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Executive Summary

This project is concerned with the occurrence of drug and alcohol abuse in Nottingham Arnold.

In September 2006, as part of our community based year-out program, we were charged with researching the scale and the extent of drug and alcohol abuse in Arnold, with a view to finding possible solutions to this problem. This research was based around a series of 12 questions (which can be found in the Conclusion) that were designed to focus this project on new, previously untried solutions to combat the growing problem of drug and alcohol abuse.

The first aspect was to attempt to gauge the existence and scale of the problem at national, regional and local levels. From this, it was agreed that there is indeed a problem, and that it is a growing one. We also looked at various solutions being employed at national and regional levels, and what possible solutions could be implemented at local level.

The sources for this research were many and varied, but it is worth noting that some of the main obstacles we came up against were due to the available information being difficult to locate and compile.

In order to look into what solutions could be placed in a local context, we had to spend some time considering what gaps there are in the current service provision, and if these are gaps that need rectification. The end result of this was the creation of a list of possible services to be considered. Each of these was subject to investigation and testing by the means of a strict set of criteria. Those that performed best were then subjected to further research, with a view to attempting to determine the need for that particular service in the local community.

The end product of this was the creation of two separate suggestions, one based in the treatment stream, one in the prevention stream. Out of these final suggestions our primary suggestion is the creation of a mobile resource vehicle, with the possible adaptation to performing basic treatments as well. A full summary of what this entails and other information can be found in Section 3b.

Although this report is by no means conclusive, we feel that it is broad enough in scope to be considered as a serious look into the problem of drug and alcohol abuse in Nottingham and Arnold specifically and its possible treatment.

Introduction

In September 2006 we were set a target to research the scale of local drug and alcohol abuse and to look into possible solutions that could be effective both in combating this problem and in meeting any gaps in the existing service provision.

This project is based around a set of twelve questions designed to lead to some possible solutions, (these are included in the Conclusion). After conducting our research we gathered the results into three areas:

1) The existence of a problem
2) Current provisions for that problem; and
3) Possible solutions to that problem, bearing in mind sections 1 and 2

For the purposes of writing this report we have further sub-divided these three areas into the following:

1a) Is there a problem?
1b) Specific geographical areas and people groups affected by this problem.

2a) What is being done about this problem? (current service provision).
2b) What is not being done? (gaps in the current service provision).

3a) Possible solutions to the problem.
3b) Suggestions based on our research.

Definitions

As part of this project it was felt important to make clear our definitions of terms used and also to give a brief introduction to systems such as the alcohol unit and the Four Tier system.

The first of these which we would like to present is our working definition of drug and alcohol abuse. This definition sufficiently matches the definitions from other sources and is used throughout the remainder of the document, especially used when interpreting quotes.

What is Drug & Alcohol Abuse?

From the internet and from asking people who work with drug and alcohol abusers these definitions are a combination of all that has been said about the problem.

Alcohol abuse:

Misuse of alcohol so that a person becomes addicted to it. It affects their behaviour and health.

Within alcohol abuse there were questions raised as to different types of misuse. When looked into more deeply it seemed that there were two main types of alcohol abuse. These were binge drinking and alcoholism.

Binge drinking:

This is classed as a man drinking over 10 units in one session and a woman drinking over 7 units in one session. "The short-term effects from binge drinking include vomiting, fights, accidents and hangovers. The long-term effects include damage to the liver, heart, brain and stomach. It can also cause certain cancers, for instance, of the mouth and throat and too much alcohol in one go can even cause a heart attack or stroke."[1]

The BBC website states: "One in three men and one in five women fail to drink sensibly. In addition, youngsters are starting to binge-drink at an earlier age."

"The latest government statistics show that more and more young women are binge drinking, even though, on a drink-for-drink basis, alcohol affects women more than men because of their build and body fat."[2]

Alcoholism:
Where a person becomes dependant on alcohol; they will find it hard to do anything without having a drink. Also, they will become less affected by it the more they drink so will have to drink more to become "drunk".

[1] Victoria Creasy, Senior Manager for Alcohol, Drugs and Tobacco at the Health Promotion Agency (HPA).

[2] news.bbc.co.uk

This picture shows an example of what comprises 1 unit of alcohol, (10ml, or 8 grams, of pure alcohol). The recommended safe limit for men is 21 units a week, with no more than 4 units in a day. For women this drops to 14 units a week, with no more than 3 units in a day. Pregnant women are usually advised not to drink, or to drink no more than 1-2units, once or twice a week, as more than this can cause damage to the foetus.

Taken from:
http://www.patient.co.uk/showdoc/23069189/

See the side panel for a fuller explanation of alcohol units.

Drug abuse:

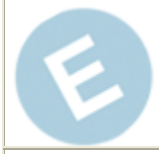
Drug abuse is the use of illegal drugs or misuse of legal drugs. These can cause a person to become dependant on the drugs. Solvent abuse is also connected with drug abuse.

Drug abuse is focused around the four main classes of drugs: stimulants (such as amphetamines and cocaine), depressants (such as barbiturates and tranquillisers), analgesics (such as pain killers) and hallucinogens (such as LSD and ecstasy).

There didn't appear to be much difference in types of drug abuse beyond the different drugs used. It would seem that there are only two options, occasional/casual users or frequent/heavy users.

The table[3] overleaf is from the D.A.R.E. [Drug Abuse Resistance Education] website,[4] and shows the amount of estimated users in the U.K. and also the prices of drugs. From the table it can be seen that there is a wide range in price as well as usage.

[3] Usage estimates: England and Wales - British Crime Survey 2003-04; Scotland - Scottish Crime Survey 2003.Street price: Drugscope survey 2005
Deaths: Office for National Statistics and General Register Office of Scotland
The total for England and Wales includes anti-depressants and painkillers such as paracetamol.
The total for England and Wales includes anti-depressants and painkillers such as paracetamol.
[4] http://www.dare.uk.com/Pages/Static/DrugKeyFacts.aspx

	Class	More details	Estimated no. users	Users, % of population	Average price	Deaths, 2003**
Cocaine 	**A**	Stimulant made from leaves of coca bush. Increases alertness and confidence but raises heart rate and blood pressure and users crave the drug.	**755,000**	**2.4 (1.4)**	**£40** per gram	**113(29)**
Crack 	**A**	Cocaine mixed with baking soda to form smokeable lumps. Gives an intense high but is very addictive and causes paranoia and aggression.	**55,000***	**0.2 (0.2)**	**£15-25** per rock	See note below
Ecstasy 	**A**	MDMA or similar man-made chemicals. Causes adrenaline rushes and feelings of well-being but also anxiety and high body temperature.	**614,000**	**2.0 (1.7)**	**£2-7** per pill	**33 (14)**
Heroin 	**A**	Sedative made from the opium poppy. Can be smoked or injected. Users feel lethargic and content but experience severe cravings for the drug.	**43,000***	**0.1 (0.3)**	**£40-90** per gram	**591 (175)**
LSD 	**A**	Man-made drug which has a strong effect on perception. Effects include hallucinations and loss of sense of time. A "bad trip" can cause anxiety.	**76,000**	**0.2 (0.1)**	**£1-5** per tab	**-**
Mushrooms 	**A**	Fungi containing the naturally occurring compound psilocybin. Users may experience giggling fits, hallucinations and altered perception.	**260,000**	**0.8 (0.1)**	**-**	**-**
Amphetamines	**A/B**	Man-made drugs which increase heart rate and alertness. Users may also feel paranoid. Newer form, methamphetamine, is very addictive.	**483,000**	**1.5 (1.4)**	**£8 -15** per gram	**33 (-)**
Cannabis 	**C**	The cannabis sativa plant or resin from it. Cannabis is a relaxant but stronger forms can also cause hallucinations and panic attacks.	**3,364,000**	**10.8 (7.9)**	**£40-140** per ounce, depending on type and quality	**11 (-)**

* Figures for heroin and crack may be underestimates as the types of groups that use these drugs, e.g. people living in homeless hostels, tend not to overlap with crime survey respondents.
** All E&W figures refer to mentions on a death certificate where cause of death is listed as drug poisoning. The first figure is where it is the only drug mentioned, the second is total number of mentions for that drug.
Cocaine and crack cocaine are indistinguishable in the body after death and so are not shown separately.
- None or no available data.

The Four Tier System

A final definition to include in the introduction to this report is that of the Four Tier System, which will be referred to throughout the report.

The Four Tier system[5] is a system that was devised for the NHS as a way of classifying the various drug and alcohol services that are available in terms of the services they provide. It allows for an easy way to distinguish between different kinds of services and also enable new services to quickly be classed and compared to existing services.

A copy of the Four Tier System is attached in this document in Appendix 1.

As can be deduced from the name, the four tier system comprises of four different classes in which services are grouped. As a rule of thumb, the higher the Tier of a service, the more extreme the cases it deals with.

In brief; Tier 1 comprises of non drug and alcohol specific services, Tier 2 of services which provide some specific services, Tier 3 of centres that are drug and alcohol focused and Tier 4 of residential centres.

[5] http://www.drugs.gov.uk/drug-interventions-programme/strategy/treatment/tiers/

Section 1a

Is there a Problem?

In this section we attempted to answer that simple yet important question; is there a problem with drug & alcohol abuse in the first place? From our investigations the answer is a resounding yes. On a national, regional and local level we have found many examples of there being a considerable problem with drug and alcohol abuse, both from national statistics and from interviews with those in the community and involved in drug and alcohol treatments within Nottingham and Arnold. Please take into consideration that this section is designed to give an overview of the problem at present, and that later we will be talking more about the specific gaps and solutions. We make no apologies for any of the shocking statistics or information we present in the report.

National

The UK has a problem with both drug and alcohol abuse. Statistically it is the second worst Country in Europe for binge drinking (behind Ireland)[6] and the rise in the drinking culture has caused all kinds of problems, at both a personal and a social level.

In terms of drugs, the UK is the second highest consumer of cocaine among 15-34 year olds in Europe (behind Spain)[7]. It is estimated there are roughly 3,000,000 cannabis users in the UK, 750,000 cocaine users, 600,000 ecstasy users and 43,000 heroin users (as shown in the table on page 8).[8]

Statistically it is more difficult to get exact figures on drug consumption and drug-related crime. However we do know quite a lot more about alcohol from government statistics and reports, so it may seem there is a tendency to focus more on the alcohol based statistics.

However, what is important to remember when looking at *all* these statistics is that each one of those figures, each number is actually a person with a family, with a life, and that the ramifications of the drugs or drink affects far beyond the numbers listed here – these are people with mothers and fathers, sons and daughters, husbands and wives, as well as many other friends and family.

[6] Institute of Alcohol Studies, Consumption & Harm, www.ias.org.uk/resources/factsheets

[7] Dare UK, Drug Trends in the UK, www.dare.uk.com

[8] Information about drugs, Cannabis, www.recovery.org.uk

That means when looking at these numbers, those affected are not simply limited to the exact numbers stated here but probably has a far greater affect (See Lucy's Story in Appendix 2).

So what kind of problems does it cause? Violence particularly has been attributed to excessive drinking or drug use, with almost half (47%) of victims of violent offences believing the offender to be under the influence of drink or drugs, that number rising to 58% in cases of stranger violence[9]. Of course again these statistics, while shocking in themselves, also reveal that a great deal of police time is wasted on situations like this which could be avoided.

Also alcohol misuse especially can be an unnecessary drain on the NHS. It's estimated that alcohol misuse costs the NHS £3 billion a year on hospital service.[10]

The space, energy and money used to treat these patients is an unnecessary and avoidable burden on those who work in the health service.

Space: Alcohol related diseases account for 1 in 8 NHS bed days; that's around 2 million[11]
Energy: Roughly 20% of acute hospital admissions involve alcohol as a factor[12]
Money: Up to 35% of all accident & emergency attendances and ambulance costs are alcohol related[13]

When looking at it purely from a financial point of view there is evidence that alcohol-related issues particularly cost authorities a significant amount. Although it is difficult to get exact figures due to debate over the definition of 'alcohol-related crime', anti-social behaviour is attributed to costing agencies an estimated £3.5 billion and, while not every case is alcohol related, anti-social behaviour is often conspicuous around alcohol licensed premises, leading us to suspect a strong connection between anti-social behaviour (and its costs) and alcohol abuse.[14]

Impact on the NHS:

Space:
Alcohol related diseases account for 1 in 8 NHS bed days; that's around 2 million

Alcohol Concern, Health impacts of alcohol, www.alcoholconcern.org.uk

Energy:
Roughly 20% of acute hospital admissions involve alcohol as a factor

The Consequences of Drinking, www.apas.org.uk

Money:
Up to 35% of all accident & emergency attendances and ambulance costs are alcohol related

Alcohol Concern, Health impacts of alcohol, www.alcoholconcern.org.uk

[9] Institute of Alcohol Studies, Crime & Disorder, www.ias.org.uk/resources/factsheets

[10] Alcohol Concern, Health impacts of alcohol, www.alcoholconcern.org.uk

[11] Alcohol Concern, Health impacts of alcohol, www.alcoholconcern.org.uk

[12] The consequences of Drinking, www.apas.org.uk

[13] Alcohol Concern, Health impacts of alcohol, www.alcoholconcern.org.uk

[14] Institute of Alcohol Studies, Crime & Disorder, www.ias.org.uk/resources/factsheets

Of course as well as the social problems, alcohol & drug abuse causes a great deal of health issues.

Alcohol abuse affects almost every part of the body, and it is well publicised the damage it causes. Misuse impacts the liver (*80% of liver-disease admissions in hospitals are alcohol related*[15]), digestive system, heart and circulatory system, brain and nervous system, bones, muscles and even the skin. Other effects include mental health problems, sexual problems, infectious diseases, malnutrition, cancer, and it can lead to the maldevelopment of the foetus in pregnant women.[16]

Conditions associated with alcohol abuse

Gastrointestinal system

- Gastro-oesophageal reflux
- Acute gastritis
- Oesophageal varices
- Oral cancer or cancer of the oesophagus or large bowel
- Pancreatic disease
- Liver disease

Cardiovascular system

- Alcoholic cardiomyopathy
- Cardiac arrhythmias
- Beriberi
- Hypertension and stroke
- Hyperlipidaemia

- Megaloblastic anaemia
- Sideroblastic anaemia
- Iron-deficiency anaemia
- Thrombocytopenia
- Leucopoenia

Respiratory system

- Chest infections

Central nervous system

- Epilepsy
- Wernicke-Korsakoff syndrome
- Peripheral neuropathy
- Memory loss

Endocrine system

- Gynaecomastia, impotence, loss of libido, low sperm count and testicular atrophy in men
- Menstrual disorders and progressive masculinisation In women
- Hypoglycaemia
- Type 2 diabetes
- Pseudo-Cushings syndrome

Musculo-skeletal system

- Acute or chronic myopathy
- Hyperuricaemia (gout)
- Osteoporosis
- Osteomalacia

Obviously the effects of drug abuse varies from drug-to-drug; cannabis often has a similar effect to cigarettes on a person's lungs and can cut a man's sperm rate or suppress a woman's ovulation; cocaine is highly risky for anyone with high blood pressure or a heart condition, and induces anxiety, paranoia, depression and is known to bring previous mental health problems to the surface; ecstasy has similar effects to cocaine, as well as causing liver, kidney and heart problems; heroin is one of the most dangerous drugs, leading to coma

[15] Alcohol Concern, Health impacts of alcohol, www.alcoholconcern.org.uk

[16] For more information on the effects of alcohol abuse go to www.alcoholconcern.org.uk and look at the fact sheet 'Health Impacts of Alcohol'

and sometimes even death from respiratory failure. All these drugs can lead to death through overdosing. It's important we remember that these problems aren't just 'side effects', they wont always naturally wear off. Problems involving the organs and mental health, especially through continued use, can lead to long-term problems[17] and further ramifications on the NHS.

This problem is a growing one; with the number of patients admitted for alcohol related diseases doubling in eight years, from roughly 125,000 in 1997/98 to 250,000 in 2005/06.[18] Government statistics also show in the UK the number of alcohol related deaths in the year 1991 was 4,144. By 2005 that number had more than doubled to 8,386, and that number is still rising each year.[19]

Regional

Nottingham as a city has a reputation in the UK for a higher level of problems with drug and alcohol abuse than the average UK City, publicised a great deal through the media.[20]

Our research did not indicate that the city as a whole, at this present time at least, suffered any more heavily than other major cities with drug and alcohol problems, although violence in connection with drink seemed to be a common theme in reports and news articles.

However, that does not mean that the state of Nottingham is acceptable. In our studies we found a number of startling statistics which indicated that the abuse of alcohol and drugs have had a major negative impact on Nottingham for some time, and perhaps none more shocking than the following statistic.

An article in 2003 in the University of Nottingham impact magazine made the shocking claim that one baby per month in the city of Nottingham is born already addicted to Heroin. [21]

One baby per month in the city of Nottingham is born already addicted to Heroin.

Impact Magazine University of Nottingham 2003

[17] For more information on the effects of drug abuse go to www.talktofrank.com and look at the 'a-z of drugs'

[18] Institute of Alcohol Studies, Impact on the NHS, www.ias.org.uk/resources/factsheets

[19] Alcohol related death rate, www.statistics.gov.uk

[20] News.bbc.co.uk

[22] The Dark Side of Nottingham, www.bbc.co.uk/nottingham/students/2003/10

That claim does not seem to suggest that the problem of drugs in Nottingham has been dealt with by any means, and if you add into that the national statistics relating crime to alcoholism and Nottingham's continued reputation for gun-crime and high murder rate then the picture of Nottingham we see is far from positive.

'[Drugs and Alcohol abuse] is a massive problem in Nottingham; we've haven't even seen it at its peak yet'
Acorn Lodge, Nottingham (see Appendix 3 for full interview).

'[Drug and Alcohol] abuse is a massive problem in Nottingham; we've haven't even seen it at its peak yet'

The Salvation Army
Acorn Lodge
Nottingham

Local

Of course locally there are a lot less statistics and figures, so our conclusions are based a lot more on talking with the key players in the community and local people about whether they saw drug and alcohol abuse as a particular issue in the area.

From interviews with a number of people working in Drug and Alcohol treatment in some way we came to the conclusion that there was a problem with drug and alcohol in Arnold, no less so than any other suburban area within Nottingham.
You can find our full interviews in Appendix 3, and you can also find more information on the drug and alcohol treatment services available in Arnold in Section 2a.

[The problem] is getting worse in Arnold, in fact in all Nottinghamshire really
Manor Pharmacy, Arnold (see Appendix 3 for full interview).

[The problem] is getting worse in Arnold, in fact in all Nottinghamshire really

Manor Pharmacy
Arnold

However, we also felt it important to talk with a number of local people to ascertain whether the problem was an apparent one or if perhaps the community in Arnold was unaware of it. From talking with those people we also came to the conclusion that, although not all were entirely certain on the specifics, there was definitely an undertone of a drink and drugs culture within Arnold and the rest of Gedling, and specific areas such as Front Street, the Bestwood Estate and Killisick were brought up in many of the interviews.

This confirmed our prediction that the problems were not solely based in the City of Nottingham but that more and more it looked like it was filtering out into the suburban areas surrounding it. In addition to the formal interviews our conclusion is also drawn from more informal interviews and conversations we did not necessarily record but which were helpful in getting a wider perspective on Arnold's issues. (More information on the local problem in Arnold can be found in Section 1b).

Section 1b

Geographical areas and People Groups

After establishing there was a problem with alcohol and drug abuse, we looked into which geographical areas in particular are associated with the issue, and also if any particular people group is affected by it more than any other, as this would greatly alter our overall conclusion if there were particular areas or groups of people that need extra attention.

Geographical Areas

Most of our research and conclusions in terms of geographical area are drawn from the previously mentioned interviews with those working in drug & alcohol treatment and local people in Arnold as well as our own observations.

The general consensus was that the key problem areas centred around pubs and a lot of problems came from the city and were simply spilling over into areas such as Arnold. A number of areas, both within Arnold and other places around Nottingham were mentioned in our formal interviews. These include:

Within Arnold: Front Street, the Bestwood Estate, Killisick, Arnold Hill & Red Hill schools, Arnot Hill Park. *Within Nottingham:* St Anne's, The Meadows, Bulwell, Clifton and Radford.

'There are underlying problems; you can see that if you go out on a Friday or Saturday night' (see Appendix 4 for full interview).

There are underlying problems; you can see that if you go out on a Friday or Saturday night

Interviews with Local People
Male, Aged 60-70

With that in mind we concluded that, although there may be a number of more difficult areas, potentially any area can develop a problem with drug and alcohol abuse and so it would not be helpful to specify any particular place within Arnold for 'special treatment', and perhaps we should look to cover a wider area than just Arnold, as the issue was clearly not specific to Arnold or any other area in Nottingham.

People groups

It was also important to establish if there was any particular group of people that needed attention. Again our conclusions lead us to believe that, while there may be certain trends in certain areas, it would be unwise to focus on a particular group of people for a number of reasons.

When looking at information we tried to make it as specific to Nottingham as possible and therefore used statistics from APAS.

APAS is a Nottingham based 'independent provider of all kinds of services designed to reduce the harm alcohol causes to individuals, families and the communities they live in'.[22]

Their most recent statistics, from April 2006 - June 2006, show they had around 1700 contacts, with roughly 200 of those being new referrals. Of those statistics (which can be found in Appendix 5), none suggest that any group suffers more than expected.

Regarding gender of the 1700, just over a 1000 of those are men, which is within the national average. In age the highest proportion is within the 19-49 region, again a national trend within the UK. Ethnicity is no different, with around 90% of those seeking help from APAS being White British.

'Anyone can suffer from drug or alcohol problems'
Betel, Arnold (see Appendix 3 for full interview).

Anyone can suffer from drug or alcohol problems

Betel resident
Gedling

Also, as we will touch on later in the report, within Nottingham City itself there exists services which cover more specific people groups in age, gender and ethnicity and so we felt to focus on any one group would probably not be a good use of potential resources as the problem is obvious amongst all people groups.

We also felt that it was important to remember that, as previously mentioned, this is a problem that extends beyond those directly suffering from alcohol or drug abuse, but affects their families and friends as well. That fact is a reminder that it is very likely that the majority of people are connected in some way with someone suffering due to drugs or the misuse of alcohol.

The overwhelming conclusion from our interviews was that it seemed a reoccurring theme that the problem of drug and alcohol abuse is spreading.

'There is a lot people don't pick up on, (the problem) is not always apparent' (see Appendix 4 for full interview).

There is a lot people don't pick up on, (the problem) is not always apparent

Interviews with Local People
Male, Aged 20-30

[22] For more information check the APAS website at www.apas.org.uk

Section 2a

What is being Done?

The next aspect of this project was to consider what is already being done to counter the problem. As the problem presents nationally, regionally and locally, it warrants looking at solutions being tried at all those levels.

One of the first responses to an increased problem is to increase treatment. This has been seen by the recent rise in NHS budget, along with a promised increase in drug and alcohol treatment places, rising to 200,000 by 2008 from 100,000 in 2002.[23] The second response is to increase awareness and education about drugs – again this can be seen by the launch of the network 'Talk to Frank' in 2003.

From this it can be seen that there is nationally a view that drug and alcohol abuse is becoming increasingly problematic[24]. However of the 200,000 additional places these must be allocated regionally, not nationally. This, combined with the information that community based rehabilitation is the most accessed form of rehabilitation[25], leads us to look further at the work being done at a regional level.

Our main source for this information is the 2005/2006 publication 'A referrer's guide to drug and alcohol services in Nottingham' by the Nottingham crime and drug partnership[26]. This publication lists many of the agencies, both public and private, that are involved in drug and alcohol rehabilitation in Nottingham.

In order to more clearly see how these services were distributed and to differentiate between services of different kinds, a Service map was created on a map of Nottingham and surrounding areas, marking all the services in the 'Referrer's guide…' using colour-coded stickers, (see Appendix 6). Immediately this showed a high density of services in the city. These services included all of the four tiers as mentioned in the introduction of this report. There were also services aimed at particular gender, age and ethnic groups, ensuring that there were no groups that could be discriminated against in the service provision. With all four tiers present in the city there is no need for anyone to turn to an outside agency.

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[24] http://www.bmj.com/cgi/reprint/329/7458/128-a.pdf

[24] http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/22_05_06_drugs_survey_bbc_icm.pdf - 74% of people believe there to be a problem with drugs in their area, rising to 75% for east midlands

[25] Community based drug services account for 87% of national treatment – this includes community based drug services, outpatient drug dependency units (DDU's) and hospital outpatients (national statistics and department of health statistical bulletin - 'Statistics from the Regional Drug Misuse Databases on drug misusers in treatment in England, 2000/01')

[26] http://www.apas.org.uk/ReferrersGuide2005.pdf

The specific area that we focused on was the community of Arnold. Due to its position on the edge of Nottingham there are no specific treatment services based in the area. Without being able to look at these and the impact they are having in the community, we instead focused on the non-drug specific services (Tiers 1 and 2) that were based in the community.

The first of these local services is Manor Pharmacy which comes under the criteria of a Tier 2 service. As well as offering a supervised consumption programme (where prescriptions are monitored), it also offers a needle exchange and methadone substitution service. Although all of these could be considered as services that are ineffectual as treatment for a service user, they nonetheless show that there are problems in the community and that there is an attempt being made to provide some kind of service. The services are also well used, with approximately 90 needle exchange kits (each containing 10 needles, syringes and a sharps box) are distributed each quarter.

Another group that is active in the community is Betel. Although they do not have a treatment centre based in Arnold there is a shop on one of the main shopping roads in Arnold. This centre serves as a Tier 1 access point, where people can find out more about the effects of drug abuse and find information about how to access the services offered by Betel.

Another aspect that we focused on is the work of The Salvation Army at these different levels. To that extent we looked at some examples of treatment centres nationally, regionally and then finally the work of The Salvation Army in the local community.

The first of the national centres we looked at was Gloucester House[27], a rehabilitation centre run by The Salvation Army based in Highworth near Swindon. This centre uses the 12 step programme devised by the AA (Alcoholics Anonymous) and different kinds of therapy. Gloucester House also looks to help service users re-establish themselves in society. Like many centres that deal with drug and alcohol abuse it seeks to first distance service users from the situations they have come from by providing sheltered accommodation in another area of the country.

One other notable feature about this service is that it is not open-access, meaning that patients have to be referred from a GP or drug agency in order to gain a place.

[27] http://www.saha.org.uk/gloucester_house.htm

The second Salvation Army service we looked at was Greig House[28], a detoxification centre based in London, near Canary Wharf. This centre practises a 14 or 21 day voluntary detoxification programme by clinical withdrawal. It is worth noting that although this treatment method is very effective in the short term, it tends to be less affective as a long term rehabilitation option. As with Gloucester House, this service is by referral only, in this case by local authority DATs (Drug and Alcohol Teams). In the meantime, local Tier 1&2 services are recommended.

In Nottingham, there are two Salvation Army run centres that deal with drug and alcohol abuse, even if it is not their primary focus. The first of these is Sneinton House[29]. This centre deals primarily with young homeless men, although they estimate that 75% of services users have a problem with drug and alcohol abuse. Although no formalised services are in place, the workers employed in the centre are expected to have a day to day knowledge of the issues being faced. In combination with this, there are individual and group counselling session being run, with a high percentage of transference from the individual to the group.

The second of the services in Nottingham is Acorn Lodge[30]. This is aimed particularly at people aged 55 and over who suffer from homelessness, although again there is a high incidence of substance abuse (90% by their estimation). It is worth noting about this service that it can only provide accommodation for 12 people at a time, and also there is a higher incidence of alcohol abuse over drug abuse. Due to its size, this service is full the vast majority of the time and therefore works closely with other services, particularly the Hostels Liaison Group.[31]

The third and final aspect of this section is to consider the work of The Salvation Army locally in Arnold. One important aspect of the work being done is the outcome of this project. The work being done is not limited to this however, and although currently there are no official programmes being run, the local centres (Sally's charity shop and the main Salvation Army Hall) practically fulfil Tier 1 functions.

[28] http://www1.salvationarmy.org.uk
[29] http://www.saha.org.uk/sneinton_house.htm

[30] http://www.olderhomelessness.org.uk/?section=4&topic=3&article=11

[31] http://www.hlg.org.uk/

Section 2b

What is Not being Done?

Following on from the previous section, it is the natural progression to look at any gaps that are present in the service provision. As any attempts at national change are beyond the scope of this project, we will focus at regional and local change instead. A further consideration of this is that many projects will include both of these categories, having an impact at local and regional level.

Due to the high density of services in the city, any project that would wish to add to the service provision, rather than duplicate earlier work, would most likely be based outside of the city centre, and would fall into one of two main streams. The first of these streams takes into consideration the lack of any non-central services, as well as the inclination of people not to travel. This information was highlighted in an informal interview with workers and services users at Sneinton House. As a result the project would then focus on creating some level of local service, based in and easily accessible to the people of Gedling and surrounding areas, such as those mentioned in Section 1b, particularly in the North Nottinghamshire mining communities, where there is perceived to be a high level of multi-generational drug and alcohol abuse.

The second stream under consideration, as well as including another gap that was identified within and about the current service provision, is that of prevention rather than cure. With Arnold not being considered to be any more or less troubled by drugs or alcohol problems than any other area in Nottingham, it makes sense to look at what possible measures could be put in place to prevent future drug and alcohol abuse, as opposed to attempting to control current abuse. This gap was identified as a lack of awareness of the services that are in place. The question posed is: 'Without a reference such as "A referrer's guide[32]…" would someone be able to find out about the services offered in their local area?'

It was considered that a useful feature of any attempt would incorporate aspects that are highly recognisable. Although this would have to be done with taste and discretion to avoid possible offence, it would have the benefits of further raising the awareness of issues associated with drug and alcohol abuse, as well as highlighting services that are currently available, and possibly being able to then direct those in need to the current service provision.

[32] As mentioned in section 2a. of this report.

There are a lot of problems with alcohol behind closed doors

Interviews with Local People
Male, Aged 60-70

'There are a lot of problems with alcohol behind closed doors' (see Appendix 4 for full interview).

Another perceived gap in the service provision was recently highlighted in the media. In the Nottingham Evening Post there was a front page article on the dangers of drinking at home.[33] This problem was also highlighted in formal and informal interviews as one of the large problems facing current treatment services – people who consume 'hazardous levels' of alcohol[34] at home, possibly without realising that they have a problem.

One of the sources of the article has a level of experience that is hard to rival. APAS (Alcohol Problems Advisory Service)[35], which has a long history of working with alcohol abusers, estimates that there are 50,000 people who consume 'hazardous levels' of alcohol in Nottingham. Among other media presentations has been a BBC 'Midlands Today'[36] news report that funding for alcohol treatment is at an all time low, some 15 times smaller than the budget for drugs treatment. This, when combined with other media reports and the rise of amounts consumed in drinking[37], shows a possible future problem.

***Alcohol is the fifth most dangerous substance**, ahead of substances such as ecstasy [18th] and cannabis [11th]*

The Lancet
http://www.thelancet.com/journals/lancet/article/PIIS0140673607604644/fulltext

The Lancet[38] reported a new study showing alternative rankings for harmful and addictive substances[39], it placed alcohol as the fifth most dangerous substance, ahead of substances such as ecstasy [18th] and cannabis [11th].

The IAS (Institute of Alcohol Studies) has plenty of supporting evidence that current services could soon be overwhelmed by more and more requirement for services that are already stretched.[40]

The fact of the matter is that despite many initiatives drug and alcohol abuse remains a problem in many communities. No project is going to be able to eradicate them as problems. What is important, regardless of past failings, is that new

[33] "Drinking at home: A hidden killer" Nottingham Evening Post, Friday April 13 2007 p1

[34] That is, over 50 units a week for men and 35 units a week for women

[35] http://www.apas.org.uk

[36] http://www.bbc.co.uk/england/midlandstoday

[37] www.ias.org.uk

[38] http://www.thelancet.com

[39] http://www.thelancet.com/journals/lancet/article/PIIS0140673607604644/fulltext

[40] In informal interviews, almost all service centre said they were at capacity for the vast majority of time

initiatives look at new solutions, or new ground, in which to attempt to have an impact on this issue. This is why we believe that any project attempting to have an effect should look at filling at least some of these gaps in the service provision.

Section 3a

What could be Done?

These following are suggestions that we came up with by looking at the gaps in the service provision as outlined in the previous section and asking people who work with those struggling with drug and alcohol issues how we could help with the problem.

Half way house
This would be a place in between a service user having 24 hour support and them being allowed straight back into the community. It would be there to offer support and allow more freedom than a hostel.

More workers
This would simply be more workers at places that currently exist, who would be qualified to assist the people already identified as struggling with drug or alcohol abuse.

Rehabilitation centre
This would be a centre that would aid people with drug and alcohol issues to work through the problem. It would be following either the 12 steps programme for drug or alcohol treatment or something of a similar nature. This would have to be a referral service.

Schools counsellor
This person would either be attached to one school or a few. Their role would be to counsel students affected by drugs and alcohol. This would also mean that if any student's friends or family are struggling with a problem, they could talk with the counsellor too.

Build on existing places
As a few of the residential places are full a high percentage of the time this suggestion would be to expand on the current buildings so the service providers can offer more places to people with needs.

Mobile treatment and resource vehicle
This would be a vehicle that would provide services, such as needle exchange, to offer to people struggling with substance misuse. Also, they would offer information on local services. This would allow them to move around the area and inform people about the dangers associated with drug and alcohol abuse.

Drug and alcohol information officer
This role is to give information mainly to schools as well as other youth venues. They would give assemblies and maybe lessons on drug and alcohol abuse and its effects.

Alcohol day centre
This would be an open access service designed to provide a safe environment in which people would be able to begin a rehabilitation programme.

Once we had all the suggestions of how we could best fill the gap we then drew up a table with these suggestions. As mentioned in the Introduction, this project was based on a list of questions designed to assess the extent of the problem, as well as judge the usefulness of any solution suggested. To decide which service would best fill the gap these questions were visited again and suggestions were given a mark out of three based on how closely they followed the criteria questions. Although the actual working out of this is not included here, it can be found in Appendix 7. Below is a table featuring the possible solutions ranked according to our scores based on the criteria, the table on the following page shows the suggestions ranked according to the estimated cost of each suggestion.

The suggestions ranked in terms of score:

Service	**Score**
Alcohol day centre	23
Mobile Treatment and Resource Vehicle	22
Half way House	22
Rehab Centre	20
Schools counsellor	18
Drugs and alcohol information officer	18
Build on existing work	15
More Workers	15

The suggestions ranked from highest to lowest in terms of cost:

Service
Rehabilitation Centre
Alcohol Day Centre
Half way house
Build on existing work
Mobile Treatment & Resource Vehicle
More workers
Schools counsellor
Drug and alcohol information officer

It is important to note that some of these suggestions could overlap. For example, the schools counsellor and the drug and alcohol information officer could be the same person or the drug and alcohol information officer could work in the mobile treatment and resource vehicle.

Although the above data was used to inform our choice as to which service would be of greatest benefit, it was not the sole information point that was used. By looking at how closely the suggestions fitted with our understanding of what the gaps in the service provision are, we were then able to consider more closely which services would best fit the needs of the area.

We also had to consider to which extent a given service was operating. Although one of the main criteria was to what extent it filled a gap in the service provision, it was decided that if the demand for a service was great enough, then that criteria could be changed to meeting a need, rather than filling a gap.

It was decided that a number of suggestions, namely the drug and alcohol information officer and the schools councillor, were unnecessary as provision for this was already being met in the local secondary schools.

After further discussion the halfway house was also discarded due to the provision again being provided in some capacity within Gedling and, although the idea of further provision was not totally out of the question, we felt filling a noticeable gap was of more value than adding to currently existing services.

Section 3b

What should be Done?

A primary and secondary choice was then made by each team member based on the information collected and their experience within this project, the assessment table and how they felt it would best fill the gap. The top two were the mobile treatment and resource vehicle and the alcohol day centre.

These are the descriptions originally written by us of what each service would offer when discussing which would be our final choice.

Suggestion 1
Mobile treatment and resource vehicle (MTRV)

An idea we came up with when looking over the needs within Nottingham and Arnold was some kind of mobile treatment and/or resource vehicle.

It would be operated by at least two people, both with access to information regarding services specific to the area the vehicle would be in, both locally and around Nottingham in general. They would also provide basic services, such as needle exchange and basic medical supplies (may require basic medical training).

The mobile treatment and resource vehicle was a concept which was born out of the need for a flexible way of providing information for people where they are – in effect, bringing the information to them rather than making them find it themselves. We very much feel from our studies that prevention through information in the long-term is more effective than a short-term 'cure', which may deal with that particular issue at the time, but does not address the next generation of drug or alcohol users until they are in the same position again.

'Those with the problem need to know that they have a problem'
Betel, Arnold

Those with the problem need to know that they have a problem

Betel
Gedling

We also identified quite early on that there was no specific area within Nottingham that needed extra attention, as every place suffered in some way from drug and alcohol abuse issues.

The MTRV would carry the advantage of being instantly recognisable, as the idea is a fairly unique one and even those who were not directly in contact with the vehicle would be aware of what it stood for.

Another advantage is that, with its potential dual purpose of Tier 1 resource centre and Tier 2 service provider the vehicle would allow a change of strategy if needed. Again, the big advantage with the vehicle is flexibility.

Of course an advantage it has over suggestions such as the Alcohol Day centre is simply that it would cost less – estimated costs of around £50,000 for the vehicle itself, plus extra for any equipment or other resources.

Suggestion 2
Alcohol day centre

As already outlined in this report, alcohol abuse is a large scale problem in Nottingham, leading to implications to health and the criminal justice services to name but a few. In line with this, one of the proposals being considered is the creation of a treatment centre designed to tackle exactly this problem. This could be taking one of two forms, at either Tier 3 or Tier 4 level.

A Tier 3 treatment centre would focus on being able to provide a hosting place for a variety of services that would be available to the public. Services that could be offered include counselling, support networks and AA-style meetings, to name but a few. By increasing the availability of these services it could help the long standing problem of alcohol abuse in Arnold and other areas.

The other possibility under consideration here is the creation of a Tier 4 residential service. One advantage of basing such a project in or near Gedling is the distance from the city. Many projects have shown that removing service users from places where alcohol is freely available helps both short and long-term recovery. This, combined with the fact that the city is capable of providing alcohol to 100,000 people each and every a night[41] (according to one estimate), would have a clear impact on people whose lives are affected by alcohol abuse.

The advantage this would have over the MTRV is that short-term the affects would be greater and more noticeable, although of course the cost would be significantly higher.

[41] http://www.nottinghamcity.gov.uk 'Notice Nottingham' report 18th February 2005

Conclusion

Firstly to find out if there was a problem with drug and alcohol abuse in our local community we aimed to answer the following 12 questions:

1. How do you define drug and alcohol abuse?
2. Is there a problem?
3. What is the scale of the problem?
4. Are there specific geographical areas in our neighbourhood that have drug and alcohol abuse related issues?
5. Are there specific people groups that suffer from drug and alcohol abuse related issues?
6. What services are provided for people?
7. Who provides what service and to whom?
8. How long have those services been in place?
9. Who are the key players in the community?
10. Are there any areas where services are not provided?
11. How might The Salvation Army meet the gap in the service provision?
12. Are there other Salvation Army centres that have addressed drug and alcohol abuse related issues?

To answer these questions we researched on the internet, conducted telephone interviews with people who work at services for drug and alcohol users and interviewed people from our community.

From our research we have found that there is a problem with drug and alcohol abuse. Also, there are gaps in the services provided in the local community; with only two key players it means there is room for more.

With this in mind we looked at ways that we thought would help fill gaps in the service provision. With all the suggestions made we went through some of the questions above and also looked at the research we had gathered to make a suggestion of which we personally felt would be our preferred service. The two suggestions that we felt would be most beneficial are a mobile treatment and resource vehicle and an alcohol day centre.

Of those two, after a great deal of discussion and thought our overall suggestion would be the mobile treatment and resource vehicle (MTRV). Although the alcohol day centre scored slightly more on our criteria scoring matrix, we felt the benefits the MTRV brought were more substantial. As previously mentioned, the low budgetary requirements and its great flexibility were both defining factors, as well as its focus on prevention over cure.

Appendix 1

The Four Tier System

Tier 1 - Non Drug Treatment Specific Services
This consists of services offered by a wide range of professionals (e.g. primary care medical services, generic social workers, teachers, community pharmacists, probation officers, housing officers, homeless persons units). Tier 1 services work with a wide range of clients including substance misusers, but their sole purpose is not simply substance misuse.

Tier 1 services may include:

- Access to a full range of health, social care, housing and other services.
- Substance misuse screening, assessment and referral mechanisms to substance misuse services from generic, health, social care, housing and criminal justice services.
- Management of substance misusers in generic health, social care and criminal justice settings.
- Health promotion advice and information.
- Hepatitis B vaccination programmes for substance misusers and their families. Alternatively, if investments in vaccinations are made within tier 2, 3 or 4 services, they can be recorded in the relevant grid.

Tier 2 - Open Access Services
Services within this tier aim to provide accessible services for a wide range of substance misusers referred from a variety of sources, including self-referrals.

The aim of the treatment in this tier is to help substance misusers to engage in treatment without necessarily requiring a high level of commitment to more structured programmes or a complex or lengthy assessment process.

Services in this tier include needle exchange programmes and other harm reduction measures, substance misuse advice and information services and ad hoc support not delivered in a structured programme of care.

• **Advice and Information**
Advice and information services provide accurate, appropriate and factual information which is accessible and meaningful (in terms of context, language and comprehensibility) to the recipient.

Access to advice and information should be provided by services in Tier 1, and may be a core component of services in Tier 2. Specific services offering advice and information are characteristic of open access services.

However, staff in all treatment tiers should provide the provision of advice and information on substance-related issues.

• **Harm reduction services (including needle exchange)**
Needle and syringe exchange schemes were developed within the wider context of harm minimisation or risk reduction, which refers to the reduction of the various forms of drug-related harm, including social, medical, legal, and financial problems, until the substance misuser is ready and able to come off.

They are important for preventing blood-borne diseases, most particularly HIV and hepatitis as well as being important public health measures. The majority of needle exchange schemes are those where sterile needles and syringes are given out and their safe disposal is offered.

• **Assessment and care management**
Assessment and care management should encourage the substance misuser to seek appropriate help and to assist their access to and engagement in treatment, whilst accepting the individual substance misuser's choice as to whether they accept treatment or not.

Care management should facilitate access to a programme of integrated and co-ordinated health and social care and to minimise disengagement ('drop out') from the treatment system. All substance misusers should have access to appropriate and effective assessment and Care Co-ordination. As a distinct service, this has been offered by Community Care teams operated in social service departments. But this should not be the exclusive territory of social workers or local authority care managers. A wide range of professionals need to be able to undertake Care Co-ordination.

Other Tier 2 services may include:
- Other services that minimise the spread of blood-borne disease.
- Services that minimise risk of overdose.
- Outreach services targeting high risk and local priority groups.
- Motivational and brief interventions for drug and alcohol service users.

Tier 3 - Structured Community Based Services
This Tier can be defined as providing services solely for substance misusers in a structured programme of care.

Services within this Tier include structured cognitive behaviour therapy programmes, structured methadone maintenance programmes, community detoxification, or structured day care (either provided as a drug-free programme or as an adjunct to methadone treatment).

Structured community-based aftercare programmes for individuals leaving prisons are also included in Tier 3.

The principal expectation is that the substance misuser attending these services will have agreed to a structured programme of care which places certain requirements on attendance and behaviour (e.g. a certain number of days or hours attendance per week, review of programme is triggered if attendance is irregular).

Community prescribing – Specialist
Community prescribing programmes involve the provision of a medically supervised drug substitute to an illicit drug misuser. The substitute can be used to maintain the individual's tolerance to the drug of misuse or to facilitate withdrawal through a reduction programme.

The prescribing programme is the basis for providing medical and psychosocial counselling and support. Community Drug Teams (CDTs) usually deliver specialist services or Drug Dependency Units (DDUs) operated by NHS Trusts.

Community prescribing – GPs
Community prescribing programmes involve the provision of a medically supervised drug substitute to an illicit substance misuser. The substitute can be used to maintain the individual's tolerance to the drug of misuse or to facilitate withdrawal through a reduction programme.

The prescribing programme is the basis for providing medical and psychosocial counselling and support. These services are delivered in general practice but often in liaison with specialist services using shared care protocols.

Structured care-planned counselling
Care-planned counselling is defined as formal structured one-to-one counselling approaches with assessment, clearly defined treatment plans, treatment goals and regular reviews, as opposed to advice and information, drop-in support and informal key-working.

Structured day programmes
Structured day programmes provide intensive community-based support, treatment and rehabilitation. They should offer clear programmes of defined activities for a fixed period of time with specified attendance criteria – usually four to five days a week.

Tier Three - Aftercare services
There are two distinct activities that could be included under the Aftercare Services heading, Services that aim to smooth the linkages between drug treatment services in prison and those in the community. Examples include:

- Projects aimed at ensuring the continuation of substitute prescriptions as patients enter and leave the prison system.
- Services aimed at picking up referrals from CARAT teams, and successfully placing them in appropriate community based services on release.
- Services that work to help those who have stabilised their lives through treatment, to make progress in employment, training or housing. For example:
    1. Projects that provide stabilised misusers with volunteered or paid employment opportunities.
    2. Projects that provide stabilised misusers with supported or subsidised accommodation.

Other Tier 3 services may include:
- Liaison substance misuse services for acute medical and psychiatric sectors.
- Liaison substance misuse services for local social services and social care sectors.
- Specialist structured community based detoxification services.

Tier 4 - Residential and Inpatient Services
Services in this tier are aimed at those individuals with a high level of presenting need. Services in this tier include inpatient drug treatment, including detoxification and residential rehabilitation. Tier 4a services usually require a higher level of motivation and commitment from the substance misuser than for services in lower tiers.

Inpatient detoxification
Inpatient substance misuse treatment programmes are specialised units for people with substance misuse disorders or inpatient services delivered in general medical or general psychiatric facilities. Inpatient services also include episodes of detoxification purchased from independent sector units.

They provide medically supervised assessment, stabilisation and withdrawal with 24-hour medical cover and a multidisciplinary team.

Residential Rehabilitation

Residential rehabilitation services are specialist services offering intensive and structured programmes delivered in controlled residential or hospital environments. These services are mainly available in the independent sector and including therapeutic communities, concept houses, 12 step Minnesota model programmes and general houses including those with a faith-based philosophy.

Appendix 2
Lucy's Story

Lucy's Story

Cannabis sparked a slide into depression for 17 year old Lucy.

Lucy from Surrey first tried smoking cannabis when she was 12 years old. 'I started using it with my mate, who was 11 at the time.' she says. 'I liked it straight away and I started smoking every day. I did that for three years.'

'I used to smoke first thing in the morning, at lunch time if I was in school, when I got home and then when I went out at night. I had to have a joint. If I didn't I got moody. If I was in school I had to leave to smoke.'

Lucy says her mum knew she was smoking the drug. 'It was a bit obvious,' she admits although she adds that her mum had no idea of how much she was smoking. Lucy also says her mum didn't try to make her quit. 'She would have done if it was another drug, but because it's cannabis, people don't seem to worry so much.'

But Lucy began to worry when she realised how much the drug was affecting her and she recently made the decision to stop taking it. She's now working with drugs education charity Hope UK to educate parents about drug use. She thinks people need to be warned about the mental impact of cannabis and says it made her depression much worse. 'You think cannabis will make it better, but after a bit you feel a lot worse. It can make you extremely paranoid and it affects your speech. I still can't say some words and I'm sure it's 'cos of smoking. People don't understand the depression side, how you can't concentrate - you literally can't do your work. They think it's harmless. It's not.'

Interviews with Key Players

Betel *Gedling*

1. On a scale of 1-5 (1 being minimal problem, 5 being massive problem) how much of a problem do you think alcohol abuse is in Arnold?
   About a 4, not just from Arnold but often see people drinking on the street

2. On a scale of 1-5 (1 being minimal problem, 5 being massive problem) how much of a problem do you think drug abuse is in Arnold?
   4, people think they have to, to fit in

3. Do you know of any specific areas mainly in Arnold but also in Nottingham where there is drug and alcohol abuse?
   Newark, Mansfield and most of Arnold

4. What groups of people suffer from D&A abuse? E.g. age, sex
   Anyone can suffer from drug or alcohol problems

5. What services are available for people with D&A abuse and which are the main ones that are used?
   We use the Betel programme. When giving treatment you need to have been in that situation so you can relate

6. Are they well known to those with the problems?
   Police, government and probation know, but you only know about Betel if you are told about it

7. Do you think that there are any services that are missing?
   The AA doesn't work; in fact most things don't work. Those with the problem need to know that they have a problem

8. What recovery methods did you use to be free of your addiction?
   The Betel programme – cold turkey and Christian values of love for God and love for people

Interviews with Key Players

Manor Pharmacy *Arnold*

1. How would you define drug and alcohol abuse?
   Never being sober, self inflicted, addiction and habit

2. Do you think there is a problem with D&A abuse in Arnold?
   Yes, definitely

3. How severe do you think the problem is?
   It depends where you work as to how aware you are of the problem. It's getting worse in Arnold, in fact in all Nottinghamshire really

4. What service do you offer to people with D&A abuse problems?
   A Needle exchange, they get the tubes back

5. Is it effective?
   Yes I believe so

6. How long have you been giving this service?
   At least 10 years

7. Do you think more help could be given?
   I think help is given, but it just needs to come from themselves

8. If yes what would you suggest?
   I don't see any gaps, it's up to the individual if they want help, and not many turn around

Interviews with Key Players

Sneinton house *Nottingham*

1. Define D&A abuse?
   Abuse of substances, which effect mental & physical health and social interaction

2. Is there problem of D&A abuse and how big is the problem?
   Yes definitely in Nottingham. There's definitely a link with criminal activity and health. A&E has a lot of people affected by drug and alcohol coming in

3. Are their specific groups of people that suffer from D&A abuse?
   Yes poorest people who can't afford it so then either end up in prison or die.

4. What services do you provide for D&A abuse?
   Workers with a day to day knowledge of the problems; also group work and one to one counselling

5. Are they successful?
   80% attendance at one to one group meetings

6. Could other services be offered e.g. another hostel, women's place, full time D&A worker etc.?
   A needle exchange and methadone injections. More drug workers would always be a good thing

7. Roughly how many people who come in have a Drugs or Alcohol problem?
   75% have issues with it which cause problems

8. Do you work along side any other places?
   Nottingham Network

9. Are there any other Salvation Army centres that address D&A abuse related issues?
   Workers trained all together. 6 specialise in Rehabilitation stations, this would work in Nottingham

10. Who are the key players in the Nottingham for D&A abuse services?
    Criminal justice – The police and the courts
    Housing
    Medical – Doctors

Interviews with Key Players

Acorn Lodge *Nottingham*

1. Define D&A abuse?
   Using it beyond what is necessary, when the amounts consumed is out of control (same with drugs). The problem often starts as merely recreational but then goes on from there

2. Is there problem of D&A abuse and how big is the problem?
   Yes - it's a massive problem in Nottingham; we've haven't even seen it at its peak yet, and drugs and alcohol are very easily available

3. Are their specific groups of people that suffer with D&A abuse?
   No, anyone from any walk of life; everyone has the same chance.

4. What services do you provide for people who suffer with D&A abuse?
   Linking with outside agencies. We also support them in decisions; give them life skills back with a safe environment and a sense of belonging, overall helping them to manage their drink.

5. Are they successful?
   Yes, not many stopped drinking statistically, but it does help them manage and sustain tenancies

6. Could other services be offered e.g. another hostel, women's place, full time D&A worker etc.?
   Only to cater for 12 people, we're full 97% of the time so the project would need to be a lot bigger. We would like to monitor people once they've left Acorn Lodge, going from Acorn Lodge into Acorn Lodge housing and then back into the community

7. Roughly how many people who come in have a Drugs or Alcohol problem?
   Roughly 90% of people (not exact). 10/12 at the moment. Drugs is not as big an issue for Acorn Lodge as its mainly older people but there are the odd one or two

8. Do you work along side any other places?
   HLG-Hostel Liaisons Group (voluntary training), outreach workers, Handle street WET centre, S.A.

hostel, Immanuel house, Framework, Mental health team, Pull Chester day centre

9. Are there any other Salvation Army centres that address D&A abuse related issues?
   Yes lots. Nearly every S.A. hostel, different hostels in London with special D&A unit. Sneinton House, Grimsby – Skegness- flats, also a lot of research at Kent University

10. Who are the key players in the Nottingham for D&A abuse services?
    Double impact, priory – detox, AA- aftercare, CJIT, Nacro, Newcastle house, Wells Road

Interviews with Key Players

Gloucester house

1. Define D&A abuse
   An inability to stop, despite the damage it causes – a need for alcohol or drugs

2. Is there a problem with D&A and how big is that problem?
   Yes, a huge problem

3. Are there particular groups that suffer with D&A abuse?
   No, it's a problem that hits everyone

4. What services do you provide for people who suffer with D&A abuse?
   Therapy most mornings and in the afternoons, AA 12 steps, 12 weeks primary programme, tests are done at random and if they fail they have to leave, meetings held outside the house. They will also find accommodation if they want help with that, and voluntary work at sheltered accommodation away from where they came from if they want

5. How effective are these services?
   If they really want it then effective

6. If someone turned up with a problem wanting help what would you do?
   Suggest an Alcoholics Anonymous or Drugs Anonymous meeting depending
   Local Drug Authority
   Recommend or referral with local G.P

Interviews with Key Players

Greig house

1. Define D&A abuse
   Cause problem to users or others

2. Is there a problem with D&A and how big is that problem?
   Yes, a significant problem exists with drugs and alcohol

3. Are there particular groups that suffer from D&A abuse?
   No, none

4. What services do you provide for people with D&A abuse?
   A Detox centre and a clinical withdrawal

5. How effective are these services?
   In the short term very effective

6. If someone turned up with a problem wanting help what would you do?
   We only accept clients that have been recommended by the Local Authority. We would send them to community tier 1&2 services

Appendix 4
Interviews with Local People

Interviews with Local People

Male, Aged 30-45

1. How long have you lived in Arnold/Nottingham?
27 years in Calverton, but often go into Arnold

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
I think there's a major problem with alcohol within Arnold, it really has noticeably got some drink issues, more so than other similar sized towns. To me it seems the pubs are becoming a lot more 'drinkers' pubs rather than 'social' pubs

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
I'm not sure about Arnold, in Calverton a few years ago there was a major problem which seemed to be dealt with by the police but that's probably just moved the problem elsewhere into somewhere like Arnold

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
I think all the major cities have drug and drink problems, it just seems the violence in Nottingham is more publicised

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
Drugs – St Anne's and the Meadows are known for drug problems, but it seems its spreading out into Clifton and Sherwood also
Drink – The drink problems seem to have moved away from Nottingham City with the 'Respect for Nottingham', but that's just pushed it out into areas like Bulwell and Clifton

Interviews with Local People

Female, Aged 60-70

1. How long have you lived in Arnold/Nottingham?
63 years, my entire life

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
Yes, and one bigger than we realise, and from my experience that problem isn't just among young people

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
Yes, although I can't say how great that problem is, but one of my family members is into light drugs (smoking pot) so I know there is a culture of it

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
Not any worse than other cities, but it could be a lot better than it is; bad publicity because of gun crime

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
Bestwood is particularly bad for drugs, drink and guns. Also St Anne's and Radford (another family member of mine lived there for a time)

Interviews with Local People

Male, Aged 16-20

1. How long have you lived in Arnold/Nottingham?
8 years

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
Not so much alcohol

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
Most of its in Nottingham itself, but there's quite a lot of soft drugs around, particularly weed

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
Definitely worse

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
Almost everywhere is hit by it. The Meadows, Radford, Forest Fields, that's where most of the dealers seem to be. Most of the problems centre around the city, but Killisick is pretty bad

Interviews with Local People

Female, Aged 45-60

1. How long have you lived in Arnold/Nottingham?
59 years

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
Yes, a major problem, particularly on Front Street. On the weekend in the evenings I'm often afraid to walk down it

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
From talking with young people I would say yes, to say no would be to close our eyes from the problem

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
The same I'd say, the press mention it a lot but in reality its just as bad as some others

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
In Arnold Front Street for alcohol, and it seems local secondary schools Red Hill and Arnold Hill have some drug issues
Also Clifton

Interviews with Local People

Male, Aged 30-45

1. How long have you lived in Arnold/Nottingham?
Lived 12 years in Mapperly, come into Arnold occasionally

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
I think so, especially in the evenings on weekends

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
I don't know

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
I heard someone talking in the City from Hope UK about drugs and its definitely supposed to be one of the worst

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
The Meadows and St Anne's are notorious, and just the city in general, spreading out even to Arnold and other areas around

Interviews with Local People

Male, Aged 60-70

1. How long have you lived in Arnold/Nottingham?
55 years

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
There are underlying problems, you can see that if you go out on a Friday or Saturday night. I don't think there it an AA meeting in Arnold

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
I can't know, only hear, but I've come into contact with people who are into Cannabis and also I know two guys who are both Heroin addicts, so I know the problem exists

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
I would think the same, every big city has those kind of problems – very linked to crime

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
I used to think mainly on Front Street (drugs and alcohol), but I don't think it's just there now, it seems to have moved on, could be anywhere. There are a lot of problems with alcohol behind closed doors

Interviews with Local People

Female, Aged 16-20

1. How long have you lived in Arnold/Nottingham?
7 years

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
Yes, I think its worse than you think, but its mainly coming from the City

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
Not hard drugs, they come from elsewhere, but weed is big amongst children/young people at school

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
Really depends where you go in Nottingham. Some bits its major, some bits its not

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
At my secondary school there are a lot of people into weed and drinking alcohol on the playing fields and around the school. Bulwell is known to be really bad and quite a few of the parks in Arnold I see young people drinking heavily

Interviews with Local People

Female, Aged 45-60

1. How long have you lived in Arnold/Nottingham?
Since 1969

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
There appears to be, particularly Front Street and Arnot Hill Park

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
I'm not sure

4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
Reports seem to suggest its one of the worst

5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
St Anne's, and in Arnold the Bestwood Estate I know is bad

Interviews with Local People

Male, Aged 20-30

1. How long have you lived in Arnold/Nottingham?
One year

2. Do you think there is a problem with alcohol within Arnold? How great is the problem?
Yes, particularly with the pubs around, definitely an area with a liot of heavy drinkers

3. Do you think there is a problem with drugs within Arnold? How great is the problem?
There is a lot people don't pick up on, its not always apparent. All kinds of drugs are done by all kinds of people

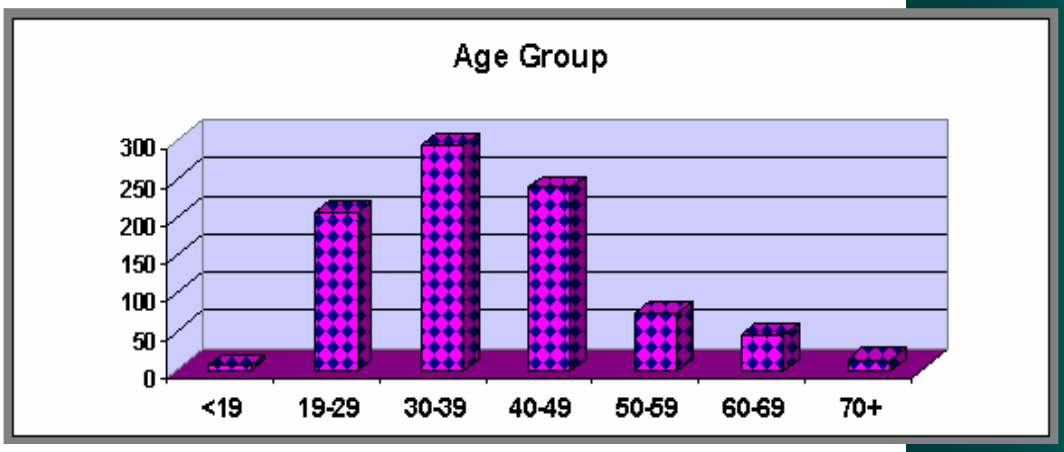
4. How do you think Nottingham compares to other cities in regards to its problems with alcohol or drug abuse?
I think it does have a reputation, but it seems to be trying to combat the problem at least

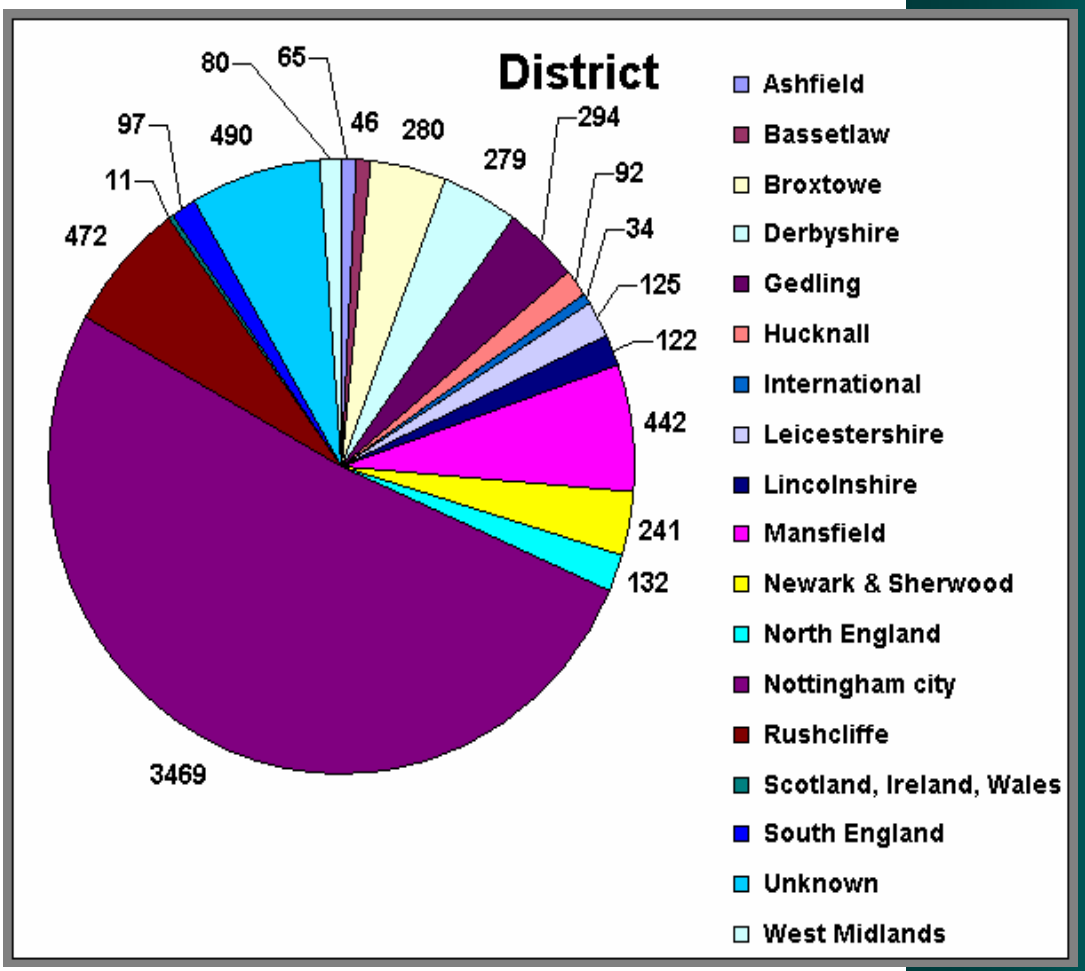
5. Do you know of any geographical areas in Arnold, Gedling or Nottingham where alcohol or drug abuse is particularly prevalent?
Not really any specifics

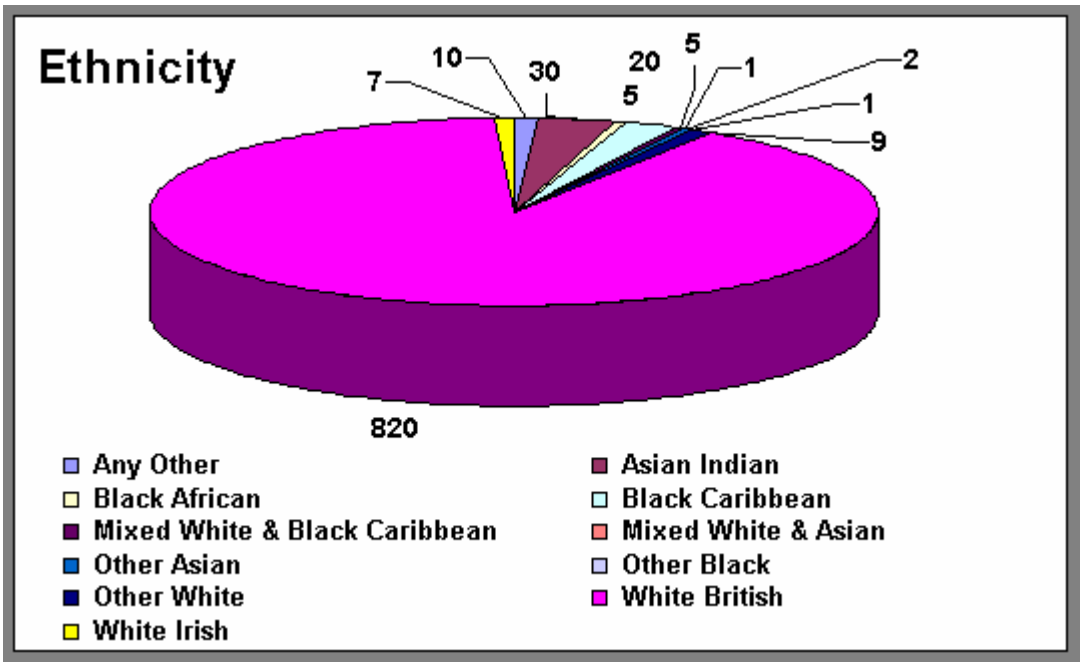
Appendix 5
APAS Statistics

APAS: First Quarter Statistics April 2006 – June 2006

Total number of contacts.....1742
Total number of new referrals 216



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30
20
5
5
1
2
1
9
820
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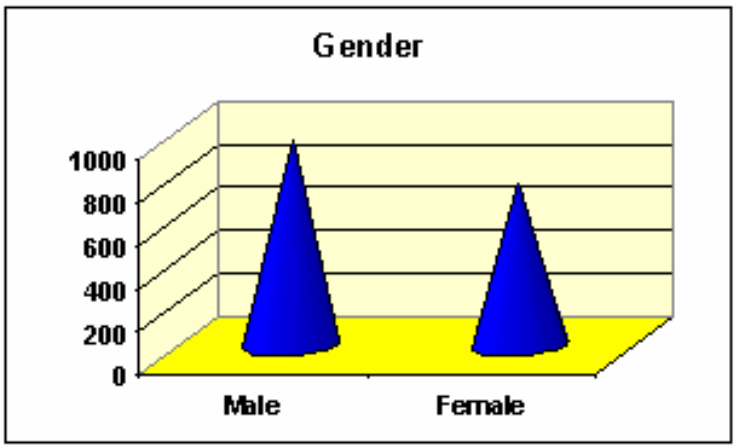
Black African
Black Caribbean
Mixed White & Black Caribbean
Mixed White & Asian
Other Asian
Other Black
Other White
White British
White Irish


Gender
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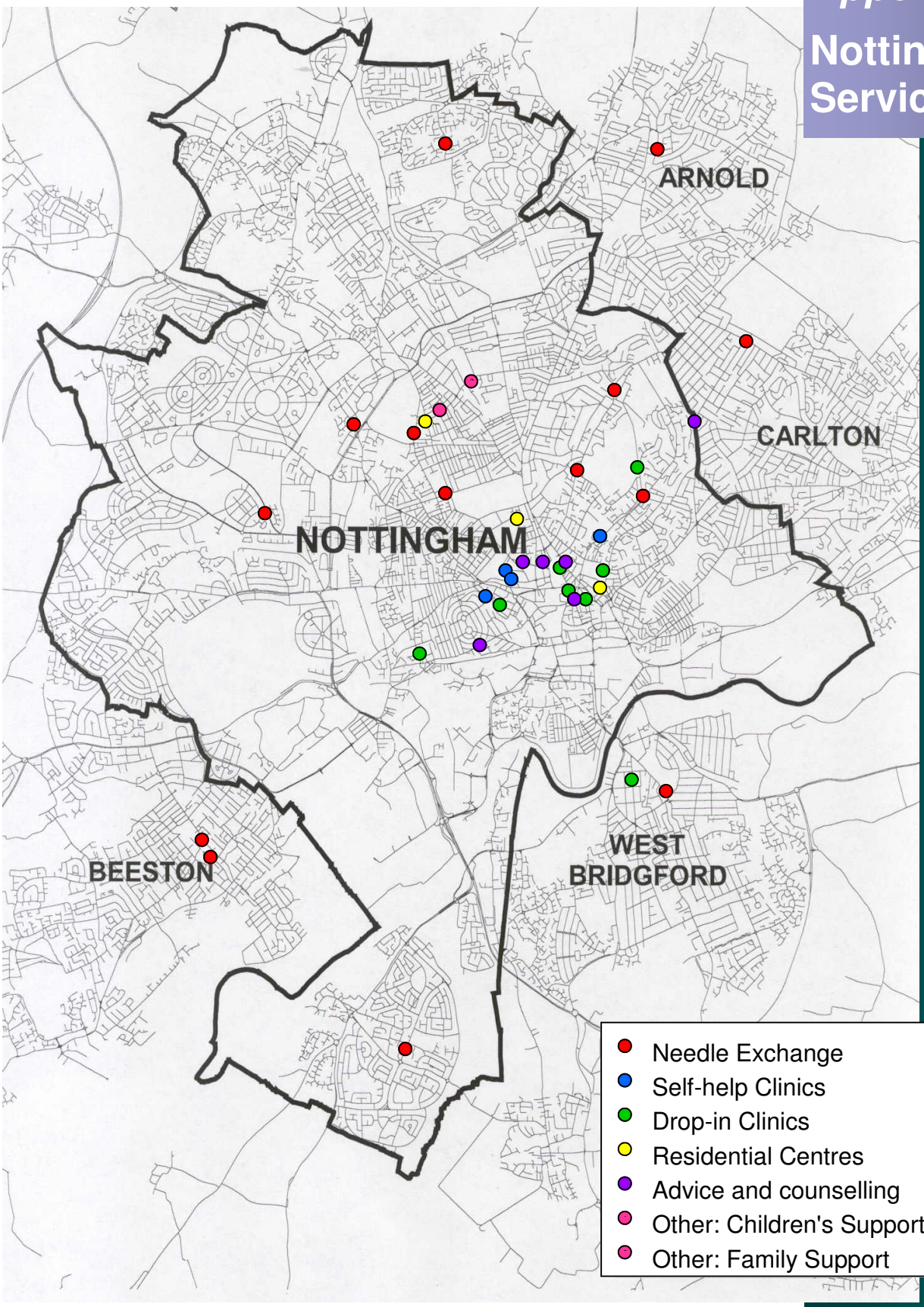
600
400
200
0
Male
Female

Appendix 6

Nottingham Services Map



Appendix 7

How we worked out the Suggestions

Value measures for suggestions

As mentioned earlier, the suggestions were placed inside a matrix, with a score out of three being given based on how closely it fulfilled each of the different criteria.

An additional note is needed to explain why; although the project is based around a set of 12 questions, only 8 of those 12 questions are listed here.
As the project proceeded, it became clear that some of the questions originally set would have little effect on our conclusion, that the final suggestions were incomparable to those original questions. For example, it is hard to look at the key players in local community as a criterion for any new suggestions.

These were the questions:

1. What is drug and alcohol abuse?
2. Is there a problem?
3. What is the scale of the problem?
4. Are there specific geographical areas that are affected?
5. Are there specific groups of people that are affected?
6. What services are provided?
7. Are there any areas where services aren't provided?
8. How the Salvation Army could meet the gap?

The following table shows our scores and how they ranked overall:

Service	1	2	3	4	5	6	7	8	Total
Half-way house	2	3	3	3	2	3	3	3	22
More workers	2	2	2	2	1	2	2	2	15
Rehab centre	3	3	3	3	2	2	2	2	20
Schools counsellor	3	2	2	2	3	2	2	2	18
D&A information officer	3	2	2	2	3	2	2	2	18
Build on existing work	2	2	2	2	1	2	2	2	15
Alcohol day centre	3	3	3	3	2	3	3	3	23
MTRV	3	3	2	2	3	3	3	3	22

From the table the Alcohol Day Centre came first. This means that it fulfilled the criteria more closely than any of the other suggested services.