Wandsworth drug and alcohol misuse needs assessment

2014/15

Authors

1) Gosaye Fida , Public Health Lead gfida@wandsworth.gov.uk
2) Theresa McDonald, Drug and Alcohol public health lead nurse tmcdonald@wandsworth.gov.uk
3) Kwabena Owusu-Agyemang, Drug and Alcohol Data analyst KOwusu-Agyemang@wandsworth.gov.uk

Table of contents

Contents Page

1 EXECUTIVE SUMMARY

Introduction

The misuse of both drugs and alcohol is a growing problem in Wandsworth like elsewhere in London.

Aims: This needs assessment reviews the baseline demand for local services for drug and alcohol, compares London and national figures, assesses local performance over a given period and highlights issues that need to be considered for future service improvement.

It is also aims to inform:

- Future commissioning intentions for drugs and alcohol
- Re-tendering of the drug and alcohol treatment system in Wandsworth.
- The re-designing the partnership's recovery oriented treatment system.

National and local drivers for the needs assessment are:

- The National Drug Strategy (2010)
- The Government's Alcohol Strategy (2012)
- Wandsworth Alcohol Strategy(2013)

Both the National Drug Strategy and the Government's Alcohol Strategy emphasise the need to commission reintegrated and recovery based services. In recognition of the challenges and opportunities common to both drugs and alcohol; it was decided to produce a combined needs assessment.

The funding for both drug and alcohol services comes mainly from the Public Health Grant (PHG), but some additional services are funded from Local Authority mainstream expenditure, an allocation from the Mayor's Office for Police & Crime (MOPAC), and Clinical Commissioning Group expenditure.

In Wandsworth a large component of the treatment system is an integrated drug and alcohol treatment model run by two providers- KCA & CDP Blenheim; this is a consortium partnership with KCA as the lead provider.

Care-planned structured treatment is delivered to approximately 896 drug users from a range of interventions known as Opioid Substitution Treatment (OST) which involves the assessment and titration of drugs such as Methadone and Subutex to those who are opiate dependent. There are also 859 clients receiving alcohol treatment in Wandsworth. Psychosocial interventions (talking therapies) are also offered individually or in a group setting and all clients have a keyworker. Preparing

clients for (community and residential) detoxification and rehabilitation and supporting them afterwards are also key components of drug and alcohol treatment.

The needs assessment has looked into epidemiological evidence, data from local and national sources to identify key areas of consideration outlined below that could inform future drug and alcohol treatment planning and resource allocation.

Key findings on drugs

- It is estimated the prevalence of opiate and crack users in Wandsworth could be 1,634 (range 1,198 - 2,084) Opiate, 1262, crack 1326 and injecting 299.
- Wandsworth drug treatment penetration rate (36%) is lower than in London (41%) and England (51%) meaning Wandsworth is treating proportionately fewer of its opiate and crack cocaine users than the London and England averages.
- There has been a decline in the age groups (18-44years) in drug treatment locally and in London. In Wandsworth, the greatest fall has been among 18-24 year olds. From 2009/10 to 2012/13 there was 42% fall in the number in drug treatment for this age group.
- There has been a reduction in primary crack users accessing treatment. The national trend estimates numbers of primary crack users are in decline – however, the decline in Wandsworth is much larger.
- The proportion of different ethnic groups in drug treatment generally reflects the overall Wandsworth demographic profile, however, under representation of Asian, and over representation of black Caribbean's ethnic groups in drug treatment is worth exploring further.
- There is under reporting of families where alcohol or drug misuse is a concern. Nationally, parental drug use is a risk factor in 29% of all serious case reviews, and 27% of serious case reviews mention alcohol misuse. In Wandsworth Children Specialist Services, for those children categorised as children in need, drugs & alcohol are highlighted as an issue for 9.6%(106/1093) of cases. The number is likely to be underestimated as drug or alcohol issues are often identified later in the assessment.
- There has been a decline in the number of drug users in treatment over the past four years and the situation in Wandsworth mirrors the national trend. This may well be caused by potential service users considering that the provision available does not meet their needs.
- Over the past few years, nationally, there have been substantial changes in patterns of drug use including increased use of novel psychoactive substances, (club drugs).

- Opiate completion rates remain relatively unchanged whereas treatment completion rates for non-opiate have improved from 25% in 2012/13 to 34% in 2013/14, although this still lower than the cluster average of 39%.
- Less than half of those injecting drug users who have been offered hepatitis B vaccinations accept the offer but only a smaller proportion of those who have accepted continue and complete the course.
- The proportion of dual diagnosis reported in the drug treatment system in 2013/14 in Wandsworth is (15%), which is lower than London (24%) and England average (18%).
- 1136 clients have accessed Wandsworth pharmacy needle and syringe provision in 2013/14. Needle and syringe provision activities can be proxy indicators of injecting drug use in the borough.
- Of the 133 eligible clients for hep C testing, 52 accepted and 66 refused the test, which is over 50% of the eligible group.
- Of the 150 new referrals to drug treatment from the criminal justice caseload in 2013/14, only 35% of them started treatment, some way below the London (50%) and England proportion (59%).
- Over the past three years (2011/12 to 2013/14) around 1 in 5 new drug and alcohol clients entering treatment in Wandsworth have some sort of housing problem.
- Self-referrals are the most common route to access drug and alcohol treatment services followed by referrals from the criminal justice system and General Practices.

Recommendations

- It is important to reconfigure the treatment system to improve access, retention and completion of treatment.
- Future treatment services commissioned in response to drug misuse will need to work alongside a strengthened programme of prevention-focussed interventions.
- Screening, assessment and referral to drug and alcohol services should be available through open access services such as primary care, children and family services, victims support, domestic violence services, sex workers support services, and police custody suits.
- Treatment services need to engage more with the 18-24 year old client group.

- The range of service provision has not kept pace with changes in the pattern of drug use. This is a gap to be addressed in future commissioning of drug services.
- There is a need for improved identification and recording of parents who have substance misuse problems living with children.
- There is a need for providers to encourage and positively engage service users to take up and complete BBV interventions.
- There is a need for service providers to improve the identification, recording and treatments of clients with dual diagnosis.
- The pattern of drug use has changed to include steroid and club drugs. Training for pharmacies should be available to accommodate the changing trend in drug use.
- Further improvement is needed in the engagement of the Criminal Justice caseload to mainstream drug treatment.
- Treatment services need to continue to increase the rates of successful completions and reduce re-presentations for opiate and non-opiates clients by ensuring this is a priority, using robust monitoring systems and using evidence based interventions.
- There is an important need for treatment services to work more closely with housing and employment services and continue to establish links to training opportunities for service users.
- It is necessary that pathways are well advertised, monitored and work effectively to increase numbers in treatment from all sources of referral.

Key findings on alcohol

- The latest prevalence estimate shows, there are approximately, 54,423 (21%) increased risk drinkers, 18,457 (7%) higher drinkers, and 54,782(21%) binge drinkers in Wandsworth.
- Nationally, there was a marked increase in alcohol-related hospital admissions across all age groups (2002- 2010), but the increase was greatest for older people: for men aged 65 and over, hospital admissions rose by 136% and 132% for women in this age group.
- The rates of alcohol related hospital admissions for all ages have increased since 2008, the increase in Wandsworth is not significantly different to the England average.
- In 2012/13 there were only five pregnant clients recorded for drug misuse and two were recorded for alcohol misuse in Wandsworth. Although the

numbers are recorded at provider level, these figures are not always reported into NDTMS database.

- Alcohol treatment completion rates in Wandsworth have improved from 2011 (33%) in 2012/13 to 331(39%) in 2013/14.

- In 2011/12 and 2012/13 Mental health services have been the major source of referrals of clients into primary alcohol treatment in Wandsworth.

Recommendations

- The overall population affected by alcohol in Wandsworth is much higher than drugs. A shift in focus of treatment services towards alcohol misuse, which has occurred in recent years, is to be maintained.
- Improved alcohol provision for those who are increasing risk and higher risk drinkers in Wandsworth is needed.
- There is a need for front line health & social care staff to be trained to identify people at risk of substance misuse and deliver Identification & Brief Advice (IBA).
- Services working with drug and alcohol misusing women should make reproductive healthcare an integral part of the care pathway.Data collection for pregnancy should be reviewed. Further work is needed on the pregnancy pathway to establish robust liaison with maternal health units.
- Service providers should have a written policy on drug and alcohol misusing parents, including the need for multi-agency planning early in pregnancy.
- There has been improvement in alcohol treatment completion rates; however, given the scale of the population affected, further improvement is needed to increase the number of successful completions.
- Treatment providers should build on the current collaborative work with mental health services to improve referrals of clients into alcohol treatment.

Service user's views

A questionnaire survey and a focus group discussion were carried out to assess the views of service users attending drug and alcohol in Wandsworth. Of the 250 questionnaires distributed we received 71 responses. In terms of demographics, 65% of respondents were male and 35% female. The points below summarise the views of respondents:

- 42% of respondents had used club drugs
- 76% had reduced their drug or alcohol use
- 72% reporting improvement in their health or well-being as a result of participating in drug and alcohol treatment services.

- Overall, 87% of respondents reported a positive experience of current services.

However, there were some aspects of services where respondents felt improvements could be made. These included:

- Groups /activities and premises could be improved.
- Aftercare services could be improved
- Some respondents asked for a return of the food day, longer opening hours of services and drop in sessions,
- Services should attract more clients and employ ex-users.

When asked how services could attract more people into treatment, suggestions of respondents included:

- 'Word of mouth' was thought to be one of the most powerful ways of communicating to current and ex-service users in the local community.
- Better referral systems to and from the Mental Health Trust
- Promotion of services offered/fliers to probation/hospital/GP surgeries.
- A change of culture and perception of service providers
- Attempts to re-engage of those service users who have left the borough for other services

Conclusion

Nationally, the proportion of the population using illicit drugs is shrinking. Alcohol misuse, however, is a much bigger concern than drug misuse: it affects far more people individually and has much wider societal impacts. The lives of most drug users and of a sizeable group of alcohol misusers are complex and often chaotic.

The treatment population is ageing – the over 40s are now the largest group starting and receiving treatment. Many are older heroin users who have failing health and entrenched addiction problems. This group is particularly hard to help into lasting recovery. While services need to address the demands of these highly complex drug users, the services also need to adapt and respond effectively to changing patterns in drug use and the needs of the wider population, such as those who get into problems with new psychoactive substances (sometimes called 'legal highs') and prescription or over-the-counter medicines.

The changing nature of drug use, and the ability to deliver against a broader range of problematic substance use, including cannabis and alcohol, poses a challenge to Wandsworth operational and commissioning framework.

Glossary

MOPAC	Mayor Office for Police & Crime
OST	Opioid Substitution Treatment
IBA	Identification & Brief Advice
PHE	Public Health England
HWBB	Health and Wellbeing Board
PHG	Public Health Grant
NDTMS	National Drug Treatment Monitoring System
LAPE	Local Alcohol Profile England
NPS	Novel Psychoactive Substances
OCU	Opiate and Crack Users
DRR	Drug Rehabilitation Requirement
ATR	Alcohol Treatment Requirement
IDAS	Drug and Alcohol treatment System
PWID	People Who Inject Drugs
AIDS	Acquired Immunity Deficiency Syndrome
MSM	Men having Sex with Men
NAT	National Treatment Agency
FRP	Family Recovery Project
DH	Department of Health
NICE	National Institute for Clinical Excellence
DfE	Department for Education
FASD	Foetal Alcohol Spectrum Disorder
FAS	Foetal Alcohol Syndrome
TOP	Treatment Outcome Profile
HCV	Hepatitis C Virus
ONS	Office of National Statistics

BBV	Blood Borne Virus

1. INTRODUCTION

1.1 National context

Nationally, the proportion of the population using illicit drugs is shrinking. Alcohol misuse, however, is a much bigger concern than drug misuse: it affects far more people individually and has much wider societal impacts. The lives of most drug users and of a sizeable group of alcohol misusers are complex and often chaotic.

Principally this is because of the sheer number of people who drink alcohol and the increasing proportion who do so in ways that risk harming their health. Whilst the more familiar drugs of misuse (such as opiates and crack cocaine) are illegal, uncontrolled novel psychoactive substances (also known as 'legal highs' and 'club drugs') are becoming more easily available; they also bring with them potential health problems.

The national drug strategy 2010 has two overarching aims by which success will be measured:

- Reduce illicit and other harmful drug use
- Increase the numbers recovering from their dependence

The national drug strategy also recognises the links between drug and alcohol treatment. The recognition in the national drug strategy that many of the challenges and opportunities are common to both drugs and alcohol; it was decided to produce a combined health needs assessment.

There has been change within the commissioning of drug and alcohol. Since 1 April 2013 national leadership for the prevention and treatment of alcohol misuse transferred from the National Treatment Agency for Substance Misuse (NTA) to Public Health England (PHE). Local authorities are now responsible for commissioning substance misuse services to meet the needs of their communities funded from Public Health Grant and overseen by Director of Public Health supported by the Health and Wellbeing Board (HWBB).

1.2 Local context

The National Drug Strategy (2010), the Government's Alcohol Strategy (2012) and the Wandsworth Alcohol Strategy *(*2013*)* prioritise the objective of creating a recovery system that focuses not only on getting people into treatment but into recovery, having overcome their dependence. This includes offering drug misusers wrap around support in terms of housing, education and employment opportunities, while focussing on families and communities affected by drug misuse and acknowledgement of the support those children of drug misusing parents need.

1.3 Rationale for the needs assessment

In order to build a strong evidence base for rigorous commissioning activity, Wandsworth has been undertaking annual needs assessments for the past ten years which have formed the commissioning cycle. The needs assessment reviews the baseline demand for local services, compares London and national figures and

assesses local partnership performance over a given period. This Health Needs Assessment (HNA) aims to inform:

- The commissioning intentions for adult drug and alcohol.
- The re-tendering of the drug and alcohol treatment system for adults in Wandsworth
- The re-design of the partnership's recovery oriented treatment system.

An integrated treatment system is commissioned for Wandsworth. It is essential that all drug and alcohol services meet the needs of problematic drug and alcohol users, their families and carers as well as the wider community.

The funding for both drug and alcohol services comes mainly from the Public Health Grant (PHG), but some additional services are funded from Local Authority mainstream expenditure, an allocation from the Mayor's Office for Police & Crime (MOPAC), and Clinical Commissioning Group expenditure.

The Needs Assessment is informed by various data sources including the National Drug Treatment Monitoring System (NDTMS), routinely collected local data, published literature and national estimates. For details of the sources of data and public health indicators for drug and alcohol please see appendix- 3.

1.4 Wandsworth demographic profile

Wandsworth has a growing population which currently stands at 306,995.It has the 8th largest population in London. The borough has a larger proportion of 25-34 year old residents than in London and there is also smaller proportion of residents aged 45 plus and under 18 compared to London (table-1).

Table 1 Gender and age group, Wandsworth, 2011

		Wandsworth		London
Gender	Males	148,646	48%	49%
	Females	158,349	52%	51%
Age group	under 18	55627	18%	22%
	18-24	29240	10%	10%
	25-34	88957	29%	20%
	35-44	52063	17%	16%
	45-54	32188	10%	12%
	55-64	22009	7%	9%
	65+	26911	9%	11%
	All	**306,995**	**100%**	**100%**

Source: ONS 2011

Wandsworth ethnic group profile is generally similar to London except for White British, Indian, Bangladeshi and Africans groups (table-2). Wandsworth ranks 21st out of the 33 London boroughs in deprivation index, more affluent than most London boroughs. The ethnic breakdown of drug users is discussed in (table- 12).

Table 2 Ethnic breakdown of Wandsworth residents, 2011

Ethnic group	Number of persons	Wandsworth %	London %
White - British	163,739	53.3%	44.9%
White - Irish	7,664	2.5%	2.2%
White - Other White	47,813	15.6%	12.7%
Mixed - White & Black Caribbean	4,642	1.5%	1.5%
Mixed - White & Black African	2,034	0.7%	0.8%
Mixed - White & Asian	3,887	1.3%	1.2%
Mixed - Other Mixed	4,678	1.5%	1.5%
Indian	8,642	2.8%	6.6%
Pakistani	9,718	3.2%	2.7%
Bangladeshi	1,493	0.5%	2.7%
Other Asian	9,770	3.2%	4.9%
Caribbean	12,297	4.0%	4.2%
African	14,818	4.8%	7.0%
Other Black	5,641	1.8%	2.1%
Chinese	3,715	1.2%	1.5%
Other Ethnic Group	6,444	2.1%	3.4%

Source: ONS 2011

2 Drug and alcohol general overview

2.1 Alcohol

While most people drink alcohol responsibly, there are still many who drink over the recommended weekly limit. Around nine million adults drink at levels that pose some risk to their health. Nationally, an estimated 1.6 million people may have some degree of alcohol dependence. Of these, some 250,000 are believed to be moderately or severely dependent and may benefit from intensive treatment[1].

The majority of adults consume alcohol: 69% and 55% of men and women in England and Wales, respectively, are weekly drinkers; 26% of British men and 18% of British women exceed the recommended limits for weekly alcohol drinking; and 7% of men and 4% of women may be classified as higher risk drinkers (more than 50 units of alcohol per week for male and more than 36 units per week for female)[2].

There are three definitions of alcohol misuse – hazardous, harmful and dependent drinking. Hazardous drinking is defined as when a person drinks over the recommended weekly limit of alcohol (21 units for males and 14 units for females). Harmful drinking is defined as when a person drinks over the recommended weekly amount of alcohol and experiences health problems that are directly related to alcohol. Alcohol is both physically and psychologically addictive. It is possible to become dependent on it. Being dependent on alcohol means that a person feels that they are unable to function without alcohol, and the consumption of alcohol becomes an important, or sometimes the most important, factor in their life. [3].However, Local Alcohol Profile England (LAPE) data categorises the four areas of drinking as shown in table-3. Applying estimates of drinking categories from Local Alcohol Profile to 2011 mid year Wandsworth population aged 16-64 year shows there are approximately 54,423 increased risk drinkers, 18,457 higher drinkers, and 54,782 binge drinkers in Wandsworth(table-3).

Table 3 Estimates of alcohol misuse in Wandsworth

Drinking categories	Wandsworth		London	England
	Number	%	%	%
Lower risk drinkers *	183,109	71.53	73.43	73.25
Increasing risk drinkers**	54,423	21.26	19.70	20.00
Higher risk drinkers** *	18,457	7.21	6.87	6.75
Binge drinkers****	54,782	21.40	14.3	20.10

Source: Based on Local Alcohol Profiles for England and ONS 2011 mid year population estimate.

*__Low risk drinker__ is defined as consumption of less than 22 units of alcohol per week for males, and less than 15 units of alcohol per week for females, *** __High risk__ is defined as drinking more than 50 units of alcohol per week for males, and more than 36 units of alcohol per week for females, ****__Binge drinking__ refers to adults who consume alcohol at least twice the daily recommended amount (8 units or more for males and 6 or more unit for females,**__increasing risk__ is defined as consumption of between 22 and 50 units of alcohol per week for males and 35 unit of alcohol per week for females.

In England, the 'lower-risk guidelines' for alcohol state that men should not drink more than 3 to 4 units per day and women shouldn't drink more than 2 to 3 units per day[4]. The consumption of alcohol is an issue across all social groups, however, in comparison with those living in more affluent areas, people in more deprived areas are: [5]

- 2-3 times as likely to die of causes influenced by, in part, alcohol;
- 3-5 times more likely to die of an alcohol-specific cause; and
- 2-5 times more likely to be admitted to hospital because of an alcohol-related condition.

This differential effect of alcohol is likely to be related to generally poorer health experienced by people living in more deprived areas.

2.2 Drugs

Drug use is less apparent to the public than alcohol use; with many communities experiencing the effects of drug use in terms of crime, drug litter and anti social behaviour. Drug users and injecting drug users are particularly vulnerable to contracting and spreading blood-borne viruses (such as hepatitis B, hepatitis C and HIV) and other infections[6]. Drug misuse is a major contributor to premature mortality, people who use drugs are up to ten times more likely to die suddenly or as a result of chronic diseases than people who do not use drugs[7].

It is clear that drug use can place an enormous strain on the families of drug users, including their children; can have a serious negative impact on the long-term health and well-being of family members; and that many drug misusers have a myriad of health and social problems which require interventions from a range of providers. For those chaotically entrenched in drug and alcohol addiction research suggests a package of support including treatment, housing, employment and positive social networks to help them recover and rebuild families their lives[8][9].

Statistics show that illicit drug use is falling. For example, the Crime Survey for England and Wales (previously the British Crime Survey), has reported that the

overall number of people who use drugs has fallen. While cannabis remains the most popular illicit substance by far, even its popularity has waned: whereas 11% of the population used it in 2001, this was down to just 7% in 2011. The most recent prevalence figures estimate that heroin and crack use has fallen significantly in recent years in England: from a peak of 332,090 users in 2005-06 to 293,879 in 2011/12 [10]. This must be borne in mind when considering the performance of the current treatment system.

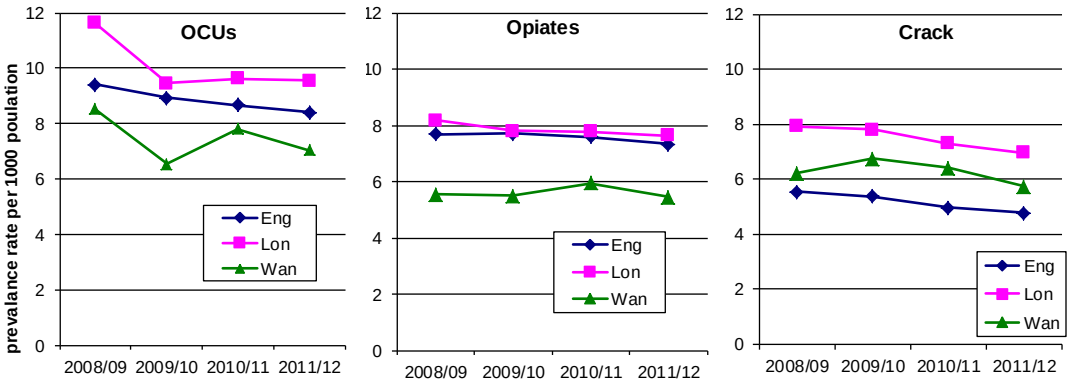
3 Prevalence of drugs and alcohol misuse in Wandsworth

The latest estimates predict that there are 1,634 people (range 1,198 - 2,084) in Wandsworth using opiates and crack cocaine aged 15 – 64 and of which 582 were in 'effective treatment' in 2013/14 (Jan 13 - Dec 13),[11] that is 36% penetration rate (Penetration rate; the ratio of drug users in treatment to the overall drug users known to the treatment system but not receiving treatment).

It's worth noting in figure-1, the rate of opiate and crack cocaine use in Wandsworth is estimated to be lower than both London and England average. It is also estimated that there are 5.72 crack users per 1,000 for people aged 15-64 years old in Wandsworth and this is lower than the rates for London (6.96/1000) but above England's rate of 4.76/1,000. Despite the lower rate of drug use in Wandsworth treatment, the penetration rate is also lower (36%) than in London (41%) and England (51%) meaning Wandsworth is treating proportionately fewer of its opiate and crack cocaine users than the London and national averages (Public Health England and Glasgow estimate). It is not clear why this should be.

The data in figure-1 does not include people taking any other drug including: Cannabis, amphetamine, powder cocaine, or 'Novel Psychoactive Substances' (NPS). Reliable data on the number of people using these substances is still difficult to obtain. However, a recent report by Public Health England suggest psychoactive substances and certain 'club' drugs continue to cause concern, as the number of people seeking treatment for them has increased significantly in England(Drug Treatment in England, 2012/13).

Figure 1 Prevalence rate of estimated Opiate and Crack Users (OCU), Opiate users, and Crack users per 1,000 population aged 15-64 year

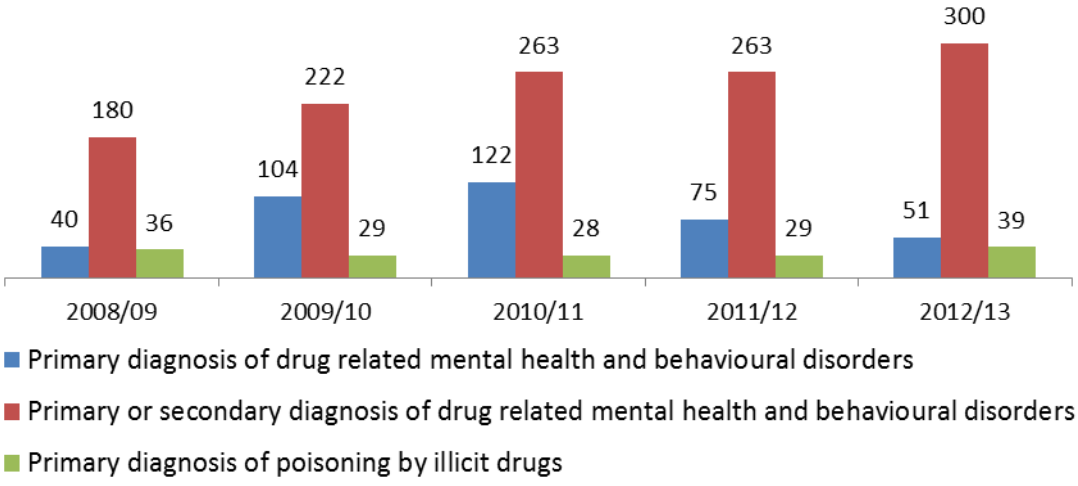


Source: Centre for Public Health, Liverpool John Moores University; Glasgow Prevalence Estimation Ltd

The decline in the number of people in Wandsworth misusing drugs as shown in figure-1 is in line with the trend both nationally and in London. Several factors are likely to have contributed to the decline in drug use in England, including criminal justice initiatives to prevent use and disrupt the supply chain (Public Health England Drug Treatment, 2012/13).

In Wandsworth hospital admissions, where the primary and secondary diagnosis was an illicit drug-related mental health disorder and behavioural problems has increased since 2008/09 as shown in Figure-2.

Figure 2 The number of hospital admissions with a drug related diagnosis, Wandsworth



Source: Hospital Episode Statistics

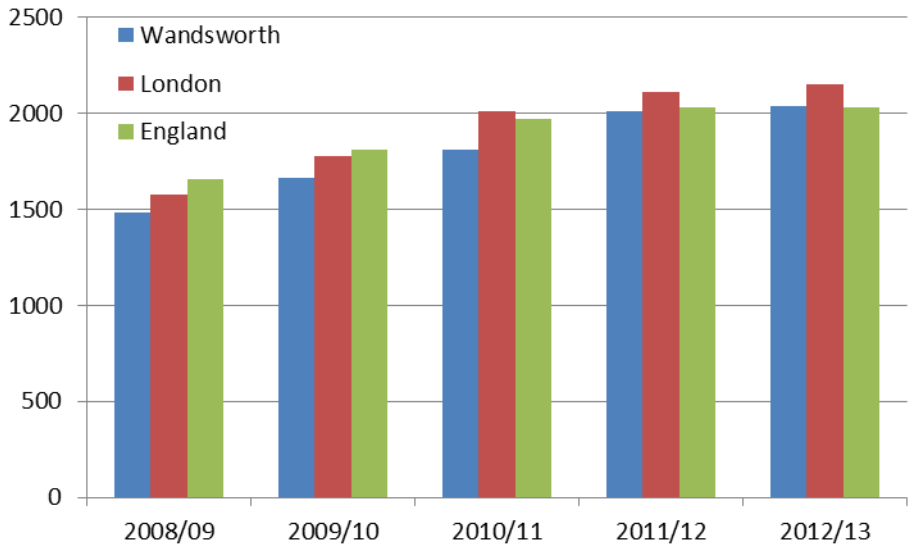
3.1 Alcohol

The situation with alcohol misuse is similar to drugs except that the population affected by alcohol misuse is much bigger. Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population. It is a broad measure, which is derived from diagnosis most strongly associated with

alcohol. In Wandsworth, the rates of alcohol related hospital admissions for all ages have been on the increase for the period 2008/09 to 2012/13(figure-3).

In 2012/13 there were 300 drug related hospital admissions (see figure-2), this contrasts to the higher number of hospital admissions for alcohol during the same period as shown in figure-3. The rates of alcohol- related admissions per 100,000 Wandsworth residents, is similar to the national rate but lower than London average as shown in figure -3.

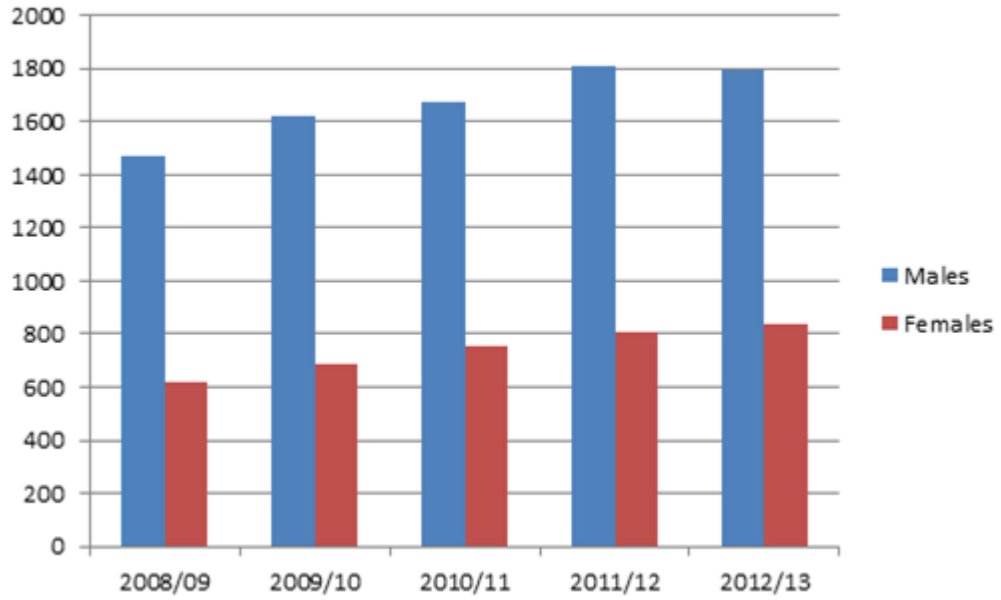
Figure 3 Hospital admissions for all residents due to alcohol-related conditions (rates per 100,000 population)



Broad measure (primary diagnosis or any secondary diagnosis Source: Local alcohol profiles for England 2012/13

Although alcohol related admissions are increasing, there is a gender difference in alcohol related hospital admission rates, with males being around twice as likely to be admitted to hospital for alcohol related conditions compared to females as shown in figure-4 below.

Figure 4 Admitted to hospital with alcohol for male and female (rates per 100,000 population)



Broad measure (primary diagnosis or any secondary diagnosis Source: LAPE, Public Health England 2012/13

The number of London ambulance call outs for alcohol related illness in 2013/14 was 2496(table-4), is higher than call outs for drugs overdoses in the same period. Alcohol related call outs have dropped over the 3 years and slightly increased in 2013/14, with the frequent callers were the 40-59 age groups as reported by the London Ambulance Service.

Table 4 London ambulance call outs for alcohol related illness, Wandsworth

2010/11	2011/12	2012/13	2013/14
2529	2331	2316	2496

Source: London Ambulance Service

4 Substance misuse and the criminal justice system

The Drug Interventions Programme (DIP) in England and Wales targets drug users in the criminal justice system, offering a range of treatment and social re-integration responses through criminal justice intervention teams based in the community and in the prison system. Since April 2013 this programme is no longer centrally funded from the Home Office and Department of Health, however limited funding is available from the Mayor's Office for Policing and Crime, and it is up to local areas to decide which mechanism to use to route offenders into treatment[12].

Drugs and alcohol, impact on the police and criminal justice system in different ways. Getting enough money to sustain drug dependency is an important cause of much acquisitive crime, and many crimes are committed by people when they are under the influence of alcohol. It is estimated that alcohol is implicated in 40% of

violent crime and 78% of assaults, and 88% of criminal damage cases are committed while the offender is under the influence of alcohol.[13]

Prior to April 2011 people who were arrested for 'trigger offences[1]' were tested for drugs in police stations. From April 2011 onwards targeted testing was introduced allowing police officers to test at their discretion. The results of these tests in Wandsworth are shown in table-5.

Table 5 Result of drug tests on detainees in Wandsworth police stations

	2010/11		2011/12		2012/13		2013/14	
	No.	%	No	%	No	%	No	%
All drug tests*	1474	100%	1975	100%	2025	100%	1646	100%
Negative	1090	74%	1367	69%	1461	72%	1055	64%
Positive *of which*	384	26%	608	31%	564	28%	591	36%
Both (Cocaine & Opiates)	123	32%	194	32%	194	34%	238	40%
Cocaine only	207	54%	324	53%	296	52%	285	48%
Opiates only	54	14%	90	15%	74	13%	68	12%

*Drug test include non-Wandsworth residents. An individual can be arrested and drug tested more than once within a year. Source: Drug Test Recorder, Wandsworth Police

The rise in the number of drug tests in 2012/13 could possibly a due to the opening of Wandsworth new custody suite which increased capacity. The proportion that tested positive appears to have increased in 2013/14 possibly due to the delayed effect of the change to targeted testing. In 2013/14 the proportion of positive tests for cocaine only and opiate only remained relatively unchanged whereas those tested positive for both opiate and cocaine showed a marginal increase to the previous years.

Not all police detainees are drug-tested and not all are Wandsworth residents. The figure in table-6 refers to detainees who agreed to test. This is obviously a 'biased' sample, as it concerns people who were caught, and who were considered suitable for drug testing and who agreed to be tested. Detainees who test positive are required by law to see a drugs practitioner in custody or in the community for up to two assessments. If deemed appropriate they are then offered interventions for substance misuse. However, the uptake of these interventions are voluntary, that explains for the disparity between the total number of positive tests in table-7 and the number of referrals to drug treatment in 2013/14. Wandsworth has an integrated drug and alcohol service where a single provider assesses the detainee in custody, and refers them to treatment. Despite such a seamless care pathway only 53 (35%) out of 150 detainees commence treatment, this is some way below London (50%) and England proportion (59%) see table-7.

Offenders receive treatment for substance misuse problems in prisons, on release from prison could be transferred to a community provider to continue their treatment although this is a voluntary option. In 2013/14 only 12% (8 out of 65) of those released from Wandsworth prison continued drug treatment within 3 weeks of release (Public Health England). The Offender Rehabilitation Act 2014 will make treatment appointments a requirement for community supervised offenders (Ministry of Justice).

[1] Trigger offences theft,robbery,burglary,aggravated burglary, taking motor vehicle aggravated vehicle-taking, handling stolen goods, going equipped for stealing, possession of controlled drug and possession of controlled drug with intent to supply.

Table 6 Individuals referred to drug treatment from the Criminal Justice caseload, Wandsworth 2013/14

Referral to drug treatment and start	Number and %
All referrals to drug treatment	180
of which are new referrals	150
Drug treatment starts	53
% of treatment starts from new referrals	35%
% of treatment starts from new referrals: London	50%
% of treatment starts from new referrals: England	59%

Source: Public Health England 2012/13

As part of their sentence, detainees that appear in court could be given a Drug Rehabilitation Requirement (DRR) or Alcohol Treatment Requirement (ATR) at the discretion of the judge. In Wandsworth in 2013/14 there were 36 and 23 DRRs and ATRs starts respectively (London Probation Service).

5 The Treatment system

5.1 Referral into treatment

Wandsworth has an Integrated Drug and Alcohol treatment System (IDAS). There are four dedicated specialist clinics for treating people affected by substance misuse (problematic alcohol and drugs misuse) across the borough; three alcohol community primary care based clinics called Fresh Start and ten Primary Care liaison practices treating opiate dependent clients in the borough. Wandsworth residents over the age of 18 and registered with Wandsworth GPs can access specialist services through self-referral or professional referral.

There are various entry points into drug treatment, self-referrals are the most common route followed by an aggregate of referral routes from the criminal justice system. The third most common entry point is from a GP referral. Comparing Wandsworth to London average highlights areas of strengths and weaknesses in our referral pathways; in 2012/13 Wandsworth had more than double the proportion of GP referrals compared to London, which highlights the successful GP integration into the treatment system(table-7). Conversely, Wandsworth has referred only half the proportion of clients through arrest referral compared to London average.

Table 7 Referral routes to drug treatment Wandsworth compared with London

	Wandsworth 2010/11		Wandsworth 2011/12		Wandsworth 2012/13		London 2012/13
	Number	%	Number	%	Number	%	%
GP	85	14%	41	13%	64	14%	6%
Self	202	34%	157	49%	193	43%	44%
Drug services	72	12%	16	5%	48	11%	10%
All Criminal Justice	130	22%	70	22%	93	21%	26%
Arrest referral/DIP	43	7%	7	2%	29	6%	13%
Probation	23	4%	5	2%	23	5%	3%
CARAT (prisons)*	15	3%	9	3%	9	2%	5%

CJS other	49	8%	49	15%	32	7%	6%
Other	101	17%	35	11%	52	12%	14%
Total	**590**	**100%**	**319**	**100%**	**450**	**100%**	**100%**
Treatment naïve at presentation	300	51%	141	44%	199	44%	44%

*Counselling, Assessment, Referral, Advice and Through care; a drug treatment service in prisons in England and Wales

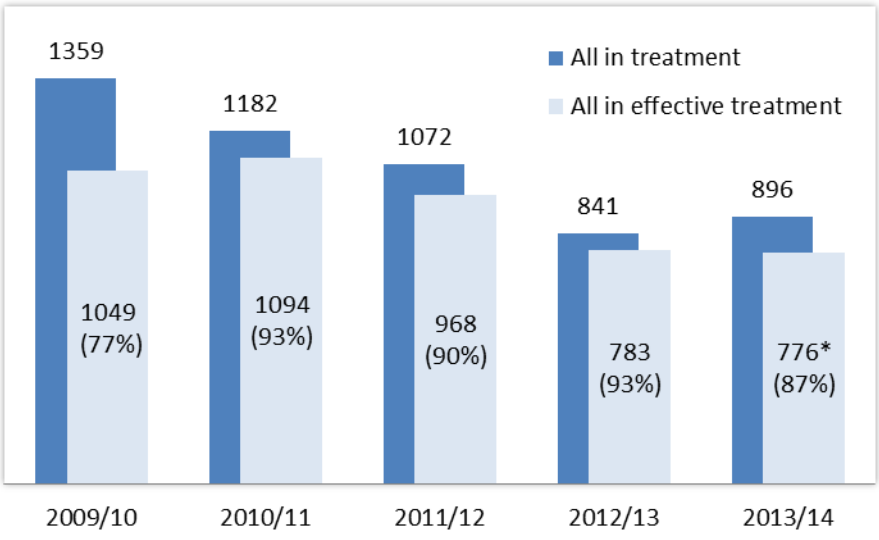
Source: National Drug Treatment Monitoring System (NDTMS)

For Wandsworth clients referred to drug treatment, 98% waited three weeks and under before commencing first treatment, this is similar to England average.

5.2 Number in treatment and effective treatment

The overall picture for people in Wandsworth in treatment for misusing any drug has been declining from 2009/10 to 2012/13; however, there was a slight improvement in 2013/14, as shown figure-5. Explanations for the decline in Wandsworth are not clear. However, nationally the factors likely to have contributed for the decline in drug use in England include: criminal justice initiatives to prevent use and disruption the supply chains and changing demographics (Drug Treatment in England, 2012/13).

Figure 5 The number of people misusing drugs in treatment in Wandsworth



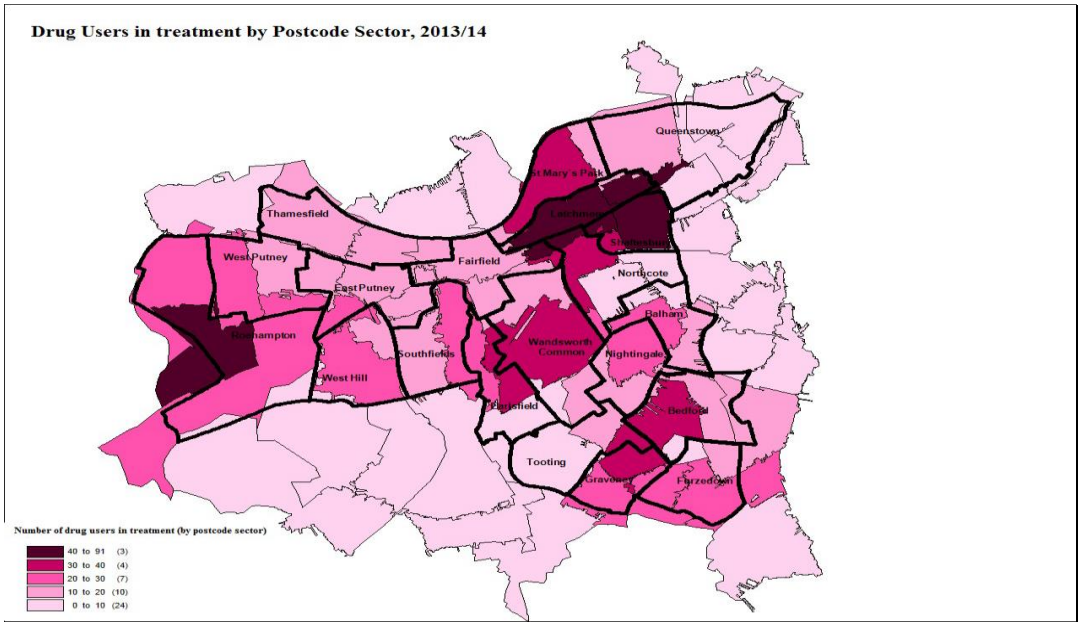
Source: National Drug Treatment Monitoring System (NDTMS)

*Effective treatment

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health, and manage their lives better. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes (Public Health England, 2012/13). Clients in effective treatment are either those in structured drug treatment for 12 weeks or more, or those successfully completing treatment within the 12 week period. Although the number of drug users in treatment rose in 2013/14, the proportion of those in effective treatment declined during the same period as shown in figure-5.
In view of the relative stability in the estimated use of opiates and crack cocaine in Wandsworth over the last few years; figure-5 shows that Wandsworth is treating proportionately fewer people who use drugs each year confirming the penetration rate is dropping.

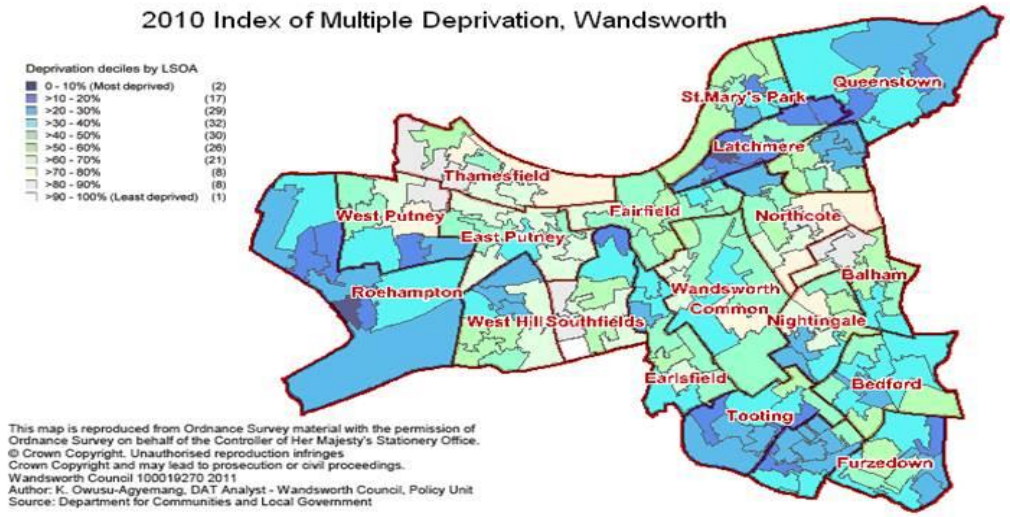
Figure 6 shows areas where clients had drug in treatment in Wandsworth in 2013/14.The majority of clients in treatment where from part of Roehampton and St. Mary's park and Latchmere , these are also areas of high deprivation as shown in figure -7 below.

Figure 6 Drug users in treatment in Wandsworth



Source : National Alcohol Treatment Monitoring System (NATMS)

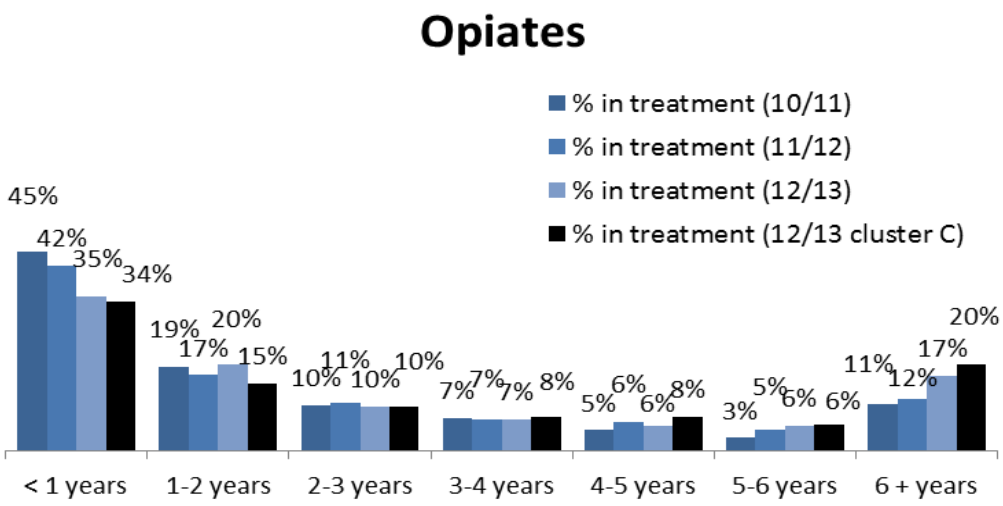
Figure 7 – Index of Multiple Deprivation, Wandsworth



5.3 Length of time in drug treatment

Figure-8 & 9 shows the marked difference in time spent in treatment between opiate and non opiate users. 35% opiate clients were in treatment for less than a year in 2013/13. This group of clients are declining and the proportion in treatment for 6 years or more are increasing (figure-8). A similar declining trend has also occurred within cluster C. Public Health England clusters local authority areas based on drug treatment clients. The least complex clients are grouped as 'A' and the most complex as 'E'. Wandsworth is in cluster E for non-opiate users and in cluster C for opiate users.[14]

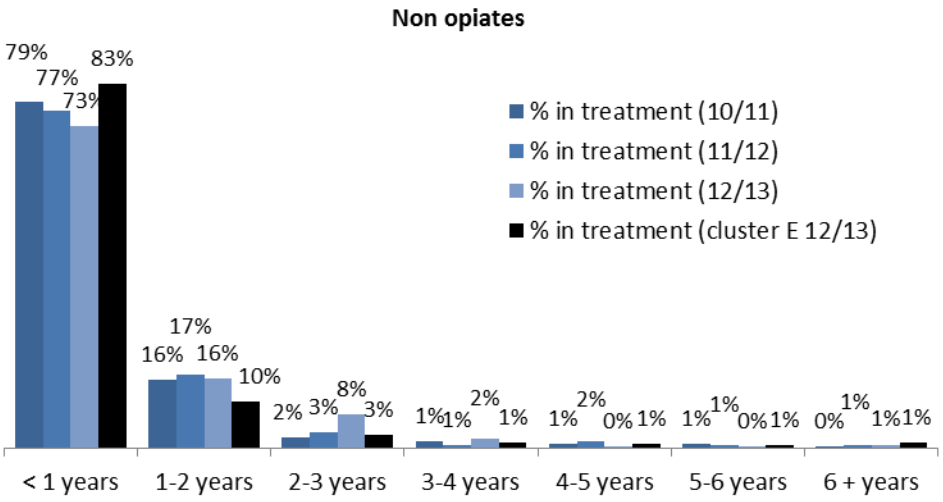
Figure 8 Times spent in treatment for opiate in Wandsworth compared to cluster



Source: National Drug Treatment Monitoring System (NDTMS)

Figure-9 also shows the majority of non-opiate users remain in treatment between 1-3 years. Figure-9 also shows in 2012/13, 73% of non-opiate users spent up to one year in treatment. There is a trend in Wandsworth for a progressive reduction in the proportion of non-opiate drug users staying in treatment for up to a year. Overall, opiate users tend to stay in treatment much longer than non-opiate users; this is to be expected due to the complex nature of drug treatment for opiate dependent clients.

Figure 9 Time spent in treatment for non-opiate in Wandsworth compared to cluster areas



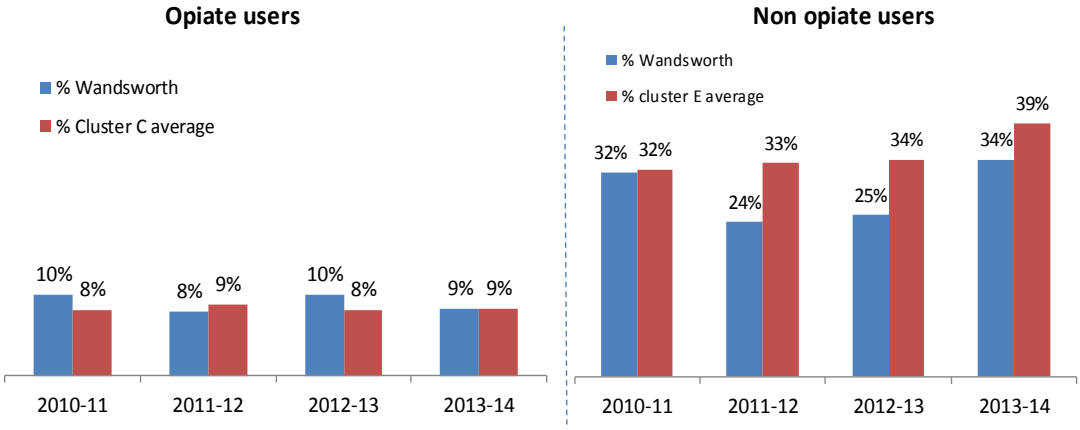
Source: National Drug Treatment Monitoring System (NDTMS)

5.4 Drug treatment completion

Successful drug treatment completion can be defined as people who have used drugs being free of drug dependency (or an occasional user of a non dependent drug) on leaving treatment.[15]

In Wandsworth, treatment completion rates for the years 2010/11, 2011/12, 2012/13 and 2013/14 were 32%, 24%, 25% and 34% for non-opiate, whilst for Cluster E they were 32%, 33%, 34%, and 39% respectively (figure-10).There was a decline in the proportion of non-opiate users completing treatment between 2011/12 and 2012/13; however, this has improved in 2013/14. During the same period the completion rate for opiates remained relatively unchanged in Wandsworth.

Figure 10 Opiate and non-opiate treatment completion



Source: National Drug Treatment Monitoring System (NDTMS)

It is noteworthy that the treatment completion rate for non-opiates in Wandsworth remained lower than the treatment completion rate for cluster E throughout the period as shown above.

5.5 Re-presentations in drug treatment

With the introduction of the recovery agenda a key performance indicator for drugs services re-presentation is defined as the number and proportion of people returning to treatment within six months after a successful completion of treatment. Overall the proportion of opiate and non-opiate users re-presenting in Wandsworth has gradually improved from 2010 to 2011 to become equal to the cluster average in 2012(table-8).

Table 8 Re-presentations to treatment within 6 months of successfully completing

	Opiates			Non opiates		
	2010*	2011*	2012*	2010*	2011*	2012*
Number of completions	88	74	67	152	124	70
Of which, re-presented	19	15	13	19	13	4
% re-presented	22%	20%	19%	13%	10%	6%
% re-presented (cluster average)	21%	21%	21%	7%	8%	6%

Source: National Drug Treatment Monitoring System (NDTMS)

*the years in table-8 are all calendar.

5.6 Alcohol referral

In the last two years the major source of referral into primary alcohol treatment in Wandsworth was from Mental Health services followed by self, family and friends. This appears to be different to the pattern of referral in London where the major source of referral has been from family and friends (table-9).

Table 9 Referral source for new primary alcohol presentations

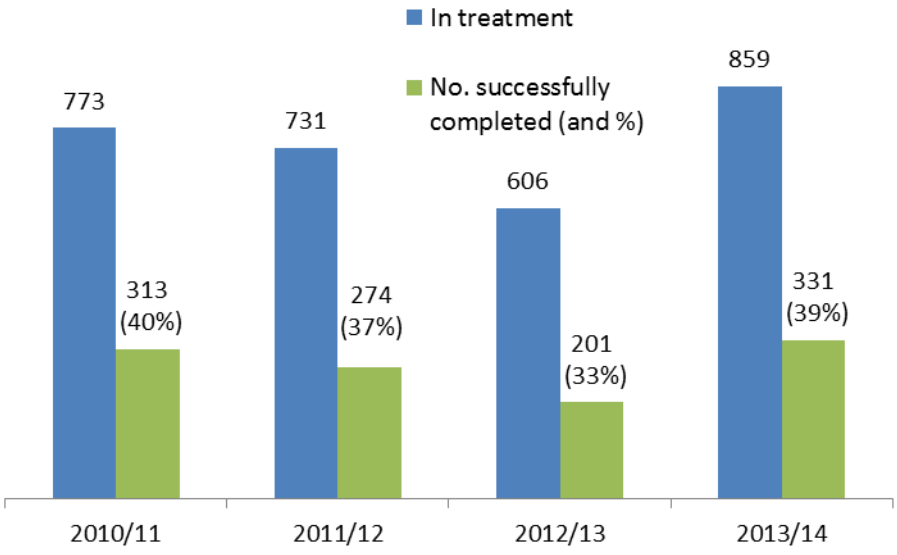
	Wandsworth 2011/12		Wandsworth 2012/13		England 2012/13
	Number	%	Number	%	%
Other	82	16%	31	7%	8%
Community Based Care Services	23	4%	17	4%	6%
Children & Family Services	4	1%	11	2%	1%
Health & Mental Health Services	292	56%	199	44%	27%
Substance Misuse Services	33	6%	30	7%	8%
Criminal Justice System	10	2%	8	2%	8%
Self, Family & Friends	73	14%	160	35%	41%
No Referral Source Recorded	0	0%	1	0%	0%
Total New Presentations	517	100%	457	100%	100%

Source: National Alcohol Treatment Monitoring System (NATMS)

5.7 Alcohol treatment and completion

There has been an improvement in successful completions of primary alcohol treatment for Wandsworth clients in 2013/14 in comparison to 2010/11 (figure-11). However, caution need to be exercised in reading the number and proportions in treatment for 2011/12 and 20112/13 as there was a data recording issue.

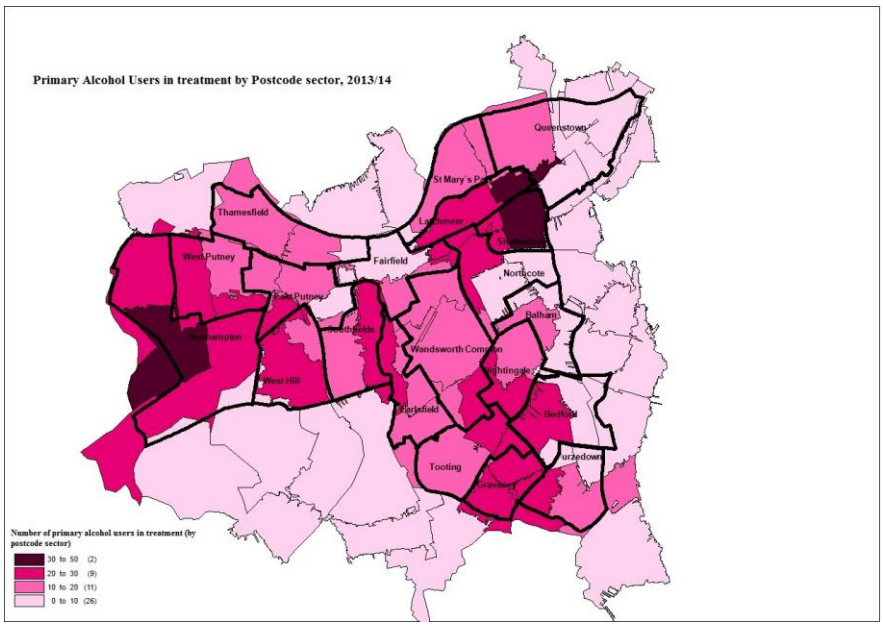
Figure 11 Alcohol treatment completion rates



Source: National Alcohol Treatment Monitoring System (NATMS)

Figure -12 Shows the majority of clients who had primary alcohol treatment in 2013/14 where from deprived wards such as such as part of Roehampton, Shaftbury, and Latchmere . These are also areas where were large number of clients had treatment for drug misuse in 2013/14.

Figure 12 Wandsworth resident in primary alcohol treatment



Source : National Alcohol Treatment Monitoring System (NATMS)

5.8 Length of time in alcohol treatment

Compared to drug clients, the length of time alcohol users remain in treatment is substantially lower; this reflects the different treatment process. The majority (55%) of them spend between one to six months in alcohol treatment in 2012/13. Compared to the London and England average, there are fewer people in alcohol treatment for over a year in Wandsworth (table-10).

Table 10 Time spent in alcohol treatment, Wandsworth

	Wandsworth 2011/12		Wandsworth 2012/13		London 12/13	England 12/13
	Number	%	Number	%	%	%
<=1 week	33	5%	30	5%	2%	3%
8 days - 30 days	74	10%	55	9%	8%	9%
31-180 days	415	57%	336	55%	52%	51%
181 - 365 days	143	20%	121	20%	22%	23%
> 1 year	62	9%	64	11%	16%	14%
Total	727		606			

Source: National Alcohol Treatment Monitoring System (NATMS)

5.9 Re-presentation in alcohol treatment

Re-presentation in alcohol treatment is defined as the proportion that successfully completed treatment in the first six months of the latest 12 month period and re-

presented within 6 months (Public Health England, 2012/13). The number in primary alcohol treatment and proportion of those who completed and re-presenting for treatment has marginally increased in Wandsworth (table-11).

Table 11 Re-presentations to alcohol treatment, Wandsworth, London and England

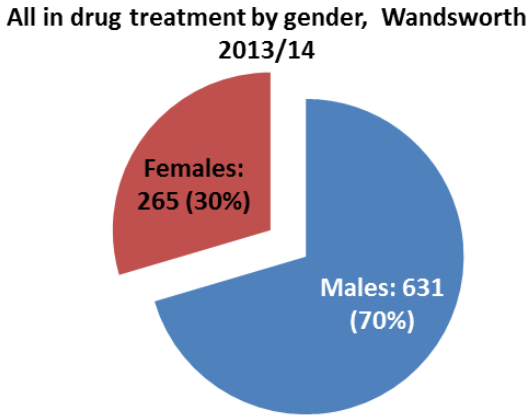
	Wandsworth		London 2013/14	England 2013/14
	2012/13	2013/14		
Number of completions	126	150	3103	22836
Of which, re-presented	14	19	353	2548
% re-presented	11%	13%	11%	11%

Source: National Alcohol Treatment Monitoring System (NATMS)

5.10 Demographics of drug and alcohol users

Wandsworth drug treatment gender profile comprises of 70% males and 30% females (figure-13) and this ratio has not changed over the last five years. Wandsworth profile slightly differs to the national gender profile in treatment, which is 75% are males and 25% females.

Figure 13 Drug treatment by gender



Source: National Drug Treatment Monitoring System (NDTMS)

Overall, the proportion in drug treatment from each ethnic group roughly corresponds to their proportion in the Wandsworth population except that there is approximately double the proportion of Black Caribbean's receiving treatment. The Asian ethnic group, who make up 3% of the treatment population despite being 9% of Wandsworth resident population, appear under represented in the treatment system (table-12). However, it is noteworthy that one conclusion in a series of reviews of Department of Health data on drug misuse and people from Black and minority ethnic groups was that 'various ethnic groups require more and better targeted information which not only enables community members to understand the impact of drugs on their communities more fully, but also helps them to access and to trust drug services when needed'.[16]

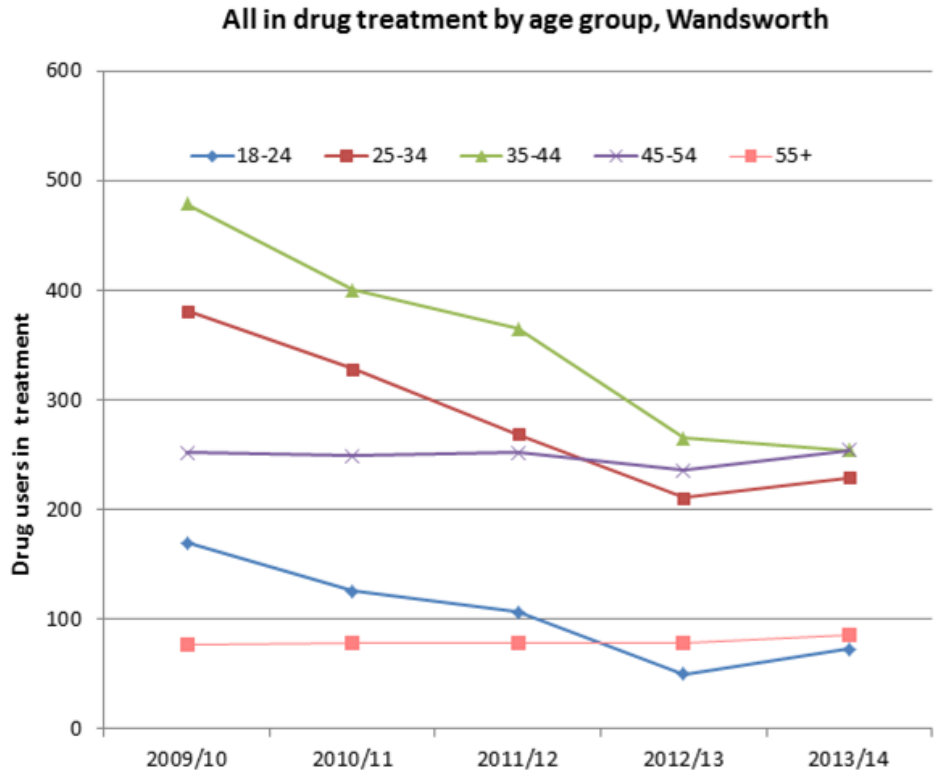
Table 12 Ethnic profile of Wandsworth residents in drug treatment, 2013/14

Ethnic group		Number in treatment	Proportion in treatment (%)	Proportion in Wandsworth population (%)
White	White British	531	59%	53%
	White Irish	31	3%	2%
	Other White	90	10%	16%
Mixed	White & Black Caribbean	30	3%	2%
	White & Black African	9	1%	1%
	White & Asian	3	0%	1%
	Other Mixed	10	1%	2%
Asian or Asian British	Indian	8	1%	3%
	Pakistani	12	1%	3%
	Bangladeshi	4	0%	0%
	Other Asian	11	1%	3%
Black or Black British	Caribbean	70	8%	4%
	African	21	2%	5%
	Other Black	37	4%	2%
Chinese/ Other	Chinese	2	0%	1%
	Other	20	2%	2%
	Not stated/missing code	7	1%	n/a
	Total	896	100%	100%

Source: National Drug Treatment Monitoring System (NDTMS); 2011 Census

National evidence shows that drug use and drug related harms are generally falling amongst the younger population. Comparing drug users in treatment between 2010/11 and 2013/14 (table- 14) there is a decline in the younger age group (age 35 and under) in treatment locally, in London and nationally. In Wandsworth the greatest fall has been among 18-24 year olds; from 2009/10 to 2012/13 there was 42% fall in the number of drug users of this age group in treatment, substantially larger than the London and England average decline.

Figure 14 All drug users in treatment in Wandsworth by age group



Source: National Drug Treatment Monitoring System (NDTMS

5.11 Alcohol client profile

Table-14 shows the change in the number of clients receiving primary alcohol treatment. There has been a steady increase in the number of Wandsworth residents in primary alcohol treatment with the exception of a marginal drop in the number of 18-24 year olds in primary alcohol treatment (table-14).

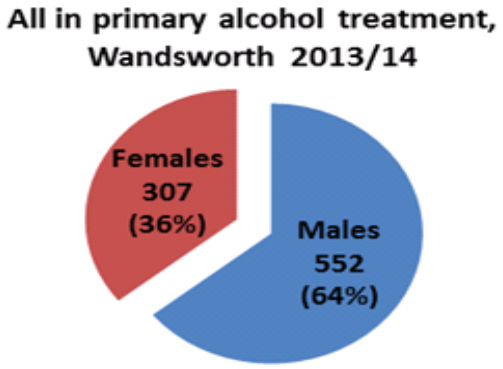
Table 14Wandsworth residents in primary alcohol treatment

	2011/12	2013/14	% change
18-24	25	21	-16%
25-34	128	166	30%
35-44	246	252	2%
45-54	200	258	29%
55+	128	162	27%
All	727	859	

Source: National Alcohol Treatment Monitoring System (NDTMS)

Similar to the drug treatment population there are a greater proportion of males in primary alcohol treatment than females (figure–15). However there are a higher proportion of females in alcohol treatment compared to drug treatment (36% and 30% respectively).

Figure 15 Gender profile of Wandsworth residents in alcohol treatment



Source: National Drug Treatment Monitoring System (NDTMS)

5.12 Primary drug use

Table-13 shows the main drug used by people in Wandsworth. It is apparent that the proportion of people using heroin and seeking treatment has risen relative to that of other drugs users over the last three years. However, the rise in the proportion of heroin may be due to the numbers of crack, cannabis and cocaine users in treatment falling by more than half during this period. As shown in table-13, crack users in treatment in Wandsworth dropped from 18% in 2010/11 to 12% in 2013/14, while the proportion for England and London dropped marginally from 4% to 3% and 13% to 9% respectively. The decline for crack and cocaine presentations to treatment reflects the trend in London and England; however the decline in Wandsworth is a concern.

Table 13 Main drug use by people in drug treatment in Wandsworth

	Heroin		Crack		Cannabis		Cocaine		Methadone	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
2013/14	434	48%	105	12%	129	14%	74	8%	36	4%
2012/13	436	52%	121	14%	95	11%	62	7%	41	5%
2011/12	518	48%	145	14%	162	15%	92	9%	48	4%
2010/11	483	41%	207	18%	185	16%	140	12%	56	5%

	Benzodiazepines		Amphetamines		Other		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
2013/14	18	2%	23	3%	77	9%	896	100%
2012/13	15	2%	15	2%	56	7%	841	100%
2011/12	32	3%	14	1%	53	5%	1072	100%
2010/11	35	3%	14	1%	62	5%	1182	100%

Source: National Drug Treatment Monitoring System (NDTMS)

People Who Inject Drugs (PWID) are vulnerable to a wide range of infections that can result in illness and death. HIV infection among PWID remains rare compared with many other countries; this probably reflects the extensive provision of needle

and syringe programmes (NSPs), opioid substitution therapy and other drug treatment in England. Only 1.4% of PWID in England have HIV and most of those infected are aware of their infection. The National Intelligence Network on drug health harms study shows[17]:

- In England around half of people who inject psychoactive drugs have been infected with hepatitis C, and only 1.4% of them have HIV.
- The proportion ever infected with hepatitis B has fallen, due to increased vaccine uptake and a decline in equipment sharing.
- The injection of amphetamine-type drugs has become more common.
- Among those injecting image and performance enhancing drugs, one in ten have been exposed to one or more of HIV, hepatitis B or hepatitis C.

Overall, the proportion of current and previously injecting clients in Wandsworth, although lower than the England average over the last three years, is slightly higher than the London average in 2012/13 and 2013/14 (table-14).

Table 14 Injecting status of new drug clients, Wandsworth

	No. of new clients	No. currently/ previously injecting	% currently / previously injecting	London %	England %
2013/14	419	133	32%	28%	42%
2012/13	306	98	32%	29%	43%
2011/12	427	130	30%	31%	45%
2010/11	548	148	27%	31%	45%

Source: National Drug Treatment Monitoring System (NDTMS)

The proportion of all clients in treatment in Wandsworth who have previously or currently injected is 39%, which is higher than the London average of 37% in 2013/14(table-15).

Table 15 All clients in drug treatment who have previously or currently injected

% of all in treatment who are previously or currently injecting			
	Wandsworth	London	England
2013/14	39%	37%	54%
2012/13	41%	38%	55%
2011/12	39%	39%	55%
2010/11	35%	39%	55%

Source: National Drug Treatment Monitoring System (NDTMS

5.13 Needle and Syringe Provision

The main aim of needle and syringe programmes is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment, such as HIV, hepatitis B and C. Needle and syringe programmes were successfully

introduced during the '80s and '90s in the face of the UK's AIDS epidemic. They now face the challenge of a change in the type of people who inject substances. Conservative estimates suggest almost 60,000 people aged between 16 and 59 in England and Wales who have used anabolic steroids in 2012/13[18]. Needle and syringe programmes have reported rapidly increasing numbers of steroid users attending their services.

In Wandsworth, there were 1136 clients[19] who accessed needle and syringe provision in the borough in 2013/14, an increase of 6% compared to the previous year (1067). The data on needle and syringe provision is a proxy indicator of opiate and injecting profile in the community. Injecting drug habits have changed over the last year and pharmacies in Wandsworth have reported (anecdotally) an increase of club drugs injected by the MSM (Men having Sex with Men) client group.

5.14 Hepatitis B

Hepatitis B (HBV) prevalence has fallen from 44% in 1990 to 18% in 2012 nationally. The decline reflects the marked increase in the uptake of the hepatitis B vaccine. In Wandsworth 2013/14 there were 425 clients eligible for Hepatitis B vaccinations. The percentage of clients who were offered and accepted an intervention is slightly higher compared to the London average, 39% in Wandsworth compared to 37% of London average. Of the 167 offered and accepted vaccination during this period, only 25 (15%) started the course of vaccination but 32 (19%) completed (the percentage completed includes those who started their treatment elsewhere).

5.15 Hepatitis C

All clients who have been recorded as either currently or previously injecting should be assessed to see whether they should be offered a Hepatitis C test. In 2013/14 there were 133 eligible clients for hepatitis C testing, of this 39% received a HCV test, lower than 57% for the London average. Of the 133 eligible clients, 52 accepted and 66 refused the test, only 50% of the client group which is a concern.

5.16 Dual diagnosis

The department of Health defined dual diagnosis as 'a broad spectrum of mental health and substance use problems that an individual may experience concurrently' (Department of Health, 2002).

Diagnosing individuals who misuse drug and alcohol and have a mental health problem is important as these clients often have the most complex needs. The number and proportion of Wandsworth drug treatment clients who have also been diagnosed with a mental health problem has generally declined over the four years to 2013/14 (table-16). This is the opposite of the trend occurring in London and England which may suggest that all dual diagnosis clients may not be identified in the Wandworth drug treatment population.

Table 16 New clients in drug treatment with a dual diagnosis

	Dual diagnosis Wandsworth	All new clients in treatment	% dual diagnosis - Wandsworth	Number new to treatment living with children	All new clients in treatment	London %	Number new to treatment living with children	All new clients in treatment	England %
2013/14	64	425	15%	3092	13714	24%	16662	69591	18%
2012/13	31	311	10%	3273	13593	23%	17699	67836	17%
2011/12	86	440	20%	3340	13518	21%	18484	67916	15%

Source: National Drug Treatment Monitoring System (NDTMS)

5.17 Parental drug misuse

A third of the treatment population has childcare responsibilities (NTA, 2010). Nationally, parental drug use is a risk factor in 29% of all serious case reviews, 27% of serious case reviews also reported alcohol misuse.[20]

For some parents, having children will encourage them to enter treatment stabilise their lives and seek support. For others, their children may be at risk of neglect, taking on inappropriate caring roles and, in some cases, serious harm. Having a parent in drug treatment is a protective factor for children. Evidence suggests parents enter, are retained and successfully complete treatment at a similar level or better than the whole treatment population.[21]

Table 17 New clients into in drug treatment living with children

	Wandsworth			**London**			**England**		
	Number new to treatment living with children	All new clients in treatment	%	Number new to treatment living with children	All new clients in treatment	London %	Number new to treatment living with children	All new clients in treatment	England %
2013/14	59	425	14%	3092	13714	23%	16662	69591	24%
2012/13	40	311	13%	3273	13593	24%	17699	67836	26%
2011/12	135	440	31%	3340	13518	25%	18484	67916	27%

Source: National Drug Treatment Monitoring System (NDTMS)

It is evident from table-17 that there has been a drop in the proportion of parents or individuals living with children receiving treatment since 2011/12. The number of parents with problematic drug misuse living with children is a concern as it suggests that there are greater numbers of drug users not in treatment who are in contact with children in Wandsworth.

In Wandsworth Children's Specialist Services, for those children categorised as children in need, drugs & alcohol are highlighted as an issue for 9.6%(106/1093) of

cases. The number is likely to be underestimated as drug or alcohol issues are often identified later in the assessment. Some caution should be given as these figures do not specify the severity of the issue, the number is likely to be underestimated as drug or alcohol issues are often identified later in the assessment process.

Wandsworth commissions two posts that provide services within the Hidden Harm framework and works with parents with identified drugs or alcohol misuse. These are; the Parental Substance Misuse Worker working in specialist children's services, and a Substance Misuse worker seconded from Criminal Justice Intervention Service (CJIS) to the Family Recovery Project (FRP). The Parental Substance Misuse Worker has received 70 referrals over the year 2013/14, and the drugs worker based in the FRP has worked with 23 families over the same period. The activities of these posts suggest that there is a clear need for this work to be carried out. It would appear that demand is high amongst some of the most problematic families presenting with multiple needs, with drug and or alcohol addiction representing just one of these intertwined issues. Both of the aforementioned posts work with families' parents and children who have reached the stage of statuary intervention.

The number of Young People in Wandsworth who received treatment for drug and alcohol misuse was 216 for the year 2013/14. This represents a young people's treatment system working well in terms of outputs, and penetration of the estimated under 18 population with problematic substance use. However, there remains some concern as NTDMS data reveals the majority of Young People receiving an intervention come from mainstream education. This is of course to be expected, as this is where the majority of the population can be reached, however, the local picture does show that those young people who are out of mainstream education, Children Looked After and those involved in the Criminal Justice system are under represented. All of the aforementioned categories are specified by Public Health England as being high risk factors for substance misuse (NTA, 2012).

A separate needs assessment for young people with substance misuse is needed to address some of the above issues in more detail.

5.18 Pregnant women and substance misuse

Pregnancy and the first two years of a child's life are a particularly important developmental phase, with a strong evidence base pointing to the central importance of a relationship with a primary carer that is sensitive and responsive to the infant's needs. Women with problem drug use have high risk pregnancies with increased mortality and morbidity among mothers and babies. Adverse outcomes include increased rates of prematurity, low birth weight and intrauterine growth restriction. The drugs used, whether prescribed or illicit, may cause neonatal withdrawal symptoms and for the majority of women lead to increased risk of sudden infant death. Furthermore poorly controlled drug use together with chaotic lifestyles can compromise parenting abilities and lead to adverse social outcomes (DH 2007).

The number of women misusing drugs has increased considerably in the past 30 years, and many women in treatment are of child-bearing age(DH, 2007). However, the number in Wandsworth in drug treatment is relatively low. In 2012/13 there were only five pregnant clients recorded for drug misuse and two were recorded for

alcohol misuse. The data for substance misuse is captured at assessment so these figures may not reflect the numbers who become pregnant throughout their overall stay in treatment.

Although the numbers are small, substance misuse during pregnancy remains a serious problem for the individual women and unborn child. Local services are asked to respond by providing services that work together and follow relevant NICE guidance. National Treatment Agency (NTA) and Department for Education (DfE) guidance recommends that women with substance misuse problems are encouraged to access antenatal care and treatment early, and to plan the necessary care along with partner agencies to reduce the risk to her and her unborn child.

There is a pregnancy pathway in Wandsworth drug and alcohol services that fast tracks woman into treatment, with the arrangement of appropriate opiate substitution treatment or detoxification in line with national clinical guidelines and onward referral for multi agency input.

Getting parents with drug problems into treatment is a priority, so they can be stabilised, have the opportunity to begin to sort out their lives, and ensure that their children are protected. However, drug treatment alone is rarely sufficient to deal with the complex needs that drug-dependent parents face. It is crucial that drug and alcohol treatment, children and families services, health visitors and other local support services work together to provide a foundation for recovery. There also needs to be support for children while their parents are in recovery. The impact on the child as the parent recovers from addiction (which may include relapses) needs to be continually addressed by children and families services.

It would be misleading to suggest that all parents who use substances are unable to provide the necessary quality of care for an optimal outcome for their baby. However, parental substance misuse is a concern with 25 per cent of children subject to a child protection plan and analysis of Serious Case Reviews 2009–2011 in England showed that parental substance misuse was apparent in 42 % of families[22].

The 2011 Munro Review of Child Protection points out that "there has been a dearth of literature addressing the issue of substance/alcohol abuse and parenting (Barlow and Scott 2010) and a significant gap in services addressing the family and child needs of substance misusing adults in the UK, with little parent-focused practice."[23]

5.19 Alcohol

The precise number of children affected by, or living with parental alcohol misuse is difficult to establish. However, estimates suggest parental alcohol misuse is far more prevalent than parental drug misuse, and there is a need for greater emphasis in policy and practice on parental alcohol misuse as distinct from other forms of substance misuse. Analysis of the National Psychiatric Morbidity Survey 2007 showed that in England[2425]:

- Around 79,000 babies under one year old are living with a parent who is classified as a 'hazardous or harmful' drinker – this equates to 93,500 babies in the UK.
- Around 26,000 babies under one year old are living with a parent who would be classified as a 'dependant' drinker – this equates to 31,000 babies in the UK
- Extensive research indicates that prenatal alcohol abuse is clearly linked to brain development
- The riskiest period for drinking in pregnancy is around the time of conception and during the first trimester when the foetal central nervous system is developing.

Foetal Alcohol Spectrum Disorder (FASD) –including its most severe manifestation, Foetal Alcohol Syndrome (FAS) – is a direct consequence of prenatal exposure to alcohol. However, it is extremely difficult to obtain estimates of the numbers of children affected by FASD due to a lack of reliable data and difficulties in diagnosis[26]

5.20 TOPs

Clients who receive drug treatment complete a Treatment Outcome Profile (TOP), which tracks the progress drug and alcohol users make in treatment. This includes information on the rates of abstinence from drugs and alcohol, reduction in drug use and injecting, and those successfully leaving treatment with secure housing and in employment.

Treatment Outcome Profile (TOP) uses 20 simple questions to monitor (start, middle and end of treatment) changes in the clients' substance misuse and other areas during their treatment journey. TOPs review summarises at the 6 month review the proportion of drug users in each group who had become abstinent within the expected range (table-18).

TOPs review summary for 2013/14 in Wandsworth shows:

- 42% of opiate users had become abstinent by the 6 month review, well within their expected range of between 37%-55%.

- 58% of cocaine users had become abstinent by their TOPs review although this proportion was closer to the bottom of the expected abstinence range (50%-81%).

- Overall, 18%-22% of clients in each drug group had decreased drug use at the end of the review period (2013/14).

Table 18 Treatment Outcome Profile at 6 months review, Wandsworth 2013/14

	% abstinence	numbers	Expected range	% improved*
Opiate	42%	51/122	37% to 55%	22%
Crack	43%	48/112	40% to 58%	18%
Cocaine	58%	21/36	50% to 81%	22%
Adjunctive** alcohol	31%	32/102	23% to 41%	18%
No longer injecting	59%	22/37	50% to 81%	3%

*Improved- the % of those who have decreased their drug use by a specified number of days for each drug, between the start and review TOP ** Opiate , Crack or cocaine user also using alcohol

Source: National Drug Treatment Monitoring System (NDTMS)

5.21 Housing and employment

Key to a successful recovery oriented treatment system is that all services are commissioned to include best practice outcomes such as: supporting alcohol and drug users to sustainable employment and suitable accommodation.
For alcohol or drug misusers, accommodation is only one of many of needs which have to be addressed.
Over the past three years around 1 in 5 new drug and alcohol clients entering treatment in Wandsworth have had some sort of housing problem. Despite larger number of alcohol clients entering treatment each year, table-19 shows that housing problems have been more pronounced among drug clients since 2011/12.

Table 19 Housing problem for alcohol and drug users in Wandsworth

	2011/12		2012/13		2013/14	
New Drug clients						
NFA* - urgent housing problem	53	9%	27	9%	55	12%
Housing problem	57	14%	43	14%	63	14%
All housing problems	110	23%	70	23%	118	27%
New alcohol clients						
NFA - urgent housing problem	22	4%	21	5%	31	6%
Housing Problem	55	11%	47	11%	48	9%
All housing problems	77	15%	68	16%	79	15%
All new drug & alcohol clients with a housing problem	187	21%	138	19%	197	19%

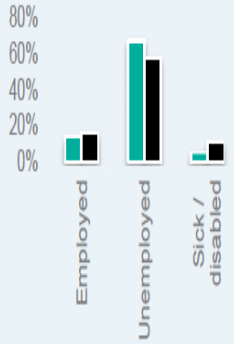
Source: National Drug Treatment Monitoring System (NDTMS)

* NFA No fixed abode

Being in work and undertaking meaningful activity is strongly associated with improved recovery outcomes, as is accessing education and training. However, the majority of people in drug and alcohol treatment will require significant support to address their education, training and employment needs and to get job ready. The data in table-20 below illustrated the scale of this challenge in Wandsworth. 68% of those who start treatment were unemployed which is 10% less than that national average.

Table 20 employment status of clients at the start of treatment

		Local	Proportion of eligible clients	National	Proportion of eligible clients
Employment status at the start of treatment	Regular employment	458	14%	25,315	16%
	Unemployed	2201	68%	90,704	58%
	Long term sick or disabled	170	5%	17,147	11%



Source : Public Health England

5.22 Club drugs

'Club drugs' is a collective term for a number of different substances typically used by young people in bars and nightclubs, at concerts and parties. These drugs can be harmful and heavy use can develop into a dependency. Despite the reported decline in overall drug use, around one million adults are estimated to have used club drugs in 2011-12. Nationally, club drug users make up just 2% of adults and 10% of young people in treatment (NTA, 2012). There is currently no data on the scale of club drugs use in Wandsworth.

5.23 Khat

Khat is a stimulant substance that is chewed. It has been used for centuries by many people living in, or who have come from, countries around the Red Sea and the east Africa.[27] According to a review published in 2013, there has been a reduction in UK Khat imports since 2005 despite an increase of 18.4% in the relevant Black and minority ethnic population, strongly suggesting a reduction in its use; that it has no direct causal link to adverse medical effects, other than a small number of reports of an association between Khat use and significant liver toxicity.[28] The Advisory Council on the Misuse of Drugs thus concluded that Khat should not be controlled under the Misuse of Drugs Act 1971. However, following wider consultation the government has decided to define Khat as a Class C drug;[29] Khat has become an illegal drug in 2014.The extent of the use of Khat in the borough is currently not known.

6 Service Users Engagement

A questionnaire survey and a focus group discussion was undertaken to gather the views of drug and alcohol service user as part of the needs assessment.

250 copies of a questionnaire were distributed, we received 71 completed forms. The age and gender profile of respondents were:

- 65% of respondents were male and 35% female respondents.
- The biggest age range of respondents was 45-55 at 58% followed by 25% of 25-34 year olds, over 55 year olds were 15% and 35-44 year olds accounted for 1%.

Ethnicity and sexual orientation of respondents:

- The biggest ethnic group was White British with 17% , however, 55% of respondent did not complete the section of the form about ethnicity.

- While self-description of ethnicity was low, 12% described themselves as belonging to other ethnic groups.

- The majority of respondents described themselves as Heterosexual at 89%, Gay 6% and Bisexual 4%, 1% left this answer blank.

Drug and alcohol misuse profile of respondents

- The majority of respondents were primarily alcohol users at 45%,

- Heroin users accounted for 28%, Cocaine and Crack Cocaine 15%, Cannabis 4%; Benzodiazepines at 1% and 6% left this answer blank.

Service users were asked if they had used newer types of drugs. The responses were:

- 23 had used Ecstasy, 2 had used Ketamine and 6 reported use of Mephedrone, Methamphetamine, GHB and 3 people reported use of an unspecified Club Drug.

Service users were asked to rate their experience of the service. The key findings were:

- Most respondents were male Alcohol, Heroin or Cocaine users aged 45-55 and White British
- 42% of respondents had used the newer drugs listed
- 66% commented positively about keyworker staff
- 76% reported reduced drug or alcohol
- 72% reported improvement in their health or well-being subsequent to treatment.
- 28% reported they have been assisted towards better housing through engagement with services
- 80% felt their needs had been met towards achieving their goal
- Overall, 87% of respondents reported a positive experience of services

However, there were some aspects of services where responses were not so positive. These include:

- Group activities and premises could be improved.
- Aftercare services could be improved
- Some asked for longer opening hours and drop in sessions, attracting more clients and employing ex-users.

Subsequent to the questionnaire data collection, a focus group discussion was carried out to gather the views in terms of what they see will improve access to services:
Suggestions of respondent included:

- Word of mouth' was thought to be one of the most powerful ways of communicating to current and ex service users in the local community.
- Better referral system to and from Mental Health Trust
- Promotion of services offered/fliers to probation/hospital/GP surgeries.
- A change of culture and perception
- Re-engagement of those service users who have left the borough for other services.

7 Literature review on prevention and effective interventions

7.1 Alcohol

Three approaches in alcohol policy can be distinguished, in order to minimise harm[30]. The first approach is aimed at limiting the availability of alcohol ("supply reduction"), e.g.by restricting opening hours/locations where inhabitants can buy alcohol, by raising the minimum legal drinking age, and/or by increasing the price of alcoholic beverages. The second approach is aimed at altering the drinking context "harm reduction"). This approach aims to minimise the harm and risks which drinking alcohol can cause. Examples of harm reduction are educating bar staff to sell alcohol in responsible way[31] , and interventions that reduce injury and violence. The third approach is education and persuasion ("demand reduction"), i.e. aiming to increase knowledge and awareness of the harm alcohol can cause, and to change alcohol-related attitudes and drinking behaviour. [32]

Several international bodies have also recommended the control of hours or days of sale, or both as means of reducing excessive alcohol consumption and related harms. For example, a recent review of alcohol control strategies by the WHO found that limiting of hours of sale was an effective method for reducing alcohol-related harms[33]. In Ireland, the Department of Health and Children's Strategic Task Force on Alcohol concluded that "restricting any further increases in the physical availability of alcohol (number of outlets and times of sales)" is among the most effective policy measures for influencing alcohol consumption and related harms[3435].

A recent well controlled quasi-experimental study from Stockholm, Sweden, focused on responsible beverage service on licensed premises, with a combination of community mobilisation, training of bar staff and stricter enforcement of alcohol laws. A substantial and significant drop in violent crime occurred in the intervention sites. This intervention clearly straddles the boundaries between community action and supply control[36].

Brief interventions by primary care practitioners for both smoking and early stage alcohol problems features strongly in literature, which demonstrates their effectiveness. While the increase in the number of people reducing their consumption in response to brief interventions is small, this increase is highly consistent across numerous different studies. Given that brief intervention is inexpensive, takes very little time, and can be implemented by a wide range of health and welfare professionals, this is a highly cost-effective strategy with considerable potential for harm reduction from a wholesale application of the method[37].

7.2 Older people, alcohol and substance misuse

According to Wadd et al (2011)[38], "evidence suggests that the UK may be on the verge of an epidemic of alcohol related harm amongst older people." Those aged 65 and over form a small proportion of those in alcohol treatment – 3% of both men and women. However, an estimated 1.4 million people in this age group currently

exceed recommended drinking limits[39].Across 2002-2010, there was a marked increase in alcohol-related hospital admissions across all age groups, but the increase was greatest for older people: for men aged 65 and over admissions rose by 136%, and for women in this age group by 132%. In 2010, there were almost half a million alcohol-related admissions for those aged 65 and over, meaning that they accounted for 44% of all these admissions, despite comprising just 17% of the population.[40]

The number of people aged 40 and over in drug treatment is rising, as is the number of people in this age group who are 'new starters'. As Public Health England (PHE) highlights in the most recent drug treatment statistics, an 'ageing population' is now becoming "one of the key features of drug treatment in England". Overwhelmingly, this ageing population is made up of heroin users; PHE notes that "this older, less healthy population with its persistent problems present a significant challenge for treatment services in the years ahead[41].

7.3 Evidence of effectiveness?

A significant underlying cause of substance misuse in older people is social isolation and loneliness. Services can help to address this through social activities and events, as well as regular support groups. Evidence suggest the use of peer support, from 'real peers', can cut across the stigma that some older people with drug and/or alcohol problems experience, helping them to feel more comfortable in a service and providing examples of positive change. Peer mentors can provide support in a range of ways, including emotional and practical support on a one-to-one basis and by facilitating groups and social activities. Providing support as a peer mentor can also help older people who have had substance misuse problems in the past to sustain the changes they have made in their lives. Consideration and provision of appropriate levels and kinds of support for peer mentors is important[42].

Alcohol treatment effectiveness does not seem to vary significantly between elderly and younger populations. Although there is some evidence that late-onset drinkers are more likely to respond to treatment than early-onset drinkers .The predominance of depression, grief and social isolation as antecedents to problem drinking suggests that specific strategies addressing these issues may be required. Treatment must focus on day-to-day issues such as loneliness, loss of independence and declining health. Such treatment has involved addressing strategies to cope with negative emotional states, dealing with drinking cues, and increasing social support[43].

7.4 Drug misuse prevention

Drug prevention was often seen in three categories: primary prevention (deter or to delay the onset of substance abuse by providing all individuals the information and skills necessary to prevent the problem); secondary prevention (helping those involved in drug use); and tertiary prevention (treatment and services for drug users). Primary prevention promotes the non-use of drugs and is aimed at preventing or delaying the first use of drugs and the transition to more serious use of drugs among occasional users. Most drug use begins during adolescence and early adulthood, when young people are developing cognitively and socially. For that

reason, predominantly primary prevention literature is mainly directed at the younger age group.
Reducing the demand for both licit and illicit drugs has been attempted through universal strategies such as mass media campaigns, selective strategies such as brief interventions by health care workers, and strategies delivered by specialist treatment agencies.

From a population-wide perspective, the level of investment in effective treatment programs needs to be a key ingredient of comprehensive prevention policies. There is suggestive evidence for population-level impacts of methadone programs on local levels of crime, and of alcohol treatment on acute and chronic alcohol-caused health problems in the community. There is also a major opportunity to intervene with family members of individuals experiencing serious alcohol and other drug, as it can increase treatment effectiveness, and minimise the inter-generational transmission of mental health and substance use problems. Strong evidence also exists for the effectiveness of brief interventions delivered by primary health care workers[44].

Brief screening interventions have an untapped potential for widespread application in primary health care and community settings. Family members, particularly children, need to be involved in treatment programs to help break inter-generational patterns of substance use and related harm. Harm reduction approaches have become widely included in treatment for illicit drugs in addition to the traditional treatment goal of reduced or no use of drugs. Goals of treatment may include reduced drug use, reduced risk of infectious disease and improved physical and psychosocial functioning.

It is important to note that expectations of a quick 'cure' are unrealistic. Dependence is a chronic, relapsing condition requiring continuing care and treatment needs to be seen as a long-term proposition with the goals being improved care and containment of problems rather than unrealistic expectations of a complete cessation of problematic use.[45]

Strang recommends that well-delivered Opioid Substitution Treatment (OST) provides a platform of stability and safety that protects people and creates the time and space to move forward in their personal recovery journeys; it has an important and legitimate place in recovery-orientated systems of care. The drug strategy is clear that medication-assisted recovery can and does happen. We need to ensure this treatment is the best platform it can be, but focus equally on the quality, range and purposeful management of the broader care and support it sits within[46].

Sticking closely to the compelling evidence for effective opioid substitution treatment and existing guidance based on that evidence will deliver many of the improvements needed, but more can and should be done. A determined assessment of the shortfalls in provision, followed by remedial action, is a priority if treatment is to fulfil its potential in supporting recovery. It is not acceptable to leave people in opioid substitution treatment without actively supporting their recovery and regularly reviewing the benefits of their treatment, as well as checking, responding to, and stimulating their readiness for change. Nor is it acceptable to impose time limits on their treatment that take no account of individual history, needs and

circumstances, or the benefits of continued treatment. Treatment must be supportive and aspirational, realistic and protective.

Arbitrarily or prematurely curtailing opioid substitution treatment will not help the patient sustain their recovery and is not in the interests of the wider community. It risks losing any advances because it is externally imposed and so has no meaning; the individual does not own the decision. This would likely lead to an increase in blood-borne virus rates, drug-related deaths, and crime. However, clear and ambitious goals, with time scales for action, are key components of effective individualised treatment, especially when the individual collaborates in planning them. Strang review group strongly supports continued reference and adherence to NICE drug misuse guidance and to the more practitioner-orientated 2007 clinical guidelines[47].

The more ambitious approach outlined will sometimes lead to people following a potentially more hazardous path, with the risk of relapse (or at least occasional lapse) as they seek to disengage from the opioid substitution treatment that has supported them. Individuals (and their families), clinicians, and services need to understand this potential risk. They need to approach the change with careful planning and increased support, and provide a 'safety net' in case of relapse. Opioid substitution treatment will improve as a result of changes at a system, service and individual level. These include[48]:

- treatment systems and services having a clear and coherent vision and framework for recovery visible to people in treatment, owned by all staff and maintained by strong leadership;
- purposeful treatment interventions that are properly assessed, planned, measured, reviewed and adapted;
- phased and layered' interventions that reflect the different needs of people at different times;
- treatment that creates the therapeutic conditions and optimism through which people, and especially those with few internal and external resources, can meet the challenge of initiating and maintaining change;
- Programmes that optimise the medication according to the evidence and guidance;
- Measuring recovery by assessing and tracking improvements in severity, complexity and recovery capital, then using this information to tailor interventions and support that boost an individual's chances of recovering and promote progress towards that goal;
- treatment services that are not expected to deliver recovery on their own but are integrated with, and benefit from, other services such as mutual aid, employment support and housing

- treatment that works alongside peers and families to give people direct access to, or signposts and facilitated support to, opportunities to reduce and stop their drug use, improve their physical and mental health, engage with others in recovery, improve relationships (including with their children), find meaningful work, build key life skills, and secure housing.

7.5 Injecting drug use

The most commonly injected psychoactive drug in the UK, either alone or in combination with crack-cocaine, is heroin. Recent evidence suggests the types of psychoactive drugs being injected in the UK may be changing with the injection of amphetamine type drugs becoming more common. In addition, the injection of image and performance enhancing drugs (IPEDs), such as anabolic steroids, also appears to have become more common over the last decade.[495051]

Injecting drug use accounts for most of the incident of infections with hepatitis C virus (HCV). HCV infection is a complex and challenging medical condition in People Who Inject Drugs (PWID). Elements of care for hepatitis C in illicit drug users include prevention counselling and education; screening for transmission of risk behaviour; testing for HCV and human immunodeficiency virus infection; vaccination against hepatitis A and B viruses; evaluation for comorbidities; coordination of substance misuse treatment services, psychiatric care, and social support; evaluation of liver disease; and interferon-based treatment for HCV infection.[52]

7.6 Evidence of effectiveness

The main aim of needle and syringe programmes is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment, such as HIV, hepatitis B and C. In turn, this will reduce the prevalence of blood-borne viruses and bacterial infections, so benefiting wider society. Many needle and syringe programmes also aim to reduce the other harms caused by drug use and include:

- Advice on minimising the harms caused by drugs.
- Help to stop using drugs by providing access to drug treatment (for example, opioid substitution therapy).
- Access to other health and welfare services.

The NICE guideline 2014 outline 10 recommendation for the management of needle and syringe programmes
http://www.nice.org.uk/guidance/ph52/resources/guidance-needle-and-syringe-programmes-pdf

Public Health England recommendations for the management of hep C include:

- Ensure that a broad range of prevention services (including harm reduction advice and in addition to needle exchange) is available for PWID and ensure that a high rate of hepatitis C testing in those attending specialist services for drug users.

- Provide harm reduction advice to reduce the spread of infection in PWID, including advice regarding lifestyle factors for those who test positive, such as reducing alcohol intake.
- Ensure that specialist services for drug users collect robust information on hepatitis C testing.
- Work closely with Clinical Commissioning Groups to ensure that commissioning is aligned and that clear pathways are developed from testing into treatment services.
- Ensure that sexual health services are offering hepatitis C testing to those at increased risk.

7.7 Drug related death

Drug use—both licit and illicit—impacts on the community through its associations with crime and violence, sexual assault, domestic violence, concerns about public safety and amenity; impacts on families, the workforce and road accident; and also impacts on health through premature death, injury and illness. Drug misuse is a major contributor to premature mortality[53]. People who use drugs are up to ten times more likely to die suddenly or as a result of chronic diseases than people who do not use drugs. Many of these deaths are preventable.

Recorded rates of drug-related deaths are higher in England than in most other European countries. This high number of drug-related deaths partly reflects the fact that the population of injecting drug users in England since the 'epidemic' of the 1980s is growing older. People with long histories of drug dependency are more likely to be in poor health and to engage in dangerous injecting behaviour, and are at greater risk of dying from overdose[54].

The substance most commonly mentioned on death certificate for overdose is opioids, especially heroin. Overdose death mostly involves a combination of opioids and other drugs such as benzodiazepine, and alcohol, which can cause respiratory depression. Previous experiences of overdose greatly increase the risk of a user dying from a later overdose. Injecting is particularly risky for fatal overdose. Users may also overdose on new psychoactive substance (NPS), as NPS tend to contain a mix of unknown substances that can have unpredictable effects. There are also risks when NPS are used in combination with alcohol and other drugs.

There is a significantly elevated risk of overdose for people in the immediate period after being released from prison. Individuals are also at risk when leaving residential rehabilitation programme or inpatient treatment, after completing a drug detoxification programme. Important steps in preventing overdose at time of change includes prompting and supporting relapse prevention, offering pathways into (or back into) treatment when needed and providing suitable aftercare[55]

Enhanced treatment engagement and continuity of treatment between services and relapse prevention interventions can reduce the risk of overdose. There are ranges of treatment options available to reduce risk, such as rapid assessment and treatment engagement for those at high risk; local access to supervised consumption

of opioid substitution treatment; support for alcohol dependence and alcohol detoxification; support for safer injecting practices and to stop injecting; information and advice. [56].

Wandsworth have developed a local drug and alcohol related death review process in line with Department of Health and Public Health England guidance. The Drug and Alcohol Related Death Review Group has been established as an important work stream of Public Health and the Joint Commissioning Unit (Substance Misuse Team) in partnership with a number of agencies. The group is responsible for reviewing, reporting and making recommendations on drug and alcohol related deaths in Wandsworth in line with Public Health England guidance.

8 Discussion

There has, perhaps, been a greater emphasis put on drug rather than alcohol misuse in the past, but the figures here show that the health and social care and the wider societal effects of alcohol misuse substantially exceed those of drug misuse. In contrast, a very large number of people use alcohol and which causes a proportionately smaller number of significant problems. As the number of alcohol users is so large, the number of people who will develop health problems because of it is much higher and the wider societal issues associated with it are much more extensive.

There are an estimated 1,700 opiate and crack cocaine users in Wandsworth, all of whom are likely to develop significant health and social care problems. But the number of Wandsworth residents using alcohol in a potentially dangerous way dwarfs the estimated number of opiate and crack cocaine users in the borough. The estimate from Public Health Alcohol Profile indicates there are at least, 54,423 people increased risk drinkers, 18,457 higher drinkers, and 54,782 binge drinker. Hospital admission data also shows that an increasing number of Wandsworth residents are admitted to hospital with alcohol-related physical and/or mental health problems and this will have implications for social care services as well. We may infer from research data that an increasing number are attending A&E departments too; between 37% and 50% of all patients have consumed alcohol before presentation at an A&E department,[57,58,59] and this situation will only worsen unless measures are in place to reduce the number of people who misuse alcohol.

Improving recovery rates from drug treatment is proven to reduce local crime, improve local public health and reduce health inequalities, and therefore represents demonstrable value for money, especially in the current financial climate. The Public Health Outcome framework measures the successful completions from drug treatment for opiate and non-opiate drug users and the number of alcohol related admissions to hospital.

In terms of treatment, the number of young people and non-opiate user in treatment have both dropped quite dramatically; especially in people aged 18-44 years, and the absolute number and the proportion of drug treatment completions is dropping for Wandsworth residents. It would appear that Wandsworth is treating fewer people with drug problems.

8.1 Conclusion

Nationally, the proportion of the population using illicit drugs is shrinking. However, alcohol misuse is a much bigger concern than drug misuse: it affects far more people individually and has much wider societal impacts. The lives of most drug users and of a sizeable group of alcohol misusers are complex and often chaotic.

The treatment population is ageing – the over 40s are now the largest group starting and receiving treatment. Many are older heroin users who have failing health and entrenched addiction problems. This group is particularly hard to help into lasting recovery. While services need to address the demands of these highly complex drug users, the services also need to adapt and respond effectively to changing patterns in drug use and the needs of the wider population, such as those who get into problems with new psychoactive substances (sometimes called 'legal highs') and prescription or over-the-counter medicines.

The changing nature of drug use, and the ability to deliver against a broader range of problematic substance use, including cannabis and alcohol, poses a challenge to Wandsworth operational and commissioning framework.

9 Key findings

9.1 Key findings on drugs

- It is estimated the prevalence of opiate and crack users in Wandsworth could be 1,634 (range 1,198 - 2,084) Opiate, 1262, crack 1326 and injecting 299.
- Wandsworth drug treatment penetration rate (36%) is lower than in London (41%) and England (51%) meaning Wandsworth is treating proportionately fewer of its opiate and crack cocaine users than the London and England averages.
- There has been a decline in the age groups (18-44years) in drug treatment locally and in London. In Wandsworth, the greatest fall has been among 18-24 year olds. From 2009/10 to 2012/13 there was 42% fall in the number in drug treatment for this age group.
- There has been a reduction in primary crack users accessing treatment. The national trend estimates numbers of primary crack users are in decline – however, the decline in Wandsworth is much larger.
- The proportion of different ethnic groups in drug treatment generally reflects the overall Wandsworth demographic profile, however, under representation of Asian, and over representation of black Caribbean's ethnic groups in drug treatment is worth exploring further.
- There is under reporting of families where alcohol or drug misuse is a concern. Nationally, parental drug use is a risk factor in 29% of all serious case reviews, and 27% of serious case reviews mention alcohol misuse. In Wandsworth Children Specialist Services, for those children categorised as children in need, drugs & alcohol are highlighted as an issue for 9.6%(106/1093) of cases. The number is likely to be underestimated as drug or alcohol issues are often identified later in the assessment.
- There has been a decline in the number of drug users in treatment over the past four years and the situation in Wandsworth mirrors the national trend. This may well be caused by potential service users considering that the provision available does not meet their needs.
- Over the past few years, nationally, there have been substantial changes in patterns of drug use including increased use of novel psychoactive substances, (club drugs).
- Opiate completion rates remain relatively unchanged whereas treatment completion rates for non-opiate have improved from 25% in 2012/13 to 34% in 2013/14, although this still lower than the cluster average of 39%.

- Less than half of those injecting drug users who have been offered hepatitis B vaccinations accept the offer but only a smaller proportion of those who have accepted continue and complete the course.
- The proportion of dual diagnosis reported in the drug treatment system in 2013/14 in Wandsworth is (15%), which is lower than London (24%) and England average (18%).
- 1136 clients have accessed Wandsworth pharmacy needle and syringe provision in 2013/14. Needle and syringe provision activities can be proxy indicators of injecting drug use in the borough.
- Of the 133 eligible clients for hep C testing, 52 accepted and 66 refused the test, which is over 50% of the eligible group.
- Of the 150 new referrals to drug treatment from the criminal justice caseload in 2013/14, only 35% of them started treatment, some way below the London (50%) and England proportion (59%).
- Over the past three years (2011/12 to 2013/14) around 1 in 5 new drug and alcohol clients entering treatment in Wandsworth have some sort of housing problem.
- Self-referrals are the most common route to access drug and alcohol treatment services followed by referrals from the criminal justice system and General Practices.

9.1.1 Recommendations

- It is important to reconfigure the treatment system to improve access, retention and completion of treatment.
- Future treatment services commissioned in response to drug misuse will need to work alongside a strengthened programme of prevention-focussed interventions.
- Screening, assessment and referral to drug and alcohol services should be available through open access services such as primary care, children and family services, victims support, domestic violence services, sex workers support services, and police custody suits.
- Treatment services need to engage more with the 18-24 year old client group.
- The range of service provision has not kept pace with changes in the pattern of drug use. This is a gap to be addressed in future commissioning of drug services.
- There is a need for improved identification and recording of parents who have substance misuse problems living with children.

- There is a need for providers to encourage and positively engage service users to take up and complete BBV interventions.
- There is a need for service providers to improve the identification, recording and treatments of clients with dual diagnosis.
- The pattern of drug use has changed to include steroid and club drugs. Training for pharmacies should be available to accommodate the changing trend in drug use.
- Further improvement is needed in the engagement of the Criminal Justice caseload to mainstream drug treatment.
- Treatment services need to continue to increase the rates of successful completions and reduce re-presentations for opiate and non-opiates clients by ensuring this is a priority, using robust monitoring systems and using evidence based interventions.
- There is an important need for treatment services to work more closely with housing and employment services and continue to establish links to training opportunities for service users.
- It is necessary that pathways are well advertised, monitored and work effectively to increase numbers in treatment from all sources of referral.

9.2 Key findings on alcohol

- The latest prevalence estimate shows, there are approximately, 54,423 (21%) increased risk drinkers, 18,457 (7%) higher drinkers, and 54,782(21%) binge drinkers in Wandsworth.
- Nationally, there was a marked increase in alcohol-related hospital admissions across all age groups (2002- 2010), but the increase was greatest for older people: for men aged 65 and over, hospital admissions rose by 136% and 132% for women in this age group.
- The rates of alcohol related hospital admissions for all ages have increased since 2008, the increase in Wandsworth is not significantly different to the England average.
- In 2012/13 there were only five pregnant clients recorded for drug misuse and two were recorded for alcohol misuse in Wandsworth. Although the numbers are recorded at provider level, these figures are not always reported into NDTMS database.
- Alcohol treatment completion rates in Wandsworth have improved from 2011 (33%) in 2012/13 to 331(39%) in 2013/14.
- In 2011/12 and 2012/13 Mental health services have been the major source of referrals of clients into primary alcohol treatment in Wandsworth.

9.2.1 Recommendations

- The overall population affected by alcohol in Wandsworth is much higher than drugs. A shift in focus of treatment services towards alcohol misuse, which has occurred in recent years, is to be maintained.
- Improved alcohol provision for those who are increasing risk and higher risk drinkers in Wandsworth is needed.
- There is a need for front line health & social care staff to be trained to identify people at risk of substance misuse and deliver Identification & Brief Advice (IBA).
- Services working with drug and alcohol misusing women should make reproductive healthcare an integral part of the care pathway.Data collection for pregnancy should be reviewed. Further work is needed on the pregnancy pathway to establish robust liaison with maternal health units.
- Service providers should have a written policy on drug and alcohol misusing parents, including the need for multi-agency planning early in pregnancy.
- There has been improvement in alcohol treatment completion rates; however, given the scale of the population affected, further improvement is needed to increase the number of successful completions.
- Treatment providers should build on the current collaborative work with mental health services to improve referrals of clients into alcohol treatment.

Appendix-1 REFERENCES

[1] PHE alcohol related treatment in England

[2]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215470/dh_129674.pdf

[3] http://www.nhsinform.co.uk/health-library/articles/a/alcohol-misuse/definition

[4] https://www.gov.uk/government/policies/reducing-harmful-drinking

5 North West Public Health Observatory. *Indications of public health in the English Regions 8: alcohol.* Association of Public Health Observatories. Liverpool. 2007

[6] Murray C, et al. UK health performance: findings of the Global Burden of Disease Study 2010. The Lancet 2013;381: 997–1020)

[7] Darke S, et al. Mortality amongst illicit drug users. Cambridge: Cambridge University Press; 2006.

[8] Strang J (2011) Recovery-orientated drug treatment: an interim report by Professor John Strang, chair of the expert group. London: National Treatment Agency for Substance Misuse, www.nta.nhs.uk/recovery-orientated-drug-treatment.aspx.

[9] Recovery Orientated Drug Treatment Expert Group (2012) Medications in recovery: re-orientating drug dependence treatment. London: National Treatment Agency for Substance Misuse, www.nta.nhs.uk/medications-in-recovery-main-report.aspx

[10] http://www.nta.nhs.uk/uploads/prevalence-commentary.pdf

[11] Public Health England. *Drug treatment in England 2012-13*. http://www.nta.nhs.uk/statistics.aspx (Accessed 11 November 2013)

[12] http://www.emcdda.europa.eu/data/treatment-overviews/The%20United%20Kingdom

[13] Alcohol-related crime: the National Archives. See http:/crimereduction.homeoffice.gov.uk/toolkits/ar020101.htm (accessed 28 October 2013)

14 The other local authorities in cluster E for non-opiate users are Brent, Camden, Ealing, Hackney, Hammersmith and Fulham, Haringey, Islington, Kensington and Chelsea, Lambeth, Lewisham, Newham, Nottingham, South Tyneside, Southwark, Waltham Forest and Westminster. Local authorities in Cluster C for opiate users are Brent, Croydon, Enfield, Hammersmith and Fulham, and Haringey.

15 National Treatment Agency for substance abuse – Facts and figures http://www.nta.nhs.uk/facts.aspx

(accessed 24 April 2014)

[16] NHS National Treatment Agency for Substance Misuse. *Issues surrounding drug use and drug services among Black African communities in England. 2.* University of Central Lancashire. Preston. See http://www.nta.nhs.uk/uploads/2_black_african_final.pdf (Accessed 11 November 2013)

[17] National Intelligence Network on drug health harms briefing. Public Health England September 2013

[18]http://www.nice.org.uk/newsroom/pressreleases/NICESeeksToLimitTheSpreadOfBloodborneVirusesAmongSteroidUsers.jsp#_edn1

[19] The figure may include residents from neighbouring boroughs

[20] Alcohol and drugs prevention, treatment and recovery: why invest? PHE 2013

[21] http://www.nta.nhs.uk/uploads/supportinginformation.pdf

16. *Department of Health (2002a) Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide. London: Department of Health.*

[22] Brandon M. et al (2012) New Learning from Serious Case Reviews: a two year report for 2009–2011. Department for Education

[23] Munro E. (2011) The Munro Review of Child Protection: Final Report – a child centred System. Department for Education.

[24] National Scientific Council on the Developing Child (2006) Early exposure to toxic substances damages brain architecture.

.

[25] Welch-Caerre E. (2005) The neurodevelopmental consequences of prenatal alcohol exposure, Advances in neonatal care 5(4): 217–229

[26] Cleaver H. (1999) Children's Needs-parenting capacity. The Stationery Office

27 Cox G, Rampes H. Adverse effects of khat: a review. *Advances in Psych Treatment.* 2003. 10.1192/apt.9.6.456

28 Advisory Council on the Misuse of Drugs. *Khat: a review of its potential harms to the individual and communities in the UK*. See https://www.gov.uk/government/publications/khat-report-2013 (accessed 25 November 2013)

29 Letter from the Home Secretary to the chair of the Advisory Council on the Misuse of Drugs. November 2013. See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/260065/letter_to_ACMD_khat.pdf (Accessed 25 November 2013)

[30] 1 Babor T, Cactano R, Casswell S, Edwards G, Giesbrecht N, Graham K, Grube J, Gruenewald P, Hill L, Holder H, et al: Alcohol: No ordinary commodity. Asummary of the book. Addiction 2003, 98(10):1343–1350

[31] . Saltz RF: Prevention where alcohol is sold and consumed: server intervention and responsible beverage service. In Alcohol: minimising theharm What works?. Edited by Plant M, Single E, Stockwell T. London/NewYork: Free association Books Ltd; 1997.
[32] Ritter A, Cameron J: A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. Drug AlcoholRev 2006, 25(6):611–624.
[33] Popova S, Giesbrect N, Bekmuradov D, Patra J. Hours and days of sale and density of alcohol outlets: impacts on alcohol consumption and damage: a systematic review. Alcohol Alcohol. 2009;
44:500–16. [PubMed: 19734159]
[34] Strategic Task Force on Alcohol. Strategic Task Force on Alcohol—second report. Ireland: Health
Promotion Unit, Department of Health and Children; 2004.
[35] Am J Prev Med. Author manuscript; available in PMC 2013 July 16
[36] Wallin E, Norstrom T, Andreasson S. Alcohol prevention targeting licensed premises: a study of effects on violence.
Journal of Studies on Alcohol 2003; 64(2):270– 277.
[37] Contributors to the Cochrane Collaboration and the Campbell Collaboration. *Evidence from Systematic Reviews of Research Relevant to Implementing the 'Wider Public Health' Agenda.* York: NHS Centre for Reviews and Dissemination, 2000.
[38] Wadd, S., Lapworth, K., Sullivan, M., Forrester, D. and Galvani, S. (2011) *Working with older drinkers* – available at http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0085
[39] Department of Health (2012) *A public health outcomes framework for England 2013-16* – available athttps://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263658/2901502_PHOF_Improving_Outcomes_PT1A_v1_1.pdf
[40] European Monitoring Centre for Drugs and Drug Addiction (2008) *Substance use among older adults: A neglected problem* – available at http://www.emcdda.europa.eu/attachements.cfm/att_50566_EN_TDAD08001ENC_web.pdf
[41] Royal College of Psychiatrists (2011) *Our invisible addicts: First report of the Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists* – available at http://www.rcpsych.ac.uk/files/pdfversion/cr165.pdf
[42] http://www.drugscope.org.uk/partnersandprojects/Recovery+Partnership
[43] Dunne FJ. Misuse of alcohol or drugs by elderly people: May need special management. *British Medical Journal* 1994; 308(6929):608–610.
[44] Prevention of substance misuse , risk and harm . Review of evidence in Australia, 2004
[45] Gowing LR, Proudfoot H, Henry-Edwards SM, Teesson M. *Evidence Supporting Treatment. The Effectiveness of Interventions for Illicit Drug Use*. Woden: Australian National Council on
Drugs, 2001
[46] http://findings.org.uk/count/downloads/download.php?file=Strang_J_27.txt
[47] http://findings.org.uk/count/downloads/download.php?file=Strang_J_27.txt
[48] http://findings.org.uk/count/downloads/download.php?file=Strang_J_27.txt
[49] Club Drugs: Emerging Trends and Risks. London: National Treatment Agency for Substance
Misuse, November 2012
[50] Kirby T, Thornber-Dunwell M. High-risk drug practices tighten grip on London gay scene
[51] Consideration of the Anabolic Steroids. London: Advisory Council on the Misuse of Drugs.
September 2010. www.gov.uk/government/uploads/system/uploads/attachment_data/
file/119132/anabolic-steroids.pdf
[52] Overcoming Barriers to Prevention, Care, and
Treatment of Hepatitis C in Illicit Drug Users Brian R. Edlin,1 Thomas F. Kresina,4 Daniel B. Raymond,3 Michael R. Carden,1 Marc N. Gourevitch,2 Josiah D. Rich,7Laura W. Cheever,6 and Victoria A. Cargill5
[53] Murray C, et al. UK health performance: findings of the Global Burden of Disease Study 2010. The Lancet 2013;381: 997–1020
[54] Darke S, et al. Mortality amongst illicit drug users. Cambridge: Cambridge University Press; 2006
[55] National Institute for Health and Clinical Excellence. Drug misuse : Opioid detoxification. London NICE 2007
[56] Department of Health (England) & devolved administrations. Drug misuse and dependence: UK guidelines on clinical management. London: Department of Health (England), the Scottish Government, Welsh Assembly Government and Northern Ireland Executive; 2007.
57 Cabinet Office. Prime Minister's Strategy Unit. *Alcohol Harm reduction strategy for England.* Cabinet Office. London. 2004.
58 Minugh PA, Nirenberg TD, Clivord PR, et al. Analysis of alcohol use clusters among subcritically injured emergency department patients. *Acad Emerg Med* 1997;4:1059–67
59 Holt S, Stewart K, Dixon JM, et al. Alcohol and the emergency service patient. *Br Med J* 1980;281:631–40
61. NTA. National Treatment Agency, 2012 report on club drugs.

Appendix-2 National guidelines on drug and alcohol

- National drug strategy
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf

  Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence http://publications.nice.org.uk/alcohol-use-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-cg115

- **Alcohol-use disorders: preventing harmful drinking**
  http://publications.nice.org.uk/alcohol-use-disorders-preventing-harmful-drinking-ph24
- **Alcohol-use disorders care pathway**
  http://pathways.nice.org.uk/pathways/alcohol-use-disorders
- **Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. http://publications.nice.org.uk/alcohol-use-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-cg115**
- **Drug misuse pathway** http://pathways.nice.org.uk/pathways/drug-misuse
- **Public Health guidance on Khat misuse**
  http://www.nta.nhs.uk/PHE%20advice%20for%20local%20commissioners%20on%20upcoming%20khat%20ban.aspx
- **Preventing drug related death** http://www.nta.nhs.uk/Turning-evidence-into-practice-Preventing-drug-related-deaths.aspx
- **Opioid substitution guidance** http://www.nta.nhs.uk/uploads/teip-ost-14.pdf

Appendix-3 Indicators and source of data

Indicators

Building recovery from substance misuse dependency in local communities is measured by the following Public Health Outcome Framework (PHOF) indicators:

- Indicator 2.15 measures the successful completions from drug treatment for opiate and non-opiate drug users
- Indicator 2.18 measures the number of alcohol related admissions to hospital.

Improving recovery rates from drug treatment is proven to reduce local crime, improve local public health and reduce health inequalities, and therefore represents demonstrable value for money, especially in the current financial climate. Every £1 spent on drug treatment saves £2.50 in costs to society.

Source of data

This needs assessment is informed by data and evidence from diverse sources listed below:

National Drug Treatment Monitoring System (NDTMS) – www.ndtms.net

- National Alcohol Treatment Monitoring System (NATMS) – www.ndtms.net
- Glasgow estimates for the prevalence of opiate and/or crack users (OCU)
- Local Alcohol Profiles for England (LAPE) – www.lape.org.uk
- Health and Social Care Information Centre (HSCIC) – www.hscic.gov.uk
- Health Protection Agency (HPA) – www.hpa.org.uk
- Drug Test Recorder (DTR) – Home Office
- Drug Interventions Programme web system (DIRWeb) – www.dirweb.co.uk
- Recovery Diagnostic Tool 2011-12 (RDT) Public Health (NTA) – www.ndtms.net
- British Crime Survey
- Hospital Episode Statistics (HES),
- Local data sets