		ITEM [8]
Report Name:	**Public Health Update to Barnet Safer Communities Partnership Board (SCPB)**	
Meeting:	**Barnet Safer Communities Partnership Board (SCPB)**	
Meeting Date:	26th October 2018	
Report Author:	**Louisa Songer** Public Health Strategist	
Outcome Required:	Information Only: Decision Required: Feedback/comments required: **X**	☐
Restricted	No	

Report for Safer Communities Partnership Board:

Substance misuse prevalence, trends, preventative interventions and local opportunities

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October 2018

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1. Executive Summary

Local Prevalence Data

The rate of opiate users in Barnet is lower than London and England, but the age profile follows a similar pattern to elsewhere in the country. The prevalence of opiate use in Barnet is highest in people aged 35-64 which is reflective of an aging heroin using population and fewer younger people commencing heroin use. Younger substance users are showing a preference to other substances such as cocaine, ecstasy and cannabis. In London and England, the largest cohort of opiate users is those aged 25-35. As the Barnet opiate using cohort ages, we can expect the group to become more complex and develop a need for wider health and social care services.

Similarly, it is estimated that there are fewer opiate and crack users in Barnet than elsewhere in the country. However, Barnet follows a different age pattern. The most noticeable difference is in the younger age group 15-24 year olds. Barnet's prevalence of OCU's in this group is higher than London and England, indicating there is possibly an group of young crack users not accessing services.

There is a large gap between the number of people accessing substance misuse treatment (for opiates, other drugs and alcohol) and prevalence estimates, indicating that there is substantial unmet need in the community. It is estimated that 61% of opiate users in Barnet are not accessing local treatment services and 88% of dependent drinkers are not accessing treatment services.

Substance Misuse Trends – Adults

A snapshot taken in the last quarter showed that of the 652 people in treatment, primary opiate users account for 58% of people in treatment. This is followed by alcohol users, forming 24% of the treatment population, crack and cocaine 13% and the remaining 5% other drugs. This is a similar picture nationally.

People accessing substance misuse treatment services in Barnet reported higher levels of mental health conditions than other areas, lower misuse of "over the counter"/prescription medication, and are more likely to be economically inactive.

A greater focus is needed on older adults and other drug users to understand the needs of this group.

Understanding the relationship between substance misuse, mental health and domestic abuse is a corporate priority. A deep dive has been completed locally to explore the relationship between the areas. Recommendations have been made to a) Addressing ineffective referral pathways, learning lessons from audit and case review b) improving the identification and management of domestic abuse in Mental Health and Substance Misuse settings by embedding best practice through evidence based commissioning and c) improve holistic, multi-agency working in Family Services to ensure parents have access to the right support at the right time

Substance Misuse Trends – Young People

The picture is very different to that of the adults service. Primary cannabis users account for 78.5% of people in treatment. This is followed by alcohol users, forming 9.2% of the treatment population. This reflects a total 65 young people in treatment. Unlike the adult population, young people in treatment are more likely to report benzodiazepine, hallucinogen and ecstasy use. Whilst opiate and cocaine use is less common than in adults, there are some young people using these substances. This is a similar picture nationally.

Risk Groups

Recent evidence has been published demonstrating the effectiveness of interventions that aim to delay the onset of, and reduce the harms of drug and alcohol misuse. There are specific groups who are more at risk of developing substance misuse issues. These include people with a family history of substance misuse, people with lower socio-economic status, people with mental health conditions, people who have been sexually assaulted or exploited, people who are not in employment, education or training, people in contact with the criminal justice system and homeless people.

The costs of substance misuse

A Cabinet Office estimate placed the economic costs of alcohol in England at around £21 billion in 2012, equivalent to 1.3% GDP. This estimate included costs relating to alcohol-related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace and problems for those who misuse alcohol and their families, including domestic violence. Similarly, drug misuse also impacts all those around the user and the wider society. The Home Office estimated in 2010 to 2011 that the cost of illicit drug use in the UK was £10.7 billion per year.

28% of costs relate to deaths linked to illicit substances. Deaths involving opioids (such as heroin) account for the majority of drug poisoning deaths. Heroin related deaths in England and Wales have more than doubled since 2012 to the highest number since records began 20 years ago. In Barnet the rate of drug related deaths has remained steady.

Prevention Opportunities

Some of the key ways we can impact alcohol related harm (including crime and disorder) centre on affecting national policy and regulation, for example considering options around taxation and price regulation and regulating marketing. Having said that, there is much that can be done at a local level, particularly when considering options for regulating the availability of alcohol. There are also intervention that can be conducted in the immediate drinking environment that have a great impact.

It is also essential, particularly when looking at preventing substance misuse more widely, to consider specific interventions that should be delivered with those particular risk groups and in particular settings. For example, offering information, advise and awareness raising in settings such as primary care, mental health services, sexual health services, health visiting, midwifery, criminal justice services, A&E, hostels, nightclubs, festivals and gyms (to target people using image and performance enhancing drugs) .

Screening, identification and brief advice should be delivered at opportunistic and routine appointments with statutory and other services such as those listed above, and skills training for vulnerable children and young people should be upscaled to help vulnerable young people develop appropriate skills such as conflict resolution and managing stress

Key recommendations for the board to consider – Putting the evidence into practice

Partners must work collaboratively on local opportunities for improving outcomes. There are local structures and processes currently in place support a reduction in drug and alcohol-related harm however there is much work to be done to ensure these structures and processes are effective.

1. **Leadership, vision & governance:** The Health and Wellbeing Board and Community Safety Partnership Board should articulate a clear and shared ambition for reducing alcohol harm, demonstrated by strong oversight of the local substance misuse strategy and implementation plan. They should also ensure strategic join up, and ensure common purpose reflected in strategy and commissioning.

2. **Planning and commissioning services:** The partnership must be up to date with the needs of the local substance misusing population and in a position to address the needs of all at risk groups, including offenders, homeless people and those with complex needs. More must be understood about the new and emerging groups such as club-drug users and older adults. There must also be an updated plan for preventing and reducing alcohol related harm.

3. **Data and Intelligence**: Routine, co-ordinated data sharing across local alcohol partners should be used to inform strategic planning and operational service delivery and relevant indicators of alcohol related harm should also be reflected in KPI dashboards across partnership boards.

4. **Alcohol Licensing:** Influencing local licencing policy is one of the most effective ways to prevent alcohol related harm. It is recommended that there should be improved recognition of alcohol-related harm in the local licensing policy with a commitment to use local crime, health and social care data to inform policy and planning.

2. Substance misuse prevalence

Public Health commission the local substance misuse treatment services. The services offer a range of interventions for residents with problematic drug and alcohol use. Although the most common substance reported in the treatment service is heroin, the service also supports residents using substances such as cocaine and crack cocaine, cannabis, amphetamines and novel-psychoactive substances.

The graph below shows the prevalence estimates[i] of opiate use in Barnet. These follow a similar pattern to London and England, although the Barnet rate is smaller than the London and England rates. The prevalence of opiate use in Barnet is highest in people aged 35-64 which is reflective of an aging heroin using population and fewer younger people commencing heroin use. Younger substance users are showing a preference to other substances such as cocaine, ecstasy and cannabis. In London and England, the largest cohort of opiate users is those aged 25-35. As the Barnet opiate using cohort ages, we can expect the group to become more complex and develop a need for wider health and social care services.

The second graph shows the estimated number of opiate users in Barnet in comparison with the actual number of opiate users in treatment. There is a large gap between the two bars indicating that there is substantial unmet need in the community. This is a priority area of action for the public health team who are working alongside the treatment provider to address this issue.

Figure 1: Prevalence rate per 1,000 population of opiate users

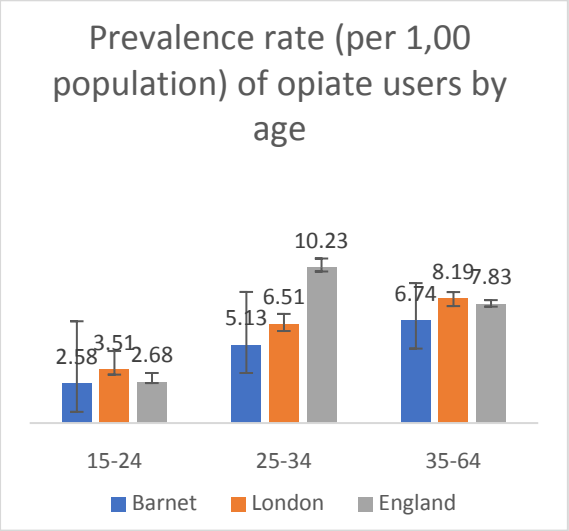
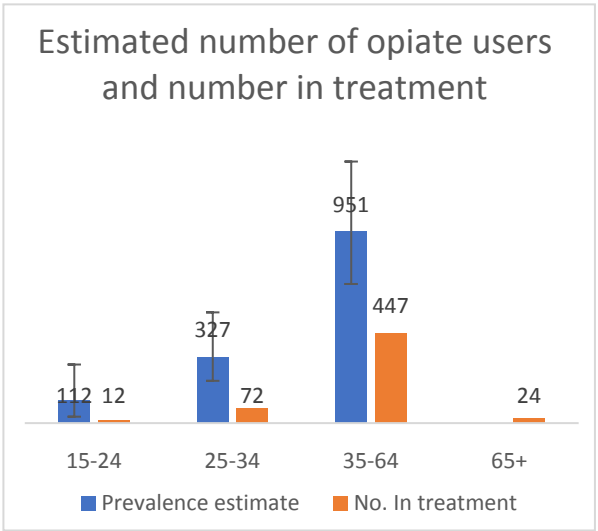


Figure 2: Estimated number of opiate users in Barnet and the actual number in treatment



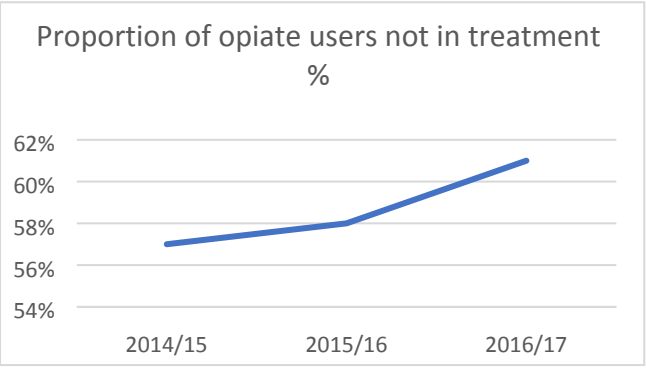
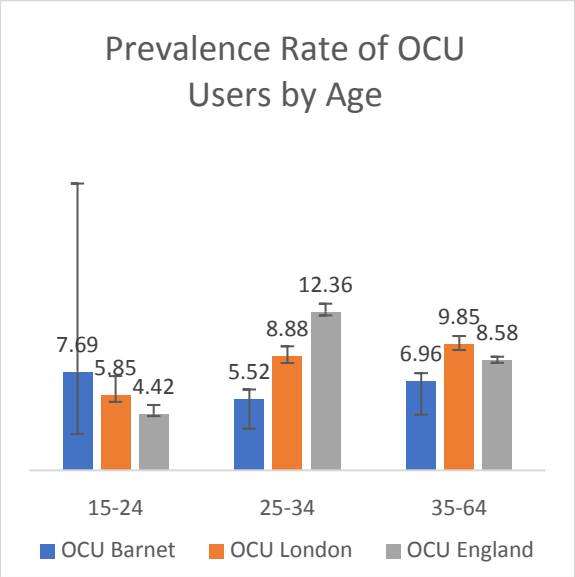


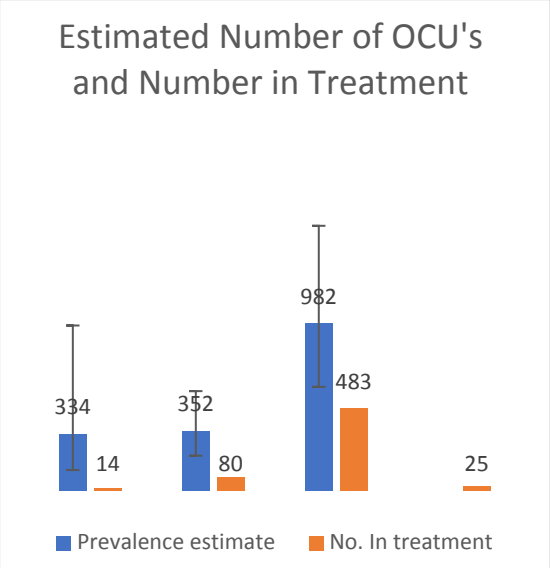
Figure 3 shows the proportion of opiate users not in treatment in Barnet. This has been increasing annually and it is now estimated that 61% of opiate users are not accessing local treatment services.

Figure 3: Proportion of opiate users not in treatment %

Similar to the above graphs, the following two graphs present the prevalence estimates and numbers in treatment for OCU's in Barnet. The most noticeable difference is in the younger age group 15-24 year olds. Barnet's prevalence of OCU's in this group is higher than London and England, indicating there is possibly a large group of young crack users.

Figure 4: Prevalence rate per 1,000 population of opiate and crack users
Figure 5: Estimated number of opiate and crack users in Barnet and the actual number in treatment

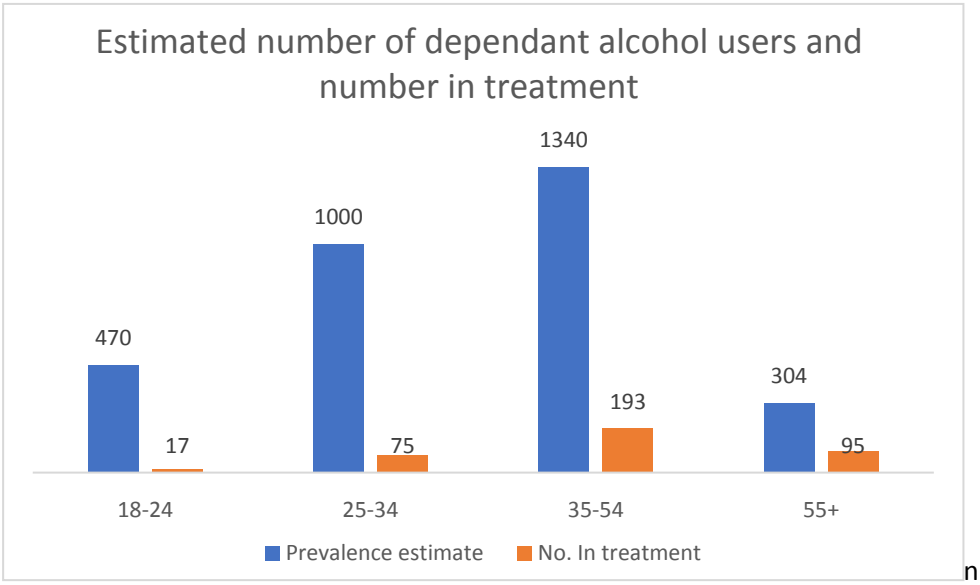




The following graph shows the estimated number of alcohol users in Barnet and the number in treatment.[ii] There are no data available to show London and England rates for comparison, however Figure 6 shows the proportion of dependent drinkers not in treatment is increasing annually and is currently 88%.

Figure 6: Proportion of dependent drinkers not in treatment %

Figure 7: Estimated number of alcohol users in Barnet and the actual number in treatment



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Whilst numbers accessing treatment have declined, the rate of successful completions of drug treatment has remained consistent and similar to England. This indicates that treatment services are effective. Similarly, the rate of successful completions for alcohol use has been improving annually.

2.15i - Successful completion of drug treatment - opiate users Barnet — Proportion - %

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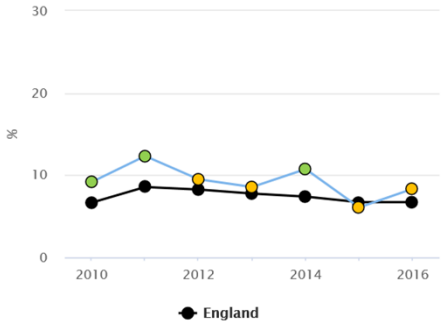

Recent trend:

Period		Count	Value	Lower CI	Upper CI	London	England
2010		56	9.2	7.1	11.7	8.3	6.7
2011		74	12.3	9.9	15.2	9.9	8.6
2012		57	9.5	7.4	12.1	9.7	8.3
2013		53	8.6	6.6	11.0	9.0	7.8
2014		65	10.7	8.5	13.5	8.0	7.4
2015		37	6.1	4.4	8.3	7.6	6.7
2016		48	8.3	6.4	10.9	7.2	6.7

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

2.15iii - Successful completion of alcohol treatment Barnet — Proportion - %

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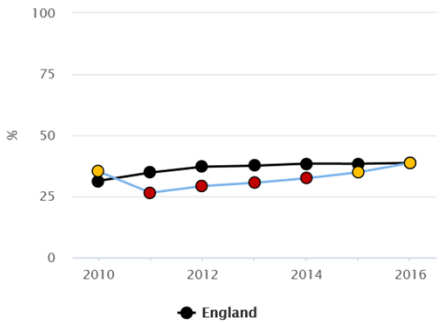


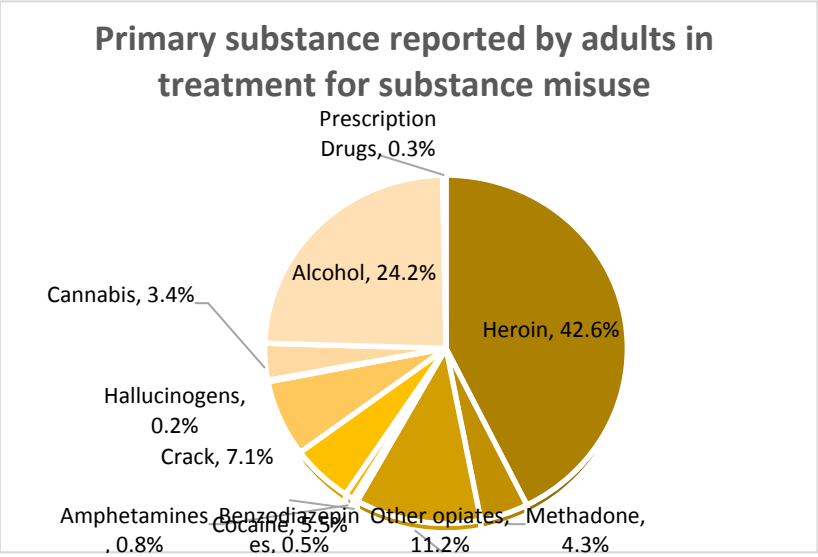
Recent trend:

Period		Count	Value	Lower CI	Upper CI	London	England
2010		96	35.2	29.7	41.0	32.0	31.4
2011		62	26.5	21.3	32.5	35.3	34.8
2012		97	29.2	24.6	34.3	35.5	37.1
2013		129	30.6	26.4	35.1	35.5	37.5
2014		130	32.4	28.0	37.1	38.1	38.4
2015		121	34.9	30.0	40.0	41.3	38.4
2016		106	38.7	33.1	44.6	40.6	38.7

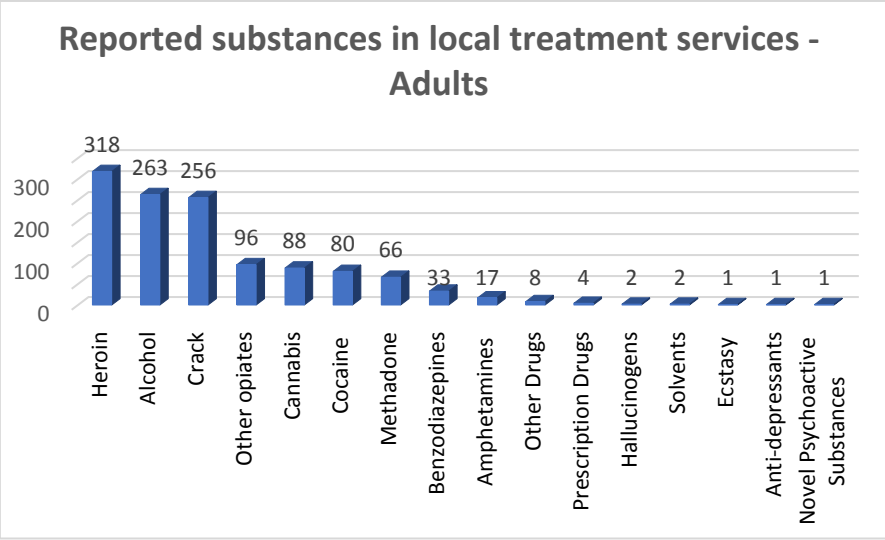
Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the National Drug Treatment Monitoring System

3. Substance misuse trends – Adults

The following graph shows a snapshot of what substances are reported by adults accessing local substance misuse treatment services. Primary opiate users account for 58% of people in treatment. This is followed by alcohol users, forming 24% of the treatment population. There were a total 652 people in treatment. This is not unusual and is a similar picture when looking at national data[iii]. National data show that just over half of the clients in contact with treatment during the year (52%) had presented with problematic use of opiates, a further 19% had presented with problems with other drugs and just under a third (29%) had presented with alcohol as the only problematic substance.



Of the 652 individuals in treatment at this point in time, 62% report using at least one other substance and 28% report using at least a further 2 substances. Opiates, alcohol, crack and cocaine, and cannabis are the most common substances used. Similar to the national picture, crack, cocaine and cannabis are the most commonly cited other drugs used.



Recent data shared with the local public health team from Public Health England also showed the following:

- There are higher than average mental health conditions reported in the Barnet substance misuse service
- The "over the counter" medicine treatment cohort is lower than the national average proportion of the treatment population
- There is a higher rate of club drug users in treatment (although this is a small percentage)
- There are higher numbers with urgent housing need (12% compared to 10% nationally)
- There are higher numbers who are economically inactive (51% compared to 40%)

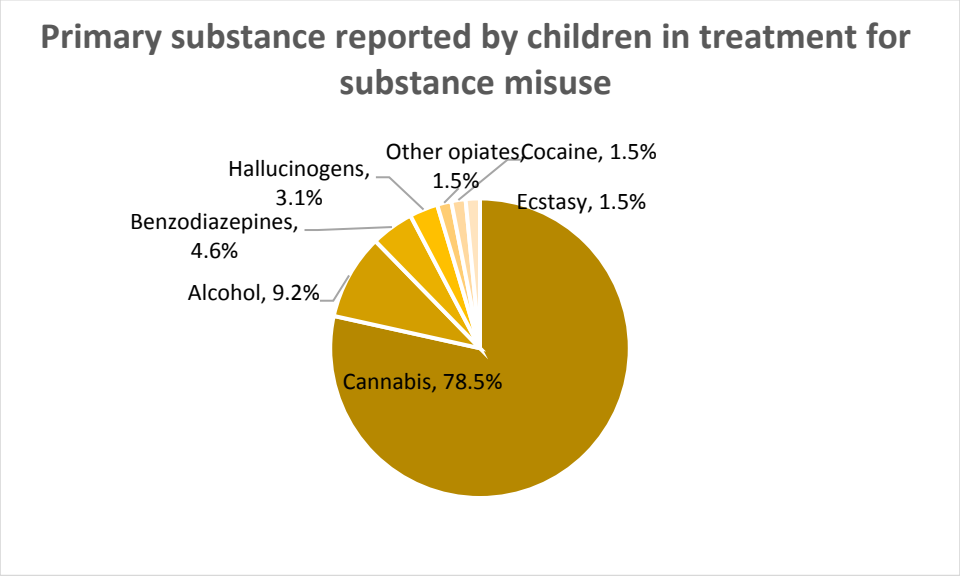
Additionally, there is a growing body of evidence[iv] exploring the way in which older people use alcohol, and detailing the nature, range and benefits of age-sensitive treatment approaches. These all present areas for further exploration locally to ensure our strategy and services are responding appropriately to local need.

Lastly, a local deep-dive exploring the relationship between substance misuse, mental health and domestic abuse was completed. The review made numerous recommendations that have been drawn together in an action plan. These include:

- Addressing ineffective referral pathways, learning lessons from audit and case review
- Improving the identification and management of domestic abuse in Mental Health and Substance Misuse settings by embedding best practice through evidence based commissioning
- Improving holistic, multi-agency working in Family Services to ensure parents have access to the right support at the right time

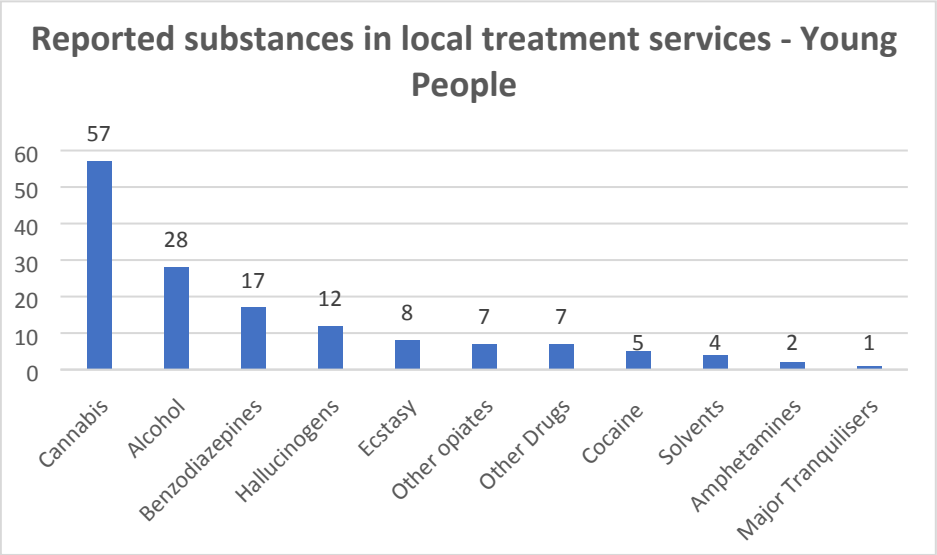
4. Substance misuse trends – Young People

The following graph shows a snapshot of what substances are reported by young people accessing local substance misuse treatment services. The picture is very different to that of the adults service. Primary cannabis users account for 78.5% of people in treatment. This is followed by alcohol users, forming 9.2% of the treatment population. There were a total 65 young people in treatment.



Of the 65 individuals in treatment at this point in time, 65% report using at least one other substance and 42% report using at least a further 2 substances. Unlike the adult population, young

people in treatment are more likely to report benzodiazepine, hallucinogen and ecstasy use. Whilst opiate and cocaine use is less common than in adults, there are some young people using these substances.



Looking at national data[v] the picture is similar. Since 2005, young people are more likely to seek help for problem cannabis use and this remains the most common problem drug. Alcohol is the second most common substance reported by young people in treatment, although this has declined over the years.

5. Preventative interventions

a) Risk groups

Earlier this year, PHE published "The public health burden of alcohol: evidence review"[vi]. The review looks at the impact of alcohol on the public health and the effectiveness of alcohol control policies.

In England, alcohol misuse is the biggest risk factor attributable to early mortality, ill-health and disability for those aged 15 to 49 years, and the fifth biggest risk factors for people of for all ages. Alcohol consumption has been identified as a factor in more than 200 health conditions, and is associated with social consequences such as loss of earnings or unemployment, family or relationship problems, and prolems with the law. Many of these harms go beyond affecting the individual consuming the alcohol and extend to their wider social and familial network including their partner, child, friends, co-workers and even strangers.

Alcohol related risk can be determined by three main factors:

- The volume of alcohol consumed
- The frequency of drinking occasions
- The quality of alcohol consumed

There are also a number of individual risk factors that moderate alcohol-related harm:

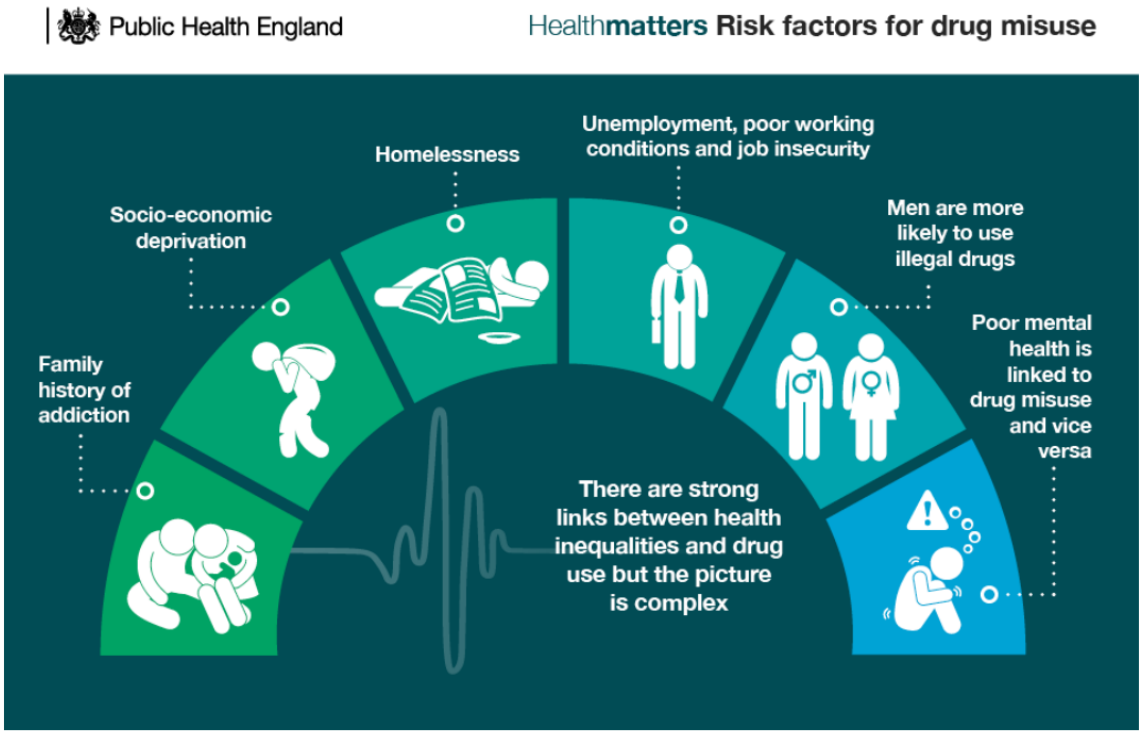
- Age: children and young people are more vulnerable to alcohol-related harm
- Gender: women are more vulnerable to alcohol-related harm from higher levels of alcohol use or particular patterns of drinking

- Familial risk factors: exposure to abuse and neglect as a child and a family history of alcohol use disorders (AUD) is a major vulnerability
- Socioeconomic status: people with lower socioeconomic status experience considerably higher levels of alcohol-related harm
- Culture and context: the risk of harm varies with the culture and context within which the drinking takes place, for example drinking while driving can result in serious penalties and harm
- Alcohol control and regulation: a critical factor in determining levels of alcohol-related harm in a country is the level and effectiveness of alcohol control and regulations

In 2017, NICE published its first guidance[vii] on targeted interventions for drug misuse prevention. The guidance defines groups at risk of drug misuse in the following categories:

- People who have mental health problems
- People who are being sexually exploited or sexually assaulted
- People involved in commercial sex work
- People who are lesbian, gay, bisexual or transgender
- People who are not in employment, education or training (this includes children and young people who are excluded from school or who truant regularly)

Established risk factors for drug misuse



b) The human-socioeconomic costs of substance misuse

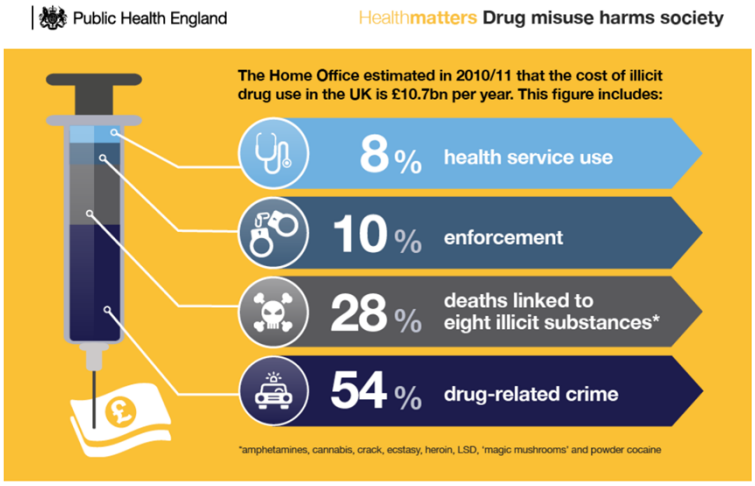
Alcohol-related harms can be tangible and can be given an economic cost, such as injuries, or can be intangible and almost impossible to cost such as emotional distress caused by living with a heavy drinker. The harms can be relatively mild, such as drinkers loitering near residential streets, or can be severe including death or a lifelong disability.

The direct costs of alcohol misuse are typically borne by government, whereas indirect costs tend to be borne by society at large, by the drinkers themselves, their families and their associates.

There have been numerous attempts to quantify the economic burden of alcohol, however it is likely that such evaluations capture only a fraction of the true 'cost' of alcohol-related harm.

A Cabinet Office estimate placed the economic costs of alcohol in England at around £21 billion in 2012, equivalent to 1.3% GDP. This estimate included costs relating to alcohol-related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace and problems for those who misuse alcohol and their families, including domestic violence. These estimates are now outdated, more recent studies indicate a cost closer to 2% GDP.

Similarly, drug misuse also impacts all those around the user and the wider society. The Home Office estimated in 2010 to 2011 that the cost of illicit drug use in the UK was £10.7 billion per year[viii]. This is broken down as demonstrated in the following diagram.



28% of costs relate to deaths linked to illicit substances. Deaths involving opioids (such as heroin) account for the majority of drug poisoning deaths. Heroin related deaths in England and Wales have more than doubled since 2012 to the highest number since records began 20 years ago.
There are also a small but rising number of deaths involving new psychoactive substances and prescription/over-the-counter medicines, including pregabalin and tramadol.

In Barnet the rate of drug related deaths has remained steady. Although the graph below shows a gradual increase, this is not statistically significant. The Barnet rate is similar to London and below that of England.

2.15iv - Deaths from drug misuse Barnet — Directly standardised rate - per 100,000

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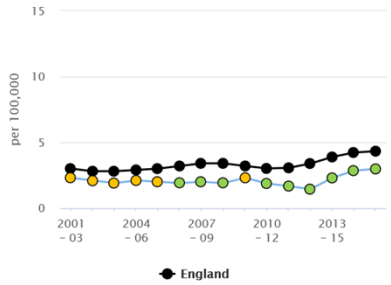
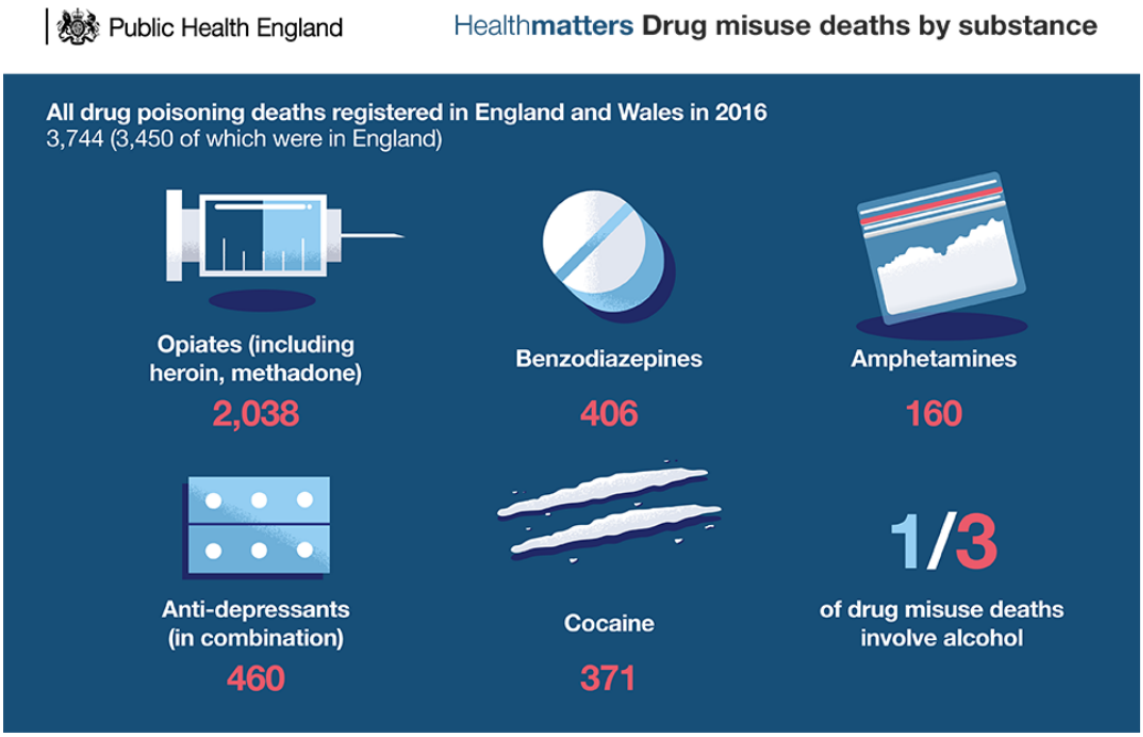


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	London	England
2001 - 03		23	2.3	1.4	3.5	2.6	3.0
2002 - 04		22	2.1	1.3	3.2	2.3	2.8
2003 - 05		21	1.9	1.2	2.9	2.5	2.8
2004 - 06		23	2.1	1.3	3.1	2.6	2.9
2005 - 07		22	2.0	1.3	3.1	2.8	3.0
2006 - 08		19	1.9	1.1	2.9	2.8	3.2
2007 - 09		20	2.0	1.2	3.1	2.8	3.4
2008 - 10		21	1.9	1.2	3.0	2.8	3.4
2009 - 11		25	2.3	1.4	3.4	2.6	3.2
2010 - 12		21	1.9	1.1	2.9	2.3	3.0
2011 - 13		17	1.7	1.0	2.7	2.2	3.1
2012 - 14		14	1.4	0.8	2.4	2.3	3.4
2013 - 15		23	2.3	1.4	3.5	2.8	3.9
2014 - 16		30	2.8	1.9	4.1	3.1	4.2
2015 - 17		33	3.0	2.0	4.2	3.0	4.3

Source: Office for National Statistics (ONS)

Research has shown that every £1 invested in drug treatment results in a £2.50 benefit to society.



c) Barnet Prevention opportunities

<u>Preventing alcohol related harm – what the evidence says:</u>

As mentioned earlier in this report, the PHE report "The public health burden of alcohol: evidence review" looks at the impact of alcohol on the public health and the effectiveness of alcohol control policies. It indicates that the key influencers of alcohol consumption are:

- Price (affordability)
- Ease of purchase (availability)
- Social norms (acceptability)

The key ways in which these influencers can be impacted are as follows:

- **Taxation & price regulation**
  Policies that reduce the affordability of alcohol are the most effective, and cost-effective, approaches to prevention and health improvement.
- **Regulating marketing**
  Exposure to alcohol marketing increases the risk that children will start to drink alcohol, or if they already drink, will consume greater quantities.
- **Regulating availability**
  Policies that sufficiently reduce the hours during which alcohol is available for sale – particularly late night on-trade sale – can substantially reduce alcohol-related harm in the night-time economy.
- **Providing information & education**
  Whilst there is little evidence to suggest that providing information, education and labelling on alcoholic beverages is sufficient to lead to substantial and lasting reductions in alcohol-related harm, this remains an important component in any overall policy approach.

- **Managing the drinking environment**
  Interventions delivered in and around the drinking environment lead to small reductions in acute alcohol-related harm. However, their implementation is resource intensive.
- **Reducing drink-driving**
  Enforced legislative measures to prevent drink-driving are effective and cost-effective. Policies which specify lower legal alcohol limits for young drivers are effective at reducing casualties.
- **Brief interventions & treatment**
  Health interventions aimed at drinkers who are already at risk (eg IBA - Identification and Brief Advice) and specialist treatment for people with harmful drinking patterns and dependence are effective approaches to reducing consumption and harm in these groups. Their success depends on large-scale implementation and dedicated treatment staffing and funding streams, without which they are less effective.
- **The policy mix**
  Stronger overall policy environments are associated with lower levels of binge drinking and alcohol-related death. The Organisation for Economic Co-operation and Development (OECD) suggests that combining alcohol polices may result in changing social norms around drinking to increase the impact on alcohol-related harm.

Preventing drug misuse – what the evidence says:

The NICE guidance "Drug misuse prevention: targeted interventions"[ix], published in 2017, outlines ways that we can attempt to prevent or delay harmful use of drugs in children, young people and adults. Many of these recommendations are also applicable to alcohol misuse.

The key ways identified include:

- **Deliver substance misuse prevention activities to high risk groups and in settings where people may use drugs**
  Offering information, advise and awareness raising in settings such as primary care, mental health services, sexual health services, health visiting, midwifery, criminal justice services, A&E, hostels, nightclubs, festivals and gyms (to target people using image and performance enhancing drugs)
- **Screening, identification and brief advice**
  Assessing whether someone is vulnerable to substance misuse at opportunistic and routine appointments with statutory and other services such as those listed above. Where vulnerability is identified, brief intervention should be offered.
- **Skills training for vulnerable children and young people**
  Skills training aims to increase resilience and reduce risk by helping vulnerable young people develop appropriate skills such as conflict resolution and managing stress.

Local prevention opportunities – putting the evidence into practice

Although many of these options are reliant on national policy, there is opportunity to impact in some of these areas through a co-ordinated partnership approach across the council. The Barnet public health team recently completed the mini-CLeaR self-assessment tool[x]. CLeaR is an evidence-based improvement model which stimulates discussion among partners about local opportunities for improving outcomes through effective collaborative working. It helps partnerships determine how the local structures and processes currently in place support a reduction in alcohol-related harm.

Many of the recommendations are also applicable to reducing drug related harm.

Although the full assessment tool is still to be completed, the initial findings suggest the following areas for improvement:

Leadership, vision & governance:
It is recommended that the Health and Wellbeing Board and Community Safety Partnership Board articulate a clear ambition for reducing alcohol harm which demonstrates a widely understood and shared vision for reducing alcohol (and drug) related harm. This should be demonstrated by strong oversight of the local substance misuse strategy and implementation plan.
Planning and commissioning services
It is recommended that an updated needs assessment is completed, addressing the needs of all at-risk groups, including offenders, the homeless, young people, women with complex need and alcohol misusers with co-existing mental health needs. Further attention should be given to older adults, club-drug/NPS users and people using OTC/prescription medications.
It is recommended that the current plan for preventing and reducing alcohol harm is updated, and reflects current evidence base, current service configuration and how this meets need at population, group and individual level. The plan will also need to reflect capacity and resources available to achieve recommendations.
Improved joint commissioning between public health and other key stakeholders (such as community safety and health) when there is shared responsibility for planning and commissioning of services can reduce drug and alcohol related harm.
Routine, co-ordinated data sharing across local alcohol partners should be used to inform strategic planning and operational service delivery. For example, responding to alcohol related crime and disorder, informing licensing decisions and targeting services. Relevant indicators of alcohol related harm should also be reflected in KPI dashboards across partnership boards.
There are strong operational relationships between substance misuse, mental health, employment and housing providers however these could be strengthened strategically with common purpose reflected in strategy and commissioning.
Communications & Social Marketing
Whilst the public health team and provider deliver alcohol campaigns throughout the year, a partnership approach to campaigns could be beneficial. These should be targeted at specific audiences based on population segmentation with clear pathways into suitable advice, information and support. A Barnet One You website is being developed that will provide an excellent campaign platform. Further thought could be given to how population level messages are targeted at young people.
Alcohol Licencing
The evidence indicates that influencing local licencing policy is one of the most effective ways to prevent alcohol related harm. It is recommended that there should be improved recognition of alcohol-related harm in the local licensing policy with a commitment to use local crime, health and social care data to inform policy and planning.

Targeting risk groups
A more systematic approach to offering information, identifying need and offering support/brief intervention in “at-risk” groups could reduce alcohol related harm through earlier identification. This would include improved screening and brief advice across a range of primary, secondary and social care services including other settings such as criminal justice settings.
Improving the resilience of at-risk children and young people.
There are a range of programmes available to children and young people in Barnet that aim to improve resilience. Substance misuse information, advice and screening form a part of many of these, however further work can be completed to further develop this aspect.

6. References

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[v]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664945/Young-people-statistics-report-from-the-national-drug-treatment-monitoring-system-2016-2017.pdf

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[x]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/690161/Local_alcohol_services_and_systems_improvement_handbook.pdf