top, regularly overdosing, are drinking excessively, live alone in temporary accommodation or are homeless, or as a result of smoking-related diseases have compromised respiratory systems.
- High risk clients are discussed in-service at daily morning briefings, weekly clinical meetings and monthly individual supervision. Joint working with key partner agencies is ensured by attendance at Dual Diagnosis multi-agency meetings, rough sleepers /homelessness panel, sexual exploitation panels, risk enablement panels, Probation meetings, child protection meetings and fortnightly MARAC meetings.
- Service users are made aware of the available pathways back into treatment if they need to re-enter at any time.

Responding to overdose

When an overdose occurs, a rapid first aid response (including the use of naloxone - which blocks and reverses the effects of opioids) can reduce the risk of the user dying. Staff are provided with information and training on recognising overdoses, calling emergency services and delivering basic life support. Services offer overdose training and naloxone to opioid users and other key stakeholders including hostel staff. We are currently reviewing the availability of naloxone in Swindon to potentially widen its availability.

Reducing risks of prescribed medications

Opioid substitution medicines can be diverted from treatment for misuse by people who have never used opioids or have inadequate tolerance to their dangerous toxic effects. Such opioid medicines have also on occasions poisoned children. In both circumstances fatal overdose can easily happen.

Services have agreed policies and practices in place to mitigate these risks, including use of supervised consumption.

Reducing the risk from changing settings and stages of treatment

There is a significantly elevated risk of overdose for people in the immediate period after being released from prison. Individuals are also at risk when leaving residential rehabilitation programmes or inpatient treatment, after completing a drug detoxification programme, and after they stop using naltrexone.
In order to prevent overdose at times of change, services promote and support relapse prevention, offer pathways in to (or back in to) treatment when needed, and providing access to suitable aftercare.

**Reducing mortality risks from delayed or chronic drug-related health problems**

Illicit drug use puts people at risk of developing long-term health complications that could lead to death. Injecting heroin, cocaine and other drugs can cause fatal conditions, such as the complications of deep vein thrombosis (DVT), serious tissue infections, blood-borne and other viral infections (particularly hepatitis C and B infections and HIV). Smoking drugs such as crack, heroin and tobacco can lead to life-threatening respiratory and cardiovascular disease. Fatal liver disease can arise from a combination of excessive alcohol use, poly drug use and viral hepatitis infection.

To mitigate these risks CGL offer a range of interventions including promoting testing and vaccination for blood borne viruses, provide safer injecting advice and giving users’ information about the wider health harm associated with their drug use.

**Using local early warning and alert systems**

By using a local early warning and alert systems the DAAT can quickly identify and share information about contaminated and adulterated drugs, changes in strength and formulation, new substances, and changing trends in substance use. The system assess the quality of intelligence coming in and the levels of likely harm, and disseminate information accordingly without causing unnecessary alarm or information overload.

**What we do to review and learn from drug related deaths**

In Swindon we have a Drug Related Death Group that meets quarterly to review any drug related deaths that have occurred during that quarter. The group is chaired by Public Health and has representation from the Senior Commissioner (Drugs & Alcohol), CGL management team, Wiltshire police, Housing and Housing providers, Mental Health Services - AWP, Probation, and Safeguarding Adults Team.

There is a process in place when a Drug Related Death occurs, the agency who hears about the death should inform, Public Health and the Senior Substance Misuse Commissioner about the death as soon as possible. That agency will then complete an agency enquiry form which will include a full review of the involvement of the service with the client and any other relevant information. The drug related deaths are logged on the drug related death log held by the DAAT. The name of the deceased will be shared with other members of the Drug Related Death Group and any further information those agencies have on the individual are forwarded to the commissioner. All cases are then fully discussed at the quarterly Drug Related Death meeting.

The purpose of the reviews is threefold:

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard drug users.
- To identify clearly what those lessons are and how they will be acted upon and what is expected to change as a result and as a consequence.
To improve inter-agency working to better safeguard drug users.

The review may also identify gaps in service provision for substance misusers and identify significant changes in illicit drug use.

Any cases that are considered to have wider implications can be referred to the Community Safety Partnership Manager who may consider the launch of a serious case review.

In addition to individual agencies informing the public health department of drug related deaths, the department is also informed by the coroner of drug related deaths. This will be after the inquest has been completed so is not as timely as the deaths informed by agencies. However, it is useful to cross reference.

Public Health are informed of deaths by suicide and reviews of these cases are also undertaken and cross referenced where appropriate with the drug related death log.

Figure 49: Swindon drug related death data April 2013 - June 2016

<table>
<thead>
<tr>
<th>Age range</th>
<th>Deaths where substance use is suspected to have contributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>0</td>
</tr>
<tr>
<td>18 - 24</td>
<td>0</td>
</tr>
<tr>
<td>25 - 34</td>
<td>10</td>
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<tr>
<td>35 - 44</td>
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<td>45 - 54</td>
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<td>55 - 64</td>
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<td>&lt;5</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Deaths where substance use is suspected to have contributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>9</td>
</tr>
<tr>
<td>Male</td>
<td>30</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
</tr>
</tbody>
</table>

Figure 50: Swindon drug related death data April 2013 - June 2016

<table>
<thead>
<tr>
<th>Deaths in period where substance use is suspected, not confirmed as cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
</tr>
<tr>
<td>2014/15</td>
</tr>
<tr>
<td>2015/16</td>
</tr>
<tr>
<td>Q1 2016/17</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>

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83 Swindon drug related deaths as recorded by DAAT to inform harm reduction drug related deaths meeting, deaths reported by CGL and partner agencies - these are not a complete record of all drug deaths.

84 Swindon drug related deaths as recorded by DAAT, deaths reported by CGL and partner agencies – these are not a complete record of all drug deaths.
5.4. Alcohol misuse adults

5.4.1. Economic review

Overall alcohol harm cost society £21 billion a year with the costs to the NHS at £3.5 billion.\(^{86}\)

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\(^{85}\) Swindon drug related deaths as recorded by DAAT to inform harm reduction drug related deaths meeting, deaths reported by CGL and partner agencies - these are not a complete record of all drug deaths.

\(^{86}\) From Evidence into Action: opportunities to protect and improve the nation’s health Public Health England October 2014

Slightly outside the scope of this needs assessment, if only because we have little control locally, it is still interesting to briefly summaries the debate regarding taxing alcohol and minimum pricing.

Many studies which have attempted to assess the “cost of alcohol” recognise the difficulties and limitations in doing this. The government regularly cites the cost of alcohol to England and Wales: as being £21 billion. This only takes into account external costs i.e. the costs imposed by drinkers upon others and excludes any personal impact. Organisations such as the Institute of Alcohol Studies have argued that this does not reflect the true cost. The revenue generated in England and Wales by duty imposed on alcohol is £9 billion. Less than half the costs that Government cite above. The Institute for Alcohol Studies suggest that higher alcohol taxes can be justified on the basis of the harm drinking causes wider society alone, without considering the impact on the drinker themselves.

On the other side of the debate, The Institute for Economic Affairs (IEA) produced a discussion paper in 2015, written by Snowdon, that argues that the government figure of £21 billion takes into account costs that are not borne directly by the government and that only the direct costs to the NHS, police, judiciary, prison service and benefits system are true costs to the taxpayer. They claim that taking into account just this narrow measure of cost i.e. direct cost to the tax payer the figure is in the region of £3.5 billion.

Putting aside the wrongs and rights of definitions, the IEA paper is interesting because it estimates the cost of alcohol by different public services.

The paper estimates the costs to the tax payer (excluding personal costs borne by the perpetrator or victim) of alcohol related crime (including violent crime, other crime such as theft, robbery or burglary, criminal damage and sexual offences) and drink driving costs equate to £1.6 billion in 2015.

The paper estimates the cost of alcohol-related harm to the NHS including alcohol-attributable admissions when the primary diagnosis was partly or wholly alcohol attributable, outpatient appointment, accident and emergency attendances (including ambulance journeys), GP and practice nurse attendances and other health costs such as treatment services, counselling, alcohol related drug prescriptions and other primary care services equates to £2 billion. The paper points out that this is less than other recent estimates and outlines the main reasons for this include methodological weaknesses in previous studies which they claim to have led to over estimates. These weaknesses include:

- the inclusion of alcohol-related conditions where the secondary diagnosis was alcohol attributable
- the premises that 35% of A & E attendances are alcohol-related which they claim is based on a questionable survey
- the evidence shows that heavy drinkers do not have more GP/practice nurse consultations than the rest of the population

The paper estimates the cost to the tax payer of welfare payments is just under £3.8 billion.

88 Alcohol and the public purse – do drinkers pay their way? Christopher Snowdon September 2015  IED Discussion paper No 63
Figure 53: Cost of alcohol to the tax payer estimated by Snowdon (2015)\textsuperscript{89}

<table>
<thead>
<tr>
<th>Cost of alcohol to the tax payer (estimated by Snowdon 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td><strong>Gross Cost</strong></td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Crime</td>
</tr>
<tr>
<td>Health</td>
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<tr>
<td>Welfare</td>
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</table>

Snowdon therefore concludes that there is no justification for increase duty as he claims that the generation of revenue from duty on alcohol more than covers the cost of alcohol to the tax payer.

Public Health England, the Royal College of GPs, Royal College of Physicians all support the concept of minimum pricing for alcohol as a harm reduction rather than income generation measure. Meier et al found that introducing taxation based on product value, alcohol-content-based taxation or minimum pricing would impact on the most harmful drinkers rather than moderate drinkers and tackle some of the health inequalities experienced by low income groups\textsuperscript{90}.

Regardless of the impact of increasing tax or introducing minimum pricing we should be aware of the different estimates and measures of the cost of alcohol harm particularly if we are expecting cost related savings of particular interventions.

In 2016 Public Health England undertook a review of the Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies\textsuperscript{91}. They estimated that the economic burden of alcohol is substantial with estimates placing the annual cost to be between 1.3% and 2.7% of annual GDP. The report looks at three key influencers of alcohol consumption: affordability (price), availability (ease of purchase) and acceptability (social norms) and evaluates the effectiveness and cost effectiveness of these policy approaches. The report found that the most effective and cost effective interventions are:

- A combination of Minimum Unit Price alongside increases in taxation of alcohol.
- Regulation of the marketing of alcohol.
- A sufficient reduction in the hours during which alcohol is available for sale, particularly late night level on-trade sale.
- Enforcing legislative measures to prevent drink driving.

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\textsuperscript{89} Alcohol and the public purse – do drinkers pay their way? Christopher Snowdon September 2015 IED Discussion paper No 63


Health interventions aimed at drinkers who are already at risk e.g. identification and brief advice and specialist treatment for harmful drinkers.

Consistent policy mix.

Interventions that were less effective include:

- Ban on alcohol sales below the cost of taxation
- Restrictions on price promotions
- Public private voluntary pledges to reduce availability
- Providing information and education (although the public has a right to be informed)
- Managing the drinking environment has limited effectiveness

5.4.2. Inequalities and the harms of alcohol misuse

According to the Marmott Report 2010\(^92\) alcohol consumption has an inverse social gradient. Those with higher incomes tend to consume more alcohol, more often than those on lower incomes. They are more likely to exceed the recommended limits on alcohol consumption. However, the report points out that although those on lower incomes are more likely to be abstinent when they do consume alcohol, they are more likely to have problematic drinking patterns and dependence than people on higher incomes. In England across all regions, hospital admission for alcohol-specific conditions for both males and females is associated with increased levels of deprivation. Rates of admission for the most deprived quintiles are particularly high.

The Marmott Review recommends the implementation of evidence-based programme of ill health preventive interventions that are effective across the social gradient by focusing public health interventions such as alcohol reduction on reducing the social gradient.

The data shown below is from the LAPE data released June 2015. This shows the alcohol specific mortality rates by deprivation decile. This clearly demonstrates that alcohol specific mortality is higher for those from more deprived communities.

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\(^92\) Fair Society Healthy Lives The Marmott Review: - strategic review of health inequalities in England post-2010
The graphs for alcohol related morbidity, hospital admissions for alcohol related conditions look very similar to that above with a strong correlation between deprivation decile and rate. However, for those under 18 admitted to hospital for an alcohol specific condition the picture is less clear amongst the top five most deprived deciles although there was still a clear distinction between the rates of those in the most deprived 5 deciles and those in the 5 least deprived deciles, with those in the most deprived deciles being admitted more frequently.

accessed 23/01/17
Figure 55: Persons under 18 admitted to hospital for alcohol specific conditions by deprivation decile\(^{94}\)

According to national research the Lesbian, Gay, Bisexual and Transgender population may actually consume less alcohol that the heterosexual community. This is because they are more likely to favour illicit substances. However, it is still essential that drug and alcohol services ensure that they are meeting the needs of all regardless of sexual orientation.

Research and statistics have consistently shown that people from most minority ethnic groups have higher rates of abstention and lower rates of consumption than the majority white ethnic group. However, drinking varies greatly both between and within minority ethnic groups and across gender and socio-economic group, resulting in a very complex national picture of alcohol consumption and alcohol-related harm across ethnicity\(^{95}\).

5.4.2.1. Alcohol consumption in pregnancy/ foetal alcohol syndrome

A government review of alcohol consumption gives precautionary guidance that it is best to avoid alcohol consumption during pregnancy.

The Chief Medical Officers’ guideline\(^{96}\) is that: “If you are pregnant or planning a pregnancy, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.” Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.

\(^{94}\) http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/7/gid/1938132984?pat/par/E12000009/ati/102/are/E06000030/iid/90856/age/173/sex/4


\(^{96}\) CMO Alcohol Guidelines Review – A summary of the evidence of the health and social impacts of alcohol consumption; CMO Alcohol Guidelines Review – Mapping systematic review level evidence; both reviews were written by the Centre for Public Health, Liverpool John Moores University
Most women either do not drink alcohol (19%) or stop drinking during pregnancy (40%)\(^7\). The risk of harm to the baby is likely to be low if a woman has drunk only small amounts of alcohol before she knew she was pregnant or during pregnancy. Women who find out they are pregnant after already having drunk during early pregnancy, should avoid further drinking, but should be aware that it is unlikely in most cases that their baby has been affected.

One of the risks of consuming alcohol during pregnancy is that the baby could be affected by Foetal Alcohol Spectrum Disorder which is the umbrella term for a range of preventable alcohol-related birth defects which include Foetal Alcohol Syndrome\(^8\). The effects on the child can be mild or severe, ranging from reduced intellectual ability and attention deficit disorder to heart problems and even death. Many children experience serious behavioural and social difficulties that can last throughout their life.

The exact prevalence of FASD in the UK is not known. International prevalence studies undertaken elsewhere indicate that that at least 1 in 100 children are affected. This would equate to at least 6,000 to 7,000 babies born with FASD each year in the UK and 30 in Swindon\(^9\).

Alcohol can have other effects besides causing FASD. It can reduce a woman’s chances of becoming pregnant and is also associated with an increased risk of infertility, miscarriage, premature labour and still birth.

Within the maternity department at Great Western Hospital there is a specialist midwife who co-ordinates the care of women who misuse substances including alcohol. There is a well-developed Care Pathway in place. Currently women are asked the number of alcohol units they consume at their first antenatal contact. Presently relatively few women disclose alcohol use compared to drug use. It may be more effective to use an alcohol screening tool rather than asking the number of units consumed.

5.4.3. Impact of alcohol misuse on ill-health
This section will examine the impact of alcohol specific hospital admissions over the period 2013/14 – 2015/16. Please see footnote below for an explanation of how hospital admissions are calculated\(^10\).

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\(^7\) UK figures from Infant Feeding Survey, 2010. A recent study (Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies; BMJ Open, 11 August 2015) shows that, 84% of mothers in the UK drank any alcohol in the first trimester of pregnancy. In the second trimester, 39% of mothers drank any alcohol. In the second trimester, 37% of mothers drank no more than 1 to 2 units weekly, 2% drank more than that, with median consumption at 0.8 units weekly. That compares with the first trimester - 28% of mothers drank no more than 1 to 2 units weekly, 56% drank more than that, with median consumption at 4 units weekly

\(^8\) National Organisation for Foetal Alcohol Syndrome UK.

\(^9\) Swindon rate based on 3000 births per year.

\(^10\) Calculating alcohol admissions
Attributable fraction values, or population attributable fractions, are the proportion of a health condition or external cause that is attributable to the exposure of a specific risk factor (such as alcohol) in a given population. Local Alcohol Profiles for England use attributable fractions to estimate the number of deaths and hospital admissions that are related to alcohol consumption.

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.

Indicator #6.01 measures the number of people admitted to hospital for alcohol-specific conditions. Although Swindon’s admission rate for this indicator is significantly lower than the England rate, detailed record level analysis of the admissions that make up this indicator provide useful insight into the local burden of ill-health from alcohol.

Alcohol specific hospital admissions for the Swindon CCG area were analysed for years 2013/14, 2014/15 and 2015/16 from data kindly provided by Swindon CCG.

5.4.3.1. Overview

The total number of alcohol specific admissions has risen from 996 in 2013/14 to 1,174 in 2014/15. Admissions have risen in most age groups for males and females with the notable exception of the under 21 age group.

The majority (around 60%) of admissions are because of mental and behavioural disorders due to the use of alcohol (codes F10). These include intoxication (F100), harmful use (F101), dependence

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The analyses described in this document relate to persons admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol specific code.

(F102) and withdrawal (F103). The two other main contributors are alcoholic liver disease (K70) and alcohol poisoning or other toxic effects (T510 and T519).

There is a clear deprivation gradient with more admissions (per 1,000) in the most deprived quintile than the least deprived.

The main admission diagnosis for males over 65 was common diagnosis was mental and behavioural disorders due to the use of alcohol - harmful use (F101), and admissions for this cause have increased 60% from 2013/14.

The main admission diagnosis for females under 40 was alcohol (ethanol) poisoning (T510) and admissions for this cause have increased almost 200% from 2013/14. This is highlights the need to focus on targeting women with messages about the risk of alcohol consumption in conjunction with the need highlighted above regarding to alcohol consumption during pregnancy.

There were most admissions on a Friday compared to other days of the week.

5.4.3.2. Analysis

Age and gender

The total number of alcohol specific admissions has risen from 996 in 2013/14 to 1,174 in 2014/15. Numbers have increased for males and females by similar amounts. There are approximately twice as many admissions for males than females.

Figure 57: Alcohol-specific hospital admission by gender

The number of admissions peaks for males and females between the ages of 41 and 50. Admissions have risen in most age groups for males and females with the notable exception of the under 21 age group.

102 Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
For those under 18 years of age the trend in hospital admissions has gone down consistently since 2006. The admission rate for those under 18 in Swindon is now in line with the national average, having been consistently significantly higher than the national average until recently.

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103 Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
104 Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
5.4.3.3. Alcohol-specific conditions

The majority (around 60%) of admissions are because of mental and behavioural disorders due to the use of alcohol (codes F10). These include intoxication (F100), harmful use (F101), dependence (F102) and withdrawal (F103). The two other main contributors are alcoholic liver disease (K70) and alcohol poisoning or other toxic effects (T510 and T519). There have been large rises in the numbers of admissions for these two conditions in the last three years. Please refer to figure 70 at the end of this report for a full list of codes and descriptions.

Figure 61: Alcohol specific hospital admissions by main alcohol-specific diagnosis\textsuperscript{106}

\textsuperscript{105} http://fingertips.phe.org.uk/profile/child-health-profiles/data#page/4/gid/1938132948/pat/6/par/E12000009/ati/102/are/E06000030/iid/90856/age/173/sex/4

\textsuperscript{106} Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
Note: the main alcohol-specific diagnosis is considered to be the one appearing in the primary diagnosis field or the first one appearing in the secondary diagnosis fields.

5.4.3.4. **Deprivation**

The Index of Multiple Deprivation 2015 has been used to explore the link between hospital admissions and deprivation. There is a clear deprivation gradient with more admissions (per 1,000) in the most deprived quintile than the least deprived. Because there are relatively small numbers of admissions when broken down into quintiles there is a lot of variation, particularly in the very high rate of admissions in quintile 4 in 2015/16.

*Figure 62: Alcohol-specific hospital admission rates by deprivation quintile*¹⁰⁷

The same deprivation gradient can be seen for the main alcohol-specific conditions, although again the quintile 4 admissions in 2015/16 make the picture less clear.

*Figure 63: Hospital admission rates by deprivation quintile for mental and behavioural disorders due to the use of alcohol*¹⁰⁸

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¹⁰⁷ Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
¹⁰⁸ Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
5.4.3.5. Focus on males over 65

In LAPE, Swindon was found to have a statistically significantly higher rate of admission episodes for alcohol-related conditions (narrow definition) for males over 65. There was an increase in admissions for this age group from 97 in 2013/14 to 139 in 2015/16. The following chart shows how the alcohol-specific admissions are distributed over different conditions. The most common diagnosis was mental and behavioural disorders due to the use of alcohol - harmful use (F101), which made up 35% of admissions for this age group compared to 24% overall and admissions for this diagnosis in the male over 65 age group have increased around 60% from 2013/14.

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109 Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
110 Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
5.4.3.6. Focus on females under 40

In LAPE, Swindon was found to have a statistically significantly higher rate of admission episodes for alcohol-related conditions (narrow definition) for females under 40. There was an increase in admissions for this age group from 105 in 2013/14 to 174 in 2015/16. The following chart shows how the alcohol-specific admissions are distributed over different conditions. The most common diagnosis was alcohol (ethanol) poisoning (T510) which made up 41% of admissions for this age group compared to 16% overall and admissions for this diagnosis in the female under 40 age group have increased almost 200% from 2013/14.

111 Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
5.4.3.7. Admission day

Data from 2014/15 has been analysed to examine the distribution of admissions over the days of the week. 19.4% of admissions occurred on a Friday and 15.2% on a Thursday. If admissions were evenly distributed, 14.3% of them would be on each day.

Although admissions were higher on a Friday this was for all different causes or diagnosis and not just for intoxication. Mental and behavioural disorders due to use of alcohol: acute intoxication made up a higher percentage of the hospital admissions over the weekend (but not Friday) – 28% on Saturday and 26% on Sunday compared to between 12% and 18% the rest of the week. Mental

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112 Swindon CCG Alcohol specific hospital admissions 2013/14, 2014/15, 2015/16
113 Swindon CCG Alcohol specific hospital admissions 2014/15
behavioural disorder due to use of alcohol: harmful use made up a larger percentage of admissions on a Monday and then decreased during the rest of the week. This may just reflect the different use of coding with intoxication more likely to be used at the weekend and harmful use during the week. If toxic effect of alcohol is also included then this would account for on average 66.6% of alcohol related admission during the weekend compared to 56% during the rest of the week.

The codes that are chosen may be influenced by the age of the patient. Younger people are more likely to be admitted at the weekend and may be more likely to be coded as intoxicated rather than harm effects. Those over the age of 80 are more likely to be admitted Monday to Thursday and potentially they are more likely to have an associated condition rather than being intoxicated.

*Figure 69: Alcohol specific hospital admission by age and day of admission*

The average length of stay was 3.5 days with the lowest length of stay 2.8 days from those admitted on a Tuesday or Friday and the longest length of stay being for those admitted on a Saturday 4.1 days.

The majority of those admitted are discharged the same day or the next day, with this ranging from 75% of those admitted on a Saturday being discharged by the end of the next day and 86% of those admitted on a Wednesday are discharged by the end of the next day. This shows that an individual admitted on a Saturday is more likely to have a longer length of stay than those admitted on other days (Thursday and Sunday had the next longest length of stay with 83% being discharged by the end of the next day).

5.4.3.8. Alcohol and older age

Analysis of the local hospital data showed that there were very few admissions for patients with a diagnosis of dementia and alcohol specific codes. During 2015/16 there were 761 emergency admissions due to a fall for those over the age of 65 years, 28 of these also had an alcohol specific diagnosis code but the specific diagnosis was not stated. This equates to under 4% of the admissions.

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114 Swindon CCG Alcohol specific hospital admissions 2014/15
Alcohol and older age – very few dementia/alcohol admissions, 4 % of admissions for falls for the over 65s had an alcohol specific code. 20 admissions for Korsakoff Syndrome relating to 13 patients 2013/14 – 15/16.

5.4.3.9.  **Korsakoff/Korsakov Syndrome**

Between 2013/14 and 2015/16 there were 20 admissions with a code for Korsakoff Syndrome (not necessarily as the primary diagnosis). These 20 admissions related to 13 individual patients. The majority of these were male over the age of 55 years.

*Figure 70: Alcohol-specific conditions*¹¹⁵

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD10 code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol-induced pseudo-Cushing's syndrome</td>
<td>E24.4</td>
</tr>
<tr>
<td>Mental and behavioural disorders due to use of alcohol</td>
<td>F10</td>
</tr>
<tr>
<td>Degeneration of nervous system due to alcohol</td>
<td>G31.2</td>
</tr>
<tr>
<td>Alcoholic polyneuropathy</td>
<td>G62.1</td>
</tr>
<tr>
<td>Alcoholic myopathy</td>
<td>G72.1</td>
</tr>
<tr>
<td>Alcoholic cardiomyopathy</td>
<td>H28.6</td>
</tr>
<tr>
<td>Alcoholic gastritis</td>
<td>K29.2</td>
</tr>
<tr>
<td>Alcoholic liver disease</td>
<td>K70</td>
</tr>
<tr>
<td>Alcohol-induced acute pancreatitis</td>
<td>K85.2</td>
</tr>
<tr>
<td>Alcohol-induced chronic pancreatitis</td>
<td>K86.0</td>
</tr>
<tr>
<td>Fetal alcohol syndrome (dysmorphic)</td>
<td>Q66.0</td>
</tr>
<tr>
<td>Excess alcohol blood levels</td>
<td>R78.0</td>
</tr>
<tr>
<td>Ethanol poisoning</td>
<td>T51.0</td>
</tr>
<tr>
<td>Methanol poisoning</td>
<td>T51.1</td>
</tr>
<tr>
<td>Toxic effect of alcohol, unspecified</td>
<td>T51.9</td>
</tr>
<tr>
<td>Accidental poisoning by and exposure to alcohol</td>
<td>X45</td>
</tr>
<tr>
<td>Intentional self-poisoning by and exposure to alcohol</td>
<td>X65</td>
</tr>
<tr>
<td>Poisoning by and exposure to alcohol, undetermined intent</td>
<td>Y15</td>
</tr>
<tr>
<td>Evidence of alcohol involvement determined by blood alcohol level</td>
<td>V90</td>
</tr>
<tr>
<td>Evidence of alcohol involvement determined by level of intoxication</td>
<td>Y01</td>
</tr>
</tbody>
</table>

5.4.3.10.  **Alcohol related conditions**

A review of current Local Alcohol Profile Data shows Swindon having particular issues in relation of hospital admissions for some demographic groups.

The table below show that for females, Swindon has significantly higher admission episodes than the national average. However, when we look at the number of females admitted for alcohol related conditions we are in line with the national average. This indicates that in Swindon we have higher than average readmissions. We are also in line with the national average when looking at the broad

¹¹⁵ International Statistical Classification of Diseases and Related Health Problems 10th Revision  
http://apps.who.int/classifications/icd10/browse/2010/en
definition of alcohol related admissions. As we saw above there is a strong correlation for these admissions and deprivation with those from most deprived areas having higher admission rates.

Figure 71: Admission episodes for alcohol-related conditions (Narrow) (Female)\textsuperscript{116}

Further analysis show that in fact it is females under the age of 40 who are pushing up the number of admissions for alcohol-related conditions. The graph and table below shows that in 2014/15 there were an additional 31 hospital admissions for alcohol related conditions (narrow) for females under 40 compared to 2013/14.

Figure 72: Admission episodes for Alcohol-related conditions (Narrow) - Under 40's (Female)\textsuperscript{117}

Swindon is also an outlier for admission episodes for alcohol related conditions (narrow) for those over 65 years of age. The rate of admissions rose in 2014/15 which showed Swindon as having higher rates of admissions that most of our comparator areas.

\textsuperscript{116} Swindon Local Alcohol Profiles https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132833/pat/6/par/E12000009/ati/102/are/E06000030/iid/91414/age/1/sex/2

\textsuperscript{117} Swindon Local Alcohol Profiles https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132982/pat/6/par/E12000009/ati/102/are/E06000030/iid/92316/age/286/sex/2
Figure 73: Admission episodes for alcohol-related conditions (Narrow) - Over 65's (Persons)

The map below shows the rate of hospital admissions for England by Local Authority. Swindon is one of only five areas with a high rate of hospital admissions for the over 65s. The increase in admissions from 2013/14 to 15/16 is entirely for males. Admissions for over 65’s is also strongly related to deprivation with those from more deprived areas having higher rates than those from the least deprived.

Figure 74: Admission episodes for alcohol-related conditions (Narrow) - Over 65’s – (Persons)

118 Swindon Local Alcohol Profiles https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132982/pat/6/par/E12000009/ati/102/are/E06000030/iid/92321/age/27/sex/4
119 Swindon Local Alcohol Profiles https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/8/gid/1938132982/pat/6/par/E12000009/ati/102/are/E06000030/iid/92321/age/27/sex/4
Swindon also has very high rates of admission for intentional self-poisoning by and exposure to alcohol condition (narrow). On this measure Swindon has been consistently high although there was a reduction in 2012-13 which was not sustained.

Figure 75: Local Alcohol Profiles for England Swindon 10.05 Admission episodes for intentional self-poisoning Alcohol

5.4.3.11. Liver disease

From 2001 – 2012, the number of people who died due to liver disease in England rose by 40% to 10,948. This is in contrast to other major causes of disease that have been declining\textsuperscript{121}.

\textsuperscript{120} http://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/4/gid/1938132848/pat/6/par/E12000009/ati/102/are/E06000030/iid/91418/age/1/sex/4

\textsuperscript{121} Anderson P (2007) The scale of alcohol related harm (Unpublished) Dep of Health
The graph and chart below show that the admission episodes for liver disease (broad) have been increasing in Swindon over the past few years. However, they are significantly lower than the national average. Further analysis of local data from GWH shows an increase of 21 admissions between 2013/14 and 2014/15 from 140 to 161. The average number of admissions per patient has remained stable at about 1.56 admissions per patient and the proportion admitted with liver disease as the primary diagnosis has increased roughly in line with the overall increase in admissions for liver disease. In short, there is no single definable cause for the increase from this analysis; however, this should continue to be monitored. The readmission for younger women was higher (2.2 admissions per person) but the numbers are fairly small.

5.4.3.12. **Cancer**

Admission episodes for alcohol related cancer have increased more rapidly in Swindon than nationally for males. Since 2006-2008 the rate in Swindon has risen from 34.93 per 100,000 to 41.19 in 2012-14. This equates to an additional 60 admissions. The rate for women has increased at a slower rate and is in line with the national average.

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5.4.4. Licencing and alcohol misuse

5.4.4.1. Licensing

In Swindon we have 335 on licenced premises (146 of which are within the SN1 area) and a greater number of off license premises. There is a cumulative impact policy in place around the Broad Green area which was highlighted as having a particularly high number of off-licenced premises in a small geographic area which were having a negative impact on the communities living in the area. Other areas which have a high proliferation of licenced premises include: Cricklade Road area which has a high number of off-licenses selling single-can, high-strength larger; Old Town which has a large number of on-licenced premises; and the bottom of the town centre which has a large number of vertical drinking premises.

The increase in single-can sales of high-strength lagers is currently an issue that is being targeted by the Licensing Authority and the police. There is a marking system in place so every can has to be UV pen marked to ensure traceability. This is now included in Swindon Licencing Policy. There is also a policy in place regarding the sale of legal highs that has been introduced into the licencing conditions for all new/review/variation applications. This prevents the sale of legal highs in off-licenses.

Swindon has fed into the national review on the licensing Act fees. Locally, all licensing fees have been reviewed and the current rates are available on the website www.swindon.gov.uk. The Swindon Licensing Statement has also been reviewed in 2015 and is available on the same website.

5.4.4.2. Future developments within licensing.

It has been recognised within Swindon that partnership working between agencies could be improved particularly with regard to data and intelligence sharing. A new Alcohol Tasking Group is planned which will enable multi-agency partners to work together on key projects such as applications become a Purple Flag town, a Local Alcohol Action Area, the introduction of Public Space Protection Orders and updating Designated Public Protection Orders and the possibility of introducing a late night levy. This may also include multi-agency training on licensing issues.

5.4.4.3. Licensing and Alcohol Misuse – Local Authority Best Practice

The following are some examples of how other local authorities are using the licensing system to tackle problems of alcohol misuse in their areas.

Voluntary Minimum Unit Pricing (MUP)

Central government had planned to introduce a minimum price per unit (40p) in their 2012 Alcohol Strategy. This would have effectively targeted the cheap, high-strength alcohol favoured by problem drinkers. Three-litre bottles of Frosty Jack’s, for example, can be purchased for £3.49. With a 7.5%ABV, one bottle contains 22.5 units of alcohol: considerably more than the weekly limit and priced at just 16p a unit. Minimum unit prices were trialled in British Columbia, whereupon they reduced consumption and hospitalisation rates.

127 “Should minimum unit pricing be introduced in the UK?”, Drinkaware, 2016 (https://www.drinkaware.co.uk/about-us/viewpoints/should-minimum-unit-pricing-be-introduced-in-the-uk/).
Excellence identifies price restrictions on alcohol as “the most effective way of reducing alcohol-related harm”.128 Despite the potential to reduce harm to problem drinkers, and the non-effect it would have on moderate drinkers, the national minimum unit pricing plans have failed to surface. However, some local authorities have implemented the idea on an informal basis. In Newcastle’s 2013-2018 Statement of Licencing Policy, they encourage applicants and existing licence holders to commit to an MUP of 50p. There is no consequence to a licence holder ignoring this – however, if they are found in review to have a negative impact on the licencing objectives, then they may receive a condition enforcing a 50p minimum.129 This negotiated, voluntary agreement between businesses and the local authority was well received and described as a means of ensuring quality in the city’s 400 venues.130

Other local authorities which have tried something similar include Blackpool Council, which has an agreement with pubs to sell drinks at a £1.50 MUP between Thursdays and Sundays.131 The Metropolitan Borough of Oldham reviewed 22 venues selling heavily discounted drinks and semi-enforced a 75p MUP (venues which did not comply would face other conditions such as extra door staff or only allowed customers to purchase two drinks at a time).132 Voluntary schemes are not ideal and can be challenged, but until a nationally-backed rollout of MUP it may be worth discussing.

Reducing the Strength (RtS)

Reducing the Strength is another voluntary initiative becoming increasingly popular nationwide, having begun in Suffolk in 2012. Targeted at street drinkers, it involves public health teams reaching out to off-licences and getting them to commit to stop stocking any drinks with an ABV above 6.5%.

LGA has produced detailed guidance on how local authorities can introduce Reducing the Strength schemes, highlighting the need to combine it with other initiatives and considering whether it’s the appropriate response to an area’s problems (rather than, say, intervening with individual retailers).133 There is also guidance on avoiding issues with competition law, which would forbid local authorities from banning specific consumer products.

Suffolk County Council stands out as a leader in reducing street drinking. In addition to implementing RtS, they invested in outreach workers which encouraged drinkers into treatment, and worked with the police to take action where there are regular disturbances. This is accompanied by a publicity

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132 Ibid.
campaign including a short film shown to retailers which highlighted the negative impact of street drinkers on all involved. They have produced great results: 90/138 off-licences participate (including supermarkets Tesco, Sainsbury’s and Morrisons), and the number of recorded street drinkers has fallen from 70 down to 20.\footnote{Ibid, p16.}

The London Boroughs of Camden and Islington have implemented RtS, and evaluated the short-term results with academics from the London School of Hygiene and Tropical Medicine.\footnote{’Evaluation of Reduce The Strength schemes in two London Boroughs’, \textit{Alcohol Policy UK}, June 2016 (http://www.alcoholpolicy.net/2016/06/evaluation-of-reduce-the-strength-schemes-in-two-london-boroughs.html)} After six months, several key findings emerged:

- They found a significant reduction in the number of off-licences stocking high-strength drinks: from 55% of retailers down to 18%.
- The median cheapest unit across all participating stores rose from 33p to 43p.
- Interviews found that many retailers were primarily motivated by ‘keeping the Council happy’, with some believing there was a possibility of improving the community via reduced antisocial behaviour.
- The primary reason for not participating was fear of losing a competitive advantage over nearby stores who chose not to participate. There was a perception that customers would just go somewhere nearby, and ambivalent feelings towards profit impacts: “\textit{In one way it’s good because you get more decent customers but you also lose trade}”.\footnote{’Reducing the Strength: a mixed methods evaluation of alcohol retailers’ willingness to voluntarily reduce the availability of low cost, high strength beers and ciders in two UK local authorities’, \textit{BMC Public Health} 16:448, May 2016 (http://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-016-3117-7).}

The longer-term impacts on health and crime cannot be measured yet, but this approach is worth considering in interacting with prospective and existing licence holders.

A Strategic Statement of Policy

Several local authorities emphasise using their Statement of Licensing Policy as a strategic document. Such Statements will make it clear what types of venues the local authority wants to see, and perhaps where too. By doing so, they can set out a clear, positive vision for what the night-time economy should be like. This may be explicitly tied in with other strategies, such as Economy and Regeneration, or Wellbeing.

For example, the City of Westminster states its preferences for new establishments: “high priority to the development of greater diversity in the types of entertainment and cultural activity on offer and in the age groups attracted to them... the council wishes to discourage drunkenness and to encourage the provision of more seating in premises which serve alcohol for people to sit and enjoy a drink and order food by table service, in place of open bar space which caters for high volume vertical drinking”.\footnote{’Statement of Licensing Policy’, \textit{City of Westminster}, January 2016, p6 (http://transact.westminster.gov.uk/docstores/publications_store/Licensing/statement_of_licensing_policy.pdf).} Placing these expectations can put the onus onto licence applicants to demonstrate how they will not negatively impact on the four licencing objectives. It may also aid...
Licencing Committees with understanding the Council’s wider intentions for health and development.

Best Practice Award Schemes

The licensing procedure can be used as an opportunity to introduce and promote various best practice schemes, such as Best Bar None. Best Bar None is an award backed by the Home Office which recognises the most responsibly managed and operated licensed premises in a local area. It is based around a partnership between local authorities and the licensed trade, with facilitation from Best Bar None staff. It began in 2003 in Manchester, and has since spread to dozens of cities in the UK and internationally.138

In addition to supporting the licensing objectives and creating a better environment, venues which join up will benefit from increased publicity and prestige. They can also receive other incentives: for instance, local authorities who run Best Bar None and a Late Night Levy can offer a 30% discount on these fees if they are participants of Best Bar None. Other incentives can include providing free/discounted security equipment and public liability insurance, as practiced by Durham County Council.139

Public Engagement

Proactively seeking the opinion of residents and community groups could help gather more representations to object to a licence application, or to measure the appetite for a new Cumulative Impact Policy. Westminster, Islington and some other authorities have a policy of writing to all residents living within 50m of premises which have applied for a licence. This is very effective at getting responses which can lead to generating representations to the Licencing Committee.140

Westminster also helps to fund a service with Citizens Advice called the Licensing Advice Project.141 Established in 2005, this service helps local residents to make their voices heard on pending licences, current operations and any other issues pending to licencing. This allows local residents some measure of control in what is by far the largest night-time economy in the UK.142

Brighton and Hove City Council launched a highly publicised engagement campaign called “The Big Alcohol Debate”. It ran from October 2011 to January 2012. This successfully drew thousands of views from residents on how they feel about local alcohol misuse and their preferences on how the night-time economy ought to develop. The results from the consultation were used to justify the expansion of their city centre Cumulative Impact Zone to become the largest in England and Wales.143

138 http://www.bbnuk.com/
141 http://www.licensingadvice.org/
Late Night Levy / Alternative Arrangements

Two powers available to licensing authorities are the Late Night Levy and Early Morning Restriction Orders. The latter, which allows for an enforced closure time of certain venues/areas between 12am-6am, has yet to be used anywhere in the UK. It is difficult to consider it an option given the resistance it will draw from the night-time economy. Late Night Levies have been implemented in a small number of areas, with the general sentiment that they require a substantial amount of work for a modest return, particularly for the local authority (which only gets 30% of the funds raised after footing the administrative costs).\(^{144}\) Currently, legislation restricts the Levy so that it must be applied across the entirety of the local authority’s area, which may not be appropriate outside of Metropolitan/London Boroughs.

One alternative to a Late Night Levy system can be seen in Reading. There, the Business Improvement District voted to introduce a ‘second-tier’ fee. Any premises staying open past midnight must contribute extra to the BID (2% of income, on top of the standard 1%). This money is used to fund projects similar to those procured through Late Night Levies: Street Pastors, Pubwatch, Doorwatch, First Aid and Purple Flag/Best Bar None accreditation.\(^ {145}\) This takes away any coercive element from the licensing authority enforcing a fee, while delivering similar results of a better, safer night-time economy.

5.4.5. Alcohol treatment system

Between September 2015 and August 2016 CGL SOLAR (Swindon’s Alcohol Treatment Service) treated 445 clients. This was a period of transition for the service as the subcontracting arrangement with the incumbent provider SWADS ceased on the 1\(^{st}\) April 2016. From this date clients previously attending SWADS at 13 Milton Road Swindon transferred to a joint alcohol and drugs premises at Unit 1, Plaza 21 Sanford Street, Swindon, which has now moved to 4 Temple Chambers, Temple Street, Swindon SN1 1SQ.

The locally commissioned service comprises a clinical provision within CGL, a Hospital Based Alcohol Liaison Service with in-reach into GWH, Street Drinkers Outreach Service and Mutual Aid support is also provided to maternity services at GWH. In addition there are further mutual aid providers and also support groups for carers (see section 6.3 Peer support).

The following section describes Swindon’s in-treatment population with regard to alcohol dependence, using data from CGL Project summary report as well as report information from National Drug Treatment Monitoring Sysytem Joint Strategic Needs Assessment support pack 2016/17.

5.4.5.1. Current service provision

Figure 79: Current substance misuse treatment services provided in Swindon

The current alcohol misuse treatment services provided in Swindon are listed as follows;

- New premises for both alcohol and drug treatment services

\(^{144}\) The Licensing Act (2003): its uses and abuses 10 years on’, Institute of Alcohol Studies, pp.121-125.

- Change from a key worker model to more efficient care co-ordination group work model
- Clinical provision within service
- Alcohol liaison nurses at GWH
- Criminal justice workers
- Street drinkers outreach
- Tele Health online support
- Hep C positive support group
- U-turn - young peoples treatment
- Prevention campaigns
- SUST – Service User representatives
- Non-commissioned services – 9 mutual aid services, viewable on MyCare MySupport
- Families and carer support group – Time4Us and CGL
- Residential Rehabilitation
- Liaison with midwifery, NSPCC (support for parents)
- Dual diagnosis
- Licensing and trading services

5.4.5.2. Referral routes

As a relatively small treatment provider with finite resources, it is imperative that SOLAR effectively targets for treatment those at risk of highest harm from alcohol. Examining referrals into service it can be seen that the majority of referrals come from allied services by established pathways i.e. Criminal justice Alcohol Treatment requirement, GP’s and Hospitals.
Comparing the figures above with national data shows that Swindon has high referrals from Criminal Justice and Health than we see nationally but a lower proportional of self-referrals. This may indicate that Swindon Alcohol Services are more targeted than other services. (See below). However it is important to ensure that the service is accessible and we would want to ensure that self-referral is encouraged.

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146 CGL SOLAR Project Summary report Alcohol only August 2016
5.4.5.3. **Hospital based Alcohol Liaison Nurses**

The current alcohol treatment service includes a Nurse led hospital based liaison service. This includes provision during normal working hours and a limited hours weekend service.

Between September 2015 and August 2016 this service has seen 460 clients 65% of whom were male. 316 of these clients were from the Swindon area and the rest from surrounding areas such as Wiltshire, Berkshire and Oxfordshire.

The largest age group to access the service were between 35 and 54 years of age but as can be seen from the table below 76 individuals were over the age of 65 years.

![Figure 82: Hospital based alcohol liaison clients by age Sep 15 - Aug 16](image)

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>18 - 24</td>
<td>16</td>
</tr>
<tr>
<td>25 - 34</td>
<td>56</td>
</tr>
<tr>
<td>35 - 44</td>
<td>102</td>
</tr>
<tr>
<td>45 - 54</td>
<td>134</td>
</tr>
<tr>
<td>55 - 64</td>
<td>67</td>
</tr>
<tr>
<td>65 +</td>
<td>76</td>
</tr>
<tr>
<td>Unknown</td>
<td>9</td>
</tr>
</tbody>
</table>

Of these clients 38% received a brief intervention from the service and 36 (21%) went on to access more specialist interventions from CGL.

The Alcohol liaison service work closely with the Independent Domestic Violence Advocate and also Safeguarding teams who are co-located. This works well but closer working with the psychiatric liaison service which is located in a different part of the building could be improved.

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147 Swindon Adult Alcohol Joint Strategic Needs Assessment support pack key data 2017-18
148 CGL SOLAR project summary report Aug 16
The Alcohol Liaison service also provides training in alcohol misuse, brief interventions and screening for hospital based staff. They also provide advice and guidance about alcohol detox to the wards.

Currently there is little connection between the hospital and community detox service. It could be that length of stay in hospital could be reduced if community detox for patients was an option. Currently there is no hospital drug liaison service at GWH and the hospital would welcome this.

5.4.5.4. Clients in treatment

An effective service is one which represents the diversity of the population it serves. As seen in previous sections, as Swindon’s population grows it is becoming increasingly diverse, both in terms of age profile and ethnicity, to which Swindon’s treatment services must be flexible to their specific needs.

Age

Swindon’s treatment population age profile is broadly similar to that seen in treatment services nationally, although the profile is narrower with fewer clients from both younger and older age cohorts and a higher proportion of 40-49 year old clients than seen nationally. While this would reflect the life stages where a client may ready to undertake treatment, attention should be given to appropriate targeting of at risk groups for example younger offenders where alcohol is a feature of their offending and isolated elderly where excess alcohol is contributing to frequency of falls or exacerbating other degenerative conditions.

![Figure 83: Age of all adults in Swindon alcohol treatment 2015-16](image)

Gender

In terms of gender, Swindon is very similar to national figure with 62% of male clients and 38% female clients locally compared with 61% males and 39% females nationally. While there are no

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149 Swindon Adult Alcohol Joint Strategic Needs Assessment support pack key data 2017/18
reliable prevalence estimates presently, attention should continue to be paid to at risk groups such as pregnant women particularly as we know that very few are being identified at booking. While females are not strongly represented in criminal justice (one of the highest referral routes into treatment locally) they are strongly represented through self-referral and general practice, underlining the need to continue the ability to self-refer into treatment.

**Ethnicity**

It is important that services reach all ethnic groups. Currently there are no reliable prevalence estimates regarding alcohol related harm and ethnicity. However, in broad terms while approximately 10% of Swindon’s population is identified as an ethnicity other than white, in alcohol treatment currently only 4% of clients are ethnicity other than white. This indicates that the service may not be engaging effectively with all ethnic groups.

Outreach work should effectively target diverse communities in Swindon and develop local connections to encourage joint work on campaigns.

*Figure 84: CGL ethnicity of clients in treatment Sep 2015 - Aug 2016*

**Time in treatment**

The current guidelines from NICE CG115 suggest that harmful drinkers and those with mild dependence might benefit from a package of care lasting three months, while those with moderate dependence might need a six month package and those with severe dependence or complex needs a package of care lasting up to a year. Swindon’s alcohol treatment length currently exceeds this with over 20% of clients being retained in treatment for more than 12 months.

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150 CGL Swindon SOLAR Project Summary Report August 2016
There has been considerable change in provision of alcohol services over the past 3 - 4 years. The data below may partially reflect these changes in provision and should be seen in this context. The service finally transitioned from SWADS to CGL in April 2016. However, the data is still a good indicator or the current performance of the local treatment service.

The clients with longer treatment journeys exiting treatment could reflect the changing working practice as the service transitioned from SWADS to CGL. For the year 2015-16 24% of Swindon alcohol clients had a treatment journey of over 12 months compared with 14% nationally.

As the treatment model changes, the alcohol service has two challenges, firstly the legacy of a large number of clients being retained in treatment for an already prolonged period. Secondly the reason for that retention possibly being due to clients continuing a high level of alcohol intake and requiring alternative specialist interventions such as medically assisted detox in the community or residential placement.

151 Swindon Adult Alcohol Joint Strategic Needs Assessment Support pack 2017-18
152 National Drug Treatment Monitoring System Recovery Diagnostic Toolkit (Partnership) 16-17
Retaining clients in treatment longer than necessary is not cost effective and has consequences on throughput of clients in treatment. However, this needs to be understood in context of successful completions (see below) and complexity of the caseload.

Conversely, early unplanned exits where a treatment journey has finished before 12 weeks are at half the level seen nationally with 6% of new presentation to treatment locally leaving early compared with 14% nationally.

Efforts should continue to manage the time in treatment length with a focus on those clients who have been in treatment for over 12 months.

5.4.5.5. **Client exits**

A client is deemed to have successfully completed treatment if their treatment length is over 12 weeks, they have reduced their drinking to non-hazardous levels or are now abstinent and do not return to treatment in the following six months.

Alcohol treatment exits are currently below national average levels which is being closely managed in performance review meetings. Fewer clients leave Swindon’s alcohol service than seen nationally, of those that do leave a lower proportion are doing so successfully and there are a higher proportion who re-present to treatment.

Referrals suggest that our clients have a variety of issues which have the potential to hinder effective treatment i.e. involvement in the criminal justice system. When looking more closely at those in treatment, there is a cohort of clients who appear to have higher risk drinking identified by SADQ scores who are being retained in service.

Figure 87: CGL clients in alcohol treatment planned vs unplanned exits Sep 15 - Aug 16

5.4.5.6. **Service efficiency**

With a lower numbers in treatment than planned, and fewer of these clients leaving treatment than seen nationally, combined with some then representing to treatment – the alcohol treatment

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153 CGL SOLAR Project Summary Report August 2016
Service efficiency is currently poor. However, there are signs of improvement as numbers of clients in treatment are increasing and the representations are numerically small (from 60 exits over a 12 month period, 7 represented to treatment).

Further work should focus in increasing planned treatment exits, especially amongst those who have been in treatment the longest.

Figure 88: Proportion of all in treatment, who successfully completed treatment and did not re-present within 6 months154

Profile of client alcohol use

As a service with multiple points of entry, CGL alcohol service has provided information and advice for the full spectrum of alcohol use. However, the commissioning intention is that they provide targeted Tier 2 information and advice via cell intervention and Alcohol Liaison Nurse but mainly Tier 3 structured treatment with community detox as needed.

The NICE care pathway for case identification diagnosis below shows how using AUDIT and SADQ tools can help identify the treatment needs of clients.

In SOLAR, looking at all 445 clients who were in treatment between September 2015 and August 2016. The AUDIT score at assessment broke down as follows.

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154 National Drug Treatment Monitoring System DOMES report Q1 2016-17
Comparing the AUDIT and SADQ scores recorded in service against the NICE care pathway – case identification diagnosis, it appears higher use clients are being appropriately identified and referred into treatment.

5.4.6. Residential treatment provision

Most substance misuse treatment interventions in Swindon are delivered in the community. This enables service users to utilize the support of family and other support networks in their recovery journeys.

For those that demonstrate higher levels of risk and need a residential placement may be considered. In order to access such a placement service users need to demonstrate they are ready for active change and a higher intensity of treatment.

Inpatient/residential placements are considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example, housing) problems.

People who are severely alcohol dependent (with a SADQ score of more than 30) need assisted alcohol withdrawal, typically in an inpatient or residential setting.

As residential rehabilitation tends to be suitable for the more complex service users, and significantly more expensive than community interventions, all referrals and assessments are reviewed by a multi-agency panel chaired by the DAAT team. All referrals are reviewed as to their suitability for placement and to ensure that a suitable treatment plan is in place to incorporate

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155 CGL SOLAR Project summary report August 2016
156 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (2011) NICE guideline CG115
preparation for placement, responses for unplanned discharge and post placement reintegration planning.

Swindon has a well-established targeted residential treatment pathway which has been recently reviewed, to now include review of community detox and support options. 58 referrals were received for consideration by the panel in 2016/17, compared with 41 in 2015/16. This increase is due to greater demand for sex worker, adult safeguarding, child safeguarding, dual diagnosis and prison release clients. The changing profile of these groups has also led to an increase in presenting complexity of cases leading to an increase in requests for longer, secondary placements to adequately meet their need.

In 2016/17 12 rehab placements have been made with 9 admissions for inpatient detox. Reasons for non-progression of referrals include poor motivation & engagement, not fitting the threshold for inpatient treatment, assessment revealed other primary needs, withdrawal in favour of community treatment, decision to transfer out of area, prison recall/ custodial sentence and withdrawal due to housing debt issues. The majority of placements were with ANA House (Portsmouth) and Gloucester House (Highworth).

Figure 90: Residential treatment placements funded by Swindon Borough Council 2015/16

<table>
<thead>
<tr>
<th>Inpatient Treatment - Substance Misuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>27 referrals were made to the Panel</td>
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<tr>
<td></td>
<td>Rehab</td>
</tr>
<tr>
<td>Actual Admissions</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Treatment - Alcohol Misuse</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>14 referrals were made to the Panel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehab</td>
</tr>
<tr>
<td>Actual Admissions</td>
<td>7</td>
</tr>
</tbody>
</table>

157 Swindon Borough Council DAAT inpatient treatment panel
5.4.7. Ambulance Service

Analysis of the 4,905 overdose, poisonings and ingestions calls to Swindon Ambulance Service shows that since 2011 approximately 9% of these calls are given advice over the phone without need for attendance, 53% are attended by the ambulance service and then conveyed to hospital with 38% of these cases being seen and treated by the ambulance service.

There is some seasonality evident, with peaks in activity in August, December and January - however without finer detail it is difficult to draw any further insight into what could be driving these trends.

For calls where a keyword such as 'alcohol', 'drug', 'intox', 'opiate', 'drunk', 'heroin' were used between 24th February and 30th November 2016, 395 calls were logged in the Swindon CCG area. The split between advice over the phone (13%), Ambulance attendance with subsequent conveyance to hospital (50%) and those being seen and treated by the ambulance (37%) are similar proportions to those under the more general heading of over, poisonings and ingestions. For those calls flagged as Opiate under Narcotic/heroin over the same period the proportions are starkly different, of the 70 calls made only 3% were given advice over the phone while 61% had an ambulance attendance and further conveyance to hospital and 36% were seen and treated by the ambulance service.

This underlines the need to take a whole systems approach for alcohol and drug callouts, as only taking account of emergency department admissions risks underestimating the impact these substances have on Swindon residents.

As new systems are now in place for recording better quality information, this area should be re-examined while also investigating the lived experience of ambulance technician staff to gain the fullest picture possible. The potential for onward referral to community drug and alcohol services as well as training needs of ambulance staff should also be considered.

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Swindon Borough Council DAAT inpatient treatment panel
5.4.8. Alcohol projects in Swindon

5.4.8.1. Alcohol Support & Advice Project (ASAP)

The ASAP pilot project began in October 2014. The project’s aim was to address the harm caused by alcohol misuse within 3 key Swindon Communities. The project provided signposting, information and advice in 3 areas identified as being under-represented in treatment services but with high alcohol related hospital admissions. The two year project was funded by One Swindon.

One of the principles of the project was that it was staffed by people who were experts by experiences, including Peer Mentors on a voluntary basis and Recovery Motivators who were paid a supplement to their benefits. All Peer Mentors and Recovery Motivators were unemployed at the start of their involvement with the project. The project was overseen by a project lead from the Substance Misuse Service CGL.

Another principle of the project was to reach people within the 3 key communities. However, as it was difficult particularly in two of the areas to engage the project proactively targeted key organisations and employers within these areas and attended community events. Although this was very beneficial at raising awareness of the impact of alcohol analysis of the referrals into service showed that it was not reaching the identified communities.

However, the project was successful in providing a pathway into employment with 7 Recovery Motivators, Peer Mentors and Recovery Champions moving on and finding paid employment. However, this made the project extremely resource intensive as new staff required a lot of training and support.

The contacts made by the project were younger and with a higher proportion of women than found in our local treatment service also the national profile of treatment users.

The project has now concluded but learning from the project will be used to develop local treatment services by encouraging engagement with businesses, providing opportunities for those who have successfully completed treatment and providing outreach into communities to engage with a more diverse client group.

5.4.8.2. The Street Drinkers Project

Street drinkers have multiple needs and issues that are addressed by a spectrum of public services and third sector organisations. The Street Drinkers Project was launched in April 2016 following recruitment of a Street Drinker Outreach Co-ordinator (SDOC). It was recognised that there was an increasing number of street drinkers who causing public concern. Data analysis showed that there were 73 individuals who were labelled as street drinkers and were known to various services including the police, health services, community safety and housing. See table below.

![Figure 92: Percentage of identified street drinker cohort known to multiple agencies](image)

<table>
<thead>
<tr>
<th>Number of agencies</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of the Street Drinker cohort known to agencies</td>
<td>11%</td>
<td>11%</td>
<td>14%</td>
<td>29%</td>
<td>7%</td>
<td>12%</td>
<td>15%</td>
<td>1%</td>
</tr>
</tbody>
</table>

159 Multiagency street drinkers pilot project scoping
The aim of the project is to improve physical and mental health and wellbeing and improve behaviour particularly offending behaviour. The outcomes to be monitored include a reduction in alcohol and drug use, a reduction in individual arrests, a reduction in reported Anti-Social Behaviour and a reduction in hospital admissions. The project involves multi-agency working including health services, housing, night shelters, In-Swindon teams, Wiltshire Police, Great Western Hospital and CGL, Swindon substance misuse service.

As of September 2016 the SDOC has a caseload of 19 street drinkers and is having a positive impact – reducing alcohol consumption, improving health and offending behaviour of some of this cohort and liaising with enforcement agencies only as a last resort.

5.4.8.3. Local Alcohol Action Area (LAAA)
Partners in Swindon have recognised the need to work together in order to reduce alcohol related crime and disorder and health related harms and improve safety particularly within the night time economy. The partners have made and application to become a Local Alcohol Action Area. The focus will be on improving data sharing within the partnership in order to optimise reducing resources most effectively. The project will also look at the safe movement of people within the night time economy. We are currently awaiting the outcome of the LAAA bid but plan to work on these issues.

5.5. Crime and Criminal Justice
The economic and social cost of drug use and its supply is estimated to be around £10.7bn per year, of which £6bn is attributed to drug-related crime.

There is a noticeably strong link between drugs and acquisitive crime. Nationally, an estimated 45% of acquisitive crimes, with the exception of fraud, are perpetrated by regular heroin/crack cocaine users. This association is perhaps made more obvious when Public Health England suggests that a typical heroin user spends around £1,400 per month on drugs. This amounts to more than two million offences.

Patterns of substance misuse have a considerable impact on community safety and confidence. These are translated through the drug and alcohol related offences analysis below, based on the intelligence provided by Wiltshire Police.

5.5.1. Alcohol and crime
Alcohol related crime in Swindon has seen a slight upward trend in Swindon between January 2014 and September 2016, however this increase is not statistically significant and is within normal levels of crime for Swindon. Between 80 and 170 incidents took place each month with peak seasonal trends seen over the Christmas and New Year Period as well as the summer period in July/August.
The most common alcohol related offences committed are those of violence with injury (approx. 30-60 incidents monthly) Violence without injury (approx. 15 – 50 incidents monthly). Other offence types averaging at around 10 incidents a month for each include Public Order Offences, Criminal Damage and Arson and also shoplifting.

As not all crime taking place is reported or recorded, this should be treated as an under representation of the levels of crime experienced in Swindon. A study in Cardiff accident and emergency departments found that around a third of violent offences requiring treatment at A&E went un-reported to the Police.

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160 Wiltshire Police crime recording system
161 Wiltshire Police crime recording system
Campaigns to encourage responsible drinking should take place in the run up to the festive period as well as peak summer periods. These campaigns should be informed by client cohort information from the A&E hospital assault data.

5.5.2. Drugs and crime
Over the last 12 months, Swindon (and indeed the Force as a whole) has seen increasing volumes of both Possession of Drugs and Possession of Weapons offences – which are both now recognised as growing problems.

The volume of Possession of Drugs offences recorded in August was the highest monthly total in more than two years and with the exception of one month – July 2015 – the volume of Possession of Weapons offences seen in August was also at the highest level seen in the last two years.

Analysis has demonstrated that the volumes of both of these offence types are not related to the number of Stop and Search operations undertaken by the Force. However, given the nature / competitiveness / danger involved in the Drug world there is a clear correlation between the volumes of both types of these offences as can be seen on the chart below. Work continues in terms of identifying and trying to stop the various DDN’s (Dangerous Drug Networks) that are operating in and around Swindon, including the infiltration of a number of Organised Crime Group’s from other major centres like London etc.

Detailed analysis undertaken by Intel and BI has demonstrated that nearly 70% of all Possession Of Weapon offences involve the use of knives or other bladed items, with the highest proportion of offenders being males either in the 13-19 or 20-29 age categories. There are also clear indications that there are an increasing number of young people becoming involved as runners on local DDN’s.

Current initiatives being considered by the Force include programs of education and awareness within schools, potential knife amnesties and working with partners, parents & other Forces to ascertain best practices.

It is no coincidence that both of these crime types feature in the top 5 flags against offences for the two age groups listed above.
Drug related crime has between 50 and 90 offences recorded per month, with little in the way of seasonal variation or trends. The most common drug related offence is that of possession of drugs with between 20 and 45 incidents per month. Other offence volumes are lower at around 7 incidents a month including Trafficking of drugs, violence with injury and violence without injury with drug related criminal damage and arson incidents recorded at a level of approximately 2 per month.

As well as drug crime being under reported as seen in alcohol offence reporting, drug use’s position as an illicit activity may mean that reporting and recording is further hampered.

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162 Wiltshire Police crime recording system
163 Wiltshire Police crime recording system
5.5.3. Criminal Justice provision
CGL have continued to build positive relationships with our partner agencies, such as Probation, Prisons and the local Police force. This has enabled the criminal justice team to look closely at trends in data; what is going on locally and tailor the service to meet any identified needs.

5.5.4. Prison releases
During the period October – December 2015 Prison releases were at the highest level seen in service since CRI has taken over. The spike in numbers of prison leavers that were unknown to service were people describing themselves as No Fixed Abode and needing to be prescribed. This was flagged with Swindon Borough Council, Community Safety Partnership and the Police as unusual and unprecedented activity.

An additional pressure was the lack of pre-release appointment being provided by the prison team for those requiring a methadone script. This breakdown in communication meant a newly released prisoner was being sent to Swindon drug services to request a methadone prescription with no prior warning to the service.

Prison establishments varied considerably from the agreed prisons framework in this period, noticeably HMP Bullingdon and Horfield reported to CRI Swindon Stars that they noticed an increase in referrals to Swindon DIP in this period.

Prison releases appear to have slowed down towards the end of December 2015, and this year have reduced to acceptable operational levels.

CRI DIP Team continue to work collaboratively with prisons and their substance misuse teams to provide a seamless release appointment, continued prescribing and support back in the community.

5.5.5. Probation
Drug Rehabilitation Requirements (DRR):
Assessments are mostly completed by CGL staff in and out of court. With this recommendation, and assessment for suitability, this allows individuals to fully participate in the programme and achieve their potential with a successful completion.

The programme for male DRRs is run from Centenary House every Tuesday and this has allowed Offender Managers to also support their service users in treatment.

Specific events and training are to take place in the forthcoming months, including Employment Training and Education (ETE) which visit the group twice a month and will be running a First Aid Training/Certificate in January. Other events to take place are; Men’s sexual health promotion and NPS (Legal High) use and harm reduction.

Female DRRs have been more challenging to engage. Originally engaged at ISIS women’s centre, this is in the process of being moved to Centenary House on a Thursday afternoon. Further efforts with be made with the Offender managers and female service users to find out how the requirement can best meet their needs in the New Year.

Alcohol Treatment Requirements (ATR):
This 12 session requirement is run from SOLAR (Community Alcohol Service) premises and 3-ways with the service user and Offender managers are held at the start, middle and end of the requirement.

5.5.6. Cell intervention
CGL continue to work when feasible at Gable Cross Custody suite by conducting cell sweeps and supporting officers with those detained due to alcohol or drug related offences.

There is a referral process in place for when CGL staff are unavailable at the custody suite that police staff can use to refer. The treatment provider has completed 2 sessions of drug and alcohol training to newly trained custody police staff this year at Devizes and have been asked to return again next year. The provider continues to provide up-to-date drug and alcohol training to Wiltshire Police and make those positive and professional links and hope to provide training on Naloxone and the Never Share Range in early 2017.

The following is a breakdown of cell interventions conducted by CRI at Gable Cross between 1st January 2015 and 31st December 2016. The number of cell interventions has increased, particularly among older age groups but there is a reporting gap in the substances associated with client offending as seen in the figure below.

Figure 97: CGL Cell intervention contacts Jan 2015 – Dec 2016\textsuperscript{164}

<table>
<thead>
<tr>
<th>Gable Cross Cell interventions</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>90</td>
<td>112</td>
</tr>
<tr>
<td>Male</td>
<td>79</td>
<td>97</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem Substance</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Cannabis</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Crack</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Heroin</td>
<td>42</td>
<td>43</td>
</tr>
<tr>
<td>NPS</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Unknown (police referrals)</td>
<td>0</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Range</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 18 to 24</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Age 25 to 34</td>
<td>34</td>
<td>42</td>
</tr>
<tr>
<td>Age 35 to 44</td>
<td>26</td>
<td>35</td>
</tr>
<tr>
<td>Age 45 to 54</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Age 55 to 67</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Age 68 +</td>
<td>&lt;5</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients Taken onto Stars Caseload</td>
<td>&lt;5</td>
<td>5</td>
</tr>
<tr>
<td>Existing STARS Client</td>
<td>39</td>
<td>44</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Refused to Engage</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td>Existing SOLAR Client</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol Only</td>
<td>&lt;5</td>
<td>0</td>
</tr>
<tr>
<td>Police referral clients written to by CGL</td>
<td>0</td>
<td>49</td>
</tr>
<tr>
<td>Out of Area</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

\textsuperscript{164} CGL cell intervention stats Jan 2015 – Dec 2016
Of particular note are the 18-24 age group, engagement with this group is of crucial importance as early intervention provides the best chance of successful treatment of drug misuse as well as greater gains in avoiding further costs associated with problematic substance misuse. There is a similar reporting gap in the substances involved in their offending.

Figure 98: CGL cell intervention contacts 18 - 24 year olds Jan 2015 - Dec 2016

<table>
<thead>
<tr>
<th>Gender</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>8</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Heroin</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Cannabis</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>NPS</td>
<td>&lt;5</td>
<td>0</td>
</tr>
<tr>
<td>Unknown</td>
<td>&lt;5</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Clients</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Police referral Clients written to</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Out of area</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

5.5.7. Modern Crime Prevention Strategy – a local response

Based on a consultation with T/Superintendent Phil Staynings, Head of Crime Prevention- Wiltshire Police.

SBC Drug and Alcohol Action Team will seek to work in partnership with Wiltshire police to deliver a local response to the national Modern Crime Prevention Strategy

<table>
<thead>
<tr>
<th>How to remove opportunities to offend</th>
<th>Build on the recent Local Alcohol Action Area submission to work closely with Police and SBC Licensing colleagues to improve community safety. Support work to increase safety in the night time economy including support of campaigns such as OnePunch. Working with Trading Standards colleagues to support test purchasing and Challenge Age 25.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Harm Reduction initiatives</td>
<td>In order to encourage early intervention with young people work in close partnership with Police and U-Turn to increase systematic screening of vulnerable young people specifically looked after children, those in contact with YOT and CAMHS, and those educated outside the mainstream.</td>
</tr>
<tr>
<td>Responding to changing substance misuse patterns</td>
<td>From 2006 until 2016, many New Psychoactive Substances (NPS) have been legally available on the high street, both from 'head shops' and a range of other retail outlets.</td>
</tr>
</tbody>
</table>

165 CGL cell intervention stats Jan 2015 – Dec 2016
However, the Psychoactive Substances Act which came into effect on 26th May 2016 banning their manufacture, sale and distribution. A multi-agency cross Wiltshire Police led group has been planning and implementing strategic response to these changes.

Retail outlets sales have been closed down but there continues to be concern about internet and other illicit sales.

<table>
<thead>
<tr>
<th>Review disposal options for offenders</th>
<th>The recent Police and Prison audit report for Wiltshire (2016) from Her Majesty’s Inspectorate of Constabulary (HMIC) advises;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wiltshire Police and partner agencies should urgently assess the need for substance misuse services in police custody and commission appropriately responsive services. (2.49).</td>
</tr>
<tr>
<td></td>
<td>The aim of substance misuse arrest referral is to use arrest as a key point at which to invite the individual to address his or her substance misuse, including onward referral to appropriate treatment and/or other services.</td>
</tr>
<tr>
<td></td>
<td>A bid has been submitted to SBC’s ‘One Swindon’ Board to investigate the availability of funds for a full time cell intervention worker for Gablecross.</td>
</tr>
<tr>
<td></td>
<td>Need to review the availability of test on arrest scheme for those arrested in town centre for trigger offences.</td>
</tr>
<tr>
<td></td>
<td>Need to review the availability and potential effectiveness of restorative justice interventions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Need to improve the effectiveness of our systems</th>
<th>Need to improve tactical planning. Need to be ahead of the curve, not reacting. Improving our speeds of response. To this end a cross Wiltshire tactical support group has been set up.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Need to integrate data support services. Increasing use of predictive analytics so we can see where future problems will be. The aim will be to build an evidence based repository for best practice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Swindon acknowledges it has an unusual profile of Sex Workers. There are significant links between prostitution and priority/ risk issues including; Class A drug use; Local drug markets/DDNs/ County Lines; Human Trafficking; Exploitation of minors (many escaping familial DA); Mental health; Social deprivation of an area; Down turn in local economy and Women involved in prostitution are 12 times more likely</td>
</tr>
</tbody>
</table>
to be murdered. Need to build on the work of the Adult Sexual Exploitation Group (ASEP) and the Adult Sexual Exploitation Tactical Group (ASET) to safeguard and offer exit opportunities for this cohort.

The Integrated Offender Management (IOM)/SWITCH cohort are a small group of Class A using offenders. There is a need to review this group and review who is included and the effectiveness of the interventions offered.

| Improving drug and alcohol messages in the media | SBC and Police communications departments to work together to increase drug and alcohol messages in the local media. These could be used to advertise an integrated response to drug seizures. |

6. Supporting recovery

   6.1. Access to Employment, Training and Education

Employment, training and education are key elements of the recovery journey and ensuring the clients are linked into services that can support them in securing employment either directly or via learning is important and evidence shows that clients who are employed or engaged in meaningful activity are more likely to find sustained and long term recovery from substance misuse.

There are three main measures of employment that drug services are monitored on at a national level. The numbers, who at the start of the treatment journey are employed, unemployed/economically inactive or those who are long term sick or disabled. In Swindon a higher proportion of clients are employment or unemployed/economically inactive than seen nationally and lower proportions of long term sick or disabled. As the quality of recording has improved, it is difficult to ascertain whether unemployment levels are a feature of the client group or a symptom of the wider economic climate.
Employment is a key means by which clients recover, the lower proportion of long term sick could suggest that clients have the capacity to seek employment but lack the means to do so.

There is a long tradition in substance misuse services to capitalise on peer mentoring, volunteering and counselling placement opportunities, both as a way of engendering long term change to recovery and as a way of supporting the recovery community.

Becoming a peer mentor is a first step on the way to training and employment for many service users. The role challenges them to take on responsibility and to get involved in helping others.

CGL has links with the Job Centre and up until very recently, most of clients on JSA/ESA worked with a job advisor who was linked into the service. This link has been lost and CGL are prioritising the re-establishment of this link.

CGL also has links to Learn direct who are now delivering the “Confidence and Motivation”, accredited level 1 course for clients at CGL. As of January 2017 8 clients had attend 20 hours of accredited learning each. CGL promote other Learn Direct Courses.

CGL are also developing a computer suite which will enable clients on site to do job searches, create CVs and access on line training. They will be supported by volunteers and peer mentors.

100 CGL clients from both drug and alcohol services are currently engaged with employment, training and education support services.

6.2. Housing

Housing is also a key issue for those recovering from substance misuse and clients can often experience stigma in relation to attaining and maintaining tenancies particularly when abstinence is a requirement. Treatment can sometimes be dependent on secure and stable housing. In Swindon

166 Swindon Adult Drugs Joint Strategic Needs Assessment support pack 2017/18
There is a higher proportion of clients having housing problems at the start of treatment for both drug and alcohol than seen nationally. At exit 92% of clients no longer have a housing need suggesting this is a key means of recovery.

Figure 100: Accommodation status at start of treatment by proportion

Current CLG are reporting that they have 27 clients of no fix abode. CGL have both an outreach worker and Service User Representative who can support clients and advocate for them on housing issues. The outreach worker has in-depth knowledge of the Council housing process and support available. Clients appreciate this service and it is well utilised.

Further partnership work needs to continue to provide support to clients, particularly those with dual diagnosis substance misuse and mental health issues regarding maintaining tenancies and progressing with treatment. Those with Korsakoffs can face particular difficulties maintaining tenancies. Some substance misuse training has been delivered to hostel staff and hostels have been allocated Naloxone for use in case of overdose.

CGL work closely with Threshold Housing and homelessness teams and with the Night Shelter when required. They link with Swindon Borough Council Housing, Rough Sleepers Panel and are involved in the risk enable panel.

6.3. Peer support

Mutual aid groups are a key component of the recovery process and there are several mutual aid / peer support groups that run in Swindon. There are current 9 different Alcohol Anonymous groups

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167 Swindon Adult Drugs Joint Strategic Needs Assessment support pack 2017/18
running within the Borough and also the SMART Recovery Group provided by the SUST (Service User Recovery Team). SUST is an independent advocacy group run by ex-service users for those that are trying to access treatment, are already in treatment or in recovery. They provide support to clients throughout their treatment and recovery journey. In order to increase uptake and promote mutual aid CGL plan drop and information sessions for all Mutual Aid services in Swindon.

Support for those caring for individuals misusing substances is also available through different agencies. Time 4 Us is a support group for parents or carers of those affected by addiction. They are hosted by SWADS and meet on a weekly basis to provide support, information and advice to help make things easier for carers and help them maintain their own health and well-being. In addition CGL also provide their own carers support group for carers of clients in treatment. They provide a range of advice and information about how to look after the carers own wellbeing as well as how to support those for whom they care.

Other organisations providing support are AdFam, Al Anon, and Nar Anon all of whom have services in Swindon.

There is also a Hep C Positive group which meets weekly in Swindon providing support and education to those affected by Hepatitis C. This group is a peer support group providing support to both individuals directly affected and also their carers.

7. Recommendations

Overview of recommendations

7.1. Priority One: Early intervention with young people and their families

1) Conduct a further review of the increase in hospital admissions for 15-24 year olds and monitor the numbers being admitted for alcohol related conditions.

2) Develop a plan to widen the strategic screening of vulnerable young people to enable early identification and intervention regarding substance misuse.

3) Ensure targeted campaigns based on prevention and education for young people and their families.

4) Develop effective transition policies to ensure no unplanned exits as young people move into adult services.

5) Review the current multi-agency provision for support for parents who are misusing substances.

7.2. Priority Two: Prevention of substance related harms for adults

6) Review planned prevention campaigns to ensure a better balance between drug and alcohol issues.

7) Conduct a review of online and digital awareness raising tools to deliver best value prevention messages.
8) Review the availability of brief interventions in partner agencies to expand the capacity of staff to have meaningful conversations and make suitable onward referrals of those with substance misuse issues.

9) Conduct a review of the current availability and effectiveness of Naloxone in preventing drug related deaths with a view to a further roll out.

10) Conduct a review of changing drug profiles, New Psychoactive Substances, prescribed medications and Steroid use.

11) Undertake a review of Opiate clients who are newly presenting to service to gain an understanding of their using history, criminal justice involvement, if moving from out of area and previous opportunities for earlier intervention.

12) Continue to support commissioned services to improve the uptake of Blood Borne Virus testing and immunisation.

13) Review the increase in demand for needle exchange services and review the content of packs against best practice advice and current resource.

14) Continue to develop and align mutual aid in Swindon ensuring service user support, peer mentoring, Smart Recovery and other support networks integrate well with commissioned substance misuse services.

15) Develop an in service stop smoking pathway for substance misuse clients.

7.3. Priority Three: Treatment services deliver effective harm reduction and sustained recovery

16) Ensure the new treatment model delivers improved outcomes regarding recovery particularly for alcohol users.

17) Continue to monitor and support the Street Drinker's project to ensure that the initial positive outcomes are maintained and consider long term funding.

18) Develop a multi-agency review process for those identified as being at imminent risk of becoming a drug related death.

19) Review how diverse groups are engaged in treatment services with a particular focus on women (including pregnant women), those with ethnicities other than White British and both older and younger cohorts.

20) Review the increasing demand and increasing presenting complexity of those referred for consideration for inpatient admissions.

21) Review the availability of community detox as an alternative to inpatient admissions.

22) Explore the feasibility of a substance misuse rather than alcohol only hospital based liaison service.
23) Improve links between commissioned services and Job Centre and Learn Direct. Focus on improving computer literacy and online access for job searches, applications and CV writing.

24) Review housing need for those who are currently unable to maintain abstinence, leaving residential rehab and those with dual diagnosis.

25) Continue to monitor and support the case review and training sessions to support effective working with dual diagnosis clients.

7.4. Priority Four: Reduce substance misuse related crime and anti-social behaviour

26) Undertake a review of clients recently released from prison who are accessing substance misuse services. Exploring any links to Dangerous Drug networks.

27) Work alongside Police and Community safety colleagues to contribute to an effective response to Dangerous Drug Networks/ County Lines issues.

28) Ensure a joined up multi-agency response to those adversely affected by substance misuse and domestic violence.

29) Undertake a further cost/benefit analysis of spend on substance misuse services against delivery of criminal justice services.

30) Work with SBC Licensing to explore ways to ensure a reduction in the harm caused by alcohol whilst maintaining a vibrant economy.

31) Work with multi-agency group to deliver the identified outcomes of Local Area Alcohol Agreement regarding night time economy and information sharing.