Joint Strategic Needs Assessment (J SNA) on Drugs and Alcohol

April 2017
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1. Executive summary and recommendations for consideration

In August 2015 responsibility for the Drug and Alcohol Strategy was transferred to the Department of Health and Social Care (DHSC) from the Department of Home Affairs (DHA). The multi-agency Drug and Alcohol Steering Group (DASG) was formed to drive the development of the Drug and Alcohol Strategy for the Isle of Man. A strategy that meets the population’s needs should be manageable within resources and effective in its outcomes. To inform the strategy, this JSNA was commissioned. The JSNA will assist in setting the priorities to steer the drug and alcohol strategy and provide stakeholders with the information to plan interventions and services that meet the needs of the population. It will also give officers the evidence and confidence to cease services that are not achieving the desired outcomes and profile budgets accordingly.

The chronic lack of formally quantifiable data sources is a major evidence/intelligence gap. This gap in data makes it difficult to forecast future service needs or to evaluate the outcomes of interventions. The qualitative data provided by partners across government and beyond offer a perspective on perceptions and beliefs. These are not always in line with the evidence. Nevertheless there is a general agreement about the principal issues and local areas for improvement both in the treatment system and in the wider issues that affect, and are affected by, drug and alcohol misuse.

1.1 Who is at risk of harm from drug and alcohol misuse and why?

There is currently no available data to profile adults in the wider community (those not in touch with services) to identify those who are most at risk of drug and/or alcohol misuse.

However, service user data collected from the Drug and Alcohol Team (DAT) and voluntary-sector service Motiv8 show that men are more likely to be in treatment than women, and the majority of those in treatment are aged 25-39 years old.

An analysis of postcode data illustrating the numbers of residents in treatment showed that the Douglas area (IM1 and IM2) was over-represented in terms of client referrals. It is not clear whether this reflects higher levels of consumption in these areas or whether residents are more likely to access treatment for other reasons, e.g. proximity to services.

Police and prison data indicate offenders both in and out of prison have the highest concentration of drug and alcohol misuse issues, addiction and dependency.
Alcohol was involved in around half of arrests in 2014/2015, and 74% of people entering prison in 2015 tested positive for at least one drug.

The ‘co-morbid needs’ data supplied by Motiv8 only covers that service and indicates 60% of clients in treatment have a mental health problem of some kind, 7% have a personality disorder, and 6% have child protection involvement. Addressing these issues in the population earlier, through improving social cohesion and strengthening mental health services - especially for those who have experienced abuse or social isolation in childhood - will reduce the risk of the development of drug and alcohol problems.

1.1.2 What is the extent of the issue locally?

The Isle of Man Youth Survey, 2015 (Children’s Services Partnership, 2016)\(^2\) gives some information about alcohol consumption and attitudes to drug misuse in the 11-18 age group:

- 87% of boys and 92% of girls aged 11-14 reported never having had an alcoholic drink
- 52% of males and 34% of females aged 15-18 reported never having drunk alcohol
- 88% reported no binge drinking over the past three months
- The data indicates that consumption of alcohol among young people is reducing. More data is required to determine whether this is an ongoing trend
- A large proportion of young people found information provided at school on alcohol, smoking, drugs and legal highs to be helpful, however, some reported having been given no information about ‘legal highs’.

There is no data available to identify which drugs are being used by people in the wider community (people not in touch with services). Prison reception data indicates the most common positive result was for cannabis. Detection rates of morphine and benzodiazepines were also high; this is mirrored in data for clients of the Probation Service.

Police seizures of illicit drugs over the past three years indicate that cannabis is by far the most commonly seized drug, followed by cocaine and heroin (seizures of heroin, crack cocaine and ‘traditional’ recreational drugs ecstasy and amphetamine have declined).

Data indicates an increased use of prescription-only medicines; this requires careful attention to control the supply. Data shows a downward trend in prescribing of hypnotic medicines (such as benzodiazepines) since September 2014.
However, in December 2015 levels were increasing again. This may indicate a need to carefully scrutinise and monitor the use of prescription medicines to ensure that they do not feed into the illicit market and that those on a prescription do not develop a dependency.

1.1.3 Provision and activity

The Isle of Man drug and alcohol substance misuse system consists of one service directly provided by DAT within the DHSC and one voluntary-sector service (Motiv8).

Together, services provide structured and non-structured treatment for adults and young people, both in the community and in prison. A person entering either service receives an assessment and package of care designed to meet their individual needs.

Service specifications are sometimes lacking and it is not clear that they would all meet accepted quality standards or be in line with best current evidence. The provision of alternative therapies (acupuncture provided within DAT) should be questioned given the lack of evidence base for these.

Both organisations providing treatment use the same core dataset, but there is variation in their data management procedures and reporting. There is no central database containing client assessment data and whole system treatment data is not formally integrated and overseen in terms of performance management.

Some GPs manage drug- and alcohol-dependent patients independently over the longer term. There is a lack of governance in place for this. A Drug Arrest Referral system (DARS) and an Alcohol Arrest Referral system are in place.

Needle exchange facilities are offered by some community pharmacies within a Locally Enhanced Service arrangement with DHSC. There does not appear to be a formal service specification for the service and no monitoring data was available for this JSNA. It was not possible to tell whether the needle exchange provision is appropriate in terms of volume and coverage, or whether it is being delivered to appropriate quality standards (as set out in NICE: Needle and syringe exchange programmes, PH52 [NICE, 2014]).

There is provision for screening for blood-borne viruses; nevertheless, there is no treatment pathway in place for hepatitis C.

In 2015/2016, 1,540 adults entered or continued in structured treatment for misuse of drugs or alcohol; the proportion of different ethnic groups in drug
and alcohol treatment generally reflects the overall demographic profile. Referrals to DAT show a slightly higher proportion using alcohol than drugs, with 11% of those referred using both alcohol and other substances. There has been a decline in the proportion of drug users and an increase in alcohol users engaged in the treatment system.

The rate of successful treatment completion (of those leaving treatment) was 51% during 2015/2016, nevertheless, full and sustained rehabilitation is seen as very difficult to achieve.

The Tier 2 and Tier 3 services are perceived to be effective by professional stakeholders and those engaged in treatment.

There is some confusion among stakeholders about what Tier 4 services are available (inpatient detoxification in particular) and how and where they may be accessed, both currently and in the future.

Some formal pathways appear to be lacking (for example for benzodiazepines or steroids), and data from the needle exchange service shows that people are injecting steroids. Service interfaces are not always well defined, for example between forensic medical examiners in the custody suite and DAT. Pathways to aftercare were not entirely clear.

The Licensing Forum promotes responsible marketing, promotion and selling of alcohol – for example, there is a new Licensing Code of Practice. Initiatives are in place to prevent the sale of alcohol to minors and identified individuals, and the display of alcohol in supermarkets is limited.

In terms of prevention activities, education sessions are provided in schools and annual campaigns relating to reducing drink driving have been undertaken.
1.1.4 Evidence of what works

The World Health Organisation (WHO, 2009) recommends provision of sterile injecting equipment through needle and syringe programmes and opioid substitution therapy as the most effective treatment options for people dependent on opioids. The evidence shows that such programmes not only benefit individuals but also entire communities through reduced crime and public disorder as shown below:

- Drug users in treatment commit fewer crimes
- Research has shown offences halve when drug users enter treatment
- Psychological interventions help in terms of greater treatment retention and fewer relapses, and a reduction in drug use
- Residential rehabilitation has shown positive outcomes in terms of improved rates of abstinence
- Needle exchange schemes reduce injecting-risk behaviours, reduce public order problems and reduce HIV prevalence.

Legislation, regulation and control of supply are the overarching interventions that are most cost-effective in reducing alcohol misuse. The more comprehensive a policy is, the more alcohol consumption is lowered and the more cost-effective the policy will be (WHO, 2009). Population-based interventions represent highly cost-effective uses of resources to reduce alcohol-related harm. These include:

- Restricting access to supply of alcohol by maintaining the regulation of retail sale opening hours
- Reducing the number of outlets selling alcohol (Bryden et al, 2012)
- Increasing the price of alcohol (Ibid).

Concern has been expressed that price increases do not make an impact on heavier drinkers, but evidence suggests (Wagenaar et al, 2009) that it has an increased differential impact on heavier drinkers and reduces consumption in lighter drinkers.

Interventions individually directed at drinkers already at risk are effective and cost-effective. Brief interventions for individual high-risk drinkers are cost-effective (WHO, 2009) but may be harder to scale up because of their associated training and manpower needs. Early intervention with systematic identification and brief advice (IBA) has been shown to be effective.
Compared to prisons and custody suites, probation services were found to be the most suitable for alcohol screening, and participants were positive about receiving interventions for their alcohol use in probation settings (Coulton et al, 2012)\textsuperscript{8}.

Evidence shows that information and education programmes alone do not reduce alcohol-related harm (WHO, 2009)\textsuperscript{4}; nevertheless, they have a role in providing information, reframing alcohol-related problems and increasing attention to alcohol in political and public agendas. Policy needs to be aligned across all levels of society to be most effective (WHO, 2011)\textsuperscript{9}.

School-based education can be important, but needs to be a part of, and in support of, the implementation of an effective and comprehensive policy across all areas of government.

### 1.1.5 Unmet need and service gaps

There is a lack of formally quantifiable consistent data sources to inform this joint strategic needs assessment. The qualitative data provided by partners across government and beyond offer a perspective on perceptions and beliefs. These are not always in line with the evidence. Nevertheless, there is a general agreement about the principal issues and local areas for improvement both in the treatment system and in the wider issues that affect, and are affected by, drug and alcohol misuse.

Tier 2 and Tier 3 services are understood to have formal pathways in place and arrangements for governance and quality assurance. However, it was not possible to formally evaluate these within the scope of this JSNA. There appears to be a lack of formal pathways particularly around the interfaces between services, for example, needle exchange service with the result that whether an individual is offered access to a particular service (or element of service) may depend on the knowledge of individual staff members.

Unmet needs in the general population and treatment penetration rates cannot be calculated until reliable prevalence data is available.

In the current treatment system, drug and alcohol service clients are excluded from low-intensity mental health services. It was perceived that some drug and alcohol service clients not engaged with DAT may have to wait up to a year to see a psychologist. A perception that the long wait for access to the pain management clinic (wait can be between two and five years) contributes to the high use of prescribed hypnotics in the Isle of Man.
There is a view that more support is needed for the increasing number of children with emerging emotional and mental health needs, as these children are vulnerable to developing drug and alcohol misuse, and more access to support for those experiencing significant life events that they cannot cope with.

Some service users felt that their referral to Tier 3 was delayed until a moment of crisis. There is therefore, a perception that services are geared to treatment rather than prevention.

We note recent developments in the UK where the Novel Psychoactive Substances Act (UK Legislation, 2016)\textsuperscript{10} was passed in 2016, which had the effect of making it an offence to produce, supply, import or export psychoactive substances (described as \textit{any} substance that has a psychoactive effect). The Isle of Man Government, Treasury Department, made a legal order under the Custom and Excise Act (IOM Legislation, 2017)\textsuperscript{11} banning the import, export, production and possession with intent to supply of psychoactive substances. The Psychoactive Substances Act 2016 (Application) Order 2016 (IOM Legislation, 2016)\textsuperscript{12} came into effect on 18 August 2016.

A notable gap in the treatment system is in arranging for shared care with GPs (where drug clients are stable on a programme of opioid substitution therapy, this is the most appropriate provision).

There is limited provision in terms of a recovery community and activity programmes for recovery and rehabilitation, particularly for those who use drugs. Additionally, there is no supported accommodation for drug and alcohol clients on-Island during or after recovery.

Improvement is needed in systems for data collection in relation to the development of a core dataset for regular reporting to the DASG on activity and effectiveness.

\subsection{1.1.6 Forecasting (3-5 years and 5-10 years)}

Until accurate local data is available on current prevalence of drug and alcohol misuse and treatment penetration, forecasting future service needs is not possible. Nevertheless, some trends appear to be emerging locally; for example, decreased use of alcohol in children and young people (as evidenced by the School Survey data [Children’s Partnership Services, 2016]\textsuperscript{7}).
Police seizures over the past three years of heroin, crack cocaine and ‘traditional’ recreational drugs ecstasy and amphetamine have declined, while seizures of cannabis and mephedrone have increased. Although rates are still high, there has been a downward trend in the prescribing of hypnotic medicines (such as benzodiazepines) since September 2014, and further work with GP leaders has potential to reduce this further.

1.1.7 Responding to unforeseen threats

Professionals consulted suggested that alcohol abuse is seen as less prevalent in young people, whereas stimulant drug use is more of a problem.

A number of those consulted noted that many drug users and the general public have little idea about emerging novel psychoactive substances (NPS), and what are commonly referred to as ‘club drugs’, and their potential for serious harm. New drugs are emerging all the time and their harmful effects are poorly understood. Clinicians in the Isle of Man Custody Suite and in the Emergency Department (ED) report very unpredictable effects and odd behaviours as a result of use of these drugs. Currently, use of these drugs is lower than more established drugs (such as cannabis and alcohol), but patterns of use are rapidly changing.

Club drug users* may not see traditional drug services as meeting their needs but rather for groups such as heroin users. Club drug users may not see themselves as needing treatment, might only consume drugs at weekends, and will often be in employment and education.

With a distinct perception about what a drug user ‘looks like’, club drug users may not see themselves as fitting in with this perceived identity and so may not seek support. Stakeholders can work to change this attitude by raising awareness of the needs of club drug and NPS users as ‘core business’ and placing them on an equal footing with alcohol and opiate treatment.

1.1.8 Data items required to establish needs in a JSNA

In the preparation of a drug and alcohol JSNA, we would look for a wide range of data describing the various facets of the impact of drug and alcohol use. There was a lack of formally quantifiable data sources to inform this

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* ‘Club drugs’ are a loose category of drugs, including ecstasy, ketamine and methamphetamine, which are primarily associated with consumption in clubs, bars and parties. There is no common link between the drugs other than the location in which they tend to be consumed.
joint strategic needs assessment. The data we would expect to access for a JSNA is set out in Table 8 on page 91. Many of these data items are not currently collated and this significantly limits the ability to either assess the need for drug and alcohol interventions or to monitor the impact of interventions that may be introduced.

1.2 **Recommendations for consideration**

The recommendations set out in this report are based on the assumption that that the DASG will act as an ongoing formal strategic partnership for alcohol and drugs oversight and performance management. The DASG should involve key stakeholders and agencies to agree a comprehensive strategy to address gaps to prevent and treat drug and alcohol misuse and maintain an appropriate legislation and enforcement framework. The DASG should agree (and ensure resources and capacity for) an implementation plan for the new strategy and be held accountable for the delivery of this plan.

Recommendations are grouped below under four functional area headings and prioritised within these areas. Priority is given through considerations of evidence of effectiveness and cost-effectiveness, local data (where available) and locally perceived urgency.

**Table 1: Summary of Recommendations**

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<th>Education and prevention</th>
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<td><strong>Recommendations</strong></td>
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- a) Agree service specification and commission the IBA intervention for alcohol misuse across appropriate services (for example, primary care, ED, criminal justice and social care).

- b) Review the content and delivery of Personal, Social, Health and Economic (PSHE) education in relation to drugs and alcohol misuse and audit against recent evidence review.

- c) Ensure improved interaction with formal pathways into and between services, (for example, housing, domestic abuse pathway etc.)

- d) Review and strengthen links to adult and children’s safeguarding boards to safeguard and promote the health and wellbeing of adults and children.

- e) Ensure an in-depth assessment of the needs of young people who are more likely to be vulnerable to substance misuse through joint working with DHSC Children’s and Families Division.
### Legislation and enforcement

**Recommendations**

a) Consider increasing the price of alcohol through minimum unit pricing when issues around the potential legal challenge have been resolved.

b) Review legislation on cannabis possession; using evidence from other jurisdictions.

c) Consider reviewing the feasibility of permitting cannabis for medical use, drawing on experience in other jurisdictions.

d) Ensure effective communication between partner agencies, for example, combining the disruption of illegal supply of drugs with support and treatment to addicts who experience reduced availability.

### Governance, data and performance

**Recommendations**

a) Develop a core data set for needs assessment, audit, monitoring and evaluation.

b) Develop formal commissioning and performance management arrangements for Tiers 1 to 4 (inclusive).

c) Ensure that relevant information-exchange arrangements are in place, using appropriate protocols across all agencies to support the continuity of care.

d) Ensure service specifications with audit, quality and performance management arrangements are in place to safeguard the quality and safety of services and targeted interventions across all agencies.

e) The DASG to review investment across the treatment system and ensure that this is sufficient for the required range of prevention, harm reduction and treatment services to meet need (when reliable data is identified).
# Treatment and rehabilitation

## Recommendations

a) Ensure that equitable access to care is supported by the existing evidence base and a clear commissioning policy.

b) Ensure formal pathways, service specification, performance and outcome management are in place for each tier 1 to 4 (inclusive).

c) Introduce shared care arrangements with General Practice by strengthening collaborative working between treatment providers and GPs.

d) Review the community pharmacy needle exchange programme to ensure appropriate levels and quality of provision.

e) Put in place a programme of work to audit and review prescribing practices for prescription drugs (hypnotics, pregabalin) linked to pain management, with GP practice leads.

f) Ensure people in treatment have recovery/rehabilitation plans that empower them to take responsibility for their own health and formal planning.

g) Improve interaction with formal pathways into, out of and between services, for example, Mental Health Services, Housing, Domestic Abuse, etc. in order to strengthen and support aftercare.

h) Develop a formal service specification and pathway for blood-borne viruses for people who use drugs in all areas of health service delivery. This should include improved arrangements for vaccination and commissioning of evidence based treatment for hepatitis C.
2. Introduction

Many people use alcohol or drugs at some stage in their lives and for some this leads to social, physical or mental health problems, and may include contact with the criminal justice system. This assessment focuses upon alcohol and non-medical drug use for purposes such as recreation, or due to addiction, that causes problems either to the individual, their family or the wider community. It should be noted that in the Isle of Man, as elsewhere, alcohol use above low-risk levels (alcohol unit guidelines for the Isle of Man [IOM Public Health, 2017]) is widespread and recreational drug use is significant, but addiction is concentrated in a relatively small number of people. The social, physical or mental health problems that occur as a result may be related to intoxication, regular excessive consumption or dependence. The problems impact on the individuals concerned, but also upon their families, with harmful effect on the mental health and wellbeing of children often lasting into their own adulthood and affecting their own later health behaviours.

Drinking in the Isle of Man takes place principally within a social context, which has a powerful influence on the amount and the patterns of drinking in the community. The effectiveness of prevention and control measures will moderate the total number of problem drinkers, and there are strong reasons for working towards changes to what is often perceived to be a hard-drinking culture in the community by being more open about the risk of health harms from drinking alcohol in excess of the low-risk levels. Alcohol is one of the three major lifestyle risk factors after smoking and obesity. It is linked to cardiovascular disease, liver disease, some cancers and some neurological conditions. After smoking and poor diet, alcohol consumption is the lifestyle risk factor which has the highest impact on the NHS (Scarborough et al, 2006-7).

Alcohol causes a range of behavioural disorders, particularly associated with violent behaviour. The Chief Constable’s Annual Report to the triennial session of the licensing court (2015) [Chief Constable, 2015] noted that around half of all arrests in the Isle of Man in 2014 involved alcohol.

Alcohol consumption is driven by many factors and some recent changes are likely to have had an impact on alcohol consumption. UK data show that by 2013, alcohol was nearly 61% more affordable than it was in 1980.

Drinking at home has increased whereas social drinking in pubs and clubs has decreased, in particular for older people. The latest data from the Office of National Statistics (ONS, 2012) report that, in the period 2009-2012, spending on alcohol per household in the UK increased by 1.3%, whilst consumption outside the household fell by 10%. There is no comparable data for the Isle of Man.
Evidence-based drug treatment can reduce costs to society and deliver real savings across government departments, notably in the criminal justice system, but also in savings to health and social care services. This is through improvement in physical and mental health, reduced drug-related deaths and lower levels of blood-borne disease (NAO, 2010)\textsuperscript{16}.

Treatment for alcohol problems is both clinically and cost-effective. A number of interventions to reduce alcohol related harm are supported by evidence of clinical and cost-effectiveness from well conducted studies. (Global Burden of Disease, UK)\textsuperscript{17}.

This Needs Assessment identifies areas of potential for policy development, joint working, population engagement, and service development. The aim is to support the development of a strategy to reduce the harm caused by drugs and misuse of alcohol, and facilitate real and lasting positive gains for individuals, families and local communities.
3. Provision and activity

This section sets out an overview of what services are currently provided for those who require drug and alcohol treatment. Key findings are:

a) The current approach to treatment provision adopts the framework as set out in ‘Models of Care’ - a guide to structuring and delivering services that is also followed in England and Wales

b) Drug and alcohol treatment services consist of Motiv8 (a Tier 2 service) and DAT (a Tier 3 provider)

c) Current provision covers most of the expectations as set out in ‘Models of Care’ - the most notable gap in service provision is the lack of ‘IBA’ for alcohol users (an evidence-based short intervention)

d) A range of treatment pathways exist between the different tiers that link specialist treatment into a range of non-specialist and generic settings

e) Tier 4 - the provision of residential specialised drug treatment is largely provided off-island.

f) Numbers of referrals into treatment have gradually increased over time

g) According to treatment data, almost exactly half (51%) of those discharged have successfully completed treatment, nevertheless; full and sustained rehabilitation is seen as very difficult to achieve.

3.1 What services are currently provided

The adoption of the tiered approach on the Isle of Man, following the Models of Care, is consistent with good practice and provides a robust and transparent approach to service delivery.

The concept of a ‘tiered’ model of provision, whilst not evidence-based, is normative practice in drug and alcohol treatment and has been the basis of provision in England and Wales for over 10 years. The model is described as “a conceptual framework to aid rational and evidence-based commissioning” and is set out in detail in:

- Models of care for alcohol misusers (MoCAM) [DoH, 2006]^{18}
- Models of care of treatment for adult drug misusers (MoCDM) [DoH, 2006]^{19}

The models are intended to set out the range of treatment options that should be provided in a given area.
3.1.1 Tier 1

The Provision of drug and alcohol related information, advice, screening and referral to specialised drug and treatment.

Provision includes:

a) PSHE education in schools

b) Some targeted health/community safety campaigns (e.g. drink driving / festive health)

c) Identification and onward referral by General Practitioners (GPs), health visitors, mental health teams and other appropriate agencies and professionals

d) A liaison nurse for the elderly provided by DAT.

Tier 1 services are provided by non-specialist practitioners and services. Depending on individual needs, this may involve Tier 1 interventions only, or be the beginning of a client's treatment journey.

Example: Tier 1 service within the Department of Education and Children - teachers and pastoral staff receive training to help recognise potential signs or risk factors of substance misuse among children and young people. Problems may be addressed within the school according to the school’s policy, or if further intervention is required they may be referred on to Motiv8 (Tier 2) for alcohol problems and the young person's worker at DAT (Tier 3) for drug related problems.

Professionals' perceptions described referral routes into Tier 2 or Tier 3 as working well overall and it was believed in some cases this was formalised in policy, however, in many cases it was reliant on individual workers’ relationships. Some Tier 1 services formally refer to DAT or Motiv8 (children only), while others are more likely to signpost and encourage clients to self-refer. Self-referrals will include clients signposted by Tier 1 services where formal referral protocols processes are in place.
3.1.2 Service Gaps - Tier 1

A number of gaps exist in relation to services that would be expected under Tier 1 according to MoCAM [DoH, 2006] and MoCDM [DoH, 2006] such as:

a) A lack of brief intervention provision for hazardous and harmful alcohol users

b) There are no formal interventions in place to support identification and management of high risk substance misusers presenting to Hospital settings and General Practices

c) Alcohol awareness in the workplace (employer)

d) Social Security Benefits Section.

3.1.3 Tier 2

Services include the provision of drug and alcohol related information and advice, triage assessment, referral to structured drug and alcohol treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare. Tier 2 consists of the Motiv8 service and a needle exchange service.

Motiv8

There is a service specification in place for the Tier 2 service operated by Motiv8. Motiv8 provides counselling and support for addictive behaviours.

The service focus is on harm reduction and a person-centred approach to treatment. Treatment is for both adults, young people who misuse alcohol, and for those affected by their own substance use or another person’s and for those affected by problem gambling and other addictive behaviours (albeit that gambling and other addictive behaviours fall outside of the scope of this report).

Referrals are received from:

- Medical professionals (GPs, health visitors, school nurse, hospital)
- Mental Health
- Criminal Justice (prison, probation)
- Social Services
- Self-referrals (or family/friend)
- Specialist DAT
Currently Motiv8 is commissioned and performance managed by the Commissioning Section – DHSC Corporate Services Division.

A standard arrangement (adopted in England and Wales) is for a “purchaser” to commission a service against a clear written service specification and performance manages it against measures as set out in the service specification. This arrangement gives a clear purchaser/provider split in which roles and relationships are clear.

The data provided by DAT and Motiv8 indicate that the most common recorded referral source for clients in Tiers 2 and 3 was self-referral.

Referrals can be made to DAT and to peer support groups (such as Alcoholics Anonymous and Self-Management and Recovery Training [SMART]).

Service data provides evidence of referrals between Tier 2 and Tier 3 in both directions, with 11% of referrals (average for both services) being from within the treatment system (i.e. from the other service).

**Needle Exchange Service**

The needle exchange service is provided by some pharmacies. This service is commissioned and overseen by the Pharmacy Adviser. Data was not available to indicate the volume of needle exchange activity that takes place. In theory, it should be possible for clients to move into structured treatment via a referral or signposting from such services if appropriate, but as needle exchange activity data was not available (self-referred clients may have been signposted but this is not recorded) it was not possible to ascertain if this happens on the Isle of Man. There appears to be no formal service specification or performance and quality management arrangements. The service should be quality checked against the NICE Guidelines: Needle and Syringe Exchange Programmes PH52 (NICE, 2014)³.

### 3.1.4 Service Gaps - Tier 2

a) A gap exists in provision in relation to the availability of extended brief interventions and brief treatment for alcohol users

b) MoCDM [DoH, 2006]¹⁹ states that aftercare should be available following inpatient provision. Aftercare following inpatient provision does not always appear to be available.
3.1.5 Tier 3

Tier 3 is the provision of community-based specialised drug and alcohol assessment and co-ordinated care-planned treatment and drug specialist liaison. The provision for this tier is provided by DAT.

**Drug and Alcohol Team**

DAT utilises a multi-disciplinary team delivering harm minimisation-focused assessment, treatment and support to people with alcohol and/or drug dependency. Support for community detoxification is provided where appropriate.

Referrals are received from:

- Medical professionals (GPs, health visitors, school nurse)
- Mental Health
- Criminal Justice (prison, probation)
- Social Services
- Self-referrals (or family/friend)
- Specialist Tier 2 (Motiv8) and Tier 4 (rehabilitation providers)
- Noble’s Hospital – ED, inpatient and outpatient Wards
- Social Workers.

In addition there are clear protocols and pathways to:

- The Youth Justice Team via DAT child and adolescent referral form or via juvenile DARS
- Victim Support – via an agreed protocol
- Police Custody Officers – via an agreed protocol
- Stop Smoking Service – via an agreed protocol
- Referrals are made to Motiv8 and to Tier 4 rehabilitation providers.

DAT runs a number of specialist services.
These include:

a) A pregnancy clinic provided by a specialist health visitor

b) Two alcohol and drug liaison nurses, who run clinics at the Hospital, work closely with the medical and paediatric units and liaise with hospital staff

c) Two health screening staff, who undertake blood-borne virus screening and liaise with the gastroenterologist based at Noble’s Hospital

d) A dual-diagnosis nurse, who carries out Dialectical Behaviour Therapy

e) A specialist young people’s worker, who engages in assertive outreach-type work and works out of hours as required.

f) Older persons liaison nurse who works closely with the Hospital wards (Older Persons Mental Health Service)

Referral data into substance misuse treatment from mental health provision indicates an upward trajectory. For example, in the financial year 2016/2017, there were no referrals from Mental Health in the first quarter, eight referrals in the second quarter, and seventeen in the third. All referrals were for drugs. More longitudinal data is necessary to better understand what historic patterns of referrals have been like and whether current levels are a return to previous norms or a new high and whether changes are due to recording practices or real changes to levels of demand.

Clients can self-refer into Tier 3, DAT, (this includes those signposted by Tier 1 services), be referred by Tier 1 providers (see the list of organisations under Tier 1) or enter treatment via a referral from Motiv8. Where formalised referral pathways exist, these were described as functioning appropriately. Structured treatment (Tier 3) provision incorporates more structured interventions including substitute prescribing. This includes outreach work in collaboration with other services to reach clients.

Tier 3-type services (for stable, prescribed clients) can also be provided by GPs, under shared care arrangements in collaboration with structured treatment services; such arrangements are not currently well organised in the Isle of Man.

In some cases clients may access Tier 2 and Tier 3 interventions concurrently, co-managed under agreed plans. The data indicates the numbers of such clients are typically low (averaging 10 clients at any given time).
An innovative, evidence-based Take Home Naloxone programme for those thought to be at risk of opiate overdose was introduced in 2016. The evaluation for this should be reported to DASG in due course.

In terms of reviewing DAT provision, the focus should be on whether it has the capacity to meet levels of demand. Data on demand will come from the Health and Lifestyle survey being undertaken by the DHSC Public Health Directorate. Once this data is available, it will be possible to understand the level of substance misuse in the population to improve provision, such as the IBA for hazardous and harmful alcohol users.

### 3.1.6 Service Gaps - Tier 3

Tier 3 provision is largely consistent with the expectations of MoCAM [DoH, 2006] and MoCDM [DoH, 2006], but with some identified gaps as follows:

- **a)** There is no formal arrangement for GP shared care provision. There is some ad hoc provision by individual GPs. However, there is no governance around these arrangements, they are not quality assured and are not robust.

- **b)** Funding for hepatitis vaccinations is currently with GPs but there is no arrangement in place to ensure that the GPs routinely vaccinate service users as part of a clear pathway. We recommend that the appropriate element of funding should be transferred to DAT to enable delivery of a consistent and seamless vaccination programme.

- **c)** There is no hepatitis C treatment funded or delivered on island. The lack of hepatitis C treatment complicates the provision of services and means that clients who are screened do not have any access to treatment with possible adverse consequences. Liaison with hepatitis services is an expectation of MoCDM.

- **d)** There is a need for a formal service specification and pathway for the provision of services for people with blood-borne viruses.

- **e)** Hepatitis C patients are seen at Noble’s Hospital, they do not offer a full service and this does not follow NICE guidelines.

There is no commissioning arrangement in place for the treatment of hepatitis C in accordance with NICE Guidelines. There are various treatments licenced for hepatitis C and those most appropriate for use with patient’s on-island should be reviewed as a priority.
For example:

- Boceprevir – for the treatment of genotype 1 chronic hepatitis C (TA2530)

- Elbasvir – grazoprevir for testing chronic hepatitis C

### 3.1.7 Tier 4

Tier 4 is the provision of residential specialised drug treatment, clear care plans for both the residential element and subsequent after-care.

There is currently no residential rehabilitation provision on the Isle of Man. Clients requiring residential treatment are sent off-island. Rehabilitation can only be accessed via Tier 3 provision and clients undergo a multi-disciplinary assessment against a clear policy to ensure that this intervention is appropriate and best meets their needs. The process ensures that only those most suited to off-island placements can access them.

There are no beds available at Manannan Court for patients requiring detoxification where dual diagnosis has been identified. Planned detoxification is carried out in the community when safe to do so. Emergency detoxifications are carried out at Ramsey Cottage Hospital and Noble’s Hospital. Planned residential detoxification is carried out off-island.

The loss of beds for in-patient detoxification within on-island Mental Health services (which appears to have arisen as a consequent of the move from Grainagh Court to the new facility at Manannan Court) should be reviewed.

### 3.1.8 Service Gaps - Tier 4

a) For on-island detoxification (alcohol) there is a lack of beds.

b) MoCDM [DoH, 2006]¹⁹ indicates “supportive accommodation” should be available to drug users. No such provision appears to exist on the Isle of Man

c) MoCDM [DoH, 2006]¹⁹ also places emphasis on the provision of effective aftercare following Tier 4 placements (where appropriate – not all clients will wish to return to their home area); it is not clear to what extent this is available in the Isle of Man.

* [https://www.nice.org.uk/guidance/conditions-and-diseases/infections/hepatitis](https://www.nice.org.uk/guidance/conditions-and-diseases/infections/hepatitis)
3.1.9 **Treatment pathway**

Overall, staff reported that pathways between Tiers 2 and 3 work well. Pathways from Tier 1 into Tiers 2 and 3 were generally reported to be functional, but in many cases dependent on inter-service staff relationships rather than formalised in policy. Formal policies do exist within some key services. Access to Tier 4 provision appears to be well managed against clear criteria. However, we were unable to verify this against outcome data.

**Figure 1** overleaf maps out the existing treatment pathway, defining the ‘tiered system’ approach to services.

This is a treatment pathway based on discussion with professionals. Some areas are supported by formal pathways, other areas we could not document that this was the case.
**Tier 1:**
Provision of drug-related information and advice, screening and referral to specialised drug treatment.
*Isle of Man provision includes PSHE education; some targeted campaigns; identification and onward referral by GPs, health visitors, mental health teams, etc.*

- Medical professionals (GPs, health visitors, school nurse, hospital)
- Social Services
- Self-referrals (or family/friend)
- Criminal Justice (prison, probation)
- Mental Health

**Tier 2:*
Provision of substance-related information and advice; triage assessment; referral to structured treatment; harm reduction and aftercare.
*Isle of Man provision: Motiv8
Needle Exchange - Pharmacies*

- Medical professionals (GPs, health visitors, school nurse, hospital)
- Social Services
- Self-referrals (or family/friend)
- Criminal Justice (prison, probation)
- Mental Health

**Tier 3:**
Community-based specialised assessment; co-ordinated, care-planned treatment; and substance-specialist liaison.
*Isle of Man provision: Drug and Alcohol Team (DAT)*

- Medical professionals (GPs, health visitors, school nurse, hospital)
- Social Services
- Self-referrals (or family/friend)
- Criminal Justice (prison, probation)
- Mental Health

**Tier 4:**
Residential specialised treatment, care-planned and co-ordinated to ensure continuity and aftercare.
*Isle of Man provision: Off-island rehabilitation as needed*

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**Figure 1: Treatment system map (including common referral sources)**
3.1.10 Unmet need

Pathways to aftercare were not entirely clear. Some service users noted they had not felt fully supported following their return from Tier 4 provision; however there are some peer support options now available that are able to contribute to aftercare support. This needs to be monitored and kept under review.

3.2 What local activity data tells us

3.2.1 Referrals into treatment

Figure 2 below outlines the number of referrals into treatment (Motiv8 and DAT combined) on a quarterly basis over the past three years. This indicates a slight reduction around the end of 2014/2015, followed by a gradual increase in referrals to the current time.

![Figure 2: Quarterly referrals into treatment services (2013/ 2014 to present)](image)
Some data was also available regarding the sources of referrals into treatment at DAT and Motiv8 during 2015/2016 - shown in Figure 3 below. The majority of clients are self-referrals; in practice, this is likely to include clients ‘signposted’ from a variety of other services.

Figure 3: Referral sources (2015/2016 data)

* The category ‘Criminal Justice’ includes referrals from IOM Constabulary, Isle of Man Prison, and Probation Services.
3.2.2 Joint working between DAT and Motiv8

Figure 4 below shows the numbers of clients co-managed between the two services (snapshot figures at the end of each quarter). The numbers are generally low.

![Graph showing number of clients co-worked by DAT & Motiv8 quarterly snapshots](image-url)

Figure 4: Number of clients jointly worked by Motiv8 and DAT (quarterly snapshots)
3.2.3 Completions/outcomes

Figure 5 below shows the quarterly number of discharges from treatment over the past three years. The number exiting treatment shows a gradual increase over time, in keeping with the rise in referrals and numbers in treatment.

Figure 5: Quarterly discharges from DAT and Motiv8 (2013/2014 to present)
Recorded reasons for discharges from the treatment system are shown in Figure 6 below. For the majority of clients, the reason for leaving the service is a successful completion - with their situation resolved or improved. However, a substantial proportion also drop out of treatment, are not attending treatment or not engaging.

Figure 6: Discharge reasons (2015/2016 data)

Overall, the rate of successful treatment completion (of those leaving treatment) for the treatment system was 51% (n=306) during 2015/2016.

* ‘Other’ includes clients recorded as admitted to hospital, discharged to the care of GP, client requested discharge, service no longer required, or where an alternative service was provided.
3.2.4 Off-island placements

There were fewer than 10 placements of patients in the UK from September 2012 to September 2013 for drug and alcohol treatment. The number of patients in a placement on 15 January 2017 was fewer than 10.

The average weekly cost of off-island placements was £450, thereby demonstrating that there is a financial cost to using this approach. It is therefore imperative that only those clients who are best suited and who would benefit from this sort of intervention are offered off-island placements.

The off-island placements are managed under the Out of Area Treatments (OATs) Policy (DHSC 2016). Key workers have ongoing responsibility for the patient’s care plan throughout the placement.

3.2.5 Liaison with secondary care services and relationship with mental health services

The ED at Noble’s Hospital has an excellent relationship with the Mental Health Team (including a triage tool for mental illness where no medical issues are present). This was developed by a working group of representatives from the Police, ED clinicians and the Mental Health Team to embed the new policies and procedures. Issues around section 132 and section 136 of the Mental Health Act orders were resolved (where there had previously been lack of clarity about what constituted a place of safety and whether ED could be considered thus). The system for admission and referral now works smoothly.

No equivalent exercise has been carried out to develop a similarly appropriate system for drug and alcohol clients. This is a significant gap that should be addressed as a priority.

3.2.6 Financial data

The total annual cost of DAT and Motiv8 services were used to calculate basic unit costs per client in treatment and per successful treatment completion (based on 2015/2016 in-treatment and completion figures).

* Section 132 (s132) – the rights that must be explained to someone when detained in hospital, including where detained under s135 or s136 as a place of safety (s135 is the legal definition of a ‘place of safety’). s136 – police power to detain someone in immediate need of care or control and remove them to a place of safety. Power to detain lasts for 72 hours.
Therefore, the costs identified do not represent the total programme budget for drugs and alcohol. This is presented in Table 2 below.

**Table 2: Basic unit costing for treatment and successful completions**

<table>
<thead>
<tr>
<th></th>
<th>Total for treatment system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number treated in one year (2015/2016: number in treatment at previous year end + number of new referrals during year)</td>
<td>1,540</td>
</tr>
<tr>
<td>Successful completions (2015/2016 – either 'Treatment completed' or 'Situation improved/resolved')</td>
<td>306</td>
</tr>
<tr>
<td>Annual service cost</td>
<td>£977,359</td>
</tr>
<tr>
<td>Simple unit cost per client in treatment</td>
<td>£635</td>
</tr>
<tr>
<td>Simple unit cost per successful completion</td>
<td>£3,194</td>
</tr>
</tbody>
</table>

**Note:** It was not possible to allocate a cost to GP input.

The financial data set out above represents a current baseline estimate. As the treatment system is changed in light of recommendations in this JSNA, it would be worthwhile revisiting the figures set out above and calculating up-to-date values to determine whether the service is becoming more or less cost-effective.
3.3  Assets - Legislation and regulation

3.3.1  Effects of drug and alcohol misuse in the criminal justice system in the Isle of Man

In addition to the earlier data regarding substance misuse among prisoners, further data was also available regarding policing activity, from the Chief Constable’s Annual Report 2015-2016 (Chief Constable, 2016). Figure 7 below shows the numbers of DARS entrants over the past three years by primary drug (this is the primary drug for which they were arrested).

The DARS programme allows those arrested for possession of a small quantity of a substance for personal use, and who have no previous drug-related convictions, to be cautioned, with no further action taken if they complete a drugs education programme. The numbers of people entered on to DARS increased in 2015/2016 to a similar level as in 2013/2014, following a decline during 2014/2015. However, the changes seen here in arrests suitable for DARS may be due to changes in policing activity rather than indicative of the level of actual offending.

![Figure 7: Number of arrested persons entered on to DARS scheme by primary drug linked to arrest](image)

The Police Alcohol Unit was set up in 2001 and since then there has been a decrease in alcohol-related crime, notably violent crime. Police data also shows a reduction in arrests for drink-driving offences over the past three years (from 130 during 2013/2014 to 105 during 2015/2016). This may be due to changes in driver behaviour or due to changes in enforcement activity.
The Chief Constable’s Annual Report 2015-2016 (Chief Constable, 2016) noted that in the financial year 2014/2015, around half of all arrests involved alcohol; two-thirds of those arrested over the age of 62 were under the influence of alcohol at the time of their arrest, and over half of those arrested in the 22-25 and 50-53 age groups were similarly intoxicated at the time of their arrest. The data also showed that in 2014/2015, two-thirds of all arrests between 22:00 and 05:00 were because of alcohol and every arrest for criminal damage during this time was due to intoxication. Despite this, for more than six years there have been no prosecutions for serving alcohol to a person who is drunk. The Chief Constable noted:

“This is either a sign of very high standards (in the licensed trade), an indication of a lack of police focus, or more likely a combination of the two.”

He further explained the intention that neighbourhood officers should in future determine where those who are so drunk that they pose a threat to the safety of others, or expose themselves to danger, obtained their drink:

“If they obtained their drink when drunk, those who served them will face investigation.”

The Chief Constable also noted that ‘pre-loading’ (drinking in private properties before visiting licensed premises late in the evening) means that the constabulary frequently encounters young people who are very drunk even before they have attempted to enter licensed premises. The discrepancy between prices of alcohol in the off-trade and the on-trade means that it is far cheaper to drink at home, and he expressed support for the introduction of some form of minimum pricing of alcohol.

### 3.3.2 Regulation of alcohol supply through licensing

In interviews with members of the public, there was a perception that over the years there has been increased promotion of alcohol and it now has a big presence in supermarkets. The Chief Constable’s report to the licensing court 2015 noted that alcohol misuse is to some degree a cultural issue, but also an issue that all areas of society, including the licensing trade, have a role in addressing.
The issuing of licences to sell alcohol is undertaken by the Licensing Court. The licensing criteria considered by the Court are based on a period when the night-time economy was larger and off-licence sales were lower than they are now. A new Licensing Bill is being developed to better align legislation with current trends and patterns in consumption.

Stakeholders (including from the Police, DHA and the third sector) were of the opinion that the night-time economy is well managed. There are currently no ‘hotspots’ for alcohol-related crime and as a result the density of licensed premises is not considered to be a problem. The new Licensing Bill will contain the ability by order to have temporary restrictions on more premises. This will enable a strong response in a given area should hotspots be identified in the future.

A new Licensing Code of Practice has been developed containing standards set for the Isle of Man, which reflect the unique circumstances, the expectations of the public and the requirements of the Licensing Court and the Constabulary. Compliance with the new Licensing Code of Practice is a statutory requirement for licensed premises.

The licensed trade works closely with the government, principally through the Licensing Forum, with the support of the Licensed Victuallers Association. This has resulted in some excellent examples of jointly developed training initiatives, which have been well taken up in the on-trade, and additional initiatives to control inappropriate sales of alcohol in the off-trade. Other interventions include ‘Pubwatch’, the ‘Challenge 25’ initiative and the ‘Banned book’ held at all licensed trade tills with photographs of those people to whom alcohol should not be sold. Licensing Forum representatives also deliver some work in schools; for example ‘Offwatch’ assemblies and provision of education targeted at year 10 pupils about medical confidentiality, and what to do if a friend is in trouble from too much to drink.
4. **What is the extent of the issue locally?**

This section describes the nature of problems relating to drug and alcohol consumption. Key findings include:

a) A lack of data regarding prevalence of drug and alcohol issues

b) Of those that are in treatment, almost two thirds are male and a third female. The most-represented age group in treatment is those aged 25-39

c) The Douglas area is over-represented in the treatment population. It is not clear whether this reflects higher demand or better access to provision for this group

d) Data supplied by Motiv8 indicated that 60% of those in treatment had at least one co-morbid need. Mental health issues were the most common co-morbid need

e) Alcohol is commonly perceived to be a greater issue than drug misuse

f) Data from the Youth Survey indicates the proportion of young people who had ‘Never’ had a drink increased from 55% in 2011 to 74% in 2015. Incidences of binge drinking have decreased among young people

g) There is a very high level of prescribing of hypnotic medicines.

4.1 **What the local data tells us - the population in treatment**

Intelligence about drug and alcohol consumption is currently lacking. The results of the Health and Lifestyle Survey will provide significant data about drug and alcohol consumption and will create a picture about the nature of the issue locally.

4.1.1 **Demographic characteristics of those in treatment**

Data on new referrals into the treatment system during 2015/2016 were available to allow description of the client group in terms of demographic characteristics.

Of the 743 referrals into both treatment services over the course of the year, demographic data were not fully known or recorded for all referrals.
In Figure 8 below, of the 650 referrals for which gender data were available, 64% were male and 36% female. DAT (Tier 3) had a slightly higher proportion of male clients referred into treatment compared to Motiv8 (Tier 2).

![Figure 8: Referrals into treatment by gender (2015/2016)](image)

In Figure 9 below, of the referrals into both services, 624 had age data available. For both DAT and Motiv8, the most-represented age group was 25-39 (accounting for 30% of all referrals into treatment). The age profile of clients referred to Motiv8 was slightly younger, with 24% of clients aged 18-24, compared to 13% of those referred to DAT.

![Figure 9: Referrals into treatment by age group (2015/2016)](image)

Some 7% of referrals to each service were aged 11-17 (a total of 63 referrals of under-18s). A more detailed breakdown of the age profile of these clients is shown in Figure 10 overleaf.
Figure 10: Age profile of under-18 referrals (2015/2016)

Figure 11 below illustrates the ethnicity of clients referred during 2015/2016, for whom this information was available, in comparison to the Isle of Man population. The vast majority of referrals were recorded as white British, which is consistent with the island population.

* Treatment system data: DAT ethnicity data refers to clients referred during 2015 and 2016 for whom ethnicity information was recorded. Motiv8 data refers to clients referred during 2015/16. Population ethnic groups from Census 2011, https://www.gov.im/media/207882/census2011reportfinalresized_1_.pdf
Data on clients’ area of residence was available for all referrals during 2015/2016. This is presented in Figure 12 below. By far the commonest postcode location reported was IM2; an area covering a large portion of non-central Douglas among other areas. A breakdown of the parts of the island covered by each postcode area can be found in Appendix B.
In Figure 13 below, the proportion of new referrals from each postcode area is compared to the estimated proportion of the island’s population resident in each area*. The Douglas area (IM1 and IM2) is over-represented among treatment service clients. It is not clear whether this reflects actual higher levels of consumption or whether residents here are more likely to access treatment.

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* Please note, this is an estimate since the census data applies to the 2011 population; in addition, census data is not grouped explicitly by postcode area, so the boundaries of the postcode areas and census districts may not be entirely coterminous.

† Census data available from: www.gov.im/media/207882/census2011reportfinalresized_1_.pdf
**Figure 14** below shows data which has been presented on DAT referrals during 2015 and 2016, illustrating the proportion of clients resident in each area whose main presenting problem was drugs, alcohol or both. This shows some substantial variation between areas, with those resident in IM2 and IM9 more likely to use alcohol, and those resident in IM7 or who did not have an address recorded as more likely to use drugs.

**Presentations to other health services**

Limited additional data was available from other health services – specifically data from ED at Noble’s Hospital refer to Table 3 overleaf.

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* Please note, this is presented as a proportion of those for whom presenting problem data was available (n=202 referrals); for 12% of referrals in this data set, this was not recorded.
Table 3: Presentations to ED with substance misuse presentation (2016/2017)

<table>
<thead>
<tr>
<th></th>
<th>Q1 - Q3</th>
<th>Estimate for Q1 - Q4 (1 year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance misuse ED presentations</td>
<td>14</td>
<td>19</td>
</tr>
</tbody>
</table>

It is not clear if all substance misuse presentations are being captured, and whether the data relates to where substance misuse is considered to be the primary cause of presentation or a related factor. More specific data over a longer period of time would enable a clearer picture to be developed of the impact of substance misuse on ED service and this should include how the presentations are defined.

### 4.1.2 Inter-linkages with drug and alcohol consumption

There are a number of identified factors that have strong inter-linkages with drug and alcohol consumption.

Some of these inter-linkages are set out below.

**Substance misuse and homelessness**

A recent survey of health needs among the homeless population of the island* found very high levels of needs relating to a variety of health problems, including substance misuse (Community Nursing, 2016)²².

Adult community nursing personnel carried out a survey of people on the caseload of the vulnerable adults health visitor for individuals classed as homeless. Of those who had a health check:

- 25% reported a current or previous alcohol problem
- 25% reported drinking every day
- 25% reported that they had a current or previous drug problem
- 44% stated they used drugs or alcohol to self-medicate for a mental health problem.

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* The definition used in the survey included individuals sleeping rough, those ‘sofa surfing’ and those living in insecure or unsuitable accommodation.
The data should be caveated insofar as it represents the health needs of those homeless people who responded to the survey – that is, it cannot necessarily be said to represent the health needs of the homeless population more widely.

**Prisoner substance misuse**

Data regarding the results of drug screening and self-report measures of substance misuse on entry to the prison was provided for the full year of 2015 (January to December). All prisoners undergo urine screening for drugs of abuse on entry to the prison; drugs screened for include opiates, amphetamines, cocaine, ecstasy, cannabis, ketamine and PCP.

The data shown in Figure 15 below indicated that, during the course of the year, 74% of all prisoners entering the establishment tested positive for at least one drug (not prescribed by their GP – those on GP-prescribed medication were excluded from the results).

**Figure 15**: Results of drug screening on reception to Isle of Man Prison (2015)
The most common drugs detected in the tests are illustrated in Figure 16 below. By far the most common positive result was for cannabis.

![Bar chart showing drug types and their percentages detected in tests.](chart)

Figure 16: Most common positive results on entry to Isle of Man Prison (2015)

Of the total 137 receptions over the course of the year:

- 74% had recently used an illicit drug; and
- 15% (n=21) were drug dependent and required substitute prescribing.

In self-report measures, 24% of receptions interviewed self-reported heavy (high-risk) or binge drinking, and 6% were alcohol dependent.
Data in Figure 17 below for drug-related offending (also provided by the prison) indicates a significant impact on law enforcement due to substance misuse. Of the 328 prison receptions during 2014/15 and 2015/16:

- 22% had a recorded index offence that was drug related (such as possession or intent to supply)
- 4% were incarcerated for crimes known to be alcohol related (such as drunk and disorderly or driving under the influence)*

* This does not include offences of which a proportion are likely to be linked to alcohol, such as public disorder offences, so is likely to be an under-estimate of alcohol-related offending.

† Source data IOM Prison and Health reporting

Figure 17: Offending related to substance misuse (2014/2015 and 2015/2016)†

- Substantial proportions of prisoners arrested for offences not directly related to substance misuse were also found to be dependent on illicit or prescription drugs. For example, 45% of those imprisoned for burglary or theft were known to be dependent on illicit drugs and 28% to be dependent on prescription drugs.
Of prisoners convicted of violence against the person, 29% were prescription drug users and 15% reported illicit drug use.

Twenty-three per cent of those convicted of ‘other’ offences were known to be dependent on illicit drugs and 20% to misuse prescription drugs. Overall, this paints a picture of the serious impact of substance misuse on the criminal justice system.

4.2 What the local data tells us

4.2.1 Suicide and accidental death

A limited range of data was available regarding suicides and accidental deaths over the past five years. This is presented in Figure 18 below. Over the past five years, 22% of all accidental deaths and 11% of all suicides were recorded as linked to drug or alcohol use.

![Figure 18: Suicide and accidental death (2011-2015)](image)

4.2.2 Premature mortality

Table 4 overleaf shows how the Isle of Man compares to the England average on measures of premature mortality and possibly preventable premature mortality for conditions that are potentially substance or alcohol related. For cancer deaths the Isle of Man is worse than the England average; however, for liver disease and respiratory disease mortality the Isle of Man overall is better than the England average.
Table 4: Public health outcomes framework data - Premature mortality rates per 100,000 population (2012-2014)

<table>
<thead>
<tr>
<th>Indicator description - under 75 mortality rate</th>
<th>Male/Female</th>
<th>Better or worse than England average*</th>
<th>IOM rate</th>
<th>England Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>From all cardiovascular diseases</td>
<td>All</td>
<td>Not significantly different</td>
<td>78.8</td>
<td>75.7</td>
</tr>
<tr>
<td>From all cardiovascular diseases considered preventable</td>
<td>All</td>
<td>Not Significantly different</td>
<td>50.1</td>
<td>49.2</td>
</tr>
<tr>
<td>From cancer</td>
<td>All</td>
<td>Not Significantly different</td>
<td>150.8</td>
<td>141.5</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Not Significantly different</td>
<td>151.6</td>
<td>157.7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Worse</td>
<td>150.3</td>
<td>126.6</td>
</tr>
<tr>
<td>From cancer considered preventable</td>
<td>All</td>
<td>Not Significantly different</td>
<td>94.1</td>
<td>83.0</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Not significantly different</td>
<td>90.5</td>
<td>90.5</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Worse</td>
<td>98.0</td>
<td>76.1</td>
</tr>
<tr>
<td>From liver disease</td>
<td>All</td>
<td>Not significantly different</td>
<td>17.0</td>
<td>17.8</td>
</tr>
<tr>
<td>From liver disease considered preventable</td>
<td>All</td>
<td>Not significantly different</td>
<td>14.7</td>
<td>15.7</td>
</tr>
<tr>
<td>From respiratory disease</td>
<td>All</td>
<td>Not significantly different</td>
<td>31.3</td>
<td>32.6</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Not significantly different</td>
<td>30.2</td>
<td>38.3</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>Not significantly different</td>
<td>32.4</td>
<td>27.4</td>
</tr>
<tr>
<td>From respiratory disease considered preventable</td>
<td>All</td>
<td>Better</td>
<td>12.4</td>
<td>17.8</td>
</tr>
<tr>
<td>From drug misuse</td>
<td>All</td>
<td>Worse</td>
<td>8.5</td>
<td>3.9</td>
</tr>
</tbody>
</table>

* where the England average is outside our confidence intervals we would be statistically significantly different (either better or worse)
4.2.3 **Estimate of adult prevalence of drug and alcohol misuse in the Isle of Man**

Currently there is no reliable data to enable estimation of numbers potentially misusing alcohol or drugs on the island. The Health and Lifestyle Survey results will provide significant information about consumption of both drugs and alcohol.

4.2.4 **Estimate of young peoples’ prevalence of drug and alcohol misuse in the Isle of Man**

The Youth Survey (Children's Partnership Services, 2016)\(^2\) is a comprehensive survey of young people on the island.

This Survey was answered by 1,370 respondents aged 11-18 (this equates to 26% of the secondary school-age population). Figure 19 shows responses to a question regarding frequency of alcohol consumption. The proportion of young people aged 11-14 who had ‘Never’ had an alcoholic drink had increased from 55% (all young people) in 2011 to 87% of males and 92% of females in 2015.

![Figure 19: Youth Survey responses to 'How often do you have a drink containing alcohol?' (2015)](image-url)
A further question asked about frequency of binge drinking (six or more drinks in a row) over the past three months. This has also reduced since previous surveys – the proportion of young people reporting no incidences of binge drinking over the previous three months increased from 74% in 2013 to 88% in 2015, while the proportion binge drinking once or twice reduced from 13% to 6%. There were no major differences between males and females in either survey.

![Figure 20: Youth Survey responses to ‘In the last 3 months, how many times have you had 6 or more alcoholic drinks in a row?’ (2015)](image)

The 2015 Youth Survey included some new questions about ‘legal highs’ (NPS). Young people were asked how harmful they believed ‘legal highs’ (NPS) to be in comparison to illegal drugs:

- 11% felt they would be less harmful to health than illegal drugs
- 29% thought they were more dangerous
- 60% thought they were ‘About the same.’

Respondents to the survey were also asked whether they felt it was easy for them to obtain legal highs, to which:

- 21% answered ‘Yes’
- 6% answered ‘No’
- 73% responded that they did not know.

A further question asked young people how helpful the information they received on a variety of topics was to them; four of the categories related to alcohol, smoking, drugs and legal highs.
The responses to these are shown below in Figure 21. While a large proportion of young people found the information they had been provided with on alcohol, smoking and illicit drugs useful, a relatively large percentage reported having been given no information about legal highs. The perceived helpfulness of information given regarding alcohol, drugs and smoking had reduced since previous youth surveys (Children’s Partnership Services, 2016)².

![Bar chart showing responses to helpfulness of information on various topics](image)

**Figure 21:** Youth Survey responses to ‘How helpful is the information and advice you get on the things listed above?’ (2015)

### 4.2.5 Service use data - Numbers in treatment

Data on the numbers in treatment over the past three years was available from both treatment services. Figure 22 overleaf shows the treatment system (note that figures are for both adults and young people, for Motiv8 and DAT combined) working with progressively greater numbers over time. The sharp increase at the end of 2013/2014 is partly due to the new DrugAware service offered by Motiv8, which started at that time. DrugAware is a free and confidential service for anyone aged 18 years or over, which offers access to counsellors who are specialists in addictive behaviours. The DrugAware offer is entirely in line with the Models of Care Approach (DoH 2006)¹⁸ & ¹⁹ adopted across the island and is likely to be increasing numbers
as it opens up new ways for those with drug and alcohol problems to find routes into treatment.

Recording is also likely to play a role: at the same time a new client record system was introduced by Motiv8, which (anecdotally) led to an increase in the recorded number of clients due to activity being more accurately recorded. Data is not available that would indicate whether increases in numbers are being paralleled with better outcomes for service users.

Figure 22:  Numbers in treatment (quarterly snapshot figures, 2013/2014 to present)

Figure 23 below shows data on quarterly referrals into the treatment system and confirms the overall increase in the treatment services’ activity levels.

Figure 23:  Quarterly referrals (2013/2014 to present)
4.2.6 **Estimates of treatment penetration**

There is a lack of data to develop a picture of the total level of demand for drug and alcohol treatment services. The results of the Health and Lifestyle Survey will go a considerable way to providing a baseline against which levels of need and demand can be modelled.

Data is available for numbers in treatment; this is shown in **Table 5** below. In 2015/2016, 1,540 adults entered or continued in structured or unstructured treatment for misuse of drugs or alcohol provided by DAT or Motiv8. The majority of service users (1,001) were being supported by Motiv8, whilst around one-third (539) were being supported by DAT.

Once data from the Health and Lifestyle Survey is available, data regarding numbers in treatment can be used to calculate a ‘penetration rate’ – that is, an estimate of those in contact with treatment as a percentage of those estimated to be ‘eligible’ for treatment.

**Table 5: Annual treatment figures (2015-2016)**

<table>
<thead>
<tr>
<th></th>
<th>DAT</th>
<th>Motiv8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number treated in one year (number in treatment at previous year end + number of new referrals during year)</td>
<td>539</td>
<td>1,001</td>
<td>1,540</td>
</tr>
</tbody>
</table>

4.2.7 **Substance use on treatment entry**

Both DAT and Motiv8 were able to provide some data regarding the substance use of those referred into treatment. This is predominantly found in an individual’s primary reason for referral to the service.
The information for referrals to DAT and Motiv8 is shown in Figure 24 below.

Referrals to DAT are relatively evenly split between drug users and alcohol users, with a slightly higher proportion using alcohol, and 11% of those referred using both alcohol and other substances. Referrals to Motiv8 showed a different pattern, with a higher proportion of clients using drugs compared with those using alcohol, and 15% of referrals being for individuals not using substances, but requiring support in relation to another problem, or to another person’s substance use.

More detailed referral reasons for those referred to the Motiv8 service are illustrated in Figure 25 overleaf.

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* Please note, the Motiv8 data shown here has been summarised into simplified categories to allow comparison with DAT data. Please see Figure 25 for more detailed information on referral reasons to Motiv8.
Figure 25 above shows greater detail in terms of the level of drinking of those referred due to alcohol misuse; 23% of clients were referred with harmful or hazardous levels of drinking, with 8% recorded as moderately dependent on alcohol at referral and 7% severely dependent.

A breakdown of the Motiv8 data is available, which indicates 91% of clients were adult and the remaining 9% were young people (aged 18 years or under is for alcohol only).
Some specific information on referral reasons for young people only is presented in Figure 26 below.

Young people were more likely overall to be referred into treatment for drinking alcohol rather than drug use, with a small proportion using both.

![Figure 26: Referral reasons for young people (aged 11-17; 2015/2016 data)](image)

15% of those referred to Motiv8 (8% of all referrals into treatment) were due to young people requiring support regarding parental drinking.

### 4.2.8 Motiv8 Clients’ additional/co-morbid needs

Figure 27 overleaf shows the additional needs of clients on the Motiv8 caseload at the end of September 2016. In total, 60% of those on the caseload had at least one co-morbid need in addition to their primary presenting problem (note, not all of these are necessarily substance users – some are significant others or children/young people needing support due to substance use in the family). Many had more than one additional need.

Clients recorded as suffering from depression and anxiety are those who have self-reported these problems, and they have also had their diagnoses confirmed through screening using recognised tools Generalised Anxiety Disorder 7-item scale and Patient Health Questionnaire 9.
Other mental health issues, including psychotic disorders, obsessive compulsive disorder, schizophrenia, and post-traumatic stress disorder, as well as learning difficulties and autistic spectrum disorders are recorded if clients have been professionally diagnosed. Those recorded as having personality disorders may be diagnosed by a professional outside the Motiv8 service, or identified by a consultant clinical psychologist working with the service. Domestic violence will be self-reported by clients or flagged on referral.

The service actively screens for parental drinking as part of the new Family Alcohol Service. Any clients presenting with alcohol issues who have children are identified as potential clients for alcohol parental impact work, and their children will also be potential clients.

The most commonly reported additional needs shown in Figure 27 above were mental health problems, with 28% of the caseload recorded as suffering from depression and 17% suffering from anxiety.

Other clients were recorded as being victims of domestic violence, experiencing suicidal ideation, or having other mental health problems or learning difficulties.
4.2.9 Referrals to mental health services for anxiety and depression (2011/2012 and 2012/2013)

In view of the overlap between a number of mental health conditions and substance misuse demonstrated in one service alone (see Figure 27 on the previous page), it is relevant to look at the numbers of referrals to mental health services for depression and anxiety as noted in the JSNA of June 2014.

Table 6: Category of referral (2011/2012 and 2012/2013)

<table>
<thead>
<tr>
<th>Category of referral (2011/2012 and 2012/2013)</th>
<th>Numbers by age group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 18</td>
</tr>
<tr>
<td>Patients referred with anxiety recorded as either an ICD-10 code or a clinical impression</td>
<td>102</td>
</tr>
<tr>
<td>Total: 834</td>
<td></td>
</tr>
<tr>
<td>Patients referred with depression recorded as either an ICD-10 code or a clinical impression</td>
<td>90</td>
</tr>
<tr>
<td>Total: 670</td>
<td></td>
</tr>
</tbody>
</table>

A total of 1,504 referrals were shown, averaging 752 per year. The same report noted a projected total increase in the prevalence of people suffering from any mental health disorder from 2007 to 2026 as +14.2% (adapted from ‘Paying the Price – The cost of mental health care in England to 2026’) [McCrone et al, 2008]. This indicates the demand for mental health provision will continue to rise over the long-term, and that the current figure of 752 can be expected to increase.

It is not suggested that all these people will have had co-morbid substance misuse issues (and therefore that the increase in demand for mental health services will be linked inextricably with rise in substance misuse treatment demand). However, in view of the interrelationship of mental health and substance misuse issues in the Motiv8 caseload and as reported by many other public service representatives, this may be of interest. However, it should be noted that the majority of dual diagnosis patients come under the care of the dual diagnosis nurse at DAT due to the complexity of the need.
4.2.10 Import data (seizures by customs)

Data concerning the seizure of imported substances between July 2015 and June 2016 (inclusive) was provided by the Treasury Customs and Excise Service. This refers only to seizures of substances where no legal action was taken.

Of the 95 recorded seizures, 39% (n=37) were of substances with potential for abuse. Of these, most were prescription-only medicines with potential use as intoxicants (sedatives, including diazepam and zopiclone, painkillers including tramadol, or stimulants such as modafinil), or steroids and similar substances used in bodybuilding culture. A smaller proportion of seizures were identified as Class B substances (all of these were cannabis products), and a very small number were recorded as other illegal substances, legal highs or an unknown substance.

The data set out in Figure 28 below shows substances as a percentage of total seizures (and therefore does not take into account the volume of substances seized). Seizures were from the postal service.

![Figure 28: Substance seizures by Isle of Man customs (July 2015/June 2016)](image)

Some historical data on drug seizures was also available covering the past three years (2013/2014 to 2015/2016). This showed the number of recorded drug seizures increasing from 20 in 2013/2014 to 84 during 2015/2016. It is,
however, impossible to tell whether this was due to increased incidence of drug importation, customs activity, or improved recording.

**Figure 29** below shows the illicit substances (this does not include those with no potential for abuse) as a percentage of all customs seizures of pharmaceuticals over the past three years. This indicates that while Class B substances (all but one of which were cannabis) declined as a proportion of all seizures, steroids and similar substances (such as testosterone and growth hormones) increased. Class A substances as a proportion of all seizures declined slightly, while prescription-only medications with psychoactive effects remained fairly constant as a proportion of seizures. However, in numerical terms, the number of seizures of steroids and psychoactive prescription medicines increased between 2013/2014 and 2015/2016.

![Figure 29: Illicit substances identified by Isle of Man customs (2013/2014 - 2015/2016)]
4.2.11 Police data – Seizures and substance-related offending

Table 7 below shows the numbers of police seizures of illicit drugs over the past three years. Cannabis is by far the most commonly seized drug, followed by cocaine and heroin. Seizures of cannabis bush and mephedrone have increased substantially in the last year. Seizures of heroin, on the other hand, have declined, as have seizures of crack cocaine and ‘traditional’ recreational drugs ecstasy and amphetamine. The data shown in the following table includes information on seizures that were for personal use (including prescriptions), and seizures for larger amounts that were presumably intended for dealing purposes.

**Table 7: Police seizures of illicit drugs**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabis resin</td>
<td>27,020.5</td>
<td>22,748.7</td>
<td>27,410.9</td>
</tr>
<tr>
<td>Cannabis bush</td>
<td>1,695.6</td>
<td>3,446.2</td>
<td>17,496.9</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2,853.9</td>
<td>18.2</td>
<td>445.9</td>
</tr>
<tr>
<td>Heroin</td>
<td>743.9</td>
<td>280.2</td>
<td>431.4</td>
</tr>
<tr>
<td>Ecstasy (tablets)</td>
<td>1,013</td>
<td>765</td>
<td>78</td>
</tr>
<tr>
<td>Cannabis plant (plants)</td>
<td>81</td>
<td>58</td>
<td>50</td>
</tr>
<tr>
<td>Mephedrone</td>
<td>1.0</td>
<td>0.0</td>
<td>20.9</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>736.5</td>
<td>0.5</td>
<td>6.2</td>
</tr>
<tr>
<td>LSD (units)</td>
<td>0.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Crack</td>
<td>7.4</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
### 4.2.12 Prescribing of controlled drugs

Nationally collated coded data from the NHS Business Services Authority (BSA) shows a downward trend in the prescribing of hypnotic medicines (such as benzodiazepines) in the Isle of Man since September 2014. However, it also indicates a very high level of prescribing hypnotics compared with England, with the Isle of Man having the highest recorded level of prescribing of any area included in the NHS BSA data for these substances (at December 2015) *.

**Prescribing of Hypnotics by GP practice**

This data has not been standardised to reflect the demographics of the practices so firm conclusions cannot be drawn. However, **Figure 30** below does indicate variations in prescribing which require further investigation to confirm whether these result from different demographics or unwarranted differences in prescribing behaviour.

* ADQ (average daily quantity) and STAR-PU (specific therapeutic group age-sex prescribing unit) are units of prescribed medication intended to allow comparison between different practices in the volume of each medication prescribed.
Data on the prescribing of tramadol and pregabalin by GP practices indicates a rise in prescriptions of these drugs over the past few years, though both show a decline in 2015/2016.

If the first six months of 2016/2017 are indicative of the remainder of the year, prescribing of both is declining presented in Figure 31 below.
5. Qualitative Feedback

Qualitative interviews were undertaken with professionals across all agencies, service users, their families or carers, and the public.

5.1. Provision and activity

5.1.1 Professionals’ views across all agencies

Mental health

There was general agreement among those interviewed that drug and alcohol misuse and mental health issues are inextricably linked, and therefore services should work hand-in-hand at all levels in recognition of this. The two services have been perceived by a range of practitioners (including from health and drug treatment services) as being pulled in different directions.

Psychology Service

a) Access to a psychologist for drug and alcohol clients was considered by some to be very poor

b) Substance misuse clients not engaged with DAT can wait 12 months for psychology services

c) DAT clients were able to access a specific psychology service (from within DAT), this resource has ceased

d) People with drug and alcohol issues are excluded from low-intensity mental health services

e) A need for better access to talking therapies for drug and alcohol clients was identified – a good counselling service at Tier 2 level and more cognitive behavioural therapies.

Service provision

a) Service needs more dual-diagnosis* provision at all levels

b) At DAT, there is a dedicated dual-diagnosis post to provide support to co-morbid clients and for liaison with mental health services.

* Dual diagnosis is a catch-all term used for those with co-morbid drug/alcohol and mental health issues.
However, stakeholders indicated that there is a lack of engagement and cohesion on the part of mental health services to deal with people with substance misuse problems. There was a view amongst stakeholders that the dual-diagnosis post was not sufficient or appropriate to meet the needs of this cohort.

**Data**

a) Lack of consistent, valuable data across all settings/agencies

b) Difficulties in sharing data between relevant organisations even if there is a will to do so. Data-sharing protocols and secure systems are not in place

c) Differing opinions regarding confidentiality and disclosure (for example, ED opiate overdose attendances are not flagged to DAT)

d) Generating and using good data will enable better evaluation of needs and service audits to verify for effectiveness. As the situation currently stands, data sits in silos.

**Inpatient detoxification**

Practitioners described a stringent assessment process for clients wishing to access inpatient detoxification, to ensure that this provision is offered to those who would most benefit.

a) There is a lack of an inpatient detoxification facility on island apart from the medical ward. Given the low numbers of clients requiring inpatient facilities and the significant costs attached it would not necessarily be cost-effective to set up such a facility on the Island

b) Observation - it is difficult to get those who are seriously ill into Noble’s Hospital for detoxification

c) There are good links in the North West area (Drug and Alcohol Rehabilitation) and other Tier 4 providers in England

d) There is a consistent view that for good rehabilitation and long-term recovery, people need to go off-island to avoid slipping back into unsupportive networks

e) On occasion people present to ED because of a crisis, at which point the need for inpatient detoxification is determined. In such circumstances, clients are sent back to their GP unless they are acutely withdrawing. If
medical treatment is required they will be admitted to the medical ward and then referred to DAT liaison nurses by the ward staff.

f) Discussions are taking place between DAT and hospital doctors about appropriate detoxification, but there are no protocols in place at the present time.

**Referral pathways**

a) Professionals highlighted the informal nature of the links between services

b) Doctors are responsive and there is good communication

c) There is a tendency to use informal links in some areas - there are a lack of clear pathways that have been developed by partners together and this impacts on the ability to make a referral

d) DAT as part of the Mental Health Service is guided by policy and therefore makes routine use of formal pathways

e) Where more formal links have been made they work well: for instance, the alcohol detoxification pathway where clients are managed by key workers with support from the health-screening nurse and nurse prescriber. This is delivered mostly in the community with help from a DAT doctor if required.

**Drug and Alcohol Team**

DAT service, when accessed, provides a good standard of care at Tier 3

Perceived gaps in provision:

a) There is a perception that there is no stand-alone drug service for those under 18 years, and no Tier 2 outreach working with young people at risk

*Note:* There is a young person’s worker employed at DAT who works specifically with under 18’s with drug misuse issues

b) The new criminal justice DAT worker would be advantageous, but there was an apparent lack of clarity about the role and function among some partners. The DAT criminal justice worker can test people who are not in treatment

*Note:* This is a new role that included setting up pathways and liaison with other services
c) The DAT caseload has a large number of people who are stable on long-term opiate substitution therapy prescriptions that may or may not be able to be reduced at some point. These clients should be looked after by GPs under shared care arrangements, unless they need changes or new problems arise. Shared care should be developed with GPs to support them, reduce client isolation and variation in practice and prescribing.

d) Some GPs were thought to be prescribing methadone or subutex, and in amounts that are more than appropriate. They were seen as supporting patients who do not want to be seen by DAT.

**Motiv8**

a) Motiv8 is seen as delivering the Tier 2 service very well, with excellent systems in place to ensure confidentiality and responsiveness.

b) There is a perception that the Tier 2 service appears to be holding some chronic Tier 3 clients.

c) Motiv8 works closely with DAT, which was believed to work well.

**Aftercare**

a) A number of stakeholders talked about the apparent lack of aftercare services.

b) There is a need for a SMART Recovery Group for drug users to meet some of this demand.

c) There are informal peer support groups, but it was noted that these can be inconsistent and depend on the reliability (and possibly relapse) of the founders.

*Note: Not clear what is being referred to.*

**Perceived Gaps in provision**

a) There is not enough Tier 1 provision:

b) No drop-in advice services

c) A lack of harm-reduction messages for children and young people

d) There is no health promotion unit, a lack of public awareness of the health messages and a need for more ‘alcohol harms’ campaigns.
Note: In relation to bullet points 1 to 4; while there was stakeholder interest in health promotion campaigns, there is no evidence that public information campaigns of the sort described are effective. Assertions regarding the need for information campaigns require setting against the evidence of what works.

e) There is a need for more general education (not just for children)

f) Information is lacking to the public about alcohol consumption and better information about NPS and their effects/dangers

g) Public attitudes need to change but this will not happen all by itself

h) Lack of IBA interventions

i) Pharmacies were well placed to be able to deliver IBA at a general population-wide level; this could be through a local enhanced service (LES) arrangement (it was noted that there is a LES in place for supervised consumption of opiate substitution therapy in pharmacies and four participate). Pharmaceutical skills were seen as under-used

j) There is a gap in the delivery of basic Tier 1 IBA more generally and at scale across the community.

Note: There is a strong evidence base for the use of IBAs which are known to be an effective intervention.

5.1.2 Service users and their families or carers

Service users were asked about their experiences of treatment services and their opinions on potential improvements or additions that would be beneficial.

Client focus

a) Both services were seen as client focused and flexible, with clients reporting that they had received the treatment they felt they needed/wanted

b) Service provision appeared well tailored to clients’ needs and clients believed they had input into the course of their treatment, with those wanting a rapid reduction supported to achieve this, and those preferring to remain on longer-term maintenance able to do so

c) Clients reported having some sort of plan and goals for their treatment. How formal and structured this was seemed to be dependent on the client’s needs and wishes
d) One of the main benefits of the current approach to treatment was the ‘counselling’ aspect of services addressing underlying issues (not specifically focused on substance use) and teaching coping strategies. This was seen as a practical approach with a positive impact on substance use and other aspects of life.

Referrals

a) The quick response time for initial appointments at Motiv8 was praised, with all those interviewed having been seen within a week.

b) For DAT the wait was described as “too long”, and was mentioned as a potential barrier to engaging with treatment.

Note: Always seen within the approved waiting times.

Treatment goals and recovery

Service users cited a number of goals that they wanted to achieve by engaging in treatment:

a) Reducing alcohol use or becoming alcohol or drug free

b) Improving mental health and coping ability

c) Increased stability

d) Strategies for managing problems in general life.

Note: None of the alcohol users interviewed at DAT wanted just to reduce; all sought abstinence. Some opiate users were happy to remain stable on methadone indefinitely, indicating that a purely abstinence-based approach to drug treatment would not be appropriate on the island.

Some service users raised concerns about undergoing detoxification. These included:

a) Unwillingness to leave the island due to personal connections

b) Fear of losing council property.

Smart Recovery

a) The benefit of the SMART Recovery Group was discussed

b) The SMART Group fulfils some of the non-medical needs not always addressed by treatment.
**Note:** SMART is a programme that is aimed at helping people to recover from any kind of addictive behaviour. SMART utilises mutual aid, in which participants build up motivation to recover and are equipped with tools and techniques to help support them. SMART is an alternative option for people in recovery who may not wish to engage in other forms of support such as Alcoholics Anonymous or Narcotics Anonymous.

### 5.1.3 Suggestions by service users for future provision

The most commonly cited suggestions were forms of support that would help them reintegrate back into the community:

- **a)** General life skills (or links to appropriate courses) such as healthy living, cooking, managing budgets
- **b)** Day courses and classes
- **c)** More formal post-rehabilitation peer support (with local individuals who had returned from rehabilitation in the UK) or peer mentoring for pre-/post-detoxification support
- **d)** To support reintegration into the community - better awareness of addiction and recovery to help address the stigma associated with the condition. Awareness-raising would be useful for families, carers of clients and for the community more generally
- **e)** Service provision - demand for access to psychological therapies to address underlying issues resulting in substance misuse.

**Note:** The data regarding levels of dual diagnosis (i.e. co-morbid drug/alcohol and mental health needs) would tend to substantiate the need for access to mental health services.

### 5.1.4 Public views

People were generally not aware of the services available for substance misusers; however, some noted that:

- **a)** Legalisation/regulation of drugs as a means to reduce some of the risks (impurities, social isolation, and marginalisation) associated with illicit drug use
- **b)** Education was the most commonly suggested solution to problems associated with substance misuse - both in terms of education about the

* More information can be found at: https://www.smartrecovery.org.uk/*
risks of drug and alcohol use, and in general life skills as a ‘protective’ measure for young people.

*Note:* As mentioned earlier (in relation to professional stakeholders) there is no evidence base for the effectiveness of awareness campaigns.

### 5.2 Who is at risk and why?

#### 5.2.1 Professionals across all agencies

Professionals identified a range of issues that put people of various ages at risk of drug or alcohol misuse. Factors most commonly cited included:

a) Genetic pre-disposition (physiology)

b) Social triggers

c) Cultural triggers

d) Being lonely and depressed

e) Significant personal life difficulties when young (emotional, psychological abuse, neglect)

f) Significant life events (divorce, bereavement)

g) Family dynamic issues and poor coping skills

h) There were generational differences

i) Problematic drinking was widely perceived to be predominant in the older population

j) Stimulant drug use is more of a problem in the young to middle-aged group, and use of cannabis is associated with younger people

*Note:* Data was not available to substantiate this perception, which seems to be partially a cultural belief about norms on the island

k) Drinking in excess of low-risk limits is culturally accepted - but this is changing generationally - and that alcohol abuse was seen as less prevalent in young people

l) The lack of social outlets might lead young people to experiment with drugs and alcohol
**Note:** The qualitative data is contrary to the evidence of the Youth Survey which in 2015 indicated large numbers of young people reporting that they never consume alcohol and that levels of consumption of alcohol are declining for this population group.

m) Agencies including health and police commented on a culture of ‘pre-loading’ – drinking at home followed by going to licensed premises later in the evening.

**Note:** Data from ED was not available to determine whether this pattern of drinking is leading to alcohol-related hospital admissions.

n) Adult victims of abuse may over-use prescription medication for coping with anxiety and depression.

**Note:** While data is available on prescription levels it is not possible to link this to the view that this is driven by low-level mental health conditions.

o) It was agreed that drug and/or alcohol misuse cuts across all social strata.

p) In terms of the culture, there are some good, protective effects of close communities, but equally a lack of support for those who fall outside the boundaries of ‘normality’. There is a perception of a conservative and judgemental culture, which may lead to people failing to seek help because of a perceived lack of confidentiality.

q) The perceived lack of confidentiality means that it is hard to rehabilitate and make a good fresh start.

### 5.2.2 Service users and their families or carers

a) DAT clients consulted were long-term drinkers or drug users (since their mid-teens).

b) Motiv8 clients consulted were alcohol users (some now abstinent) – some long-term users or whose use had escalated in later life. Most self-referred into services, or were referred by a GP or social services.

Those whose substance use had initiated earlier in life often cited a triggering factor, such as:

a) Family issues

b) Early trauma (such as the death of a parent)

c) Normalisation of substance use among family and/or peers

d) Their own mental health problems
e) For those whose alcohol misuse had become more problematic in recent years, this had also generally been triggered by life events, including the breakdown of relationships, the stress of caring for a family member with health or mental health problems, or other stressful changes.

f) Clients and volunteers at Graih (the homelessness service in Douglas) believed the impact of substance misuse was greater among those with lesser social or financial resources.

g) Among their peers (individuals in inadequate and/or insecure housing) the likelihood, and consequences, of substance misuse were likely to be greater.

5.2.3 Public views

The general perception of some members of the public was that alcohol was the most problematic substance for adults due to its social acceptability, while drug use was not commonly encountered openly.

Public views as follows:

a) For young people, drugs were very accessible (more so than alcohol due to strict enforcement of licensing).

b) The main drugs being consumed were cannabis and ‘legal highs’ (NPS)

*Note*: Such views are necessarily subjective and are to some extent indicative of cultural beliefs rather than the true picture of alcohol and substance misuse on the island.

c) One young person commented; ‘a small minority of peers were known to use drugs, but they had never seen drugs and believed that most young people were unlikely to come across them’

*Note*: According to the results of the Youth Survey the experience of this young person is by no means unique and it would appear that alcohol consumption is decreasing among younger people.

d) Some parents were fearful for their children of secondary-school age, being aware that their children know who uses drugs and from whom they could be obtained.

*Note*: Such concerns are not consistent with actual patterns of drug and alcohol use as described in the Youth Survey.

e) The public recognised that substance misuse may be a symptom of other problems.
f) Concern was expressed for vulnerable children such as those who are excluded from school

g) Younger individuals did not feel that the normalised use of alcohol, or drinking to excess, was problematic.

Note: Again that the comments set out above are not consistent with the data from the 2015 Youth Survey.

5.3 What is the extent of the issue?

5.3.1 Professionals across all agencies

Without exception, the view of health and other associated professionals was that “Alcohol dependency is the largest concern”.

a) Professionals were of the opinion that drinking well in excess of low-risk limits is accepted, but this is changing in the younger generation

Note: This assessment of changing drinking patterns among young people is substantiated by the data from the Youth Survey

b) Informal estimates offered by stakeholders put numbers of higher-risk drinkers at around 13,000 and dependent drinkers at around 3,000

Note: This was a subjective assessment given the lack of quantitative data

c) In relation to drug use, a number of stakeholders felt that there is a lack of awareness of the scale of the problem

Note: There was an anecdotal sense that there is a significant drug problem on the Island but interviewees were unable to substantiate their views, which were based on their own judgement rather than with reference to quantitative data. Opinions along this line tended to be a subjective assessment about what levels of drug consumption ‘should’ be like on the Isle of Man

d) Professionals stated that poly-drug use was the most usual pattern: with people using alcohol and other drugs, mostly opiates and alcohol

Note: This is not entirely substantiated by data on people in drug treatment, which indicates only 11% of referrals were for co-morbid drug and alcohol need

e) Professionals indicated that services generally are starting to see more use of NPS

Note: There is no evidence to back up this perception

f) Pregabalin and benzodiazepine misuse was seen an issue (i.e. the misuse of drugs intended for medicinal purposes). Dependence on non-illicit
medicines such as tramadol, diazepam and codeine was perceived to have become more prevalent (albeit that there is not data to substantiate this). It was believed that some clients ‘top up’ their illicit drug use with prescription medicines including pregabalin, valium, gabapentin, tramadol, hypnotics. It was also asserted that some drug users favour prescription drugs as they are not illegal, therefore reducing risk of prosecution.

*Note:* These are all opinions that collection of quantitative data would usefully verify.

g) Among younger people, cannabis (although now Class B) was perceived as commonly used socially. There is a perception that cannabis is widely available, but interviewees could not substantiate this view.

h) Professionals commonly reported the issue that “Lack of data is chronic”

i) One example cited was that there was a perception that suicides and accidental deaths on island most often involved alcohol or drugs in some way, and that some respiratory deaths may relate to drug misuse, but this is not necessarily recorded.

*Note:* Given that there is a perception that some drug-related deaths are not necessarily recorded, there would appear to be a gap in the data that is available that would quantify the full extent of the issue.

### 5.3.2 Service users and their families or carers

For many clients, alcohol was seen as the main problematic substance, and was linked to a normalised heavy-drinking culture on the island.

The qualitative data indicated a strong cultural belief among clients about drinking levels.

Other issues reported by service users included:

a) Uses of prescription medication – doctors were considered to be lenient in terms of how often they prescribe. Clients reported some individuals “abusing the system” i.e. giving false information to their GP in order to obtain medications to both use themselves, as well as to sell on.

b) Poly-drug use was common amongst their acquaintances, with people using alcohol, cannabis, prescription-only medicines and/or NPS or other drugs.

c) Social stigma and the close-knit community made it difficult to move on from a substance-misusing history.
d) Feedback from the SMART Group raised concern that substance use was negatively portrayed in the media and felt that those affected by substance misuse were not prioritised by the Isle of Man’s government.

e) Feedback from clients of the Graih Homelessness Service raised concern that the limited nature of accessible social housing contributed to the social problems that put people at risk of substance misuse. The small and close island community was seen as a disadvantage, since it was difficult for those wishing to make changes to extricate themselves from their previous (destructive) social contacts. Clients also commented on the social acceptability of alcohol use.

f) Graih clients and volunteers expressed the view that greater awareness of substance misuse problems on the island has probably developed in recent years due to increased third-sector involvement, which has raised the profile of the social issues resulting from substance misuse.

### 5.3.3 Public views

There was a strong cultural belief among those members of the public who were consulted about the nature of alcohol consumption on the island. It was common for those interviewed to perceive that attitudes towards alcohol on the island encouraged and normalised intoxication and excessive drinking in particular. Where members of the public had some experience of substance-misuse issues in their own family or circle of friends, a different picture of prevalence emerged.

Others felt that it was not an evident problem (other than in Douglas on a Saturday night), but noted that most of the court cases reported in the papers were drug or alcohol related. Other views expressed included:

a) The problem has worsened over the past ten years, with increasing drug and drink-fuelled crime

b) At the weekends, there were high numbers of young people with head injuries through accidents and violence related to drunkenness who were taken to ED

**Note:** The observations from members of the public do not accord with other data that is available. For instance, the 2015 Youth Survey indicates high numbers of young people who never drink (74%) and that levels of drinking are decreasing over time. There would appear to be a degree of disconnect between perceptions and actual levels (of youth drinking). Perceptions appeared to be informed by the local media which may have created a picture of higher levels of alcohol-related problems than is actually the case.
c) Of those members of the public consulted, none reported holding negative or judgemental views regarding drugs and alcohol use, and appeared to hold understanding and sympathetic views towards users.

d) Legalisation and regulation was identified as a possible solution, and a sensible option for future drug policy.

e) There is a perception that the community in general is very conservative, judgemental and negative in its view of substance misusers.
6. **Evidence of what works**

This section sets out the evidence for the most effective interventions for drug and alcohol treatment. Key findings include:

- Globally, approaches to tackling drug-related harm have shifted to health and social care departments, away from criminal justice approaches
- Identification and brief advice have a strong evidence base for their effectiveness - for every eight people who receive simple advice, one will reduce their drinking to lower levels
- School based education programmes have some evidence of effectiveness, and are most effective when combining social competence and social influences. Stand-alone drug awareness programmes are ineffective
- There is no evidence for the effectiveness of general alcohol awareness campaigns. Despite this, alcohol awareness campaigns are still considered to have a role in providing information.

6.1 **Reducing drug-related harm**

Literature on substance misuse emphasises that a criminal justice approach to reducing drug-related harm is increasingly seen as ineffective. The emphasis is on moving leadership of this agenda to health and social care departments and away from criminal justice agencies. This change has been made in the Isle of Man and hence policy on the island conforms to international standards and expectations.

Evidence demonstrates that drug treatment is effective in:

- Reducing illicit drug use
- Reducing the spread of blood-borne viruses
- Reducing criminal activity
- Achieving abstinence and better physical health
- Lowering the risk of overdose.

Pharmacological drug treatment interventions are shown to have better outcomes in terms of:

- Reduced illicit drug use
- Reduced criminal behaviour
• Lower levels of HIV risk
• Better retention rates.

This suggests that harm reduction (i.e. providing substitution opioid drugs) has its place alongside approaches to drug treatment that are based on abstinence.

Information campaigns

There is little evidence that information campaigns aimed at raising awareness of drug misuse have an impact on levels of consumption of drugs. Whilst it is not an evidence-based approach, the provision of drug advice and information is a requirement of MoCDM under the range of interventions that should be provided at Tier 1.

Guidance

Guidance for effective drug treatment services includes:

a) Drug misuse and dependence: UK Guidelines on clinical management (DoH, 2007)²⁴
b) Models of care for treatment of adult drug misusers (MoCAM) [DoH, 2006]¹⁸
c) NICE Clinical Guideline: Drug misuse Prevention: Targeted Interventions [NG64] (NICE, 2017)²⁵
d) NICE Clinical Guideline: Drug misuse in over 16s - psychosocial interventions [CG51] (NICE, 2007)²⁶
e) NICE Clinical Guideline: Drug misuse in over 16s - opioid detoxification [CG52] (NICE, 2007)²⁷
f) NICE Technology appraisal guidance: Methadone and buprenorphine for the management of opioid dependence [TA114] (NICE, 2007)²⁸
h) NICE Clinical Guideline: Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings [CG120] (NICE, 2011)³¹ and NICE Guideline: Coexisting severe mental illness and substance misuse: community health and social care services [NG58] (NICE, 2016)³²
i) NICE - Public Health Guideline: Needle and syringe programmes (PH52) (NICE, 2014)³

NICE publishes a range of quality standards and pathways to support the implementation of the evidence based guidance.
6.2 Reducing alcohol-related harm

Legislation, regulation, and control of supply are the overarching interventions that are most cost-effective in reducing alcohol misuse. The more comprehensive a policy is, the more alcohol consumption is lowered, and the more cost-effective the policy will be.

6.2.1 Restricting access to supply

Population-based interventions such as restricting access to the supply of alcohol by maintaining the regulation of retail sale opening hours, reducing the number of outlets selling alcohol (Bryden et al, 2012)\(^5\), and increasing the price of alcohol (ibid)\(^6\) all represent highly cost-effective uses of resources to reduce alcohol-related harm.

Changes in price through taxation is not in the power of the Isle of Man Government to make, as alcohol arrives on the island ‘duty paid’. The system is therefore linked to the alcohol policy and taxation of the UK. Nevertheless, the principle that increasing the price of alcohol will reduce the amount consumed (particularly in young people) and the overall amount of alcohol-related harm remains.

An alternative to raising prices through taxation is to introduce minimum unit pricing per unit of alcohol.

6.2.2 Identification and brief advice

Early intervention with systematic IBA has been shown to be effective:

- For every eight people drinking at increasing-risk or higher-risk levels who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels (Moyer et al, 2002)\(^33\).
- Increasing-risk and higher-risk drinkers are likely to benefit from brief advice given by generic workers in almost any setting (Moyer et al, 2002)\(^33\).

There is a robust literature on the effectiveness of IBA. In a review of the evidence (Bien et al, 1993)\(^31\) note that brief interventions have consistently been found to be effective in reducing alcohol consumption. IBAs show greater levels of effectiveness than clients receiving no intervention, but also demonstrate as much effectiveness as more extensive treatment. Other studies have noted that the benefits of IBA are not limited to health care settings. Coulton et al. (2012)\(^35\) identified that probation services were found
to be suitable for screening and participants were positive about receiving interventions for their alcohol use in probation settings.

### 6.2.3 Education programmes

Evidence of the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm shows that information and education programmes alone do not reduce alcohol-related harm (WHO, 2009)\(^4\); nevertheless, they have a role in:

- Providing information
- Reframing alcohol-related problems
- Increasing attention to alcohol on the political and public agendas.

This may be particularly relevant in a culture such as in the Isle of Man; a place that does not condemn risk-taking behaviour but gives a high degree of respect to individuals’ autonomy to make their own choices in a context where most can afford to do so.

School-based education can be important, but the literature indicates a number of important caveats to education programmes. A recent review of the literature by the Scottish Government (Warren 2016)\(^45\) noted that the evidence is not strong for school-based prevention work, and that the effect sizes are small.

The Scottish Government (Warren 2016)\(^45\) paper notes that data demonstrates the most effective interventions are those that combine social competence (that aim to improve personal and interpersonal skills), and social influences (reducing the influence of society by addressing norms for instance). The elements of effective education programmes were identified as:

- Interactive programmes with high levels of participation
- Multi-component programmes that include other elements
- Age appropriateness, with the optimal time being at the transition from primary to secondary education.

A number of named programmes that have been standardised and subjected to robust research were identified as being beneficial and cost-effective.
These programmes were:

- The Good Behaviour Game
- PreVenture
- Strengthening Families
- Unplugged
- Life Skills Training.

A number of educational programmes that have been demonstrated to have been ineffective. These include:

- Stand-alone school-based activities designed to increase knowledge of drugs
- Diversionary activities (such as theatre- and drama-based education)
- Fear arousal approaches
- Mentoring programmes
- Mass media campaigns.

The authors therefore conclude that the most effective responses are those that are linked to wider strategies that promote general health and wellbeing.

It is worth noting the distance between perceptions about the effectiveness around education campaigns as vocalised by stakeholders during interview, and the much more nuanced account of their effectiveness as set out in the literature.

The evidence from the paper makes clear that, whilst education programmes can be valuable, their use must be carefully considered, and the type of programme must be carefully selected and designed.

6.2.4 Information campaigns

The situation with regard to alcohol information campaigns is mixed. In a review of the effectiveness of alcohol programmes, Anderson et al. (2009) note that “Generally, public information campaigns are ineffective in reducing alcohol related harm” and that the results of counter-advertising (that is running campaigns to decrease the appeal of alcohol) are “inconclusive”. Therefore what evidence there is does not suggest much effectiveness. However, the authors also go on to say that while “the evidence shows that information campaigns do not reduce alcohol-related
harm; nevertheless, they have an important role in providing information and in increasing attention and acceptance to alcohol on the political and public agendas (ibid).”

It is also worth noting that the delivery of information campaigns is an expectation of Tier 1 provision as set out in MoCAM (DoH, 2006), which sets out an expectation that alcohol information and advice is one of the interventions offered.

### 6.2.5 Guidance

Guidance for effective alcohol treatment services includes:


b) NICE Clinical Guideline: Alcohol-use disorders: diagnosis and management of physical complications [CG100] (NICE, 2017)


f) NICE Public Health Guideline Alcohol: school-based interventions [PH7] (NICE, 2007)

g) Department of Health: Models of care for alcohol misusers (MoCAM) [DoH, 2006]

h) Department of Health: Signs for Improvement: Commissioning interventions to reduce alcohol-related harm (DoH, 2009)

NICE publishes a range of quality standards and pathways to support the implementation of the guidance.
7. Conclusions

7.1 Unmet needs and service gaps

There is a lack of formally quantifiable data sources to inform this JSNA. The qualitative data provided by partners across government and beyond offer a perspective on perception beliefs. These are not always in line with the evidence. Nevertheless, there is a general agreement about the principal issues and local areas for improvement both in the treatment system and in the wider issues that affect, and are affected by, drug and alcohol misuse.

Primary among the conclusions is the need for an improvement in systems for data collection. Robust data will identify local need and enable a formally integrated performance management overview. Specific data requirements are explored in this section.

The second major issue is the lack of formal pathways, service specification, and performance and outcome monitoring.

From the results set out in this report, a number of conclusions can be drawn. These have been set out in relation to the headings used in this report.

7.1.1 Provision and activity

a) Current treatment provision is structured in line with the standards and expectations as set out in MoCAM and MoCDM (DoH, 2006)\(^{18,19}\). This means that structures are in line with received practice in England and Wales.

b) The tier two and tier three services (Motiv8 and DAT) are seen as effective by professionals across agencies and by service users alike – clients agree care plans and goals with practitioners and can choose a treatment option that best meets their needs (in particular, whether to pursue harm minimisation or abstinence).

c) There is good communication and linkages between the treatment services supported through regular multidisciplinary meetings.

d) There are a number of innovative roles and services within the treatment system at tier two and tier three.

e) There is some confusion about those outside of the treatment providers about what provision for inpatient detoxification is available, and how patients can access inpatient detoxification.
f) Difficulties are reported in getting seriously ill patients into the medical ward for detoxification (in particular Manannan Court).

g) There is a lack of shared care arrangements with GPs. Where drug and alcohol clients are stable on a programme of opioid substitution therapy and holding down a job, with a family and stable accommodation, this is the most appropriate provision. At present these clients are managed by DAT, while those clients who are chaotic and waiting for access to services are being managed by their GP in the community.

h) While there is a full range of treatment options available which are in line with the expectations of MoCAM and MoCDM (DoH, 2006)\textsuperscript{18,19}, there appears to be less available in terms of a recovery community and activity programmes for recovery and rehabilitation.

i) There is a lack of IBA provision an intervention that is clearly set out as an expectation under MoCAM(DoH, 2006)\textsuperscript{18}.

7.1.2 Extent of the issue

a) Currently there are no reliable data for which to estimate the numbers of drug and alcohol users on the island and the demand for treatment. This represents a significant gap in understanding.

b) Whilst there is a lack of quantitative data, there is a consensus among stakeholders consulted that alcohol misuse is a much bigger problem than drug misuse; it affects many more people individually and has much wider societal impacts.

c) The quantitative data that is available indicates alcohol consumption is reducing among young people. This suggests intergenerational issues emerging in the types and quantities of drugs used (both legal and potentially also with regard to illicit drugs).
d) Data from those in treatment suggests an even split between drug and alcohol users. Given the lack of population level data it is not possible to determine whether the treatment population reflects levels of drug and alcohol use (and therefore demand for treatment), or whether some groups of users are over-represented in treatment.

e) Treatment data indicates the majority of clients have complex needs affecting their physical and mental health. This indicates that treatment provision needs to recognise and reflect the complexity of clients and ensure that clear and robust pathways are available into a range of other specialist services - particularly mental health. Given this, it is of some concern that drug and alcohol clients are excluded from low-intensity mental health services.

f) The community with the highest concentration of people with drug and alcohol misuse issues is offenders, both in and out of prison. Given this, particular attention should be paid to pathways for offenders into treatment - whether they have been in prison or are in the community.

g) The data available tends to indicate changing patterns of drug use, for example an increasing use of prescription-only medicines, and the emergence of new psychoactive substances. Monitoring needs to put in place to quantify the current extent of the issue and how this evolves over time. Furthermore, this means that services need to be adaptive and respond effectively as the drug treatment population evolves.

h) There is a high level of use of prescribed hypnotics on the Island. This may be due in part to the long wait for access to the Pain Clinic (which can be between two and five years). Nevertheless, the more controlled drugs that are prescribed, the more potential exists for diversion of these prescription-only medicines. The use of prescribed hypnotics needs to be monitored closely to prevent illicit use.

i) There is currently a lack of audit and performance management arrangements in place to ensure the quality and delivery of targeted interventions across all agencies.

7.1.3 Evidence of what works

a) Evidence indicates a criminal justice approach to reducing drug related harm is ineffective. Drug and alcohol treatment is led by health and social care departments, which means the island operates in line with internationally recognised norms and expectations.
b) There is evidence that policies which restrict access to the supply of alcohol represent cost-effective ways to reduce alcohol related harm. Consideration should be given to this on the Isle of Man.

c) There is no systematic provision of evidence-based IBA interventions to reduce increasing risk and higher risk drinking, either routinely delivered by health or allied professionals as part of the assessment, diagnosis and referral processes they may undertake, or in the wider community. There is a strong evidence base for the effectiveness of IBAs in health and non-health settings, and the literature further suggests that brief interventions can be as effective as more extensive treatment (see for instance Bien et al, 1993)\(^3\)\(^4\). The lack of IBA is a clear gap in current provision.

d) Health education, including information about drug and alcohol harms, is lacking in schools. The evidence base suggests that drug and alcohol education is most effectively delivered as part of wider work around social and personal development and resilience skills rather than having a stand-alone focus on drugs and alcohol (Warren, 2016)\(^4\)\(^5\). Consideration should be given to providing health education with the important caveat that any programme adopted should be in line with the evidence base for effectiveness and, ideally, should follow a standard model across all schools.

### 7.1.4 Links - Drug and Alcohol Misuse and Domestic Abuse

There is a link between drug and alcohol misuse and domestic abuse. This is beyond the scope of this JSNA. However, funding from the Seized Asset Fund has been approved to extend the JSNA chapter to include domestic abuse. This will include an assessment of need and detect service gaps, with a view to identify service needs to address the domestic abuse problems in perpetrators and victims.

### 7.1.5 Improvements in data

There needs to be a core data set for needs assessment, monitoring and evaluation.
The range of data items that we would have expected to access for the JSNA is set out in **Table 8**. The table indicates which data items were available and which were not.

**Table 8: Core data-set for needs assessment monitoring and evaluation**

<table>
<thead>
<tr>
<th></th>
<th>Available</th>
<th>Used in Needs Assessment</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult drugs</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Drug misuse deaths</td>
<td>✓</td>
<td>×</td>
<td>Benchmark data available, not local data</td>
</tr>
<tr>
<td>Hospital admissions for poisoning</td>
<td>×</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Hospital admissions for poisoning</td>
<td>×</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Drug (or alcohol) treatment recovery</td>
<td>✓</td>
<td>✓</td>
<td>Incomplete (detailed waiting times data and non-representations not available)</td>
</tr>
<tr>
<td>Number of adults who attended</td>
<td>✓</td>
<td>✓</td>
<td>Incomplete (numbers available but historical data [2013/14])</td>
</tr>
<tr>
<td>rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Analysis of alcohol and drugs treatment client data | Breakdown by:  
- gender,  
- age  
- postcode  
- condition  
- route of admission  
- repeat admission  
In order to compare current treatment provision with need | ✓ | ✓ |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional provider data</td>
<td>✓</td>
<td>Available by manual trawl</td>
<td></td>
</tr>
</tbody>
</table>
| Routes into drug (or alcohol) treatment | By gender, grouped as:  
- Self referral  
- Referred through CJS  
- Referred by GP  
- Hospital / A&E  
- Social services  
- All other referral sources | ✓ | ✓ |
| Blood-borne viruses | Adults new to treatment in 2015-16 eligible for a HBV vaccination who accepted one | × | × |
| Provider data that should be collected which would be accessed in a deep dive exercise | By manual trawl |
| Number of adults citing prescription / over-the-counter | Illicit use  
- Non illicit use  
- By gender | × | × |

* Apart from gender and age group, none of this section of data can be benchmarked against council areas, as data is held by NDTMS and not published. Suppression for small numbers in any publication also applies, therefore the majority of these small data would not be requested in a JSNA for a small population.
| Adults who entered treatment in the year and received care from a mental health service for reasons other than substance misuse | Opiate and non-opiate, Alcohol, By gender | × | × |
| Adults who entered treatment in the year | By employment status | × | × |
| Adults who entered treatment in the year | By housing status | × | × |
| Adults new to treatment | Citing club drug use and opiate use | × | × |
| Adults new to treatment | Citing club drug use (no opiate use) | × | × |
| **Additional adult alcohol** | | | IOM Mortality data was used, as is of good quality. Hospital admissions data not collected as locally deemed too incomplete to be reliable. |
| Mortality | Years of life lost due to alcohol related conditions, Alcohol specific mortality, Mortality from chronic liver disease, Alcohol related mortality | ✓ | ✓ |

* These are grouped as: ecstasy, ketamine, GHB/GBL, Mephedrone, NPS other (predominantly cannabinoid, predominantly stimulant, predominantly sedative/opioid, predominantly hallucinogenic, predominantly dissociative).
<table>
<thead>
<tr>
<th>Hospital admissions</th>
<th>Available</th>
<th>Used In Needs Assessment</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons admitted to hospital for alcohol specific conditions</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Persons admitted to hospital for alcohol related condition</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol related conditions</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Age groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persons under 18 admitted to hospital for alcohol specific conditions</td>
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<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol related conditions under 40s</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol related conditions 40-64 years</td>
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<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol related conditions over 65 years</td>
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<td>x</td>
<td></td>
</tr>
<tr>
<td>Alcohol related conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol related cardiovascular disease conditions</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for mental and behavioural disorders due to use of alcohol condition</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol liver disease condition</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for alcohol related unintentional injuries conditions</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Admission episodes for mental and behavioural disorders due to use of alcohol condition</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Available</td>
<td>Used In Needs Assessment</td>
<td>Comment</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-----------</td>
<td>--------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Admission episodes for intentional self-poisoning by an exposure to alcohol condition (narrow)</td>
<td>×</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Incidence rate of alcohol related cancer</td>
<td>×</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other impacts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol related road traffic accidents</td>
<td>×</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number in treatment at specialist alcohol misuse services</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
### Alcohol related conditions (continued/…)

<table>
<thead>
<tr>
<th>Comment</th>
<th>Available</th>
<th>Used in Needs Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful completion of treatment for alcohol</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Proportion waiting more than three weeks for alcohol treatment</td>
<td>×</td>
<td>×</td>
</tr>
</tbody>
</table>

### Substance misuse in young people

Data would be based on young people accessing specialist substance misuse services in the community and, where stated, the secure estate.

<table>
<thead>
<tr>
<th>Comment</th>
<th>Available</th>
<th>Used in Needs Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers in services</td>
<td>All</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Length of time in services and interventions delivered</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Length of time in services</td>
<td>0-12 Weeks</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>13-26 weeks</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>27-52 weeks</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Longer than 52 weeks</td>
<td>×</td>
</tr>
<tr>
<td>Intervention delivered</td>
<td>Pharmacological only</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Psychosocial only</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Pharmacological plus Psychosocial</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Other interventions</td>
<td>×</td>
</tr>
<tr>
<td>Planned exits</td>
<td>✓</td>
<td>×</td>
</tr>
<tr>
<td>Number of young people leaving specialist substance misuse interventions in a planned way</td>
<td>✓</td>
<td>×</td>
</tr>
</tbody>
</table>

* None of the numbers or rates from any data search could be published if numbers are too small ie less than six. This is relevant for small island populations, where much has to be withheld from publication to protect anonymity.
Once the data items listed above are available, consideration should be given to a JSNA “refresh” - i.e. renewing the report by adding in the data that is currently unavailable.

The data can also be used to develop a deeper understanding of the operation of the entire drug and alcohol system. Consideration should be given to benchmarking the data in two ways:

**Progress against baseline** - once data for the items above have been obtained for a given period (most likely, one year) progress should be monitored by benchmarking future returns against the first year of data which should be used as a baseline measure.

**Comparison against a similar jurisdiction** - the Public Health Directorate may wish to enter into a reciprocal agreement with a public health team from another jurisdiction (most usefully another Crown Dependency such as Jersey and Guernsey) to compare data sets. This will enable a comparison about performance against a similar population with a similar socio-economic profile. (Necessarily this form of benchmarking will be contingent on whether the area that data is compared against collects the same data sets).
7.2 **West Midlands Quality Review (WMQRS)**

The WMQRS review of DAT is due in October 2017.

The service will be reviewed against the Recovery Partnership - Community Substance Misuse Services Quality Standards Framework (Recovery Partnership, 2016)\(^{46}\) which includes NICE guidelines.

The review findings should be reported to DASG.
8. **Recommendations**

The recommendations set out in this report are based on the assumption that that the DASG will act as an ongoing formal strategic partnership for alcohol and drugs oversight and performance management. The DASG should involve key stakeholders and agencies to agree a comprehensive strategy to address gaps to prevent drug and alcohol misuse and maintain an appropriate legislation and enforcement framework. The DASG should agree (and ensure resources and capacity for) an implementation plan for the new strategy and be held accountable for the delivery of this plan.

Recommendations are grouped below under four functional area headings and prioritised within these areas. Priority is given through considerations of evidence of effectiveness and cost-effectiveness, local data (where available) and locally perceived urgency. Some performance measures are also suggested.

**Table 1: Summary of Recommendations**

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education and prevention</strong></td>
</tr>
<tr>
<td>a) Agree service specification and commission the IBA intervention for alcohol misuse across appropriate services (for example, primary care, ED, criminal justice and social care)</td>
</tr>
<tr>
<td>b) Review the content and delivery of Personal, Social, Health and Economic (PSHE) education in relation to drugs and alcohol misuse and audit against recent evidence review</td>
</tr>
<tr>
<td>c) Ensure improved interaction with formal pathways into services, (for example, ED, Mental Health Services, housing, domestic abuse pathway etc.)</td>
</tr>
<tr>
<td>d) Review and strengthen links to adult and children’s safeguarding boards to safeguard and promote the health and wellbeing of adults and children</td>
</tr>
<tr>
<td>e) Ensure an in-depth assessment of the needs of young people who are more likely to be vulnerable to substance misuse, working jointly with DHSC Children’s and Families Division.</td>
</tr>
</tbody>
</table>
### Legislation and enforcement

**Recommendations**

a) Consider increasing the price of alcohol through minimum unit pricing when issues around the potential legal challenge have been resolved

b) Review legislation on cannabis possession; using evidence from other jurisdictions

c) Consider reviewing the feasibility of permitting cannabis for medical use, drawing on experience in other jurisdictions

d) Ensure effective communication between partner agencies, for example, combining the disruption of illegal supply of drugs with support and treatment to addicts who experience reduced availability.

### Governance, data and performance

**Recommendations**

a) Develop a core data set for needs assessment, audit, monitoring and evaluation

b) Develop formal commissioning and performance management arrangements for Tiers 1 to 4 (inclusive)

c) Ensure that relevant information-exchange arrangements are in place, using appropriate protocols across all agencies to support the continuity of care

d) Ensure audit, quality and performance management arrangements are in place to safeguard the quality and safety of services and targeted interventions across all agencies

e) The DASG to review investment across the treatment system and ensure that this is sufficient for the required range of prevention, harm reduction and treatment services to meet need (when reliable data is identified).
## Treatment and rehabilitation

**Recommendation**

a) Ensure that equitable access to care is supported by the existing evidence base and a clear commissioning policy

b) Ensure formal pathways, service specification, performance and outcome management is in place for each tier 1 to 4 (inclusive)

c) Introduce shared care arrangements with General Practice by strengthening and formalising collaborative working between treatment providers and GPs

d) Review the community pharmacy needle exchange programme to ensure appropriate levels and quality of provision

e) Put in place a programme of work to audit and review prescribing practices for prescription drugs (hypnotics, pregabalin) linked to pain management with GP practice leads

f) Ensure people in treatment have recovery/rehabilitation plans that empower them to take responsibility for their own health and formal planning

g) Improve interaction with formal pathways out of and between services, for example, ED, Mental Health Services, Housing, Domestic Abuse, etc. in order to strengthen and support aftercare

h) Develop a formal service specification and pathway for blood-borne viruses for people who use drugs in all areas of health service delivery. This should include improved arrangements for vaccination and commissioning of evidence based treatment for hepatitis C.
Appendices
Guidelines for reducing risk to health from drinking alcohol for England and Wales were updated in January 2016 from previous guidelines given in 1995. The 2016 update reflects a better understanding of the links between alcohol and cancer and coronary heart disease, which tell us that the risks from alcohol start from any level of regular drinking, and rise with the amount being consumed. New guidelines have therefore been set at a level that aims to keep the risk of mortality from cancers and other diseases ‘low’, and states that the vast majority of the population can reduce health risks further if they reduce risks below the guideline levels or do not drink alcohol at all.

The new alcohol unit guidelines for the Isle of Man were published in February 2017. The new guidelines state that both men and women should drink no more than 14 units a week, that these units should be spread over the week (rather than ‘saved up’) and that people should aim to have two alcohol-free days a week (IOM Public Health, 2017).
## Appendix B: Postcode areas

### Table 11: Isle of Man Postcodes

<table>
<thead>
<tr>
<th>Postcode (first three digits)</th>
<th>Area/s covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM1</td>
<td>Central Douglas</td>
</tr>
<tr>
<td>IM2</td>
<td>Pulrose</td>
</tr>
<tr>
<td></td>
<td>Saddlestone</td>
</tr>
<tr>
<td></td>
<td>Farmhill</td>
</tr>
<tr>
<td></td>
<td>Anagh Coar</td>
</tr>
<tr>
<td></td>
<td>Upper Douglas</td>
</tr>
<tr>
<td></td>
<td>Broadway Area</td>
</tr>
<tr>
<td></td>
<td>Willaston</td>
</tr>
<tr>
<td></td>
<td>Governors Hill</td>
</tr>
<tr>
<td>IM3</td>
<td>Onchan</td>
</tr>
<tr>
<td>IM4</td>
<td>Crosby</td>
</tr>
<tr>
<td></td>
<td>Braddan</td>
</tr>
<tr>
<td></td>
<td>Marown</td>
</tr>
<tr>
<td></td>
<td>Strang</td>
</tr>
<tr>
<td></td>
<td>Glen Vine</td>
</tr>
<tr>
<td></td>
<td>Baldrine</td>
</tr>
<tr>
<td></td>
<td>Baldwin</td>
</tr>
<tr>
<td></td>
<td>Lonan</td>
</tr>
<tr>
<td></td>
<td>Onchan</td>
</tr>
<tr>
<td></td>
<td>Laxey</td>
</tr>
<tr>
<td>IM5</td>
<td>Peel</td>
</tr>
<tr>
<td></td>
<td>Patrick</td>
</tr>
<tr>
<td>IM6</td>
<td>Kirk Michael</td>
</tr>
<tr>
<td>IM7</td>
<td>Ballaugh</td>
</tr>
<tr>
<td></td>
<td>Andreas/Bride</td>
</tr>
<tr>
<td>IM8</td>
<td>Ramsey</td>
</tr>
<tr>
<td>IM9</td>
<td>Castletown</td>
</tr>
<tr>
<td></td>
<td>Ballasalla</td>
</tr>
<tr>
<td></td>
<td>Colby</td>
</tr>
<tr>
<td></td>
<td>Ballabeg/South</td>
</tr>
<tr>
<td></td>
<td>Port St Mary</td>
</tr>
<tr>
<td></td>
<td>Port Erin</td>
</tr>
</tbody>
</table>
Appendix C: Qualitative feedback from professionals, service users, carers and the public

Professionals comments across all agencies - Provision and Activity

- “People have to reach crisis point before they are able to access help, and at that point it’s a lot harder to come back from than if people get help earlier.”
- “For those with substance misuse and mental health problems it can be a real struggle to get help; neither side [service] really want to work with them.”
- “We are a small community and generally there are good relationships between services on an individual basis: we just pick up the phone” (referral pathways).
- “There is no benzodiazepine pathway or steroid pathway (although we know from the needle exchange records that people are injecting steroids).”
- “We have good acute services but not enough preventive services.”
- “It is very hard to rehabilitate. There is no real recovery community, no programme of planned activities – there is nothing for addicts to do to fill their time if they are not in employment. This is what is lacking.”
- “I get the impression that clients are well-supported for the duration of their [detox] intervention, but there is not much thought given to what happens next – so people can come out of detox, either inpatient or in the community, but they go back to the exact same situation they were in before – same accommodation, associating with the same people, so is it any wonder that they end up relapsing?”
- “We need to talk more and drive a re-setting of social norms.”
- “These professionals have a great deal more to offer as the front face of the Health Service to facilitate better self-care”.
- “We can do IBA in ED but we would need a pathway for referrals (and so would anyone else delivering IBA interventions).”

Comments from service users and their families or carers - Provision and Activity

- “It’s not so much about the drinking, it’s about the lifestyle and developing as a person – I feel like here they look at a ‘person with an alcohol problem’, not an ‘alcoholic’.”
- “SMART helps keep you in the moment – we review the past week and talk about what we could have done differently, and we think about the week ahead – look forward and plan for any potential triggers and how we will deal with them. It’s very practical. We get
inspiration from each other – you might see someone further on in recovery than you, but because we’re all coming from the same place it makes you feel like you can get there too.”

Public Views - Provision and Activity

• “I’m sure there are services available, but if you’ve never needed them, why would you know about them?”

Who is at risk and why?

Comments from Professionals across all agencies

• “Hard drinking is becoming less cool.”
• “Unless you are sporting or musical, and encouraged in this by your parents – there’s little to do.”
• “People use drugs and alcohol to manage and deal with emotions in different ways; we need more effective resilience and awareness raising programmes – not just for children. We are very good at burying our heads in the sand because we do not want to see ourselves as ‘that kind of island’.”
• “This is not an underclass problem; it appears in all different professions and all social levels”.
• “If you walk into Noble’s you will see someone you know, who will ask or guess why you are there.”

Comments from service users and their families or carers

• “Some of the guys that come in here, the rest of us are glad when they get arrested and are going to jail – because they’re drinking so much they might die otherwise. At least it means in jail they’ll get a break.”
• “There is heroin use in Port Erin and Port St Mary, but it’s often hidden – people in those areas tend to be middle class and not have any of the associated deprivation if they are using hard drugs. Peel has some issues but again it’s not obvious there because people can afford it. The problems [associated with substance misuse] in Douglas and Ramsey are really bad. I’d say most people here are from Ramsey.”
Comments from the Public

• “I think [substance use] is a response to something else negative in a person’s life - some people do not have guidance, love, support or a sense of responsibility to a family. I feel like maybe no one’s ever said to them ‘Think about the consequences before you go down that path’.”

• “There’s not much for young people to do that’s not competitive sport or musical activities at high level”.

• “When you speak to young people, they seem to judge how good a night out was by how drunk they got. I think it’s a bit of a shame for them.”

• “My friends and I do drink ‘shots’ when we go out, or Jagerbombs. They do not taste great, but it’s part of the night.”

• “Alcohol is fine, there aren’t problems with it - it’s just people having a good time... though my friend who’s a copper is always complaining about people being drunk and disorderly. Drugs, though, that’s a problem – but if you use drugs you’re just a bit stupid.”

What is the extent of the issue locally?

Comments from Professionals across all agencies

• “There is more heroin than you might expect in view of being an island with potentially better barriers to supply.”

Comments from service users and their families or carers

• “Everybody I know drinks.”

• “There are a lot of people with alcohol problems on the island. Some are in denial about it; there are a lot of functioning alcoholics, so for many it’s hidden. It’s very accessible. There is a drinking culture - people say ‘come on, have a drink, don’t be boring’, but then they demonise alcoholics. There are a lot of people with high disposable income - people in the financial sector or e-gaming.”

• “If people know you’ve been having problems because of alcohol – some will blank you in the street, there’s gossip – and it’s a small island. You can be constantly bumping into people you do not want to see. People do not let you forget your past even if you’re trying to move forward.”
• “People are lacking sober connections – it’s so easy to slip back into your old ways, with your old community. You can get sober quite easily if you want to – but staying sober is very hard. There’s nowhere to go, nothing to do, you’re socially isolated. All the ‘normal’ social contact tends to revolve around drinking.”

**Comments from the Public**

• “Once you are aware of the signs and symptoms, you are more aware of what is going on around you.”
Appendix D: Client characteristics and service activity split by service

Figure 32: Gender of referrals into treatment (2015/2016)

Figure 33: Age group of referrals into treatment (2015/2016)

Figure 34: Ethnicity of referred clients (2015/2016)
Figure 35: Primary reason for referral (2015/16)

Figure 36: Referral reasons for young people (aged 11-17; 2015/2016 data)
Figure 37: Quarterly referrals to DAT service (2013/2014 to present)

Figure 38: Quarterly referrals to Motiv8 service (2013/2014 to present)
Figure 39: Numbers in treatment (quarterly snapshot, 2013/2014 to present)

Figure 40: Quarterly referrals (2013/14-2016/2017 to present)
Figure 41: Quarterly discharges from DAT and Motiv8 (2013/14-2016)

Figure 42: Discharge reasons for DAT clients (2015/2016 data)*

* The category 'Other' includes discharges due to client death, hospital admission, discharge to care of GP and others. All sources with fewer than five clients recorded were combined into this category.
Figure 43: Discharge reasons for Motiv8 clients (2015/2016 data)

- Situation Improved/Resolved: 42%
- Did not Attend: 23%
- Did not Engage: 19%
- Other: 4%
- Inappropriate Referral: 3%
- Patient left island: 3%
- Duplicate Referral: 3%
- Referred to Other Speciality: 2%

- Treatment Completed: 43%
- Did not Attend: 17%
- Did not Engage: 15%
- Alternative Service Provided: 3%
- Inappropriate Referral: 3%
- Referred to other speciality: 3%
- Client left island/Deceased: 2%
- Treatment no longer required: 2%
Table 9:  Successful completions (2015/ 2016)

<table>
<thead>
<tr>
<th></th>
<th>DAT</th>
<th>Motiv8</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number treated in one year (number in treatment at previous year end + number of new referrals during year)</td>
<td>539</td>
<td>1,001</td>
<td>1,540</td>
</tr>
<tr>
<td>Successful completions (either 'Treatment completed' or 'Situation improved/Resolved')</td>
<td>98</td>
<td>208</td>
<td>306</td>
</tr>
<tr>
<td>Percentage of completions successful</td>
<td>42</td>
<td>56</td>
<td>49</td>
</tr>
</tbody>
</table>

Table 10:  Basic unit costing for treatment and successful completions (2015/ 2016)

<table>
<thead>
<tr>
<th></th>
<th>Treatment Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DAT</td>
</tr>
<tr>
<td>Number treated in one year (number in treatment at previous year end + number of new referrals during year)</td>
<td>539</td>
</tr>
<tr>
<td>Successful completions (either 'Treatment completed' or 'Situation improved/Resolved')</td>
<td>98</td>
</tr>
<tr>
<td>Annual service cost</td>
<td>£693,600</td>
</tr>
<tr>
<td>Simple unit cost per client in treatment</td>
<td>£1,287</td>
</tr>
<tr>
<td>Simple unit cost per successful completion</td>
<td>£7,078</td>
</tr>
</tbody>
</table>
Appendix E: Methodology

Quantitative methods

The following quantitative data informed this needs assessment. Some data sets were incomplete. Where possible, comparison was made with figures from other places including England for:

- Mortality and morbidity data
- Service data from providers
  - Demographic data (2015/2016)
  - Detail of substance use
  - Referral patterns, current caseload, activity, length of time in treatment and discharges
  - Clients’ additional/co-morbid needs
- Outcome data (e.g. ‘recovery’ rates)
- Financial data (basic unit costing per client in treatment, per successful completion)
- Pharmacy (prescribing data)
- Customs (import data).

Qualitative methods

Researchers from CPI conducted qualitative interviews with representatives from:

- Public Health Team
- Isle of Man Corporate services, including Health Intelligence, Occupational Health and Human Resources
- Hospital and Primary Care doctors
- Community Nursing
- Pharmacy
- Motiv8 (non-governmental organisation, drug and alcohol service provider);
- DHSC DAT
- DHSC and Mental Health Team
- DHA, Chief Executive’s Office
- Prison/Probation Services
- Isle of Man Constabulary
- Victim Support
- Isle of Man Council for Voluntary Organisations
• Customs and Excise
• Licensing Forum
• Isle of Man Housing
• Adult Social Care
• Isle of Man Education and Youth services and Children’s Services
• Children’s Centre charity
• Graih Homelessness Support Service.

Interviews were carried out with service users of DAT and Motiv8 along with consultation of a group of SMART Recovery group members.

Clients of the Graih homelessness service (a group potentially at risk of substance misuse) were also consulted to discuss substance misuse-related issues in their peer group. Some additional information was gathered from a Homelessness and Health Survey carried out by a vulnerable adults health visitor and Graih.

A ‘drop-in’ public engagement exercise was advertised through social media and at the five venues where conversations were held. In addition members of the public were offered the opportunity to provide their views via email or telephone interview.

Together, stakeholders provided information relating to:

• Which substances are being misused, and which are most often misused;
• Who might be most likely to misuse drugs and/or alcohol;
• Experiences of accessibility, acceptability and effectiveness of treatment;
• What the problems are in families and communities relating to substance misuse;
• Whether the problems here are different to those experienced in England; and
• Measures/actions that could contribute to preventing drug and alcohol misuse, including through public policy (e.g. changes in licensing, pricing, legislation).

A stakeholder meeting of those involved was held at the end of the data-gathering exercise to look at initial emerging data and themes, and to allow comment and discussion.
Acknowledgements

The Centre for Public Innovation would like to thank all stakeholders, government departments, external agencies and members of the public who have helped to contribute towards the production and completion of this document.

Acronyms

DARS  Drugs Arrest Referral System
DASG  Drug and Alcohol Steering Group
DAT  Drug and Alcohol Team
DHA  Department of Home Affairs
DHSC  Department of Health and Social Care
ED  Emergency department
GPs  General Practitioners (Doctors)
IBA  Identification brief advice
JSNA  Joint Strategic Needs Assessment
LES  Local Enhanced Service
MoCAM  Models of Care for Alcohol Misusers
MoCDM  Models of Care for Drug Misusers
NHS BSA  NHS Business Services Authority
NPS  Novel Psychoactive Substances
PSHE  Personal, Social, Health and Economic Education
SMART  Self-management and recovery training - Motiv8
WHO  World Health Organisation
YTD  Year to date
# References

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Reference</th>
<th>Page No(s.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>(Commissioned by) Isle of Man Children’s Services Partnership (2016). <em>2015 Isle of Man Youth Survey.</em></td>
<td>7,13,52,54</td>
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<tr>
<td>4</td>
<td>WHO (2009). <em>Evidence of the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm.</em> WHO Regional Office for Europe: Denmark</td>
<td>10,11,84</td>
</tr>
<tr>
<td>6</td>
<td>Ibid, P76 (WHO, Ref 4 above)</td>
<td>10,83</td>
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<tr>
<td>9</td>
<td>WHO (2011). <em>European Action Plan to Reduce the Harmful Use of Alcohol.</em> WHO Regional Office for Europe: Denmark</td>
<td>11</td>
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Global Burden of Disease Profile: UK


Department of Health and Social Care (2016) Mental Health Service, Drug and Alcohol Team Out of Area Treatments (OATs) Policy, Isle of Man Government


Community Nursing (2016). *The Unhealthy State of Homelessness: Adult Community Nursing Audit 2015/16*


National Institute for Health and Care Excellence (2017). Drug misuse prevention: targeted interventions. NICE guideline [NG64]


National Institute for Health and Care Excellence (2016). Coexisting severe mental illness and substance misuse: community health and social care services [NG58]


36 Anderson P., Chisholm, D., Fuhr, D., (2009), Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol, Lancet, 373, p.2237

37 Ibid, p.2243 (Ref 36 above).


Ibid

Multiple Notes for the Same Source: If two notes for the same source follow one right after the other, you may use the abbreviation "Ibid." Latin for "in the same place." If the note refers to the same source and page number, no page number is necessary.
Our mission is to improve the outcomes of services for their users, with a particular emphasis on the most disadvantaged.

The Centre for Public Innovation is a Community Interest Company that provides research, training, support and advice in the fields of health, social care, criminal justice and community development.

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