



Tower Hamlets Substance Misuse Needs Assessment 2017/18

Final version
November 2018

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1 Executive Summary

Conducting a Substance Misuse Needs Assessment is important to treatment planning and commissioning as it reviews service demand, offers comparison to relevant regional or national baselines and assesses local partnership performance over time.

The previous two needs assessment have informed the process of re-commissioning and implementing the current Reset services. The Reset services are operating for some time now and the purpose of this document is to support current treatment delivery. However, findings will also inform the next re-procurement process as current contracts with the main service providers will come to an end in October 2019.

This assessment has reviewed the needs of the Tower Hamlets' substance misusing population to support the Drug and Alcohol Action Team (DAAT) and its wider partnership to respond to future treatment demand. The wealth of quantitative and qualitative information in this document should also help to contextualise and support partners in the delivery of the Tower Hamlets Substance Misuse Strategy.

Impact of Reset Drug and Alcohol services

- The Tower Hamlets treatment system is the largest in London with more than 2,000 clients
- The treatment system has become more diverse, attracting more women, students and young adults to treatment
- Successful treatment outcomes have much improved since Reset services started in Oct 2016
- 411 clients left treatment successfully in 2017/18
- Representations rates are comparable low and clients achieve very good rates of abstinence when attending structured treatment

- The introduction of short term treatment episodes has improved engagement with alcohol only and alcohol & non-opiate clients
- The Blood Borne Virus (BBV) offer is exceptional and should be maintained

Key issues emerging

Treatment system

- The treatments system has been established successfully, but more can be done to improve some areas outlined in this document
- While client diversity has increased, treatment uptake of LGBTQ and Somali residents can be improved
- Treatment outcomes are improving, but further improvements are possible, especially for opiate clients
- Unmet need remains above national average for opiate and/or crack users in the borough
- More clients from the criminal justice system would benefit from effective treatment
- Residential rehabilitation remains a under-used resource open to suitable clients

Future need and service demand

- Prevalence of opiate and/or crack users remains high indicating need for services responding to complex clients
- 3,400 Alcohol depended residents indicate high unmet need
- The opiate treatment population is ageing while the deaths related to substance misuse remain above the national average
- Service users and treatment naïve users continue engaging over-proportionally with health and enforcement agencies
- Alcohol related harm remains high based on hospital admission, alcohol related deaths, ambulance call outs and alcohol related ASB

- Local residents continue to experience regular drug dealing and drug related crime and ASB, negatively impacting on their quality of life and perception of the Borough
- Mental health needs are high in the treatment population. Clients with mental health episodes in hospital are often drug and alcohol related indicating an unmet demand
- Rough sleepers and hostel clients remain a key target group requiring specialist support
- Service user engagement remains underdeveloped. Service user input remains crucially in diversifying the treatment system.

Moving forward

- Support women accessing treatment, improve suitable treatment spaces and treatment outcomes for female opiate users
- Utilise “Don’t bottle it up” Audit C online tool as an opportunity to engage treatment naïve clients including young professionals and students
- Improve collaboration and partnership work between Reset services
- Improve pathways to housing and education, training and employment
- Ensure assertive outreach with Somali population
- Re-establish partnership working between Reset treatment and Ambrose King focusing on Chemsex and LGBTQ clients
- Reset Treatment service to work closer with Tower Hamlets Mental Health (IAPT)
- Services providers to develop stronger Service user involvement and co-production
- Work closer with CCG and develop better understanding of ageing client cohort and related co-morbidities
- Develop better intelligence about health issues of clients in drug and alcohol treatment

- Outreach team started to engage with local traveller community in Bow and identified needs around alcohol.
- Improve partnership work and information sharing between DIP and key prisons to improve treatment engagement.
- TH DIP service to assess DRR and ATR clients and ensure that those clients are engaging with Reset treatment
- Reset treatment to improve support for suitable clients applying for residential rehabilitation. DAAT to deliver additional training to reduce barriers and increase demand.
- DAAT to investigate if there is locally a link between drug related deaths and prison release.
- Develop pathway between Royal London Hospital and Reset Treatment to increase successful referrals.

Re-commissioning

- Re-commissioning and implementing a new treatment system can be disruptive to clients and staff, impacting negatively on partnership outcomes. Implementing successful services takes time and the current re-commissioning cycle of 3 years is too short to avoid the negative disruption of service implementation. It is recommended to move longer service contracts.

Value for money - Why invest?

- Investing in treatment services to reduce drug and alcohol misuse and dependency will not only help to save lives but will also substantially reduce the economic and social costs of drug and alcohol related harm.
- Research has shown that every £1 invested in drug treatment results in a £4 benefit to society.
- Drug treatment in Tower Hamlets in 2016/17 prevented around 46,000 criminal offences and reduced crime by 32%
- Drug treatment reduced social and economic cost by around £18m in 2016/17

2 Introduction and context

2.1 Strategic context

Tower Hamlets Substance Misuse Strategy 2016-19¹

The Substance Misuse strategy provides the strategic frame work of all drug and alcohol related partnership work in the borough. The strategy outlines Tower Hamlets Partnership's approach to tackling the problems associated with drugs and alcohol misuse in the borough.

The document was developed in partnership between London Borough of Tower Hamlets, NHS East London & the City, the Metropolitan Police, the London Probation Service and other partners and builds on the existing 'three pillars' approach to tackling drugs and alcohol in Tower Hamlets through:

- **Prevention and Behaviour Change:** including information, education, support to parents, health messages and communications etc.
- **Treatment:** through screening and identification, assessment and care planning, effective treatment, after care and reintegration, peer mentoring and support throughout the lifecycle
- **Enforcement and Regulation:** including dedicated drug task force, integrated offender management, licencing and enforcement, enforcement of controlled drinking zones

The strategy sets out the broad framework for drug and alcohol interventions across the borough and identifies a range of priorities that address the pillars listed above. The coordination of these functions makes the strategy a direct responsibility of the Drugs and

Alcohol Action Board and the day to day management within the Safer Communities' service in the Council; through community safety, licencing and the DAAT.

The Tower Hamlets Substance Misuse Strategy is closely aligned to the National Drug Strategy. The Tower Hamlets strategy replicates the three main pillars relevant to local priorities.

National Drug Strategy 2017

The National Drug Strategy was published in July 2017 and included the four main priorities:

- 1 Reducing demand,
- 2 Restricting supply,
- 3 Building recovery, and
- 4 Global Action (new priority).

1 Reducing demand

The new strategy focuses on a targeted approach for high priority population groups including Vulnerable young people, NEETs, Offenders, Families, Women with experience of extensive physical and sexual violence, Sex workers, Homeless population, Veterans and Older drug users (aged above 45).

The strategy is also targeting evolving and emerging threats including New psychoactive substances (NPS), Chemsex, Image & performance enhancing drugs, Misuse of & dependence on medicines and mental health problems.

2 Restricting supply

Priorities to restrict supply are oversea transit routes, drugs at the border, domestic cannabis production and drug gangs & related exploitation. The strategy also focuses on tackling specific crime types including drug driving, ASB, Drug-related offending and prisons.

3 Building recovery

¹ Access document here:

https://www.towerhamlets.gov.uk/Documents/Consultation/Substance_Misuse_Summary_2016_19.pdf

Priorities include the pathway from custody to recovery, physical and mental health improvements but also Peer-led recovery. Employment, meaningful activities and families are further key priorities to support and sustain recovery.

4 Global Actions

This priority is focusing on shaping international policy and practice including:

- Reducing transmission of HIV/AIDS
- Increasing access to controlled medicines
- Promoting human rights

Orange Book - UK guidelines of clinical management of drug misuse and dependence

All drug treatment providers are responsible for delivering drug treatment within the context of the UK guidelines of clinical management of drug misuse and dependence (“Orange Book”).²

The new guidelines were published in 2017 and replaced the document in place since 2010.

Mayor of London Health Inequalities Strategy 2018³

The Mayor of London recently consulted on the Health Inequalities Strategy 2018 which includes a key objective to reduce the use and harms caused by illicit drugs and alcohol (Objective 5.3)

The Mayor is committed to work with London boroughs, treatment

² Department of Health and Social Care:
<https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management>

³ Draft Health Inequalities Strategy 2018
<https://www.london.gov.uk/moderngov/documents/b17375/Item%204%20-%20Appendix%205%20-%20Health%20Inequalities%20Strategy%202018%20Monday%2003-Sep-2018%2014.00%20London%20Assembly%20.pdf?T=9>

providers, the voluntary sector and researchers to understand how best to meet Londoners’ continually evolving needs. These include tackling complex issues such as where Londoners have both mental ill health and drug or alcohol problems, changing patterns of drug use (including so-called ‘legal highs’), changing supply routes (including ‘county lines’) and tackling drug related deaths.

2.2 Tower Hamlets treatment budget

In 2017/18 the treatment budget was £ 7.9 m and is based on Public Health Grant (PHG), LB Tower Hamlets Main grant and Mayor’s Office for Policing and Crime (MOPAC) funding. The funding covered the borough’s treatment provision, the Drug intervention programme (DIP) and residential rehabilitation.

Table: Tower Hamlets Overall Substance Misuse treatment budget

Financial year	Budget
2015-16	£ 8,258,848.50
2016-17	£ 8,245,875.88
2017-18	£ 7,902,921.00
2018-19	£ 7,274,921.00
2019-20	£ 7,274,921.00

(Source: Local data)

Budget lines 2016-2018 are inclusive of Mayor’s Office for Policing and Crime (MOPAC) funding, Public Health Grant (PHG) and LBTH Main Grant.

2019-2020 Budget line is yet to be confirmed but is included as a forecast. Mayor’s Office for Policing and Crime (MOPAC) funding for the DIP was around £613k.

2.3 Main treatment providers in Tower Hamlets

Substance Misuse treatment provision in Tower Hamlets is being delivered through the Reset Drug and Alcohol Service. Reset is an integrated service which provides drug and alcohol treatment to

Tower Hamlets residents aged 18 or over and support to family and friends who are concerned about someone's drug and/or alcohol use.

Support offered includes a wide range of interventions:

- advice and information for people who use drugs and/or alcohol and concerned others,
- community alcohol and opiate detoxification,
- healthcare assessments,
- testing for HIV, Hepatitis B and C, Hepatitis B vaccination and referral to treatment where necessary,
- access to needle exchange,
- assessment for residential detoxification and rehabilitation services,
- counselling and 1:1 key working,
- bespoke M-Pact programme for substance misusers with children (aged between 8 and 17),
- support for clients experiencing domestic violence,
- onward referral to further support services as required, and
- signposting and access to mutual aid groups such as AA, NA and Smart Recovery.

The service is delivered by three providers:

Reset Outreach & Referral Service (ORS) delivered by Providence Row are tasked with outreach work and referring clients into treatment.

Reset Treatment Service delivered by East London Foundation Trust (ELFT) is the main treatment service through which service users are engaged into the treatment system.

Reset Recovery Support Service delivered by Change, Grow and Live (CGL), delivers recovery support interventions alongside pharmacological and psychosocial interventions delivered by Reset Treatment.

Drug Intervention Programme (DIP): the borough's Drugs Intervention Programme coordinates the identification, assessment and referral into treatment for those involved in the criminal justice system. The programme makes referrals to Reset Treatment Service. The DIP team includes DIP Outreach, Prison Exit Team, Integrated Offender Management (IOM), Treatment Referral, a Court worker and an Arrest Referral Team operating out of Police custody.

Primary Care (formerly Shared Care): Works in partnership with the Clinical Commissioning Group and the GP Care Group to support the prescribing and broader physical health care needs of substance misusers across Primary care settings in the borough.

In addition there are several other contracts in place including:

- Reset Homeless Service (Health E1) providing support for homeless population
- Specialist Midwife based at Royal London Hospital
- Beyond the Streets – Prostitution Support Programme
- Blood Borne Virus (BBV) Team (run by ELFT / Reset Treatment Service)

3 Methodology

Local commissioning teams are conducting an assessment of need, assessing the degree of met and unmet need in the partnership.

According to Public Health England (PHE), the needs assessment should identify the following:

- What works in structured drug treatment services and what unmet needs there are across the system
- Hidden populations and their risk profiles
- Enablers and blocks to treatment pathways

The needs assessment will be used by the DAAT Board and the DAAT commissioning team to:

- Inform treatment planning,
- Make evidence-based commissioning decisions, and
- Inform the Public Health Substance Misuse JSNA

The core data used to support this needs assessment is sourced from the National Drug Treatment Monitoring System (NDTMS) which is a monitoring and performance management system. The NDTMS data is used, to assess service user need and treatment performance and to support an understanding of treatment demand to inform substance misuse intervention priorities for the Tower Hamlets partnership.

Particular analysis sourced from NDTMS includes:

- Treatment mapping information including referrals and presentation to treatment, new treatment entries, those in effective treatment, treatment exits and successful completions,
- Partnership and provider performance,
- Profiles of treatment users and those in the treatment

system, including age, gender, ethnicity, profile of drug used and client complexity.

- Parents in treatment and children living with clients in treatment

Additional partnership data was gathered and analysed supporting the findings of this assessment, which include:

- Prevalence of substance misuse in the community (OCUs)⁴
- Data from PHE fingertips,
- Alcohol consumption estimates and Local Alcohol Profiles for England (LAPE),
- Needle exchange and supervised consumption data,
- Hospital admissions (Alcohol related),
- Drug related crime data, and
- London Ambulance callout data and more.

All data discussed, represents the latest available data at the time of writing this document.

The data analysis and findings of this SMNA have been tested and enriched by qualitative work with service users and staff in a variety of workshops and focus groups, engaging more than 100 people.⁵

- Workshops with Somali Service user and Somali community at MIND Tower Hamlets
- Workshops with service users from Recovery Support Service, Reset Treatment
- Workshops with Reset Pre-residential treatment group
- Workshop with staff from Outreach and Referral service, Reset treatment and Recovery Support Service
- Consultation with Substance Misuse Forum

⁴ Opiate and / or crack users are those using opiates and crack placing a disproportionately large burden on the substance misuse treatment services.

⁵ See full list in Appendix 3

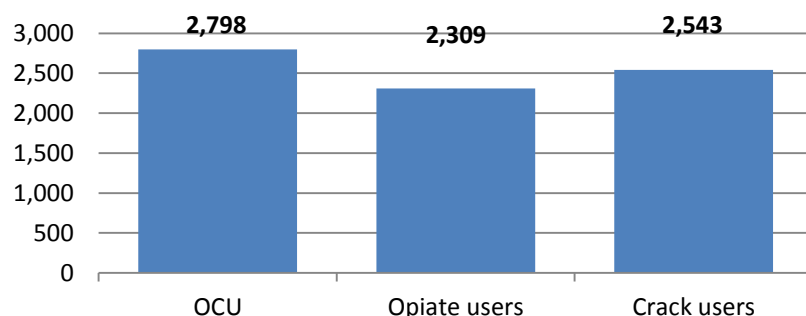
4 Estimating the drug and alcohol misusing population

4.1 Opiate and/or crack users in Tower Hamlets

PHE has published a new estimate for the Opiate and/or Crack (OCU) population in England and all local authorities. The estimate refers to the period 2014/15 and suggests a total of 2,798 OCUs, representing a fall of around 20% from 3,561 in 2011/12.

This is a statistically significant decrease of OCUs in Tower Hamlets. The same estimate also suggests a total of 2,309 opiate users and 2,543 crack users.⁶

Table: Estimated number of OCUs, Opiate and Crack users in Tower Hamlets



(Source: PHE Prevalence data, 2014/15, published 2017)

The nature of the estimate means that the true figure of users will be between the lower and upper estimate. See table below.

⁶ These estimates are the most recent estimates available and they include 95% lower and upper confidence intervals.

Estimates are based on in direct counting based on NDTMS treatment data, probation records, Police and Prison data. Two methodologies are applied, 1) capture – recapture and 2) multiple indicator method

Table: Estimated number of OCUs, Opiate and/or Crack users including confidence interval (CI) in 2014/15

	OCU	Lower CI	Upper CI	Opiate users	Lower CI	Upper CI	Crack users	Lower CI	Upper CI
Tower Hamlets	2,798	2,342	3,245	2,309	1,937	2,672	2,543	1,982	3,169

(Source: PHE Prevalence estimate, 95% confidence interval)

4.2 National and London OCU estimate

PHE estimate a total of 300,783 OCUs in England and Wales. The real figure will be between 297,986 and 311,128 OCUs. The total figure increased slightly by 2% between 2011/12 and 2014/15. However, this change is not statistically significant.

PHE estimate a total of 52,487 OCUs in London. The real figure will be between 50,955 and 55,550 OCUs. This means that around 5% of all London OCUs are in Tower Hamlets.

Local Authorities (LA) in London

According to the prevalence estimate, Tower Hamlets had the largest number of OCUs in London, followed by Hackney and Ealing. The lowest numbers of OCUs were in Merton, Bexley and Kingston upon Thames. See table below.

Table: OCU estimates by LA - TOP 5 LAs in London

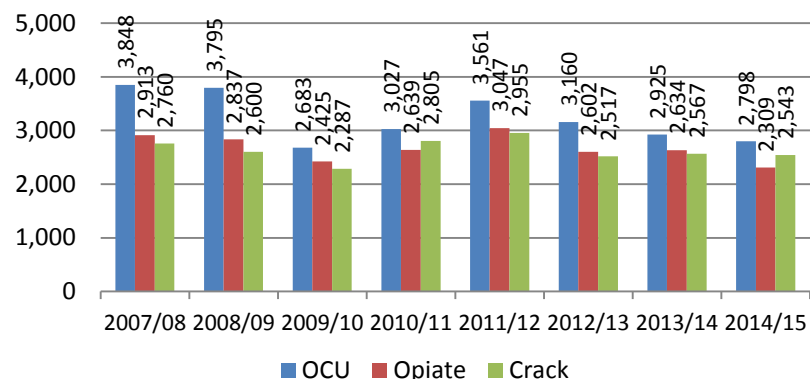
Local Authority	Total
Tower Hamlets	2,798
Hackney	2,553
Ealing	2,464
Newham	2,400
Lambeth	2,387

(Source: PHE Prevalence data, 2014/15, published 2017)

4.3 Prevalence estimates over time in in the London Borough of Tower Hamlets (LBTH) ⁷

The Tower Hamlets OCU and Opiate populations have decreased significantly between 2011/12 and 2014/15. OCU and Opiate estimates are the lowest for 5 years. However, the fall of Crack user numbers to around 2,550 is not statistically significant. The Table below shows trends between 2007/08 to 2014/15.

Chart: Prevalence over time in Tower Hamlets – total numbers



(Source: PHE Prevalence data, 2014/15, published 2017)

4.4 Prevalence estimates per 1,000 population

Prevalence rates for OCUs, Opiate and Crack in Tower Hamlets are significantly above London and England rates. The LBTH Crack using estimate is nearly twice as high as the National and London rate.

Table: Prevalence estimate per 1,000 population

	OCU	Opiate users	Crack users	15-64 population
Tower Hamlets	13.17	10.87	11.97	212,492
London	8.87	6.89	6.63	5,915,778
England	8.57	7.33	5.21	35,102,533

(Source: PHE Prevalence data, 2014/15, published 2017)

The Tower Hamlets prevalence rate was the second highest in London (2nd place shared with Westminster); only the Hackney rate with 13.4 per 1,000 populations was slightly higher.

When compared to the 32 PHE opiate comparator areas, the Tower Hamlets prevalence rate is the 13th out of 32 comparator areas. The highest was in Blackpool (20 out of 1,000) followed by Kingston upon Hull with 19 out of 1,000.

4.5 OCU prevalence by age

The total estimate of 15 to 24 year old OCUs in Tower Hamlets has not changed between 2011/12 and 2014/15. However, the total number of 25 to 34 years olds has decreased while OCUs aged above 35 years increased. This estimate is in line with the trend of an ageing opiate user population in the borough and in England and Wales.

⁷ New injecting estimates are currently not available.

Table: Tower Hamlets OCU prevalence by age (Rate per 1,000 population)

Age group	Total number	Rate per 1,000 population
15 to 24	410	9.8 per 1,000
25 to 34	852	10.2 per 1,000
35 to 64	1,536	17.7 per 1,000

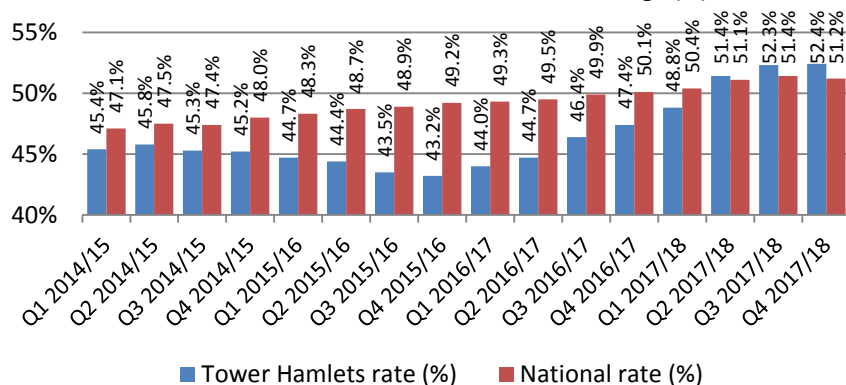
(Source: PHE Prevalence data, 2014/15, published 2017)

4.7 Unmet need - Opiate and / or crack users

This data show users dependent on opiates and/or crack cocaine and not in the treatment system. Since the revision of the prevalence rate, new data has been made available and the Tower Hamlets rate of unmet need for OCU clients was revised down to 45.2%, slightly below the national average (47.1%).

However, quarterly unmet need data is now published in the NDTMS DOMES report and the rate shows that falling numbers of opiate clients mean that the rate of unmet need has increased to 52.4% in Q4 2017/18, now slightly above the national average (51.4%). See chart below.

Chart: Unmet OCU need in Tower Hamlets & National average (%)



(Source: NDTMS DOMES report)

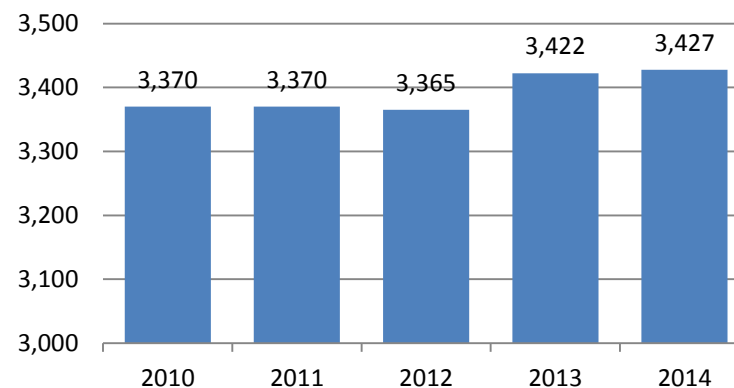
4.8 Estimating size of the alcohol dependent population in Tower Hamlets

Estimates are based on Adult Psychiatric Morbidity Survey (APMS) 2014 but are combined with local population structure and hospital admission rates data enabling the estimation. The estimates show a prevalence of people with alcohol dependence potentially in need of specialist assessment and treatment (Audit score 20plus).

Dependent drinkers in Tower Hamlets

The data estimates a total of 3,427 dependent drinkers in need of assessment and potential treatment in the borough. Based on this, around 82% of those drinkers are currently not in treatment and their needs might be unmet.⁸

Chart: Dependent drinkers over time 2010 to 2014



(Source: PHE / LAPE based on Health Survey for England 2011 to 2014)

⁸ PHE NDTMS Alcohol commissioning tool 2016/17. Around 609 alcohol users were in treatment in 2016/17.

Dependent drinkers in TH – lower and upper estimate

The nature of the estimate means that the true figure of dependent drinkers will be between the lower and upper estimate. See table below.

Table: Dependent drinker estimate (incl lower and upper) in 2014

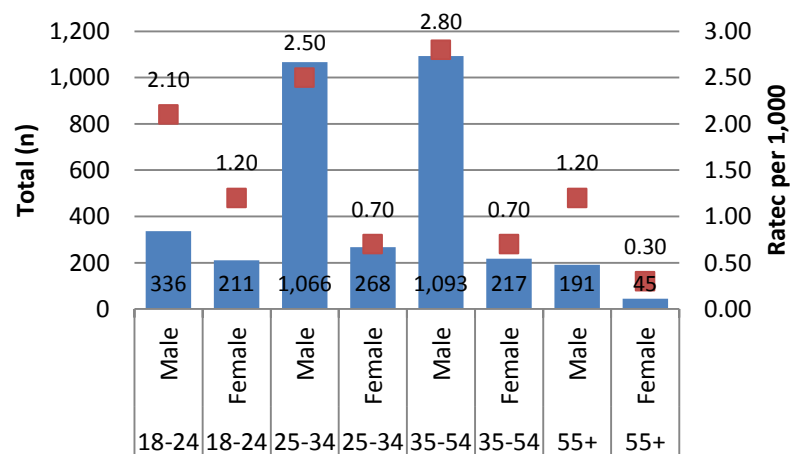
Lower estimate	Estimate - Dependent Population	Upper estimate
2,597	3,427	4,875

(Source: PHE / LAPE based on Health Survey for England 2011 to 2014, 95% CI)

Age and gender breakdown dependent drinkers in Tower Hamlets

Overall, 78% (2,687) of depended drinkers were male while around 22% (740) were female. Males in the age groups 35 to 54 and 25 to 34 had the highest estimated number and highest rate of dependency.

Table: Dependent drinkers in Tower Hamlets by age and gender (rate per 1,000 and total (n))



(Source: PHE / LAPE based on Health Survey for England 2011 to 2014)

Dependent drinkers in London

The data shows that Tower Hamlets had the 7th highest rate of dependent drinkers in London. The highest was in Islington (2 per 1,000) followed by Lambeth (1.84 per 1,000) and Hackney (1.83 per 1,000). In terms of total numbers, Lambeth had a highest number of dependent drinkers (4,701) followed by Hackney (3,716). See table below.

4.9 Alcohol consumption in the Tower Hamlets adult population

Alcohol consumption is a contributing factor to hospital admissions and deaths from a wide range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society as a whole £21 billion annually. Alcohol-related harm is determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly related to levels and patterns of consumption.

A large proportion of the adult population is not drinking any alcohol. The size of the group of abstainers is far larger compared to London or England and most other local authorities which is attributed to the cultural and religious makeup of the borough.

Table: Adult drinking and abstainer population (%)

	Tower Hamlets		London	England
	% total adult population	Lower CI (%)	Upper CI (%)	% total adult population
Abstainers	47.6	38.4	57.1	24.3
Drinking population	52.4	61.6	42.9	84.5

(Source: PHE / LAPE based on Health Survey for England 2011 to 2014, 95% CI)

In January 2016 the Chief Medical Officer (CMO) issued revised guidance on alcohol safe consumption limits.⁹ The new guideline advises that in order to keep to a low level of risk of alcohol-related harm males alongside female should drink no more than 14 units of alcohol a week.

The table below shows that around 1 in 5 adults in Tower Hamlets drink more than 14 units of alcohol a week. This proportion was below London and England rates. Around a third of adults in Tower Hamlets drink less than 14 units a week, only half of the England average. This is caused by the large abstainer population in Tower Hamlets.

Table: Adults reported to drink less and more than 14 units of alcohol each week (%)

	Tower Hamlets			London	England
	%	Lower CI	Upper CI	%	%
Less than 14 units a week	32.1	24.9	40.2	n/a	59.1
Over 14 units a weeks	20.4	13.8	29.0	21.6	25.7

(Source: PHE / LAPE based on Health Survey for England 2011 to 2014, 95% CI)

Drinking very large amounts of alcohol on a single occasion increases the likelihood of experiencing acute alcohol-related harms. The percentage of those aged 18plus who reported to drink more than 6 units of alcohol (women) or more than 8 units of alcohol (men) on their heaviest drinking day in the last week is used to quantify the binge drinking risk population.

The table below shows that the Tower Hamlets rate is below London and England rates.

⁹ <https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking>.

Table: Adults binge drinking on heaviest drinking day¹⁰ (%)

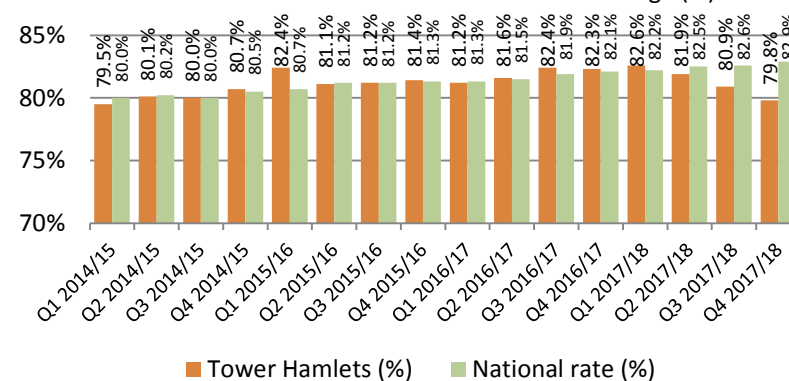
	Tower Hamlets			London	England
	% of total adult population	Lower CI	Upper CI	% of total adult population	% of total adult population
Binge drinking	11.8	7.1	18.9	13.2	16.5

(Source: PHE / LAPE based on Health Survey for England 2011 to 2014, CI 95%)

4.10 Unmet need – Alcohol users

Quarterly unmet need data is now published in the NDTMS DOMES report and the rate shows that after an increase in 2015/16, the rate stood in 2017/18 at nearly 80%, a rate now slightly below the national average of 82.9%. See chart below.

Chart: Unmet OCU need in Tower Hamlets & National average (%)



(Source: NDTMS DOMES reports)

¹⁰ Percentage of adults binge drinking on heaviest drinking day in the last week (women more than 6 units, men more than 8 units)

4.11 Predicting the future drug treatment population

Based on NDTMS treatment data, PHE published in 2017 “*Predicting the future drug treatment population to 2020*”¹¹ suggesting the following treatment trends on national level:

Opiate users

- Number of treatment naïve opiate users is to fall.
- Unplanned exit rate of opiate clients projected to rise.
- Opiate completions rate to continue to fall.
- Mortality rate of opiate users to increase.
- Based on assumption that no new incidence or external change will occur, opiate population in treatment will decline.
- By the end of 2020, 30% of opiate users in treatment will be aged 40 and over.
- By the end of 2020, 60% of opiate users in treatment will be using for more than 20 years.

Non-opiate users

- The non-opiate treatment population will remain stable, possibly slightly increase.
- The non-opiate population will have a slight ageing trend but not as acute as that seen for opiates.

While not all national trends are comparable to Tower Hamlets, the suggested trends are a reminder that our services need to adopt to be able to respond effectively to future challenges.

¹¹ Predicting the future drug treatment population
<http://www.emcdda.europa.eu/system/files/attachments/6151/2.%20M.%20White%20-%20Predicting%20the%20size%20and%20characteristics%20of%20the%20drug%20treatment%20population%20in%20England.pdf>

*Tower Hamlets Pupil attitude survey 2017*¹²

The Tower Hamlets Pupil attitude survey from 2017 asked secondary school children about their drug and alcohol use.

Around 6% of respondents had taken drugs in the past. When asked about their recent drug usage, it shows that solvents and cannabis were the most frequently used substances. When asked about their alcohol use, the majority of secondary school children (76%) said that they never had an alcoholic drink. Around 15% of pupils said that they have had alcohol, 6% did not want to say and a further 4% were unsure.

There were differences in reported alcohol use of secondary pupils by ethnic group. Bangladeshi pupils, at only 1%, were by far the least likely to have tried alcohol. White pupils were the most likely, with 48% reporting that they have had an alcoholic drink in the past.

Recommendations

- More local residents would profit from alcohol treatment. Achieving an increase of 10% would require additional 300 clients starting alcohol treatment a year. The Reset treatment short treatment episodes will play a crucial role in achieving this ambition.
- Utilise “Don’t bottle it up” Audit C online tool introduced in Summer 2018 as an opportunity to engage new clients to treatment, especially treatment naïve clients including young professionals and students
- Reduce proportion of unmet need of opiate and/or crack users in treatment. Treatment offer will need to cater for ageing client cohort and clients with long history of substance misuse

¹² Source: Pupil Attitude Survey 2017 Tower Hamlets

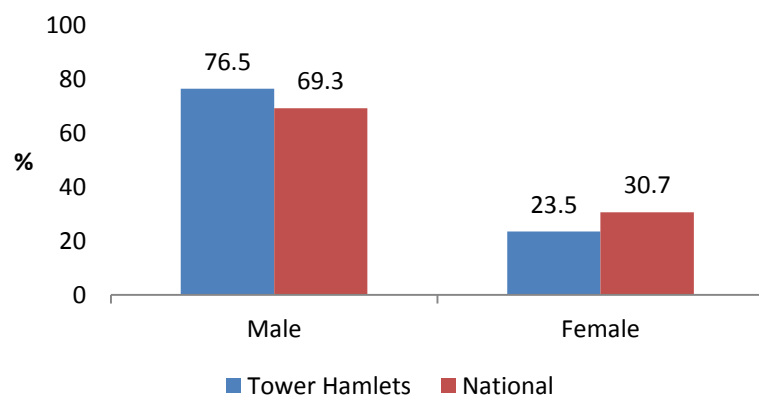
5 Local treatment population in Tower Hamlets

The treatment profile data is taken from various NDTMS reports including the Adult Activity Partnership Report 2017/18 and the Diagnostic and Outcomes Monitoring Executive Summary (DOMES) 2017/18.¹³

5.1 Gender – All in treatment

In 2017/18, out of 2,069 adults in drug and alcohol treatment, around 23.5 per cent (486) were female clients and 1,583 (76.5%) were male clients. Based on this data, the female population remains under-represented in treatment when compared to the National average of 30.7 per cent. However, the partnership has attracted more women into treatment as numbers increased from 444 to 486, a 9.5% increase. Still, the challenge remains to attract more female drug and alcohol users into treatment.

Chart: Gender split – Clients in treatment 2017/18 in Tower Hamlets & National average (%)

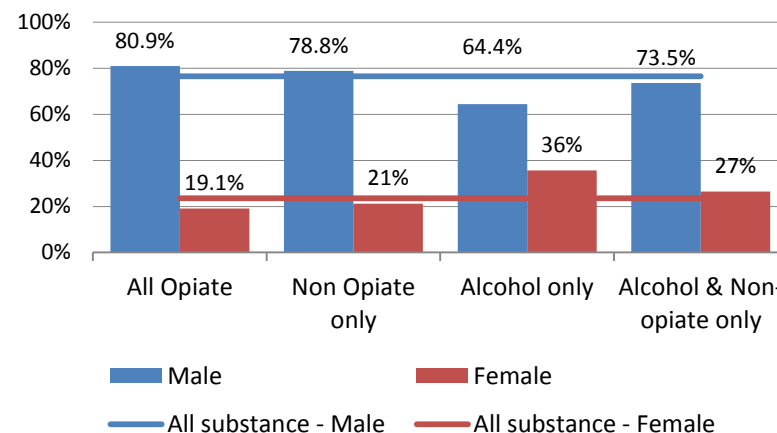


(Source: NDTMS Q4 Adult Activity 2017/18)

¹³ Data is aggregated up from partnership figures uploaded to NDTMS and therefore may differ from figures used elsewhere in this report.

Client data broken down by substance reveals some gender differences. While already noticeable in the OCU and alcohol prevalence data, treatment data shows that women are more likely to be in alcohol only treatment and the proportion of females in opiate treatment is much smaller. See chart below.

Chart: Clients in treatment by gender and substance group



(Source: NDTMS Adult Activity Q4 2017/18)

Treatment engagement of complex female clients was raised in workshops with service users and staff. Going forward, targeted developments are necessary to engage more women, including in-reach to new Riverside women's hostel. Treatment providers must ensure that services are safe, suitable environments for women including the new location in Johnson St (Stepney).

Care-coordinators also have the responsibility to reduce barriers for women including the fear of social service involvement where children are living with clients.

5.2 Age - All in treatment

The age structure of adults in treatment closely correlates to the treatment offer and need in the community.

The largest group of clients by age were those aged 30 to 44; they represent nearly 50% of all clients in treatment during 2017/18. The size of this group was the same when compared to the England average (49.2%). This supports the picture of an ageing client cohort. Importantly, the physical age of is client cohort is actual high than the actual age, increasing the risk of other health complications in the future.

The cohort of young adults in treatment increased between 2016/17 and 2017/18 to 6.2%. This is above the England average but remains a local priority. In recent years, young adults were accessing non-opiates treatment targeted at offenders and the LGBT community. However, this focus has recently shifted and will be re-established going forward with closer working links to the Ambrose King Sexual health clinic.

Table: Age profile – treatment population in 2017/18

Age group	Tower Hamlets	Tower Hamlets	England	Tower Hamlets
	All in Treatment - Total	All in treatment (%)	All in treatment (%)	Census population 18 plus (%)
18 – 24	130	6.2%	5.8%	19%
25 – 29	186	9.0%	9.1%	20%
30 – 34	307	14.8%	14.0%	17%
35 – 39	379	18.3%	18.4%	11%
40 – 44	334	16.1%	16.8%	8%
45 – 49	306	14.8%	14.8%	6%
50 – 54	208	10.1%	10.4%	5%
55 – 59	124	6.0%	5.8%	4%
60 – 64	60	2.9%	2.8%	3%
65 plus	35	1.7%	2.1%	8%

(Source: NDTMS Q4 Adult Activity 2017/18 / ONS Census 2011)

Client age and substance shows some interesting differences. Data below indicates that alcohol only clients come from all age groups and peaks are less pronounced.

However, the majority of all opiate clients are in the age group 30 to 49 years with around 73.6%.

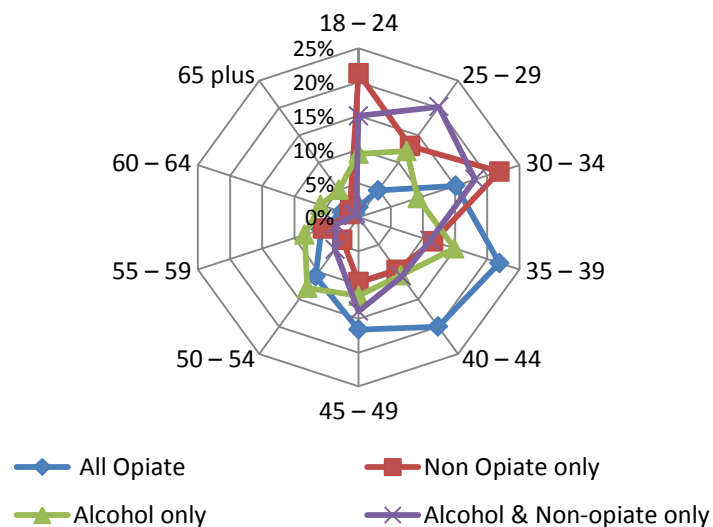
More than half of non-opiate only clients are aged 18 to 34 (56.2%) while 18 to 24 years olds made up 21.3% of non-opiate clients only. See table below.

Table: Clients in treatment by age and substance used (%)

	All Opiate	Non Opiate only	Alcohol only	Alcohol & Non-opiate only	All clients
18 – 24	1.5%	21.3%	9.4%	15.0%	6.2%
25 – 29	4.9%	13.0%	12.1%	20.2%	9.0%
30 – 34	15.1%	21.9%	9.2%	18.1%	14.8%
35 – 39	21.9%	11.6%	14.9%	11.1%	18.3%
40 – 44	20.0%	9.6%	10.6%	10.8%	16.1%
45 – 49	16.6%	9.6%	11.6%	13.9%	14.8%
50 – 54	10.8%	4.1%	12.9%	5.9%	10.1%
55 – 59	5.8%	5.5%	8.4%	3.5%	6.0%
60 – 64	2.6%	1.4%	5.9%	0.7%	2.9%
65 plus	0.8%	2.1%	5.0%	0.7%	1.7%

(Source: NDTMS Q4 Adult Activity 2017/18)

Chart: Treatment population by age and main substance



(Source: NDTMS Q4 Adult Activity 2017/18)

Ageing opiate users – Aged 35 and older

Data indicates that the opiate treatment population is ageing as the proportion of clients aged 35 and older has increased from 69% in 2015/16 to 78.5% in 2017/18. The national trend of an ageing population is also prevalent in Tower Hamlets. Remarkably, less than 20 clients aged 18 to 24 were in treatment in 2017/18.

Table: Opiate user aged 35 plus out of all opiate clients in Tower Hamlets (%)

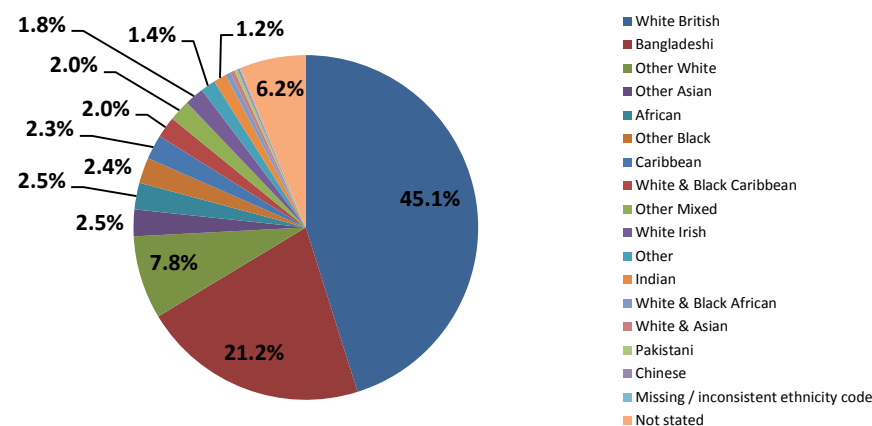
	2015/16	2016/17	2017/18
Opiate clients 35 plus	69.3%	74%	78.5%

(Source: NDTMS Q4 Adult Activity reports)

5.3 Ethnicity - All in treatment

The majority of clients in treatment were White British with 45.1%. This proportion is bigger than the White British 18plus population (35.7%) as estimated in the last Census 2011. In comparison, the 21.1% of Bangladeshi in the treatment population was slightly smaller than the Bangladeshi 18 plus population in Tower Hamlets (25%). Around 7.8% of clients in treatment were of White Other origin, an under-representation compared to the general 18plus population of 15%.¹⁴

Chart: Treatment population by ethnicity



(Source: NDTMS Q4 Adult Activity 2017/18)

Some differences emerge when analysing ethnic group and substance. Data indicates that White British clients were the largest group of all alcohol only clients (51.7%), followed by Other White (8.4%) and Bangladeshi (5.9%) clients. This can be explained by different abstinences rates in different communities.

A different picture emerged for opiate and especially for opiate only clients. In the opiate only group, the Bangladeshi group was

¹⁴ GLA LA Population estimate by ethnicity and Age 2016

substantially over represented with 47% of all clients. See table below.

Table: Ethnicity and substance use of clients

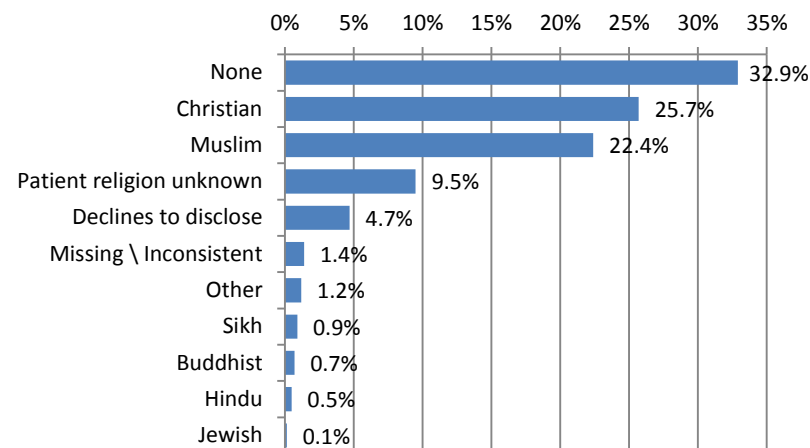
	Opiate only	All Opiate	Non Opiate only	Alcohol only	Alcohol & Non-opiate only	All clients
White British	25.0%	43.1%	34.9%	51.7%	49.5%	45.1%
White Irish	*	1.9%	*	2.0%	*	1.8%
Other White	11.5%	7.8%	7.5%	8.4%	7.3%	7.8%
White & Black Caribbean	*	1.9%	4.1%	1.5%	2.4%	2.0%
White & Black African	*	*	*	*	*	0.5%
White & Asian	*	0.5%	*	*	*	0.4%
Other Mixed	*	1.4%	*	3.2%	2.4%	2.0%
Indian	*	0.9%	*	2.0%	*	1.2%
Pakistani	*	*	*	*	*	0.3%
Bangladeshi	46.8%	27.9%	22.6%	5.9%	12.9%	21.2%
Other Asian	5.8%	2.4%	4.8%	2.7%	*	2.5%
Caribbean	*	2.0%	*	3.0%	2.1%	2.3%
African	*	1.3%	4.1%	5.4%	2.4%	2.5%
Other Black	*	1.4%	4.8%	3.7%	3.8%	2.4%
Chinese	*	*	*	*	*	*
Other	*	1.0%	*	2.5%	2.8%	1.4%
Not stated	3.2%	5.8%	7.5%	6.4%	7.0%	6.2%

(Source: NDTMS Q4 Adult Activity 2017/18, * data suppressed, less than 5 clients, missing code excluded from table)

5.4 Religion

NDTMS started recording the religion and faith of local service users from April 2016. The data shows that around one third of new clients had no religion (32.9%), followed by Christian (25.7%) and Muslims (22.4%) clients.

Chart: New treatment starts by religion



(Source: NDTMS Q4 Adult Activity 2017/18)

5.5 Sexuality

The recent Tower Hamlets GP practice survey in 2016 indicates that 82% of patients registered in Tower Hamlets were heterosexual, 6% were gay or lesbian and 2% were bisexual.

Compared to this data, the Tower Hamlets treatment population has a fair representation of gay / lesbian and bisexual clients in treatment (around 5%). However, further targeted intervention with the LGBT community should impact positively on the numbers because this group, especially MSM have a high rate prevalence of substance misuse.¹⁵ See table below.

¹⁵ See research about substance misuse in LGBT community

<http://lgbt.foundation/policy-research/part-of-the-picture>

http://www.scottishtrans.org/trans_mh_study/

Sex & drugs & EDM: the use and distribution of drugs within a London Chemsex scene Christine Schierano & Gary R. Potter

Table: Clients in treatment by sexuality

Sexuality	Tower Hamlets	England
	All in treatment %	All in treatment (%)
Heterosexual	91.3%	87%
Gay / Lesbian	3.9%	2.3%
Bi-Sexual	1.2%	1.5%
Other / Not stated / Missing	3.6%	9.2%

(Source: NDTMS Q4 Adult Activity 2017/18)

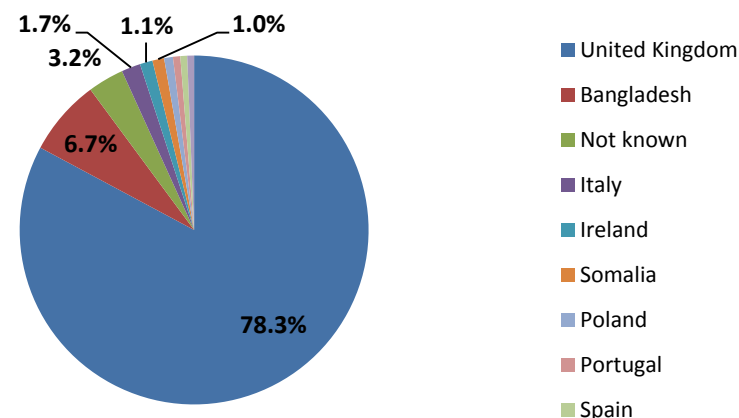
Interestingly, current treatment data shows a high proportion of LGBT clients in the non-opiate (14%) and alcohol & non opiate (7.6%) treatment cohort. Numbers were very low for opiate & others clients and opiate only clients. This data indicates links to existing needs in the LGBT community including Chemsex.

Moving forward, the partnership and treatment providers need to Re-establish the effective Chemsex pathway between Reset treatment and Ambrose King Sexual Health clinic.

5.6 Country of origin

The majority of clients in treatment in Tower Hamlets were UK nationals. The nationality status was recorded in the earliest episode of the client's latest journey. The second largest country of origin was Bangladeshi (6.7% or 156 clients), Italy (1.7%), Ireland (1.1%) and Somalia (1%).

Chart: Treatment population by nationality



(Source: NDTMS Country of origin report, 2015/16)

5.7 Focus on Somali treatment population ¹⁶

Over the last years, the number of Somali clients in treatment has remained low (around 1% of all in treatment). Before Reset started in Oct 2016, a project targeting the Somali community, had only limited success encouraging clients into the main stream treatment service.

This challenge remains as Khat is still prevalent in the community. However, the quality of Khat has decreased and is now mainly available in dry form. Service users confirmed that some Chat houses remain in the area but the price for Chat has increased. There is also evidence that some former Khat users move on to other drugs and alcohol.

The workshops with Somali service users and the Somali community in Jan 2018 revealed that attendees had some awareness of the

<http://dissem.in/p/85139555/sex-and-drugs-and-edmthe-use-and-distribution-of-drugs-within-a-london-chemsex-scene>

¹⁶ Workshop with Somali service users held on the 16th Jan 2018 and Somali community 18th Jan 2018 at Mind in Tower Hamlets in Bow.

Reset treatment service. However, language issues, stigma and social isolation continue to create barrier to access treatment.

Mental health needs in the community remain closely linked to substance misuse. The workshop revealed some evidence for self-medication with mainly alcohol.

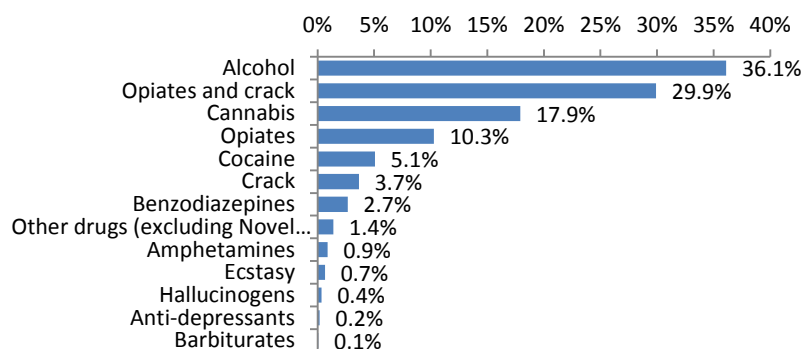
Moving forward, the local Somali community will remain a key focus of the Outreach and Referral service targeting specifically the Bow / Bromley by Bow area to engage clients in existing community hubs.

It will be worthwhile to explore if outreach teams could target GP practices with a sizable Somali patient cohort. Outreach teams should also work closer with the Community Alcohol Partnership.

5.8 Substances cited of all in treatment

The data takes into account that many clients are poly drug users and use alcohol in addition to other drugs. More than one third of clients stated that they used alcohol in the 28 days before treatment started. Nearly 30% of all clients cited opiates and crack while nearly 18% used cannabis.

Chart: Substances cited - All clients in treatment (%)



(Source: NDTMS Adult Activity 2017/18)

Please note that as a client may cite more than one substance in their treatment journey (as a primary, secondary or tertiary problematic substance), the figures may sum to more than the total number of clients in treatment. Alcohol figures are based on records where it was cited as a secondary or tertiary substance only, primary alcohol records have been excluded from this data set.

5.8.1 Novel Psychoactive Substances - NPS¹⁷

In the United Kingdom, use of synthetic cannabinoids among prisoners is of particular concern. A survey conducted in 2016 in the United Kingdom’s prisons found 33% of the 625 inmates reported the use of ‘Spice’ within the last month (this compares to 14 % of last month cannabis use).¹⁸

A previous study conducted in 2015 by the HM Inspectorate Prisons interviewed 1,376 prisoners in eight prisons and found that 10% were using ‘Spice’ in their respective prison.¹⁹

It is also know that some local areas have experience serious health crisis related to NPS and spice.²⁰

Locally, capturing NPS use or spice in the local treatment population has been a challenge. Over the last few years, numbers have been very low, 5 in 2016/17 and only 1 in 2017/18.

¹⁷ Source: Adult Activity report 2015/16 Tower Hamlets Partnership

¹⁸ User Voice (2016), Spice: the bird killer. What prisoners think about the use of spice and other legal highs in prison? Available at:

<http://www.uservoice.org/news/user-voice-news-blog/2016/05/nhs-report-by-user-voice-hears-directly-from-inmates-the-true-horrors-of-nps-use-in-prisons/>

¹⁹ HM Inspectorate of Prisons (2015) Changing patterns of substance misuse in adult prisons and service responses. A thematic review by HM Inspectorate of Prisons, December 2015. Available at:

<https://www.justiceinspectors.gov.uk/hmiprison/wp-content/uploads/sites/4/2015/12/Substance-misuse-web-2015.pdf>.

²⁰ <http://www.emcdda.europa.eu/topics/pods/synthetic-cannabinoids>

Unfortunately, the recording of substances used by clients is not able to capture NPS very well, especially if a client also cites opiates, non-opiates and alcohol.

Discussion with key workers brought to light some anecdotal evidence that NPS and spice have been used by some local homeless people. A low number of incidents related to spice and NPS were reported by hostel providers. However, it is not seen as a major problem. One reason for that is the availability of affordable and good quality opiates.

5.8.2 Fentanyl²¹

Fentanyl has recently emerged into the UK heroin street market in the North East of England. It is likely a contributory factor in recent multiple heroin-associated deaths.

Fentanyl is a powerful synthetic opioid analgesic, originally created for surgery recovery and treatment of short term pain. It is similar to morphine, but is 50 to 100 times more potent. Although fentanyl is abused as a substance in its own right, it is more commonly detected as an additive in heroin.

In Tower Hamlets, this question has been discussed with service users and knowledge of Fentanyl has been very low, with limited evidence of its existence in the borough. However, some service users have been aware of incidents reported in the media and the high risks related to the drug.

5.9 Injecting Behaviour and Blood Borne viruses

5.9.1 Injecting behaviour

²¹ National Crime Agency (2017): Recent Deaths possibly linked to Fentanyl. Available at: <http://www.nationalcrimeagency.gov.uk/publications/795-recent-deaths-possibly-linked-to-fentanyl/file>

The level of needle and syringe sharing among people injecting drugs (PWID) has fallen across the UK, but needle and syringe sharing remains a problem, with over 1 in 6 reporting sharing of needles and syringes in the past month.²²

Sharing of injecting equipment is the single biggest factor in blood-borne virus transmission among individuals who use and inject drugs. It also elevates mortality risk and those who inject have a more complex profile, and are therefore harder to treat.

The estimate of **773 injectors** in 2011/12 is now largely outdated but remains the only available estimate for service demand. This figure translates into a prevalence rate of 4 injectors for every 1,000 local residents which was twice the England or London rates.

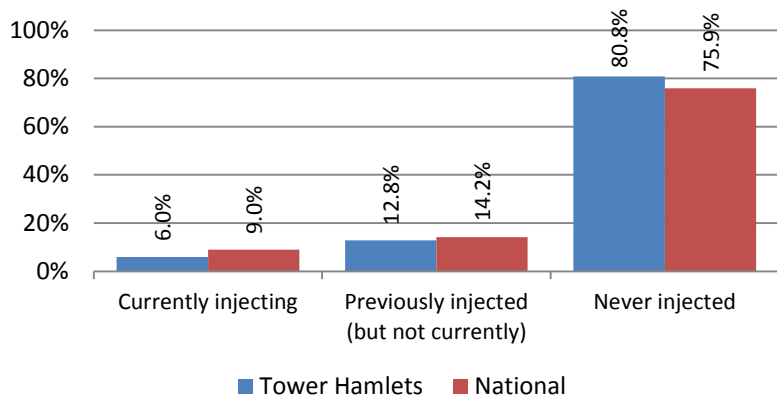
It is estimated that around 10% of the injecting population (total of 77 injectors in Tower Hamlets) are admitted to hospital each year for bacterial infections.²³

The treatment system is currently engaging a sizeable number of injectors or former injectors. Out of those 1,069 clients starting treatment in 2017/18, around 19% (195 clients) were injecting or had previously injected. The size of the injector group was slightly below the national treatment population average of 23%.

²² PHE Shooting up 2017 report
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/663003/Shooting_Up_2017_report.pdf

²³ DOH, Drug misuse and dependence UK guidelines on clinical management; Prepared by Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf, accessed 22-03-18

Chart: Injectors in treatment in Tower Hamlets and England 2017/18



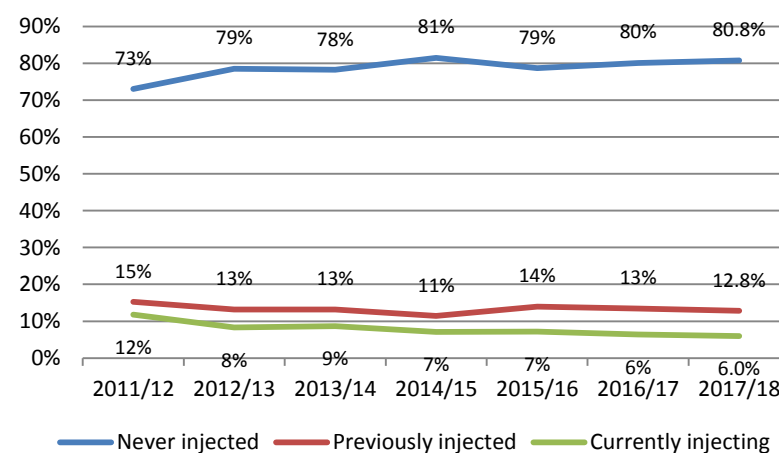
(Source: NDTMS Adult Activity Q4 2017/18)

Out of those 195 clients, 62 (32 per cent) were currently injecting and 133 (68 per cent) were previously injecting drugs. Overall the number of current or past injectors has fluctuated between 257 in 2013/14, 189 in 2016.17 and 195 in 2017/18.

Opiate clients are most likely to be injector and previously injectors. However there are small numbers of non-opiate and non-opiate & alcohol clients being injectors and previously injectors.

Over the last 9 years, the proportion of new clients injecting has halved between 2011/12 and 2017/18. The proportion of previous injectors in treatment has also fallen by 3 percentage points.

Chart: Proportion of clients starting treatment by injecting status (%)



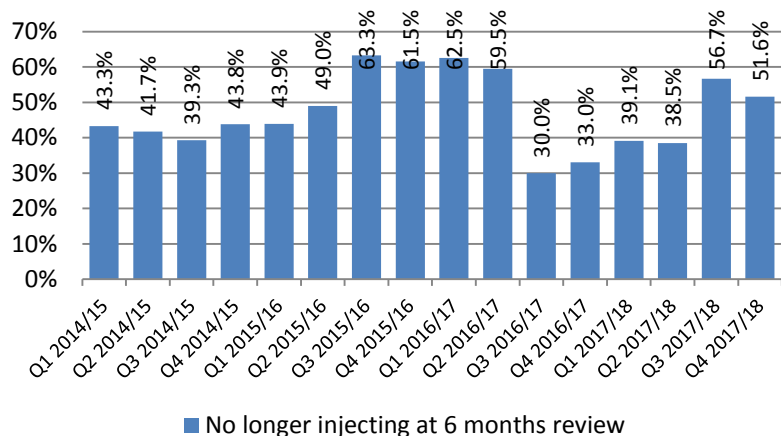
(Source: NDTMS Adult Activity Q4 2017/18)

Reducing injecting behaviour

Treatment outcomes for injectors at review stage dropped after Q2 2016/17, a trend most likely linked to the change in the Tower Hamlets treatment system.

In Q4 2017/18, more than 50% of injectors stopped injecting at six month review. This rate remains within the expected rate as suggested by PHE. However, the rate remains below strong performance in 2015/16. See chart below.

Chart: Proportion of injectors stopping injecting at TOP review stage Tower Hamlets (%)



(Source: NDTMS DOMES – Stopped injecting Tower Hamlets, Q4 2017/18)

5.9.2 Blood Borne Viruses (BBV)

Drug users who share injecting equipment can spread blood-borne viruses. Providing opioid substitution therapy (OST) and sterile injecting equipment and antiviral treatments protects them and communities, and provides long-term health savings.

This section summarises data about clients in treatment who have had a Hepatitis B vaccination and current or past injectors who have been tested for Hepatitis C.

5.9.2.1 Hepatitis C

Hepatitis C is an important health protection issue that increases people’s risk of developing serious long term disease. About a third of people infected with Hepatitis C virus will eventually develop liver cirrhosis, where normal liver tissue is replaced by scar tissue, accompanied with an increased risk of developing liver cancer.

Hepatitis C prevalence remains high in the UK (2 out of 5 PWID²⁴ are living with Hep C) and half of those infected are undiagnosed. Hepatitis C remains the most common blood-borne infection among people who inject drugs (PWID). There are significant levels of transmission among this group in the UK.²⁵

Hepatitis C in Tower Hamlets

Research indicates that around 50% of those ever injecting drugs have been infected with hepatitis C.²⁶ Based on this estimate; we expect that around 390 people in Tower Hamlets live with an active Hep C infection.

According to Tower Hamlets treatment data, in 2017/18, a total of 140 clients had a positive HEP C antibody test. 30 of those clients were referred to HEP C treatment (21.4%) (Source: DOMES 2017/18)

Overall, Tower Hamlets is performing better compared to the national average in providing HCV tests for clients in treatment. More than 90% of all eligible clients had the test while more than 85% of all new presenting clients had the test. See chart below.

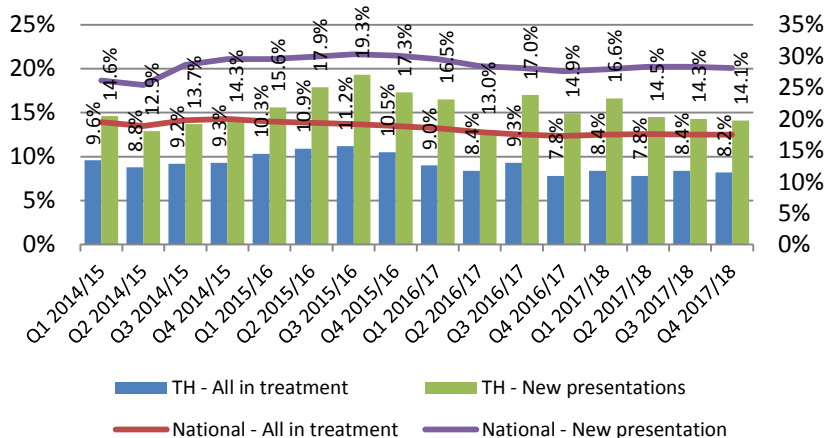
²⁴ People who inject drugs

²⁵ PHE Shooting up 2017 report

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/663003/Shooting_Up_2017_report.pdf

²⁶ PHE Shooting up 2017 report

Chart: Clients with no record of a HCV test as a proportion of all eligible clients in treatment (%)



(Source: NDTMS DOMES report)

5.9.2.2 Hepatitis B

Hepatitis B remains rare, but vaccine uptake needs to be sustained, particularly in younger age groups. In the UK, around 1 in every 200 PWID is living with hepatitis B infection. About three - quarters of PWID report taking up the vaccine against hepatitis B, but this level is no longer increasing, and is particularly low in younger age groups and among those who recently began injecting.²⁷

Hepatitis B in Tower Hamlets

Research indicates that around 14% or 108 persons of the injecting population (773) had a Hep B infection or has a current Hep B infection.²⁸

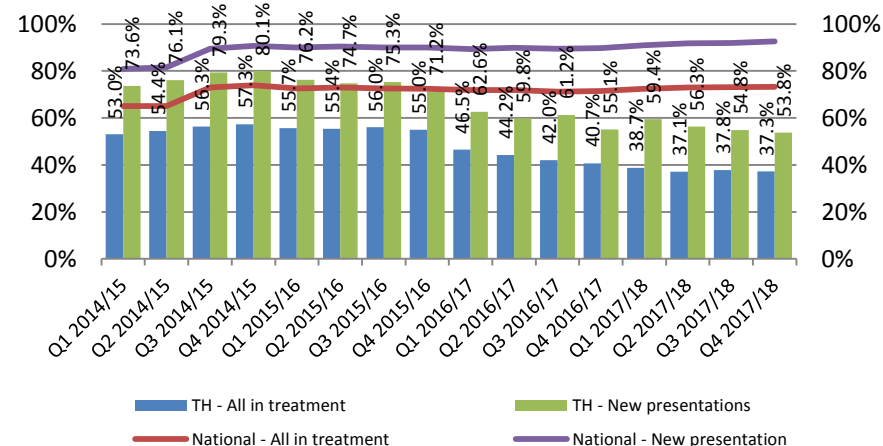
²⁷ PHE Shooting up 2017 report

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/63003/Shooting_Up_2017_report.pdf

²⁸ DOH, Drug misuse and dependence UK guidelines on clinical management; Prepared by Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group

In Tower Hamlets, the number of clients in treatment without completing HBV vaccination has decreased over the last three years. See chart below.

Chart: Clients with no record of completing a course of HBV vaccinations as a proportion of eligible clients in treatment (%)



(Source: NDTMS DOMES report)

5.9.2.3 HIV

HIV levels in the national treatment population remain low, but risks exist as around 1 in 100 PWID is living with HIV.

Most clients have been diagnosed and will be accessing HIV care.

However, HIV is often diagnosed at a late stage among PWID.²⁹

Based on the national data, it is estimated that around 8 PWIDs live with HIV in Tower Hamlets.

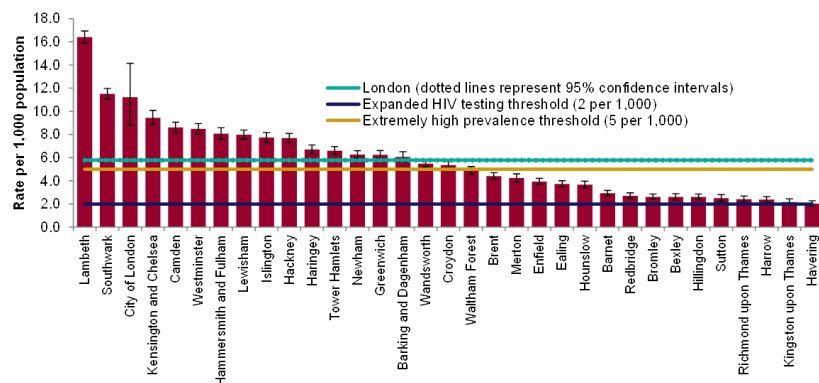
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf, accessed 22-03-18

²⁹ PHE Shooting up 2017 report

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/63003/Shooting_Up_2017_report.pdf

Overall, HIV diagnosis in the Tower Hamlets population is just above London average but the 12th highest in London. See chart below.

Chart: Diagnosed HIV prevalence per 1,000 residents aged 15-59 years by local authority, London, 2016



(Source: Annual Epidemiological Spotlight on HIV in London: 2016 data)

The same data suggests that that around 48 HIV diagnoses per 100,000 population aged 15 years or older occurred in Tower Hamlets in 2016.³⁰

Limited local data exists but local EMIS records of the Reset Treatment cohort showed that in 2017/18, 10 clients were diagnosed with HIV.

Summary

Provision of effective interventions needs to be maintained and optimised. The provision of effective interventions to reduce risk and prevent and treat infections needs to be maintained. These

³⁰ Spotlight on HIV

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672671/HIV_Spotlight_London_slideset.pdf

interventions include needle and syringe programmes, opioid substitution treatment and other treatments for drug misuse and dependence.

Vaccinations and diagnostic tests for infections need to be routinely and regularly offered to people who inject or have previously injected drugs. Care pathways and treatments should be optimised for those testing positive.³¹

5.10 Complexity in the treatment population

Data discussed in this section is taken from the latest NDTMS Recovery Diagnostic Toolkit (March 2018). All complexity information presented relates to all Opiate, non-opiate and non-opiate & alcohol clients in treatment over a 12 month time period.

Complexity levels

Clients usually present to treatment with various needs in addition to substance misuse. They are grouped into levels of complexity based on needs, including their employment and housing status, their physical and psychological health, all of which will significantly affect their chances of successfully completing treatment.

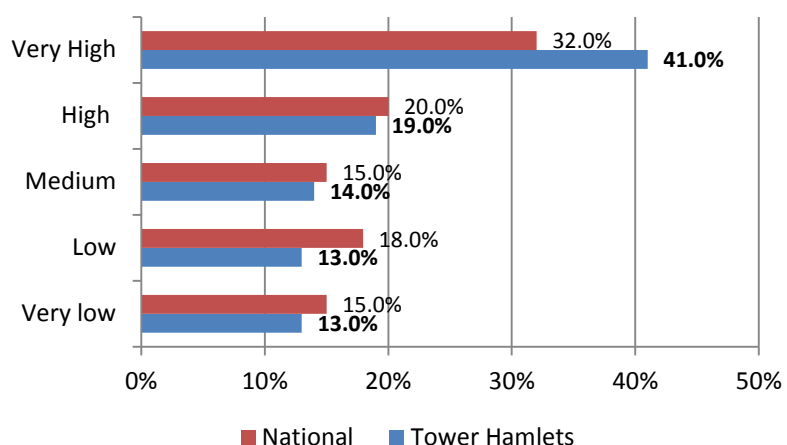
Historically, complexity levels of the Tower Hamlets treatment population have been very high. Most recent data shows that complexity levels remain high, with around 41% of clients in treatment classified with very high complexity levels compared to a national average of 32%.

At the other end of the complexity spectrum, Tower Hamlets has a lower proportion of clients with Very low (13%), Low (13%) and Medium (14%) complex needs. See Chart below.

³¹ PHE Shooting up 2017 report

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/63003/Shooting_Up_2017_report.pdf

Chart: Distribution of treatment population by complexity level



(Source: NDTMS Recovery Diagnostic Toolkit, March 2018)

Complexity levels have not changed much between 2014/15 and 2017/18. However, compared to 2013/14, complexity levels decreased for two years but are on the rise again. It remains to be seen if the trend will continue over the next few years. See table below.

Table: Complexity level in treatment population in Tower Hamlets (%)

Complexity levels	13/14	14/15	15/16	16/17	17/18
Very low	10%	11.8%	13.4%	13%	13%
Low	12.6%	14.7%	14.5%	15%	13%
Medium	11.4%	11.9%	12.9%	12%	14%
High	20.5%	22.5%	21.2%	22%	19%
Very High	45.5%	39.1%	37.9%	39%	41%

(Source: NDTMS Recovery Diagnostic Toolkit, March 2018)

In general, complexity levels will impact on the successful treatment outcomes. For example, completion rates decrease with growing

levels of complexity. In Tower Hamlets, clients with a very high complexity have a completion rate of 3 per cent and clients with high or medium levels of complexity achieve completion rates of 9 to 12 per cent respectively.

However, clients with very low complexities have more recovery capital achieving far higher rates of successful completions in Tower Hamlets (50 per cent) compared to England (43 per cent).

Interestingly, about three years ago, the partnership was not achieving the desired completion rates for the lower complexity groups. This trend has been reversed and the partnership is performing far better than the National average. This trend will need to be sustained in the future. The short treatment episodes and recovery interventions in the Reset treatment system will play a crucial role to achieve that.

Table: Treatment population by client complexity group 2017/18 (total & %)

	Very low	Low	Medium	High	Very high
Tower Hamlets clients (n)	220	209	238	315	685
Tower Hamlets completions (n)	111	54	29	29	21
% completions - All in treatment (TH)	50%	26%	12%	9%	3%
% completions - All in treatment (National)	43%	21%	14%	7%	3%

(Source: NDTMS Recovery Diagnostic Toolkit, March 2018)

5.11 Opiate clients in treatment

Around 40% of the opiate clients in Tower Hamlets have been in treatment for less than 1 year while 21% have been in treatment for

more than 1 year but less than 3 years. Another 38% of clients have been in treatment for more than 3 years. See table below.

Table: Opiate clients - Length of time in treatment in Tower Hamlets

2017-18	< 1 years	1-2 years	2-3 years	3-4 years	4-5 years	5-6 years	6 + years
Number in treatment	514	169	90	71	64	58	266
% in treatment	42%	14%	7%	6%	5%	5%	22%

(Source: NDTMS Recovery Diagnostic Toolkit, March 2018)

Only around 20% of clients had no previous treatment journey while 80% have been in treatment before. More than 40% of opiate clients have been in treatment for 4 or more times.

Table: Previous treatment journeys of Tower Hamlets opiate clients

2017-18	None	1	2	3	4 or more
Number in treatment	235	182	170	132	513
% in treatment	19%	15%	14%	11%	42%

(Source: NDTMS Recovery Diagnostic Toolkit, March 2018)

Nearly 50% of opiate clients in treatment have been using drugs for more than 21 years. Only very small proportion started using in the last three years (2% of all opiates clients in treatment). The table below shows that clients have been using drugs for considerable number of years.

Table: Opiate using clients career length in Tower Hamlets (n/%)

2017-18	0-3 years	3-6 years	6-9 years	9-12 years	12-15 years	15-18 years	18-21 years	21 + years
Number in treatment	26	36	51	74	108	140	201	587
% in treatment	2%	3%	4%	6%	9%	11%	16%	48%

(Source: NDTMS Recovery Diagnostic Toolkit, March 2018)

Recommendations

- Ensure that the treatment system continues responding to complex and diverse treatment population
- Support women accessing treatment, improve suitable treatment spaces and improve treatment outcomes for female opiate users
- Targeted developments are necessary to engage more women, including in reach to Riverside women’s hostel
- Ensure that services are safe, suitable environments for women including the new location in Johnson Street (Stepney)
- Reduce barriers including the fear of social service involvement where children are living with clients
- Establish closer partnership working between Reset Treatment and Ambrose King Sexual Health clinic
- DAAT to work closer with CCG and develop better understanding of ageing client cohort and related co-morbidities
- Develop better intelligence about health issues of clients in drug and alcohol treatment
- Outreach team started to engage with local traveller community in Bow and identified needs around alcohol. This project should be developed further to encourage engagement with Reset Treatment
- The Somali community will remain a key focus of the Outreach and Referral service targeting the Bow / Bromley by Bow area to engage clients in existing community hubs. Explore if outreach teams could target GP practices with a sizable Somali patient cohort.
- Outreach team to engage with Community Alcohol Partnership and explore joint working with local communities
- Maintain level of BBV interventions in the borough

6 Treatment system

6.1 Treatment entry

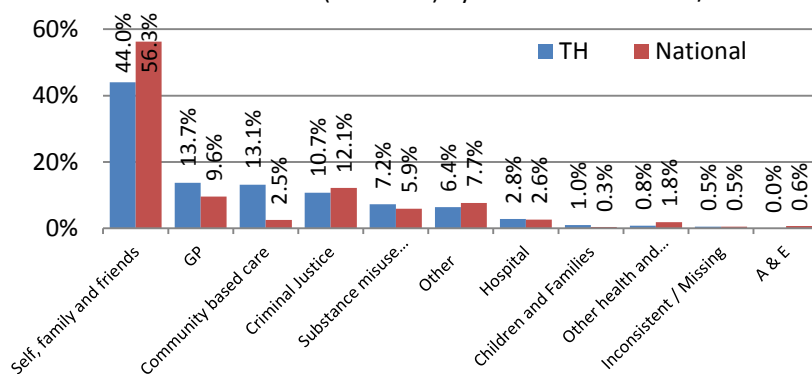
Referral routes

In 2017/18, the majority of 1,048 new treatment starts originated from self-referrals including referrals from friends or family (44%). This route was followed by referrals from GPs (13.7%); Community based care (13.1%), Criminal Justice (10.7%) and other substance misuse services. Compared to the national average, criminal justice and self-referrals were slightly less pronounced.

Referrals from the criminal justice system account for only 10.7% of all referrals including prison exits and DIP / Arrest referrals. This represents all fall compared to the years before. Referrals from GPs account for 13.7% of all referrals, which was above the national average (9.6%).

While self-referrals are critical to treatment completions and positive outcomes, it remains unclear if the lower proportion of self-referral in Tower Hamlets means that treatment outcomes might suffer.

Chart: Referrals into treatment (all clients) by referral source 2017/18



(Source: NDTMS Treatment Adult Activity reports 2017/18)

Waiting times – 3 weeks and under

Public Health England requires treatment services to start an intervention within 3 weeks of a client presenting to the service. The Reset treatment service has achieved that in 2017/18. All treatment intervention started within 3 weeks or less.³²

Treatment entry by substance

There were some notable differences in the referral routes. Self-referrals were most likely for non-opiate clients (49%) while the rate for alcohol clients was much lower with 39%.

However, GPs and Community based organisation appear to be more effective in referring clients to alcohol only clients. Also, a much larger cohort of opiate clients originated from the criminal Justice system when compared to other substances.

Table: Referral routes by substance in Tower Hamlets 2017/18

	All Opiate	Non-Opiate only	Alcohol Only	Alcohol & non-opiate only
Self, family and friends	45.8%	49.1%	39.5%	43.9%
Criminal Justice	16.9%	14.9%	5.3%	10.1%
GP	14.8%	7%	15.5%	12.6%
Community based care	12%	9.6%	16.1%	12.6%
Children and Families	0%	*	0%	*

³² (Source: NDTMS Reset Treatment Adult Activity report Q4 2017/18)

Hospital / A& E	*	*	6.3%	*
Substance misuse services	8.6%	7.9%	3.9%	8.6%
Other	*	*	10.9%	7.1%
TOTAL	432	114	304	175

(Source: NDTMS Adult Activity reports 2017/18, * data suppressed)

Referrals between Reset Treatment and Recovery Support service

Clients attending treatment in Reset are encouraged to take up Recovery support interventions provided by Recovery Support. While around half of the total treatment client cohort should attend Recovery Support, numbers are currently below that ambition.

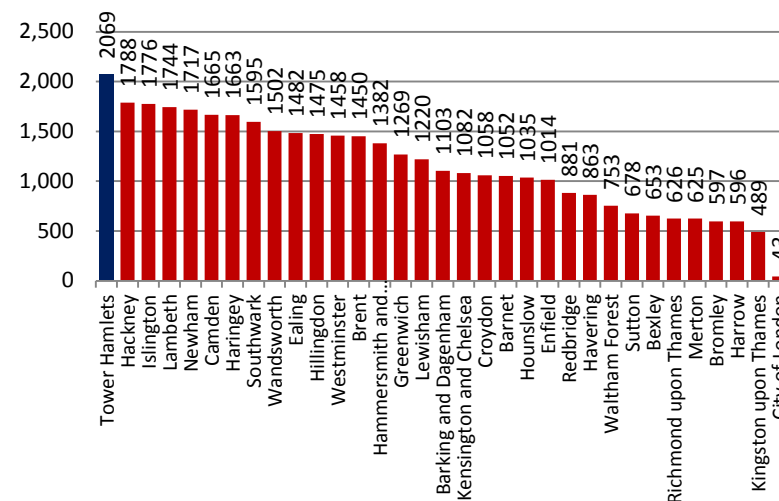
While more than 2,000 clients attended treatment in Reset, around 644 clients started a treatment episode with Recovery Support. Going forward, more clients need to profit from the offer by the Recovery Support Service.³³

6.2 In treatment population

Total Treatment population

In 2017/18, Tower Hamlets continues to have a largest treatment system with 2,069 clients in treatment. The status of the largest system in London is driven by the large group of opiate clients in treatment (60%).

Chart: Clients in treatment by London borough in 2017/18



(Source: NDTMS, SC and re-presentation rate 2017/18)

While clients are treated by the main provider Reset, around 15% of all clients attend recovery support intervention with the Recovery Support service. In addition, a small number of clients attend Residential treatment providers discussed in Section 8.

Total treatment population over time by substance

Client numbers have decreased before and after the introduction of the new Reset treatment system in Oct 2016. While some of it was caused by the transfer to the new service, numbers dropped already when the old services started to discharge clients before the introduction of Reset.

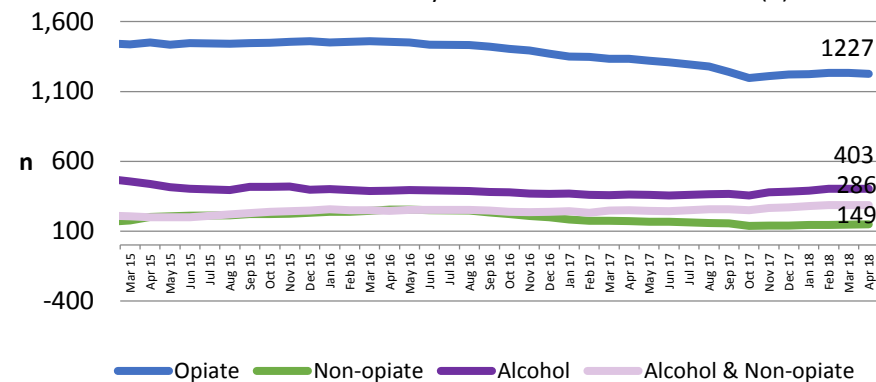
However, client numbers are recovering and reached a total of 2,065 in March 2018. Especially, alcohol only and alcohol & non opiate client numbers have improved to the highest levels since

³³ Source: Reset Treatment and Recovery Support Service Monitoring data 2017/18

2015. Tower Hamlets remains the local authority with highest number of clients in treatment in London.

However, to reduce unmet need, non-opiate, alcohol and opiate clients in treatment need to increase further in the future.

Chart: Clients in treatment over time by substance in Tower Hamlets (n)



(Source: NDTMS, Monthly client numbers)

6.3 Reducing Drug and Alcohol use - Abstinence levels

Clients are assessed at the start and various stages of treatment. As part of the assessment, key workers complete a treatment outcome profile (TOP) which measures treatment progress.

The data below shows the abstinence levels of clients at 6 months review stage over a period of 12 months. The data indicates that treatment has regained its effectiveness after a drop in performance in 2016/17, mainly caused by the changes to the treatment system.

Abstinence levels achieved in treatment for Opiates, Crack, Cocaine and Alcohol in 2017/18 are now all within the range expected by Public Health England.³⁴ See table below.

Table: Abstinence rate by selected substance while in treatment (%)

	2015/16	2016/17	2017/18
Opiate abstinence	29%	18.2%	28.8%
Crack abstinence	28.9%	16.4%	28.9%
Cocaine abstinence	34.5%	12.5%	52.6%
Alcohol abstinence	21.2%	16%	34.7%

(Source: NDTMS DOMES report, Q4 various years)

6.4 Treatment exits and completions

In 2017/18, 869 Tower Hamlets clients left the treatment system. Nearly 50% of clients left treatment in a planned way, a rate higher than the national average (40%). Around 40% of clients left treatment in an unplanned way, a rate above the national average (35.7%).

Table: Treatment exits / discharges in 2017/18 (%)

	Planned exits	Referred on	Unplanned exits	Transfers to prison
Tower Hamlets	47.8%	5.7%	40.9%	5.6%
National	45%	15.3%	35.7%	4%

(Source: NDTMS Adult Activity report, 2017/18)

³⁴ PHE expected range: Opiate: 25.9%; Crack: 23.4%; Cocaine: 32.3%; Alcohol: 16.1% (Source: NDTMS DOMES Q4 2017/18)

Successful completion rate – Discharges only by substance

Treatment outcomes reflect the complexities of clients presenting to treatment. As discussed earlier, opiate clients will achieve much lower rates compared to less complex alcohol only clients for example.

Overall successful completions show a positive trend in 2017/18, following a significant fall when Reset was introduced. In the period between November 2016 and April 2017, the service established itself and priorities were to reassess clients and to settle clients into the new service. This meant that the overall rate of successful completions for all substances decreased noticeably.

By the end of the FY 2017/18, alcohol and alcohol & non-opiate clients achieved positive rates, close to the top quartile ranges of comparable local authorities. The rates for opiate and non-opiate are also recovering but need some more time to achieve the Tower Hamlets ambition to be one of the best performing treatment services.

Table: Successful discharge rates by substance (%)

	2015/16	2016/17	2017/18
Opiate clients	8.5%	5.9%	5.9%
Non-opiate clients only	58.1%	47.2%	37.7%
Alcohol clients only	35.1%	29.5%	41.6%
Alcohol & non-opiate clients only	35.6%	31.7%	40.1%

(Source: NDTMS DOMES reports, various years)

Re-presentation rates by substance

The quality of a successful completion is measured against the proportion of clients that re-present to treatment within 6 months of successfully leaving treatment. This is calculated by taking the number of clients successfully completing treatment in the first half

of a 12 month period and then monitored for re-presentations to treatment in the latter 6 months of the same reporting period.

Overall, the re-presentation rates have improved in the partnership. The rates for alcohol and alcohol & non-opiate clients are now within the Top quartile range for comparable Local Authorities. While rates for opiate and non-opiate clients remain outside this ambitious target in Q4 2017/18, the targets looks achievable moving forward.

Table: Re-presentation rates by substance (%)

	2015/16	2016/17	2017/18
Opiate clients	18.4%	13.7%	12.8%
Non-opiate clients only	6.3%	9%	6.3%
Alcohol clients only	13.3%	12.3%	2.8%
Alcohol & non-opiate clients only	5.6%	8.1%	2.2%

(Source: NDTMS DOMES reports, various years)

Successful completions and non-re-presentation rate (PHOF 2.15)

The PHE PHOF KPI measures any successful completions within 12 months not representing to treatment within 6 month after completion.

Current results are below the targeted top quartile performance against comparable LAs with a similar client cohort. However, the Partnership Phof KPIs are improving but remain critical until the period of low successful completions (SCs) occurring in Nov 2016 to March 2017 are not used to calculate the KPI anymore.

Improvements are expected by Sept 2018 if current trends of successful completions and representations in the Reset service continue. See table below.

Table: PHOF 2.15 Successful completion and Re-presentation by substance in Tower Hamlets (%)

	2015/16	2016/17	2017/18
Opiate clients	7.8%	8.5%	4.5%
Non-opiate clients only	36.6%	50.9%	24.7%
Alcohol clients only	27%	36.8%	27.6%

(Source: NDTMS DOMES reports, various years)

The introduction of the new treatment system had a substantial impact on key KPIs. The transformational change of the treatment system meant that the PHOF 2.15 declined and its recovery will take a considerable time.

Data shows that , pre Oct 2016, higher numbers of successful completions (SCs) had a positive impact on Phof (rate increased) while in the initial 6 months of the Reset service only very low numbers of clients left the service and completed treatment (Nov 2016 to April 2017). This meant that the impact on Phof KPIs was initially delayed and consequences were felt in 2017/18.

The Phof figures published in April 2018 include the complete period when Reset treatment had low successful completions and the Phof results in this period were the lowest.

PHOF 2.15 Successful completion and Re-presentation by substance in Tower Hamlets (%) by gender

PHE published the Phof outcome data by gender in autumn 2018. The new data shows that female opiate clients in Tower Hamlets have much poorer treatment outcomes than men. Going forward, this discrepancy will be targeted and needs to improve. The difference is less pronounced for opiate and alcohol clients. See table below.

PHOF 2.15 Successful completion and Re-presentation by substance in Tower Hamlets (%) in 2017/18

	Total	Male	Female
Opiate clients	4.8%	5.2%	3.1%
Non-opiate clients	30.3%	30.5%	29.6%
Alcohol clients	33%	31%	36%

(Source: PHE Commissioning support pack 2017/18)

Recommendations

- Develop better pathways into treatment and promote services to increase clients in treatment
- Engage more female clients in treatment and improve pathways for complex female clients including opiate users

7 Criminal Justice

7.1 Background

The Drug Intervention Programme (DIP) in Tower Hamlets is run in-house and is central to the borough's aims to reduce crime and re-offending. By placing drug workers at all stages of the Criminal Justice System, the programme identifies, assesses and refers drug and alcohol misusing offenders into appropriate treatment and support services.

Particular emphasis is placed on: identifying individuals at the beginning of their drug related criminal careers; the ability to affect behaviour change for those unwilling to participate in treatment; women selling sex (to contribute the Violence against Women and Girls (VAWG) and Domestic Violence (DV) agendas) and the development of a co-located IOM Team.

*Community based treatment, offending and re-offending*³⁵

PHE and MOJ research based on national treatment and prison data shows the positive links between community-based treatment for substance misuse and changes in re-offending.

For both pre-treatment offending and post-treatment re-offending, it was found that males, those from Black and Ethnic Minorities, those who are homeless and those with a current or lifetime history of injecting drugs are more likely to offend; while those who are older or are in treatment for substances other than opiates are less likely to offend.

³⁵ Ministry of Justice / PHE (Oct 2017): Impact of community based drug and alcohol treatment on re-offending.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/655101/PHE-Moj-experimental-Moj-publication-version.pdf

Clients who had been in prison prior to starting treatment and those who re-presented to treatment were more likely to re-offend. Clients who successfully completed treatment or were still in treatment at the end of the period were less likely to re-offend.

7.2 Criminal justice clients in treatment

7.2.1 Proportion of Tower Hamlets treatment population in contact with criminal justice

Out of all clients in treatment in 2017/18, Opiate clients were most likely to be in contact with the criminal justice system. The Tower Hamlets rate of 20% was marginally below the national average of 20.9%.

The rate of non-opiate clients in Tower Hamlets in contact with the criminal justice system was with 13.7% similar to the National average (13.3%). The proportion of alcohol only and non-opiate & alcohol CJ clients was also similar to the overall national averages.

Table: Proportion of Tower Hamlets treatment population in contact with criminal justice in 2017/18³⁶ (%)

	Criminal Justice clients (n)	Criminal Justice clients (%)	National Average (%)
Opiate	303	20.0	20.9
Non-opiate	21	13.7	13.3
Alcohol	26	5.9	6.4
Alcohol & non-opiate	28	11.1	11.6
TOTAL	378	17.9	N/A

(Source: NDTMS DOMES Q4 2017/18)

³⁶ In contact with the criminal justice system defined as clients taken onto a CJIT caseload within 42 days of the earliest triage or the first referral source of the treatment journey is a criminal justice referral route
(n) = number of clients in treatment in contact with the criminal justice system / all in treatment Latest period: 01/04/2017 to 31/03/2018

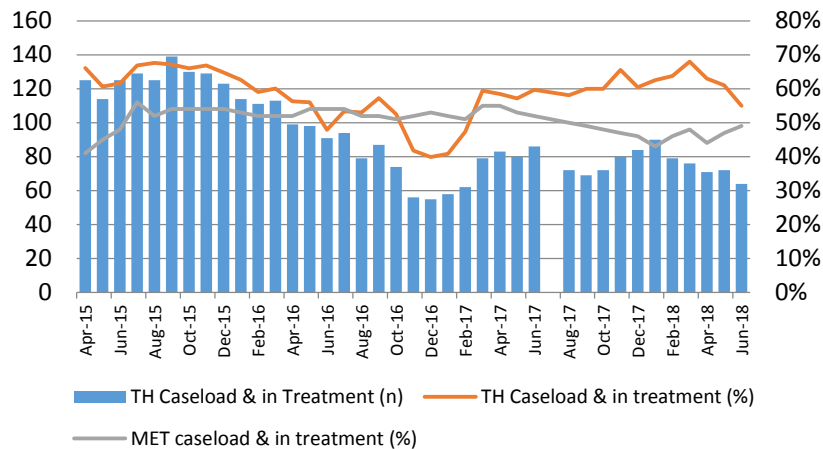
7.2.2 Referrals into treatment

The DIP service in the borough is very important, being a major referrer into treatment. In passing clients onto treatment providers the DIP works to support the client in treatment for up to 12 weeks, in some cases for longer depending on the client’s needs.

The table below sets out the treatment uptake of DIP referrals between April 2014 and March 2018. Overall, the monthly DIP caseload and the number of clients on caseload and in treatment fell over the last 24 months. However the overall rate of engaging clients into treatment has remained overall stable around 50% to 60%. The table below also shows that the roll out of the new treatment system and the development of new pathways meant that performance dropped between Sept to Dec 2016.

Reasons for falling DIP numbers include the move of Drug Rehabilitation and Alcohol Treatment Requirements (DRR/ATR) clients to Reset Treatment and a general fall of orders from the courts.

Chart: Clients on caseload and in treatment DIP and MET (n and %)



(Source: NDTMS CJIT Quarterly Summary Report Data)

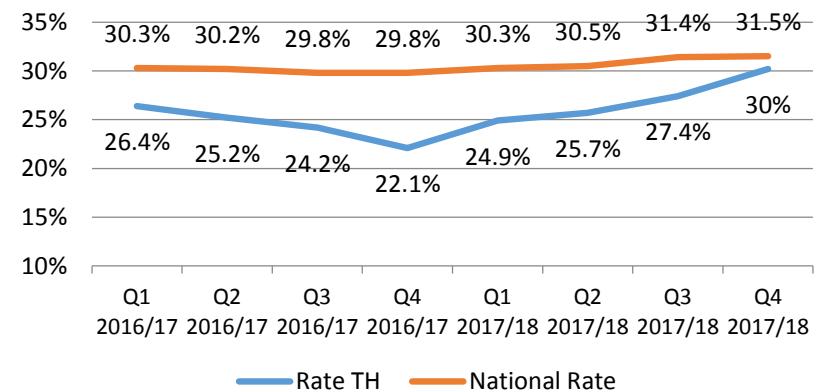
7.2.4 Prison referrals into treatment

PHOF 2.16³⁷ is a new indicator measuring treatment engagement after a client is released from prison.

Around 30% of prison referrals engage successfully in community based structured treatment. The latest TH data shows that the rate has improved over the last 12 months and is just below the national average. Poor performance was caused by reasons data quality, mainly in prison.

The recent PHE Audit of local data has indicated that actual engagement was around 50% in Tower Hamlets.³⁸ While more clients could engage in treatment after being discharged from prison, the actual number is much high than the official PHOF 2.16 figure. Nevertheless, there is scope to improve partnership work and information sharing between DIP and Thames prison. Stronger links between DIP and prison should impact positively on the Phof 2.16 outcomes.

Table: Engagement in treatment after prison discharge PHOF 2.16



(Source: PHE NDTMS DOMES 2017/18 report)

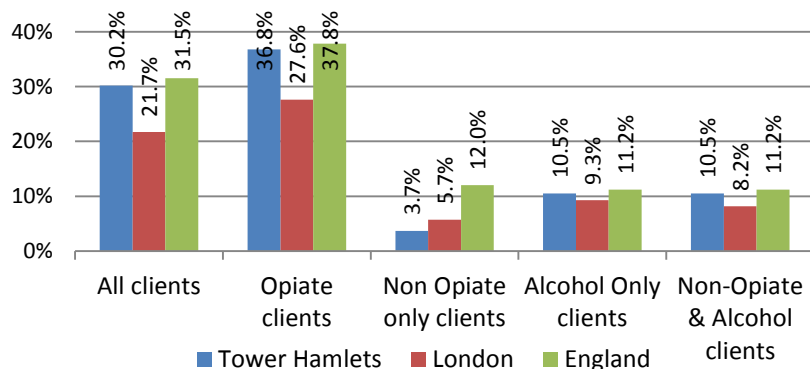
³⁷ Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison (PHOF 2.16)

³⁸ PHE report: Prison Exit Tower Hamlets, Sept 2017

PHE published additional data showing further details behind the PHOF 2.16 measure.³⁹ The PHOF 2.16 data can be broken down by four substance groups.

The data shows that, non-opiate clients are least likely to start treatment after leaving prison in Tower Hamlets. While this is not necessarily unusual, as there is no need for a script, this could be further explored. There might be potential to improve performance around this indicator focusing on clients who are not opiate clients, encouraging more of them into treatment. See table below.

Chart: Treatment start by substance – Prison exit clients 2017/18



(Source: NDTMS PHOF 2.16 by substance, Jan 2017 to Dec 2017)

³⁹ The report shows all adult clients who were released from prison and discharged from prison-based treatment with a discharge reason of 'Transferred - not in custody', indicating further structured treatment is needed post-release and the individual has been referred to a community-based treatment provider (as per the NDTMS Business Definitions v3.04).

Of this cohort, it shows the number and proportion who successfully started a treatment episode in the community within 21 days. It also shows the proportion of these who re-present back to prison-based treatment within the 21 day window.

7.2.5 Treatment outcomes – criminal justice clients

Analysis of the treatment outcomes for criminal justice shows that the successful completions rates of criminal justice clients were lower for opiate, non-opiate and alcohol clients when compared to the total client group. However, rates were better for alcohol only clients.

Please note that the small size of the criminal justice cohort, especially the non-opiate and alcohol clients, will inevitable create a statistical error margin which makes it difficult to compare both client cohorts fully.

However, it can be observed that successful completions of criminal justice opiate clients are below the rate of all opiate clients in treatment. See table below.

Table: Successful completions by substance in 2017/18 (n & %)

	Criminal Justice clients only		All TH clients	
	n	%	n	%
Opiate	8 (247)	3.2	73 (1,232)	5.9
Non-opiate	7 (20)	35.0	55 (146)	37.7
Alcohol	5 (24)	20.8	168 (404)	41.6
Alcohol and non-opiate	13 (32)	40.6	115 (287)	40.1

(Source: NDTMS DOMES Q4 2017/18)

7.2.6 DIP CJIT data⁴⁰

Client activity is recorded on the local DIP case-management system. There were 869 individual clients in contact with the DIP generating 1,251 contacts between April 2017 and March 2018. Out

⁴⁰ Data has been sourced from DIP Nebula case management system and covers the period of 2017/18.

of all clients, 662 unique Tower Hamlets residents were in contact with DIP.

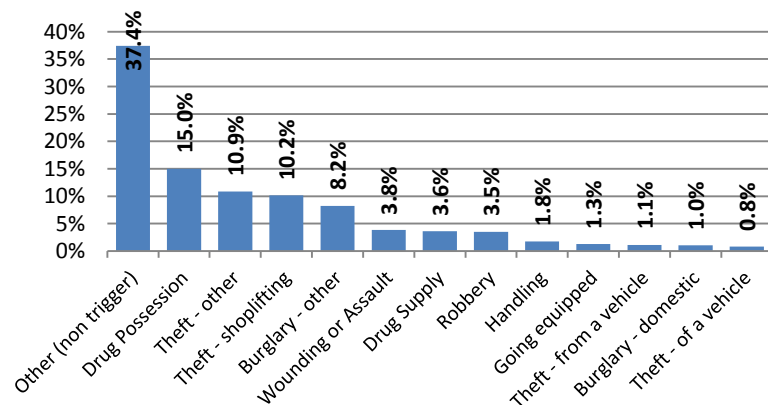
It is not unusual that around half of all contacts do not join the DIP caseload. This is because out of borough clients are referred on to other boroughs, some clients go to prison, some do not attend the follow up appointment and others do not want to engage with the service at all.

89% of DIP clients were male and 11% female. In general, criminal justice clients are more likely to be male when compare to the overall client cohort.

Recorded offences DIP clients

The chart below shows the distribution of offences of clients in contact with DIP. While the largest group were other non-trigger offences, around 30% were drug possession, theft (theft – other and theft – shoplifting) and burglary offences. See a full breakdown below.

Chart: Recorded Offences of DIP clients TH residents 2017/18

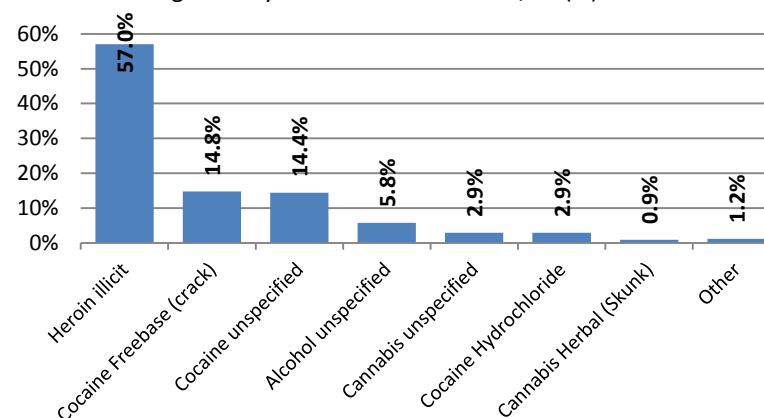


(Source: DIP CJIT / DIR records, 2017/18)

Primary substance cited by DIP clients

The chart below shows that 57% of clients when in contact with DIP cited heroin as their primary drug. Nearly 15% cited Crack or Cocaine (14.4) respectively while 5.8% mentioned Alcohol use as primary substance.

Chart: Main drug cited by contact with DIP 2017/18 (%)

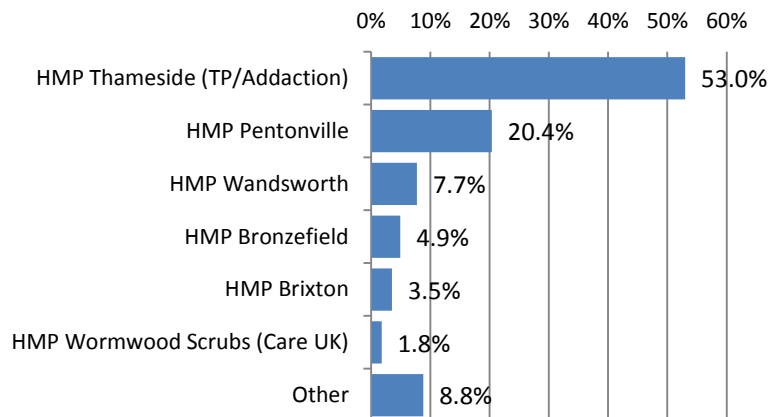


(Source: DIP CJIT / DIR records, 2017/18)

7.2.7 Prison Exit clients

The PHE data shows that the majority of exits (285) between Jan 2017 and Dec 2017 of Tower Hamlets residents originated from prisons mainly in London and the South East. The majority originate from HMP Thameside (151), HMP Pentonville (58) and HMP Wandsworth (22). HMP Thames side and Pentonville are the prisons the team works most closely with.

Chart: Prison release of Tower Hamlets residents by secure establishment (%)



(Source: NDTMS PHOF 2.16 by substance, Jan to Dec 2017)

Out of all clients released from prison, less than 10% represent back to prison with 3 weeks in Tower Hamlets, not dissimilar to London and England averages.

Table: Clients re-presenting back into prison based treatment within 3 weeks in Jan to Dec 2017

Area	Rate
Tower Hamlets	7.4%
London	9.5%
England	8.3%

(Source: NDTMS PHOF 2.16 by substance, Jan to Dec 2017)

The majority of prison releases of TH residents were opiate clients (220 / 77%), followed by non-opiate clients (9.5% / 27) and alcohol only and non-opiate and alcohol clients (each 29 / 10.5%).

The majority of clients are opiate clients in need of a script after release from prison. This is supported by local data where around

half of clients need scripting. Non-opiate clients were the least likely to engage in treatment after prison release.

7.3 Women involved in prostitution

Women involved in prostitution on the streets of Tower Hamlets remains a key priority. In October 2017, Beyond the Streets were commissioned to continue outreach and support work in the borough, working closely with this most complex, high need group of women.

Women involved in prostitution are predominately reported to be from marginalised social backgrounds and have suffered abuse/violence in their lives. It is estimated that the vast majority of women have a drug and/or alcohol addiction and would profit from treatment.

However, this group of women are exposed to high risk environments including violent perpetrators and present a vast amount of complex needs ranging from issues such as: Domestic violence, Mental Health, Criminal activity (ASB) and Children’s services/protection issues. Successful engagement with Reset treatment requires close support from Beyond the Streets, mitigating and navigating many other needs first.

Beyond the Streets are also continuing the TH Prostitution Partnership co-ordinator work, linking closely with partners such as the LBTH MET Police, East London NHS services (RESET), Domestic Violence team, Housing, Outreach and Social services to ensure that the client needs are prioritised and met.

Initiatives such as the Court Diversion Scheme (CDS) are in place as a preventative measure for this cohort’s offending behaviour. Women involved in prostitution are given verbal ‘cautions’ by police officers

to engage with Beyond the Streets and the Drug Intervention Programme (DIP).

Beyond the Streets have been working with around 20 women while a regular street count delivered an estimate of around 90 women involved in prostitution on the streets of Tower Hamlets. (Source: Beyond the Streets monitoring data Sept 2017 to August 2018)

Reducing demand – Stop and Think

The Borough continues to deliver the Stop and Think training programme for buyers of sex, aiming to tackle demand. Participants were charged by the MET Police for buying sex but are encouraged to attend the training session and avoid prosecution.

The Stop and Think programme has engaged 30 buyers of sex in 2017/18. The programme will continue in the 2018/19 educating buyers about their actions aiming to reduce demand.

Recommendations

- Improve partnership work and information sharing between DIP and key prisons, improving engagement with treatment. Stronger links between DIP and prisons will impact positively on the Phof 2.16 outcomes
- TH DIP service to assess DRR and ATR clients and ensure that those clients are engaging with Reset treatment

8 Residential rehabilitation provision

Residential rehabilitation is an integral part of the Tower Hamlets treatment system, a vital option for some people requiring treatment and is therefore accessible to anyone who needs it.

Access to residential rehabilitation, also known as Tier 4 provision, is managed by the Tower Hamlets Residential Rehabilitation Panel. The panel comprises of representatives from the council and its key providers (i.e. DAAT Commissioning Manager, DIP Manager and ELFT (Consultant Psychiatrist) and service managers from Reset Recovery Support Service).

The panel meets on a bi-weekly basis to assess applications from local residents for funding (i.e. residential detoxification and rehabilitation). The total funding available for residential detoxification and rehabilitation for 2017/18 was in the region of £400,000. This section presents local data for 2017/18 and complementary data released by NDTMS for the FY 2016/17.

8.1 Local Residential Rehabilitation data

Data discussed here is taken from a live database set up to monitor costs of residential rehab. Information is based on completed discharges and information available following discharges (costs, treatment outcomes etc.) up to March 2018.⁴¹

Clients in residential rehabilitation

Overall client numbers presented to the residential rehab panel have fallen to 36 in 2017/18, a number much lower than the years before. Out of those clients going to residential rehab, a higher proportion is accessing treatment because of alcohol misuse. The

proportion of alcohol only clients increased to 56%, compared to 44% of clients entering because of drug misuse.

Table: Residential rehab clients by drug and alcohol need (%)

	2015/16	2016/17	2017/18
Alcohol	30%	52%	56%
Drugs	70%	48%	44%

(Source: TH DAAT, Local residential rehabilitation data)

In 2017/18, around 63% of clients completed treatment in residential rehab. Alcohol clients (70%) were more likely to complete treatment compared to drug clients (50%).

Table: Discharge reason residential rehab clients 2017/18 (%)

	Alcohol only	Drugs	All clients
Disciplinary discharge	10%	33%	19%
Self-discharge	10%	17%	13%
Treatment completed	70%	50%	63%
Other	10%	-	6%

(Source: DAAT, Local residential rehabilitation data, 2017/18)

Treatment outcomes and the average cost of most treatment modalities (Detox, Detox & Primary and Secondary) remained stable in 2017/18.

Overall, the cost of a successful completion/discharge was around £7,044 per client in 2017/18. The largest number of clients started rehabilitation in Broadreach House, Bridges and Equinox. However, clients accessed treatment in 15 different providers in 2017/18.

⁴¹ Selected information can be missing if discharge reports from rehab providers are not submitted or information is missing.

Demography

The gender split in 2017/18, was 83% male clients while only 17% female clients entering residential rehab. Overall client numbers decreased in 2017/18 for both genders but the number of female clients decrease proportional more than male clients.

Table: Clients presented to residential rehab panel by gender (% / n)

	2015/16	2016/17	2017/18
Female	39% (21)	32% (21)	17% (6)
Male	61% (33)	68% (45)	83% (30)
Total	54	66	36

(Source: DAAT, Local residential rehabilitation data)

The 2017/18 ethnicity structure was relative similar to general TH treatment population. The White group was most likely to access the residential rehab. Compared to 2016/17, the proportion of Asian clients increased.

Table: Clients presented to residential rehab panel by ethnicity (%)

	2015/16	2016/17	2017/18
White	53%	63%	50%
Asian	22%	9%	19%
Black	8%	3%	3%
Mixed	6%	11%	14%
Other Group	2%	6%	6%
Not disclosed	7%	8%	8%

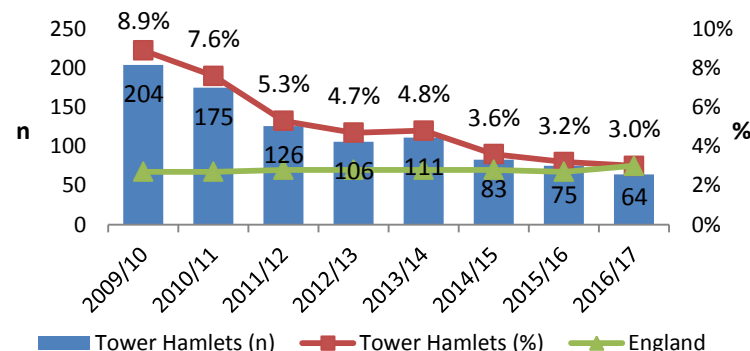
(Source: DAAT, Local residential rehabilitation data)

8.2 NDTMS data - Residential Rehabilitation

The official NDTMS residential rehab data shows that in 2016/17, only 3 per cent of all clients in Tower Hamlets had a residential rehab episode as part of their treatment journey. The data shows a continuous fall of the number of clients accessing residential rehab between 2009/10 and 2016/17. The proportion of Alcohol only and

Drug clients in residential rehab has decreased and is was close to the England average. See charts below.

Chart: Residential Rehabilitation 2009/10 to 2016/17 – All clients



(Source: NDTMS Tier 4 Treatment Map Needs Assessment Data / Commissioner Pack)

Recommendations

- Developments over the last 18 to 24 months demonstrate that the partnership has seen a decrease of clients presenting to the residential rehab panel and that its budget is not fully being utilized.
- As a consequence, some of the budget has been used to partially fund the housing first pilot which will support entrenched, homeless drug and alcohol users with their housing situation. Clearly, some homeless users are too unwell to access residential rehab and will have a much better chance of success by being supported and housed locally.
- Reset Treatment to improve support for suitable clients applying for residential rehabilitation. DAAT to deliver additional training to reduce barriers and increase demand.

9 Harm reduction

Data discussed in this section is supporting the assessment of substance misuse related issues in the community.

Health incidents or deaths as a result of drug and alcohol misuse, ambulance service callouts, drug offending trends and needle exchange information supports our understanding of needs and service demand in Tower Hamlets.

The data helps our understanding of the cohort of ‘treatment naïve’ residents, potential clients who could profit from interventions by substance misuse services in the borough. Overall the information will help in planning treatment, targeting and profiling future interventions.

9.1 Deaths related to drug poisoning and drug misuse

This section gathers local and national trends about deaths related to drug poisoning and drug misuse⁴² taken from the ONS publication Deaths related to drug poisoning in England 2017.⁴³

The figures show deaths *registered* for each calendar year, rather than deaths *occurring* each year. This is important because almost all drug-related deaths are certified by a coroner. Due to the length of time it takes a coroner to complete an inquest, around half of

drug-related deaths registered in 2017 will have actually occurred prior to 2017.⁴⁴

Figures based on registration year for local authorities can be influenced by variations in registration delays, and should be treated with caution. For that reason, latest LA data is published for the period 2015 - 2017.

9.1.1 Deaths related to drug poisoning and drug misuse in England and Wales

Drug poisoning deaths involve a broad spectrum of substances, including legal and illegal drugs, prescription-type drugs and over-the-counter medications.⁴⁵ Some of these deaths may also be from complications of drug abuse, such as deep vein thrombosis or septicaemia from intravenous drug use, rather than an acute drug overdose.

It is important to be aware that over half of all drug poisoning deaths involve more than one drug and/or alcohol, and it is not possible to tell which substance was primarily responsible for the death.

Deaths related to drug poisoning

In 2017, 3,756 drug poisoning deaths⁴⁶ were registered in England and Wales, a number similar to levels in 2016 (3,744). The growth of deaths related to drugs has now slowed down, a positive trend compared to the medium term increase of 27% between 2012 and 2017.

⁴² Data does not include Alcohol related deaths. Alcohol related deaths published separately by ONS.

⁴³ Published in Aug 2018 by ONS: Deaths related to drug poisoning in England and Wales: 2017 registrations
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations>

⁴⁴ In England and Wales, general trends in drug-related deaths are broadly equivalent, regardless of whether the data is analysed by year of occurrence or year of registration.

⁴⁵ either prescribed to the individual or obtained by other means

⁴⁶ involving both legal and illegal drugs

The overall mortality rate stood at 66.1 deaths per 1 million population, a very small increase compared to 2016 (65.8 deaths). The rate remains the highest rate since comparable records began in 1993.

As in previous years, the majority (67%) of deaths related to drug poisoning were for males (2,521 male deaths and 1,235 female deaths). However, female deaths increased at a rate of 5.4% compared to a fall of male deaths by 2%.

The male mortality rate stood at 91.4 per 1,000,000, while the female mortality rate increased to 42.9 deaths per 1,000,000 females.

Deaths related to drug misuse⁴⁷

As in previous years, most of all 3,756 *drug poisoning deaths* in 2017, 2,503 deaths (69%) were from *drug misuse* involving illegal drugs. The pattern of mortality rates from drug misuse closely matches the overall trend seen for all drug poisoning deaths.⁴⁸

Deaths related to drug misuse decreased between 2016 and 2017 by 3.6%. However, females deaths increased by 1.8% while male deaths actually decreased by 5.5%.

The data shows that men were more likely to die from drug misuse compared to women. Contributing factors to this significant difference are:

- Men are more likely to take illicit drugs than women,

⁴⁷ The definition of a drug misuse death is either:

(a) a death where the underlying cause is drug abuse or drug dependence or
(b) a death where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved.

⁴⁸ Please note that all drug mortality rates are age standardised. Age-standardised mortality rates per 1 million populations, standardised to the 2013 European Standard Population.

- Males and females are using different types of controlled substances,
- A higher purity of Heroin on the market and a cheaper price, causing potentially more deaths.

Selected substances mentioned in deaths related to drug poisoning⁴⁹

Heroin

In 2017, there were 1,164 deaths involving heroin and morphine in England & Wales, a decline of 4% (45 deaths) and the first decline since 2012. The National Crime Agency (2018) reports that heroin purity levels have remained stable between 2016 and 2017.

Deaths involving heroin and morphine had increased from 579 deaths in 2012 to 1,209 deaths in 2016; the increase between 2012 and 2015 followed the “heroin drought”, which occurred in 2010 to 2011. This was subsequently followed by increased purity of heroin, thought to be one factor in increased overdoses.

Fentanyl

Despite deaths from most opiates declining or remaining steady, fentanyl deaths have increased by 29%, rising from 58 deaths in 2016 to 75 deaths in 2017. Fentanyl and its analogues have been found mixed with heroin, causing accidental overdose in users.

Using evidence from similar patterns in the US and Canada, the National Crime Agency reason that the addition of Fentanyl’s to heroin is possibly due to their cheaper cost and higher potency.

Public Health England issued a warning to heroin users and health officials regarding the contamination of heroin with potent synthetic opiates such as fentanyl. Carfentanyl, a synthetic opiate

⁴⁹ ONS: Deaths related to drug poisoning in England and Wales: 2017 registrations.

much more potent than fentanyl, was first seen mentioned in death certificates in 2017 and accounted for 27 deaths, that is, 87% of the 31 deaths related to fentanyl analogues in 2017.

There has been no record of Fentanyl in the Tower Hamlets so far. Workshops with service users and key workers did not indicate that the drug was used or available.

Deaths from cocaine⁵⁰

There were 432 deaths related to cocaine in 2017 in England and Wales, compared with 371 deaths in 2016. The age-standardised rate in 2017 was 7.5 deaths per 1 million population, which is the highest rate recorded since the start of the time series.

Deaths mentioning cocaine show a rising trend since 2011, in which they have increased from 1.9 deaths per 1 million populations. Cocaine is the second most commonly used drug, according to the Crime Survey for England and Wales, after cannabis.

The recent European Drug Report noted that rising production of cocaine in its origin countries and higher drug purity have been felt in Europe. Further, the report identified England and Wales as the highest users of cocaine in Europe (based on recent use among young adults).

The National Crime Agency (2018)⁵¹ reported that crack cocaine purity has continued to rise for the fifth year and that purity at user level is at an all-time high, with little variance between wholesale and user level.

⁵⁰ It is not possible to distinguish the form of cocaine (such as, powder cocaine or crack cocaine) in relation to these deaths.

⁵¹ <http://www.nationalcrimeagency.gov.uk/publications/795-recent-deaths-possibly-linked-to-fentanyl/file>

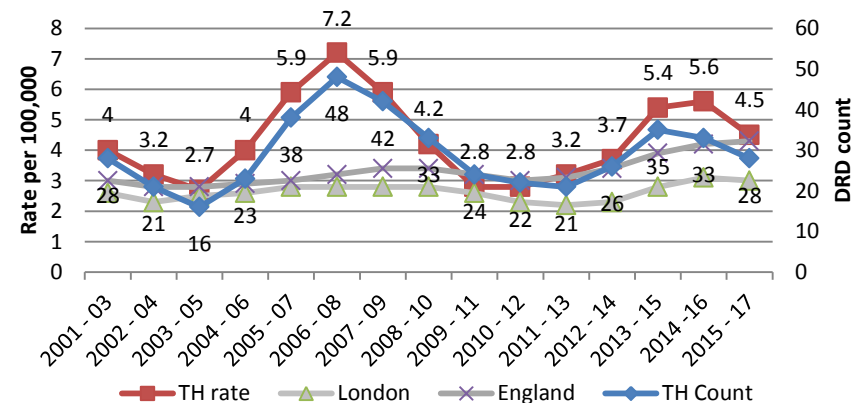
9.1.2 Local trends - Registered deaths related to drug misuse (residents)⁵²

Deaths related to drug misuse in Tower Hamlets

The number of deaths related to drug misuse in Tower Hamlets has fallen to 28 DRDs in the 2015-17 period. The rate stood at 4.5 per 100,000 population but remains above the London (3 per 100,000) and England rates (4.3 per 100,000).

The substantial decrease of deaths in Tower Hamlets between 2006/08 (48 deaths) and 2011/13 (21 deaths) was followed by a subsequent increase to 35 deaths in 2013/15. However, the latest developments are encouraging, showing the recent drop of drug misuse deaths in Tower Hamlets.

Chart: Trends over time in Tower Hamlets, London & England



(Source: Deaths related to drug misuse in England & Wales. 2015-2017, Local Authorities)

⁵² Data is taken from the national mortality database which includes the following information: sex, age, postcode of usual residence, the dates the death occurred and was registered, ICD-10 codes for all conditions mentioned on the death certificate and the text from the coroner's death certificate. Figures are for persons usually resident in each local authority, based on boundaries as of May 2016.

Out of the 28 Tower Hamlets deaths, 25 were Males and 3 Females. This translates to a rate of 7.5 per 100,000 for males, significantly above the London (4.6) and England (6.3) rates.

Table: Deaths related to substance misuse by gender 2015-17 in TH, London & England

	All Person	Males	Females ⁵³
Tower Hamlets	4.5	8.4	n/a
London	3.0	4.6	1.5
England	4.3	6.3	2.3

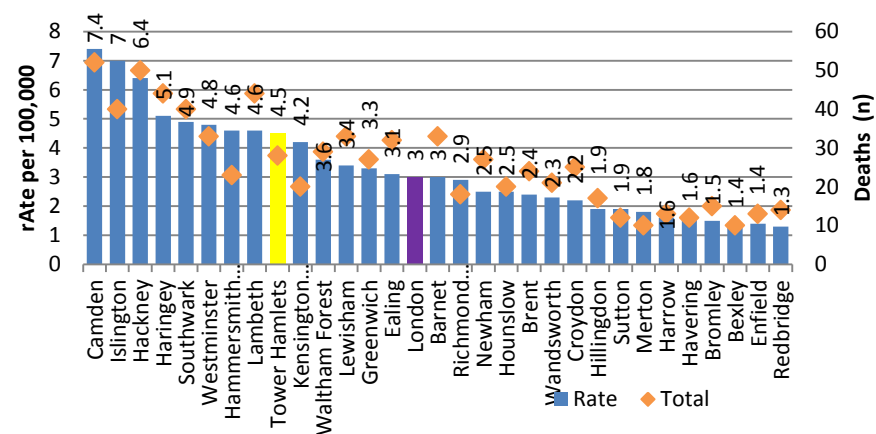
(Source: Deaths related to drug misuse in England & Wales. 2015-2017, Local Authorities)

Tower Hamlets rates in comparison to other areas

The Tower Hamlets mortality rate per 100,000 residents has remained above the London average. While the Tower Hamlets rate is the 8th highest in London, it remains below higher rates in Camden (8.4), Islington (7), Hackney (6.4) or Haringey (5.1)

The highest numbers of deaths were registered in Camden (52), Hackney (50), Lambeth (44), Haringey (44), Southwark (40) and Islington (40). The largest increase between 2014-16 and 2015-17 were recorded in Camden (+10) and Hackney (+8). See chart below.

Chart: Registered deaths related to drug misuse – London boroughs (rate and total) 2015/17



(Source: ONS Number of deaths and age-standardised mortality rate for deaths related to drug misuse, by local authority, all persons, England and Wales, deaths registered 2015-2017, City of London, Barking & Dagenham and Kingston data suppressed)

The highest deaths related to drug misuse rates in England and Wales were recorded in Blackpool (18.5 per 100,000) followed by Neath Port Talbot (14.5), Hartlepool (14.6) and Swansea (14.4).

9.1.3 Deaths of clients in treatment

The proportion of clients accessing treatment who died in Tower Hamlets in 2017/18 was similar to national rates.

Table: Proportion if clients accessing treatment who died (%)

	Tower Hamlets (%)	National average (%)
Opiate clients	1.0%	1.2%
Alcohol only clients	1.5%	1.0%

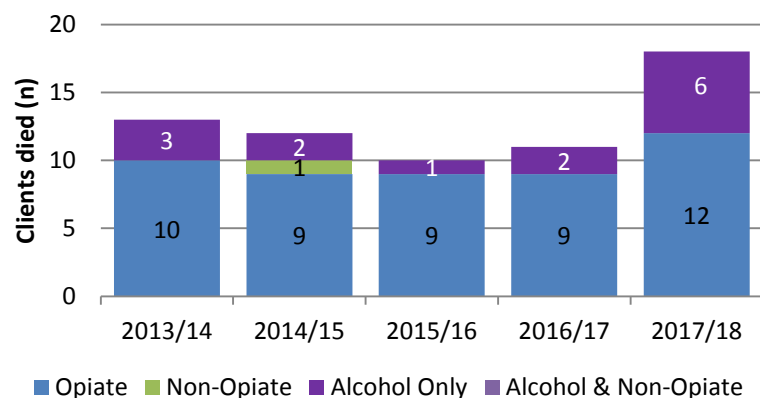
(Source: NDTMS DOMES report)

All clients discharged as “Client died” were Opiate or Alcohol only clients in 2017/18. This data is not comparable with the ONS Deaths by substance misuse figures discussed earlier.

⁵³ The Tower Hamlets rate for females is suppressed for statistical reasons.

However, the overall number of clients discharged as “Client died” increased to 18 in 2017/18, representing an overall increase compared to the previous years.

Chart: Discharge reason in TH partnership – Client died



(Source: NDTMS, Adult Activity, Partnership Discharge reason – Client died)

9.1.4 Local drug related deaths audit 2017⁵⁴

The audit of deaths notifications for clients in treatment and/or known to treatment received by TH DAAT analysed 109 deaths in the period of Q4 2011/12 to Q4 2017/18.

The analysis showed that the number of deaths remained high but relatively consistent with around 17 deaths a year. The largest group of those dying were men (>80% of all deaths) and the majority of those were White British (64%). Clients aged 35 to 44 and 45 to 55 made up 63% of all deaths while the average age at death was 48 years (Male: 48 years / Female: 47 years).

⁵⁴ TH DAAT (2018): Analysis of death notifications submitted to TH Drug Alcohol Action Team (DAAT), April 2018, internal paper.

Recommendations

- Further analysis is planned to investigate the potential link of death and prison release. DAAT and treatment providers have also agreed to produce better reporting and sharing of death notifications.

9.2 Alcohol specific and related deaths

9.2.1 Alcohol specific deaths

Data from 2016 shows that the rate of alcohol specific deaths in Tower Hamlets was the 9th highest in London with around 9.9 per 100,000 population. This was above London average of 8 per 100,000 but remains below the England rate of 10.4 per 100,000 populations.

Chart: Alcohol specific deaths over time



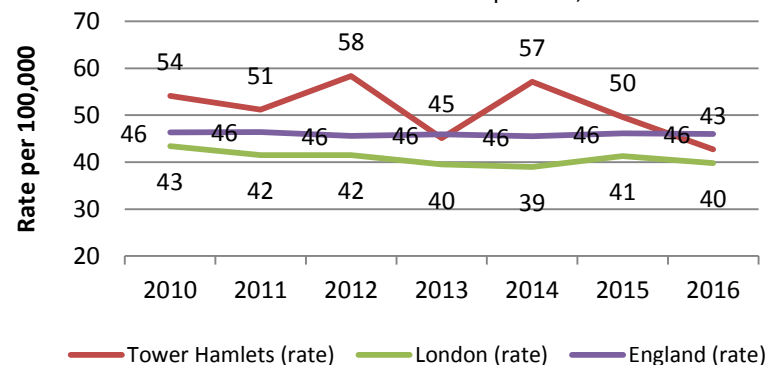
(Source: PHE Fingertips tool, May 2018)

9.2.2 Alcohol related deaths

Data from 2016 shows that the rate of alcohol related deaths in Tower Hamlets was the 9th highest in London with around 42.7 per

100,000 populations. This was noticeable above London average of 39.8 but below the England rate of 46.

Chart: Alcohol related deaths over time Rate per 100,000



(Source: PHE Fingertips tool, May 2018)

According to the data, more residents die of alcohol specific death compared to drug related reasons.

In discussion with Reset staff, it became clear, that working with clients in palliative care is not unusual. However, data is unavailable because palliative care is not recorded on the local data system.⁵⁵ However, DAAT are in the process to utilise health data from the CCG to support our intelligence about co-morbidities and wider health issues.

9.3 Naloxone use in Tower Hamlets

Naloxone is a safe and effective antidote to opioid overdose. Naloxone ‘kits’ for users are usually wallet-sized packets containing two doses of naloxone ready for injection and other items, including syringes, brochures, simple rescue-breathing masks, and brief educational materials about overdose risks and management.

⁵⁵ Keyworker stated to work with 5 to 6 clients currently in palliative care (Reset, 26/07/2018)

Research in the US has shown that Naloxone is a successful and cost effective way to prevent overdose deaths. Findings are likely to broadly apply to the UK. However, one weak link remains whether drug users given the kits actually carry them around.⁵⁶

Naloxone in Tower Hamlets

Since 2014, around 800 naloxone kits have been purchased and have been made available to the treatment population via local services. However, the recording of its distribution only commenced with the introduction of Reset in November 2016.

Naloxone is currently available in Reset Homeless Service (Health E1), Reset Treatment, DIP and the Reset Referral and Outreach Service. Since 2017/18, Naloxone training and distribution is recorded on NDTMS. In the same year, Reset treatment service trained and issued 136 kits to clients. (Source: NDTMS, DOMES Q4 2017/18)

In addition, the Reset Outreach and Referral service and the DIP service distributed another 78 (66 & 12) kits in 2017/18. Some local data shows that a large proportion of clients (around 50%) require a new kit after losing, giving away or using the old kit.⁵⁷

Naloxone was discussed with service users and knowledge of Naloxone was limited to clients with opiate addiction. However, none of them carried naloxone or were offered it.

Going forward, the DIP will train and issue Naloxone via the Criminal Justice Through care team and not via Prison Exit team, offering Naloxone to all criminal justice clients.

⁵⁶ http://findings.org.uk/PHP/dl.php?file=Coffin_PO_2.txt&s=eb

⁵⁷ Reset Outreach & referral service, monitoring data 2017/18

9.4 Needle exchange in pharmacies and treatment services

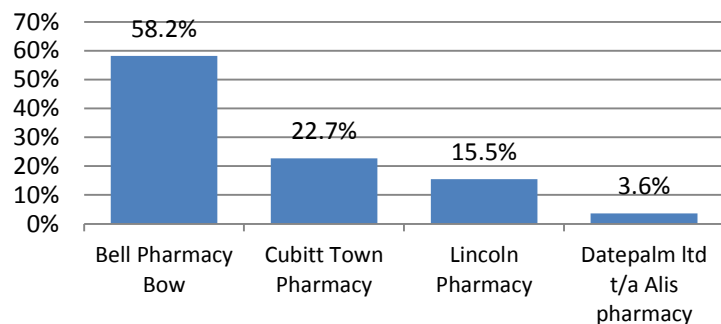
Needle exchange information discussed here is collected by local pharmacies and the Reset treatment services.

9.4.1 Needle exchange in local pharmacies – New registrations

In 2017/18, 110 unique clients registered with the four pharmacies in the borough providing needle exchange. Registrations appear to have decreased from 178 in 2016/17 to 110 in 2017/18.

The majority of clients are registered with Bell (58%) on Roman Road, followed Cubitt Town Pharmacy (22.7%) and Lincoln Pharmacy (15.5%) on St Pauls Way.

Chart: New client registrations in local pharmacies in 2017/18



(Source: Pharm Outcomes Needle exchange registration 2017/18)

Needle exchange - Client profile

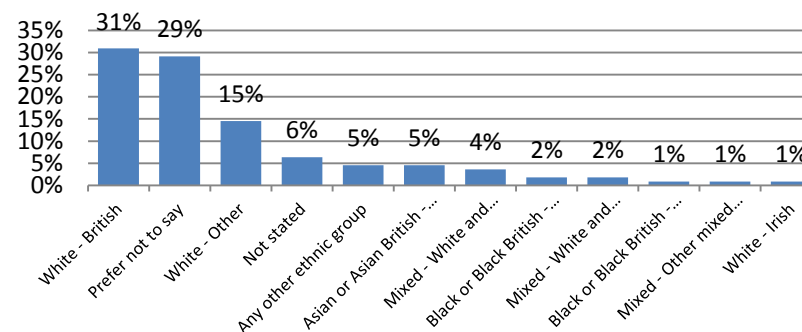
Gender

Gender data shows that 87% of registrations were by male and around 12% by females. This is interesting as the overall split of clients in opiate treatment in Tower Hamlets is 80% males and 20% females.

Ethnicity

The ethnicity breakdown shows differences with far lower proportions of Bangladeshi clients compared to the whole treatment population. However, data collection is much poorer than treatment data with many clients not stating their ethnicity.

Chart: New registrations by ethnicity in 2017/18 (%)



(Source: Pharm Outcomes Needle exchange registration 2017/18)

Local residents

Around 82% of newly registered users of the needle exchange in local pharmacies are local residents while around 17% were not.

Drugs injected

Majority of clients who registered in 2017/18 stated to inject Heroin. However the second largest group were users of performance enhancers and steroids. Majority of those were not in treatment while some heroin users picking up needles were also in treatment.

9.4.2 Needle exchange – Treatment services in 2017/18

Treatment services in Tower Hamlets have distributed anonymously needles & syringes, foil and other supporting items for years. Since Nov 2016, the Reset drug and alcohol service continued to offer this service. Data for 2017/18 includes information from Health E1

Homeless service; Outreach and referral service (ORS) and Reset treatment showing that around 84,000 needles were distributed.

Data indicates that the majority of Health E1 and Reset exchanges were with residents in treatment (80 plus %). However, ORS distributed the majority of needle exchange packs to individuals not in treatment (70%). See table below.

Table: Needle exchange services in Tower Hamlets 2017/18

	Number of visits / exchanges	Total needles distributed (n)	Proportion of clients in treatment (%)
Health E1	217	7,466	80%
Reset treatment	1,037	43,922	87%
ORS	907	32,647	32%
Providence Row			
Total	2,161	84,035	n/a

(Source: Service monitoring data 2017/18)

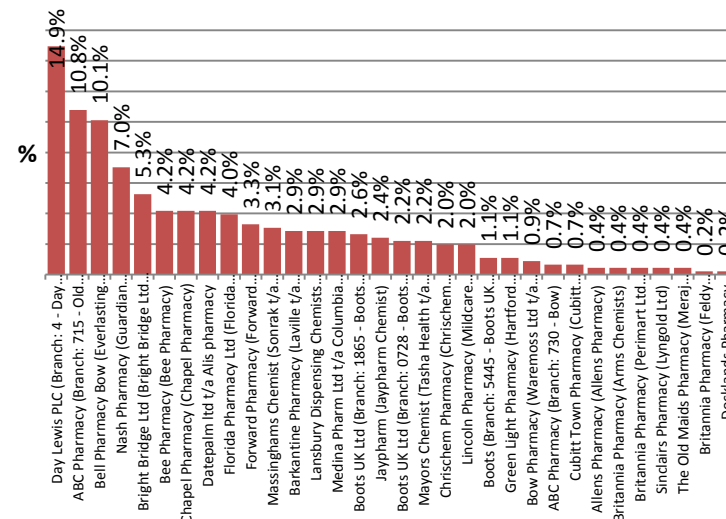
9.5 Supervised consumption

Community Pharmacies play a key role in the care of substance users, through the provision of services to supervise methadone or buprenorphine consumption. The Pharmacist is instrumental in supporting drug users in complying with their prescribed regime, therefore reducing incidents of accidental deaths through overdose.

It is widely acknowledged that Community Pharmacies provide a significant point of contact for Service users having regular daily contact with them. A total of 455 people registered with pharmacies in the borough for supervised consumption between April 2017 and March 2018.

The highest number and proportion of registrations were with Day Lewis PLC (14.9% / 68 total), ABC Pharmacy (10.8% / 49 total) and Bell Pharmacy (10.1% / 46 total). See chart below.

Chart: Supervised consumption clients - Registrations by pharmacy

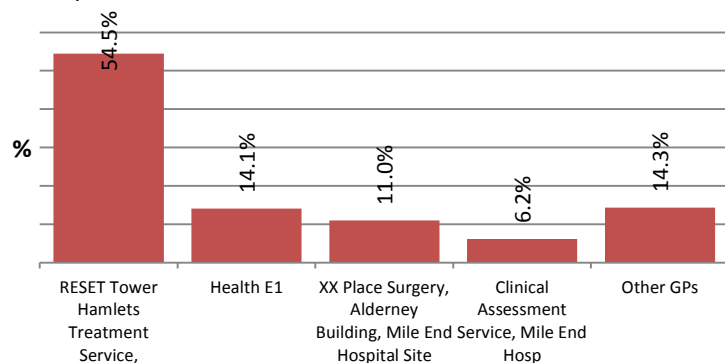


(Source: Pharm Outcomes data Supervised consumption registrations, 2017/18)

The chart below shows clients on supervised consumption and the source of their script in 2017/18.

Nearly 55% of clients on supervised consumption received their script from Reset treatment. Around 14% scripts were issued by Health E1 followed by XX Place Surgery in Mile End. Around 6% of clients registered for supervised consumption were given a script by the Clinical Assessment centre in Mile End Hospital while around 14% were issued a script by 21 different GPs in the borough.

Chart: Supervised consumption clients - Registrations with GPs or drug treatment provider



(Source: Pharm Outcomes data Supervised consumption registrations, 2017/18)

Supervised consumption - Client profile

Gender

The gender profile (75% male and 25% female) was slightly different to the gender split of the opiate treatment population in the borough which was 80% males and 19% females.⁵⁸

Age

Clients using the supervised consumption service are more likely to be aged 35 to 44 (44%) and 45 to 54 (25%). The age structure is similar to that of opiate clients in treatment.

What is being distributed? – Transactions

The majority of transactions are methadone solutions (84.4%) compared to a lower proportion of Buprenorphine tablets (15.6%).⁵⁹

⁵⁸ Source: Pharm Outcomes data Supervised consumption registrations, 2016/17

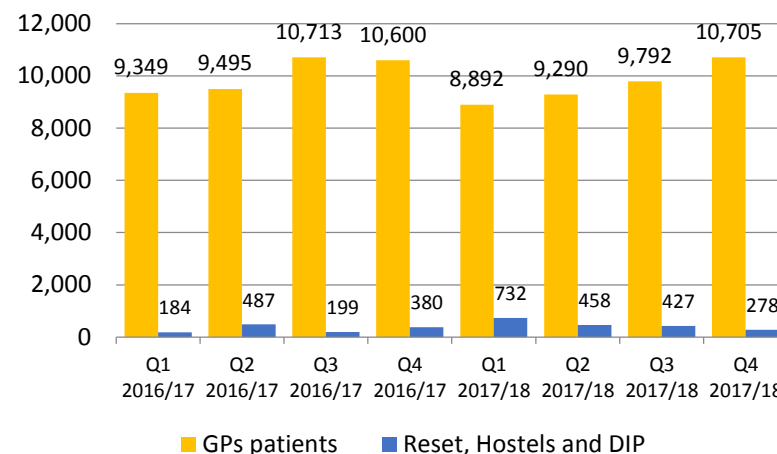
⁵⁹ Source: Pharm Outcomes data Supervised consumption - transactions, 2017/18

9.6 Screening for alcohol related harm - Audit C

AUDIT / Audit C is the gold star screening tool used to determine drinking levels and is employed across GPs and front line staff in our treatment and partner organisations.

The vast majority of nearly 41,000 Audit / Audit C assessments delivered in 2017/18 were conducted by local GPs (39,000). However, Reset treatment service, TH DIP and local Hostels contribute to this number. See chart below.

Chart: Audit C completions in 2017/18 by organisation



(Source: Local service data)

GP Audit C assessments

This section presents data about the results of those alcohol interventions delivered by GPs. The information shows the GPs with the highest numbers of patients with 8+ AUDIT C or 16+ Full Audits.⁶⁰ A total of 9,347 patients scored 8 plus in Audit C or 16 plus

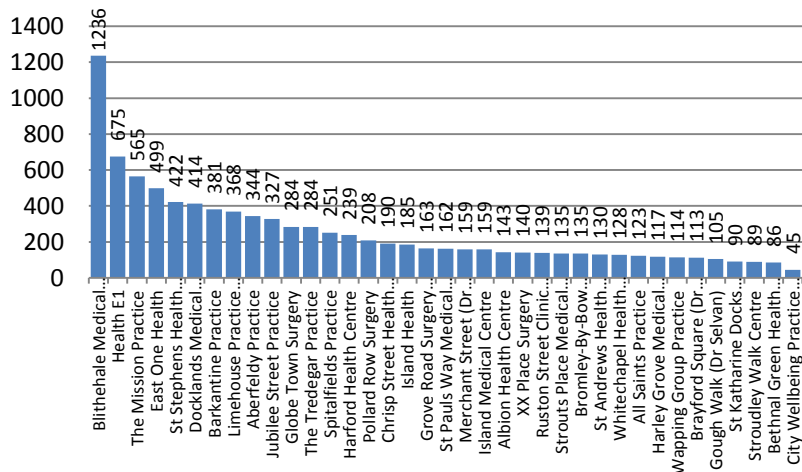
⁶⁰ This data set includes All 16+yr patients with Audit-C 8+ or Full Audit 16+ 2014-2015 and THCAT Referral 2014-2015. Please note: CEG Target is 10% of patients scoring 8+ AUDIT C or 16+ Full Audit have a coded written referral to THCAT

in Audit. Scores above that indicate potential demand for alcohol treatment.

The median shows that each GP had around 162 patients with an Audit scoring 8+ AUDIT C or Audit 16+. However, some GPs have much larger patient numbers who fit into this criterion.

For example, Blithedale Medical Centre (1,236), Health E1 (675), The Mission Practice (565), East One (499), St Stephens Health Centre (422) and Docklands Medical Practice (414) had more than 400 patients in this category. See Chart below.

Chart: Total number of Audit-C 8+ / Full Audit 16+ in 2017/18



(Source: CEG Alcohol Dashboard 2017/18)

Recommendations

- The audit completion data demonstrates that GPs are a crucial identifier of alcohol related harm. GPs are already an important source of referrals into treatment, however clearly more patients could profit from engagement with Reset Treatment and the development of additional Reset satellites at GPs will be of great importance.
- Ensure that the referral pathway between GPs and Reset Treatment is as easy as possible and utilised
- The partnership has established the Don't Bottle it up online tool which allows residents to complete Audit C online and learn more about their alcohol use. This tool will be promoted further to engage treatment naïve alcohol users.

10 Impact of drug and alcohol misuse on local residents

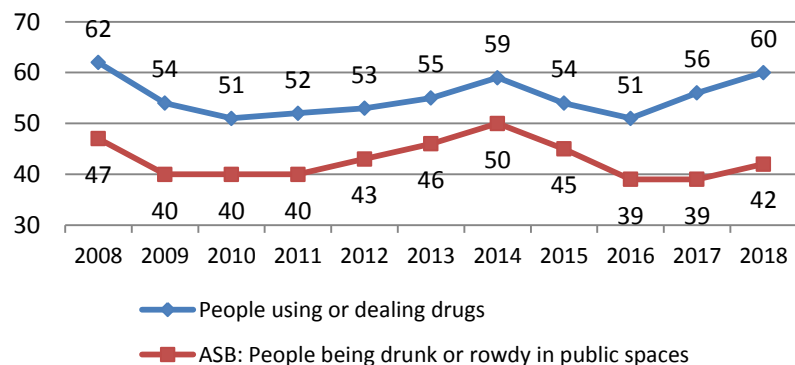
10.1 Perception of alcohol related Anti-social behaviour

The annual local resident's survey asked residents to say to what extent they felt each issue was a big problem in their area

Concern about drug use and dealing remains relatively high: six in ten of those surveyed (60%) felt that people using or dealing drugs was a big problem in their local area. Concern levels have risen 9 points since 2016. See chart below.

Around four in ten residents (42%) feel people being drunk or rowdy was a problem in their area. This was similar to the levels over the last two years but well below the level recorded in 2014 of 50%.

Chart: TH Annual residents survey results over time



(Source: Tower Hamlets Residents Survey, 2018)

Drunk and rowdy behaviour

A deep dive in 2017 showed that views were similar across groups, though Bangladeshi residents were more likely than White and other BME groups to feel it was a problem (47 vs. 37%). (TH ARS 2017)

Drug use and drug dealing

Bangladeshi residents were far more likely than White residents, or residents from other BME groups, to feel drug use was a big problem in their area (68 vs. 52 and 51 per cent). By area, those in the West of the borough were the most likely to feel it was a problem, while those in the South were the least likely (63 vs. 45 per cent).

By social grade those from social grade C2 households were far more likely than those from AB households to feel drug use was a problem (68 vs. 48 per cent).⁶¹ (TH ARS 2017)

10.2 Children & Families and Hidden Harm

10.2.1 Impact of parental substance misuse on children⁶²

There is now a body of evidence detailing the adverse impact of dependent parental alcohol and drug use on children, particularly regarding their physical health, psychological wellbeing and personal alcohol and drug use, where much of the evidence show consistent impact.

Impact of alcohol

Physical impact

- Parental alcohol dependency is associated with child maltreatment and poor outcomes.
- Between 2011 and 2014 parental alcohol misuse was recorded as a factor in 37% of cases where a child was seriously hurt or killed.

Psychological impact

⁶¹ Social grades A: upper middle class, B: middle class, C1 lower middle class, C2 skilled working class, D: working class. E not working

⁶² PHE Parental substance misuse tool May 2018

- There is increasing evidence that adverse childhood events such as living in a household with problem alcohol use can contribute to long term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviours, such as smoking, heavy drinking and cannabis use.

Impact on child's own alcohol and drug misuse

- Children of parents with an alcohol dependency are more likely to become dependent themselves in later life.

Impact of drugs

Physical impact

- Parental drug dependency can have significant adverse consequences for children at all stages of their development. These include poor physical health and wellbeing (including poor diet and poor hygiene) and a higher risk of neglect.

- Between 2011 and 2014 parental drug misuse was recorded as a factor in 38% of cases where a child was seriously hurt or killed.

Psychological impact

- There is increasing evidence that adverse childhood events such as living in a household with problem drug use can contribute to long term harms. If a child experiences four or more risk factors during childhood they have a substantially higher risk of developing health-harming behaviours, such as smoking, heavy drinking and cannabis use.

Impact on child's own alcohol and drug misuse

- Children of parents with a drug dependency are more likely to become dependent themselves in later life.

Educational and social impact

- Where children experience parental drug dependency there is a higher risk of them becoming involved in offending behaviour and/or having lower educational attainment.

- Children of drug dependent parents are more likely to take on inappropriate caring roles for siblings or dependent parents.

10.2.2 Parental drug and alcohol use in Tower Hamlets⁶³

Alcohol dependent parents

PHE estimates that around 610 dependent alcohol users in Tower Hamlets live with children in their household. The number of children in those households is estimated to be around 1,177.

Currently, around 23% of those adults are in treatment while around 25% of those children live with clients in treatment.

Opiate dependent parents

PHE estimates that around 750 adults with an opiate dependency live with children. The estimated number of children living in those households was around 1,359 children.

PHE estimates show that around 56% of those opiate dependent adults are in treatment while around 66% of those children live with clients in treatment.

As discussed earlier, drug and alcohol misuse of parents can impact very negatively on children. While the Tower Hamlets figures indicate a further need for interventions and outreach, treatment engagement of parents is higher when compared to national and benchmark averages.

⁶³ PHE estimate – Prevalence 2018

M-PACT Programme

Tower Hamlets is currently running a successful M-PACT programme at the Recovery Support Service. Over the last 12 months (2017/18), 30 families and their children engaged in this evidenced based interventions. Around 83% of them completed the programme successfully.

Clients living with Children⁶⁴

Around 17.5% of clients (183 of 1048) starting treatment in 2017/18 were living with children in Tower Hamlets. Clients are considered to be 'living with children' if they report at any point in their treatment journey that they live with at least one child. The majority of those were opiate clients (68), followed by Alcohol (55), Alcohol & Non-opiates (32) and Non-opiate (28) clients.

Treatment outcomes of Clients living with Children

Nearly one quarter of all clients in treatment live with children. Their overall successful completion rate was around 23.5%.

Opiate successful completion rates of clients with children were 4.6% below the whole opiate treatment population rate of 5.9%. The SC completion rate for Alcohol clients with children (43.2%) was similar to the general rate for Alcohol clients of 41.6%. Data indicates that clients with children in treatment for non-opiates and alcohol & non-opiates don't have significantly different completions rates compared to clients without children.

Recommendations

- Continue important work of Hidden Harm co-ordinator
- Encourage more volunteers to the local M-Pact programme
- Training for social care staff

⁶⁴ NDTMS DOMES report Q4 2017/18 12 months period.

10.3 Pregnancy of clients in treatment

In 2017/18, out of 264 females starting treatment, 8 were pregnant at the point of assessment (3%).⁶⁵ However, the number of pregnant drug and alcohol users is higher overall when compared to those in treatment.

Tower Hamlets commissions the Substance Misuse Midwife Service which works with complex substance users who are pregnant. Care is provided fortnightly within a multidisciplinary clinic.

In 2017/18, the service worked with 39 females alone. However, only 30% had a keyworker and were in treatment in Tower Hamlets.⁶⁶ The service is referring women into treatment if not know to it.

For some women, this clinic is the only support they receive. The majority of referrals to the service originate from the Main Midwife Service, Children and Social care, local GPs and Reset drug and alcohol services.

10.4 Mental Health needs

New treatment starts – Mental health needs identified

At assessment stage, mental health needs were identified in 47.3% of all clients starting treatment. This rate was above the national average of 40.8%. This new data published via NDTMS shows the highest need in non-opiate and alcohol & non-opiate clients while the lowest proportion of need was recorded in non-opiate clients.

⁶⁵ NDTMS Adult Activity Q4 2017/18

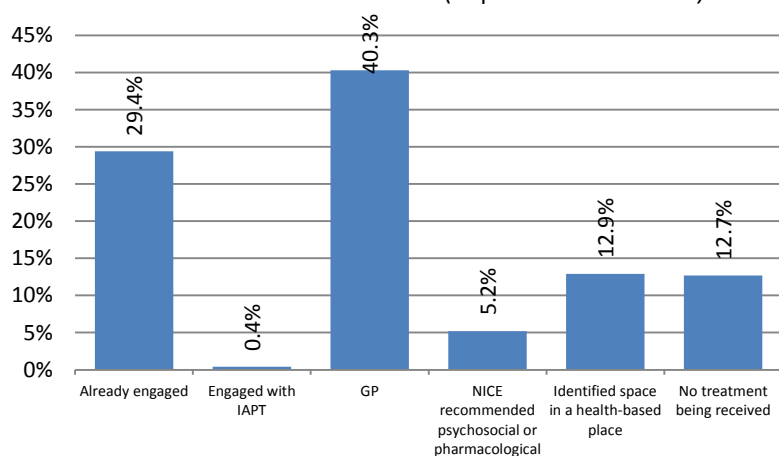
⁶⁶ SM Midwife Monitoring data 2017/18

Table: Tower Hamlets treatment starts - Mental Health needs

	Opiate only	All opiate	Non Opiate only	Alcohol only	Alcohol & Non-opiate only	All clients
Need identified (%)	39.6%	47.2%	51.8%	43.8%	50.5%	47.3%
Need identified (n)	21	204	59	133	100	496

(Source: PHE NDTMS Q4 Adult Activity 2017/18)

Chart: Mental Health treatment received (as point of assessment)



(Source: PHE NDTMS Q4 Adult Activity 2017/18)

Estimate of mental health need of all substance misusing population

Based on the 2017/18 rate of mental health need at assessment stage (47%), it can be suggested that out of 2,800 OCU's and 3,400 dependent drinkers, around 3,100 have a need for mental health services. See table below.

Table: Estimate of mental health need of all substance misusing population in TH

	Total (n)	Mental health needs (NDTMS) (%)	No of clients with mental health needs (n)
Clients in treatment	2,069	47.3%	1,035
Opiate and/or Crack (OCU)	2,798	47.3%	1,399
Dependent drinkers	3,427	47.3%	1,714
OCU & Dependent Drinkers	6,225	47.3%	3,113

(Source: PHE estimate and NDTMS clients in treatment 2017/18 and own calculation)

Hospital admissions diagnosis of drug related mental health and behavioural disorders⁶⁷

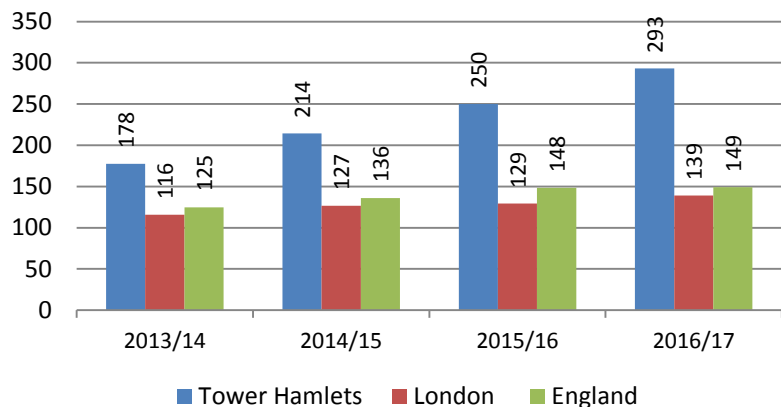
Hospital data shows that the rate of admission with a diagnosis (primary & secondary) of drug related mental health and behavioural disorder is increasing in Tower Hamlets.

The rate was double the London and England rates and the second highest in London. The highest rate in 2016/17 was recorded in Hackney with 330 per 100,000 residents.

In total, 900 admissions were recorded in this category with 627 for males and 271 for females. Please note that one person can have more than one admission.

⁶⁷ Full title of data: NHS hospital finished admission episodes with a primary or secondary diagnosis of drug related mental health and behavioural disorders

Table: Hospital admissions with diagnosis (primary & secondary) of drug related mental health and behavioural disorders ⁶⁸



(Source: NHS Digital, Hospital admissions, 2018)

Recommendation

- Reset Treatment service to develop effective pathways with Tower Hamlets Mental Health (IAPT)

⁶⁸ A finished admission episode is the first period of in-patient care under one consultant within one healthcare provider. Please note that admissions do not represent the number of in-patients, as a person may have more than one admission within the year.

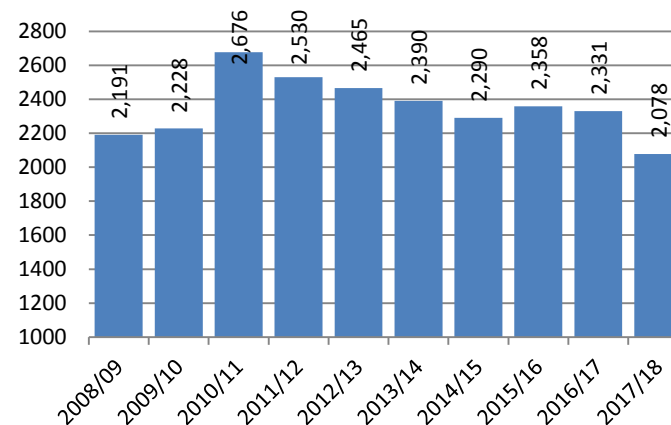
10.5 Demand on services - Ambulance call outs

The following information has been collated from the Safe Stats database showing London Ambulance Service call outs for alcohol related incidents and drug overdose incidents.

Alcohol related call outs

The chart below shows that alcohol related callouts to the London Ambulance Service over the last 10 years peaked in 2010/11 and have been falling in recent years to 2,078 in 2018.

Chart: Alcohol related ambulance call outs 2008/09 to 2017/18



(Source: Safe Stats / LASS London ambulance data)

The table below shows the gender profile of call outs in 2017/18. Around two third of call outs were for male patients.

Table: Gender breakdown alcohol related ambulance call outs

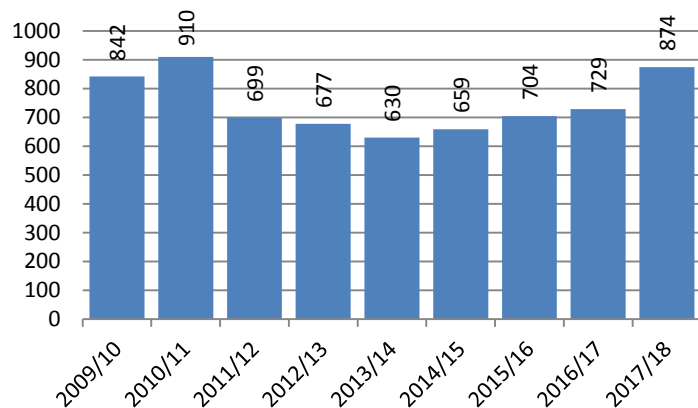
Gender	Total	%
Male	1,365	65.7%
Female	672	32.3%
Missing / Un-recorded	41	2%
Total	2,078	

(Source: Safe Stats / LASS London ambulance data)

Drug overdose – Ambulance callouts

The chart below shows that drug overdose callouts to the London Ambulance Service over the last 9 years. The numbers have increased substantially over the last five years to 874 in 2017/18.

Chart: Drug overdose call outs in Tower Hamlets 2009/10 to 2017/18



(Source: Safe Stats Ambulance call outs)

While the majority of drug overdose call outs were for male patients. Nearly 40% were for females. This is substantially different to treatment information or prevalence rates.

Table: Gender breakdown alcohol related ambulance call outs 2017/18

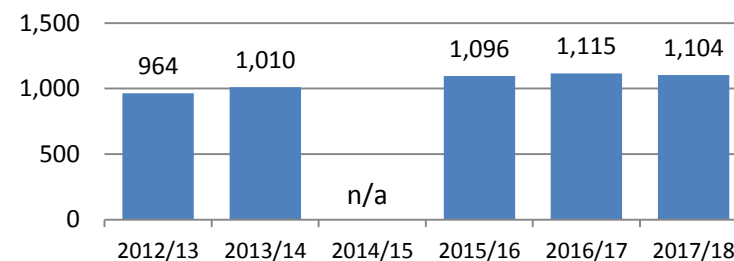
Gender	Total	%
Male	462	57.7%
Female	398	39.5%
Missing / Un-recorded	14	1.6%
Total	874	

(Source: Safe Stats Ambulance call outs)

10.6 Licensing - Premises licensed to sell alcohol and ASB

Tower Hamlets has a relative high number of premises licensed to sell alcohol. In 2017/18, around 1,100 premises were licensed, representing an increase of around 15% from 2012/13. See chart below.

Chart: Premises licenses in Tower Hamlets



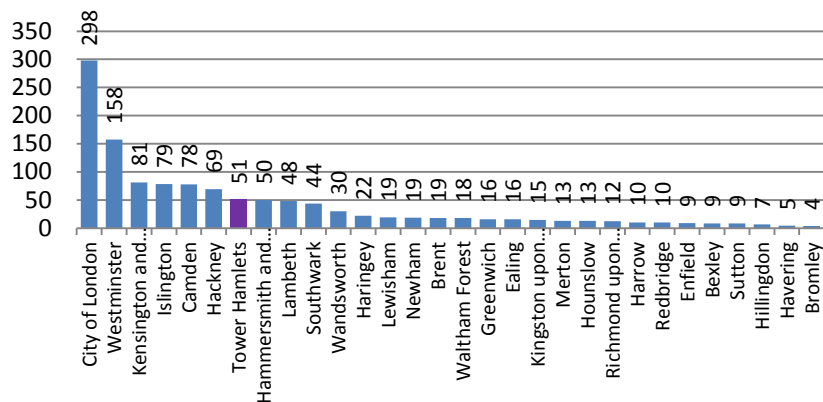
(Source: Home Office & local data)

Research shows that a higher density of licensed premises has strong links to crime and disorder in an area. Higher densities of alcohol outlets appear to be associated with higher hospital admission rates for conditions wholly attributable to alcohol consumption.⁶⁹

The crime and disorder trend can be observed in Tower Hamlets. The number of licensed premises is relative high compared to the size of the borough, a situation similar to other central London areas.

⁶⁹ Research on the relationship between alcohol outlets and alcohol <https://onlinelibrary.wiley.com/doi/full/10.1111/add.14285>

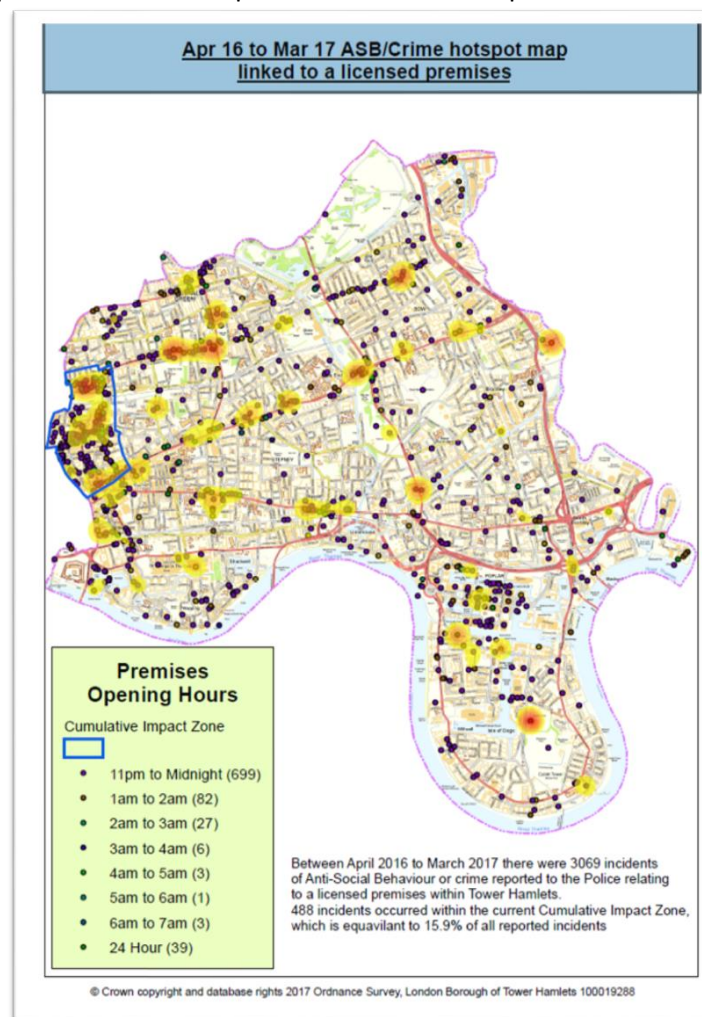
Chart: Rate of premises licensed to sell per square kilometre 2016/17



(Source: PHE Fingertips, ONS / Home Office)

Analysis of ASB data showed that licenses premises and ASB correlates in specific hotspots. Those hotspots include Bricklane, Bethnal Green, Mile End and Whitechapel road. See map below.

Map: ASB & Crime hotspots linked to licensed premises



(Source: Local TH data)

In general, emerging evidence is suggesting that local authorities more active in implementing licensing policy, including using cumulative impact zones and increased licensing enforcement, may

see bigger falls in harm outcomes. It is clear that local licensing decisions may have an impact on the health of the local population and the burden on local hospitals.⁷⁰

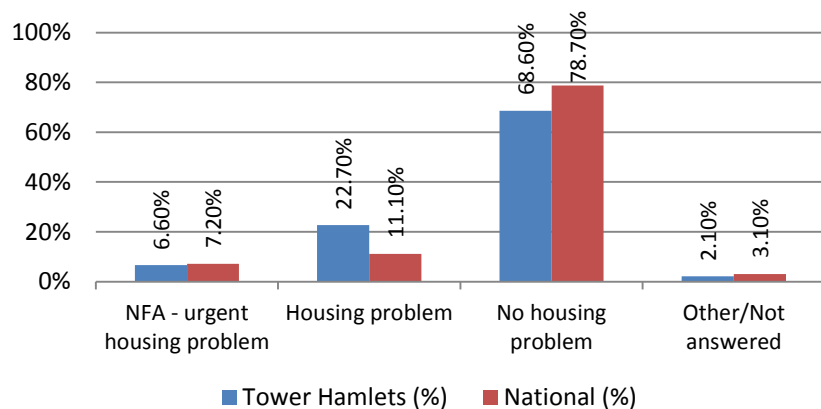
10.7 Housing and homelessness

10.7.1 Accommodation needs of clients in treatment

At assessment stage, clients discuss their current housing situation and accommodation status. While, the majority of clients had no housing need, a sizeable group had urgent housing needs.

Around 35% of new clients entering treatment had a housing need or an urgent problem. This was more than 10 percentage points above the national average or around 25%

Chart: Accommodation need - New treatment starts



(Source: NDTMS, Adult Activity reports 2016/17)

⁷⁰ Source: A rapid evidence review of the effectiveness and cost-effectiveness of alcohol control policies: an English perspective. Burton R., Henn C., Lavoie D. et al. The Lancet: 2017, 389, p. 1558–1580.

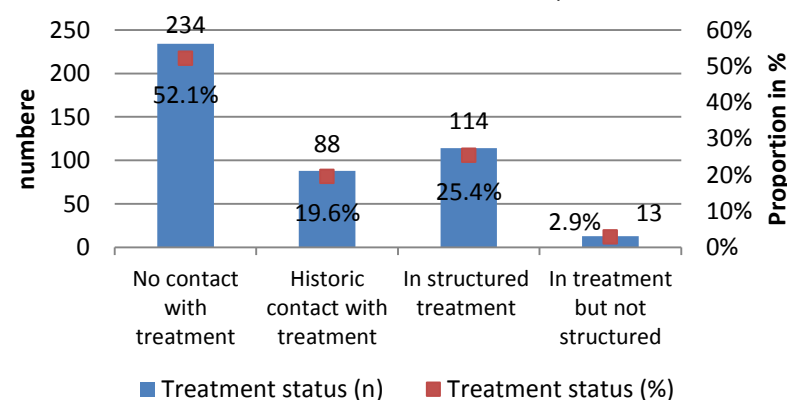
10.7.2 Tower Hamlets Hostel clients in treatment⁷¹

A recent audit of hostel clients showed that at this point in time, around 25% of hostel clients were in structured treatment while another 3% were in treatment but not structured (either pre or post structured treatment).

The majority of hostel clients were not in treatment (52%) while around 20% have been in treatment in the past. However, it is clear, while a large number of clients have, not all hostel clients have drug and or alcohol related needs.

Hopetown clients were least likely to be in drug or alcohol treatment compared to the overall client average. Edward Gibbons House and Dellow Centre had the highest proportion of clients in treatment.

Chart: Hostel clients in treatment - Audit in Q3 2017/18



(Source: Local data, audit of Q3 2017/18 data)

The next stage focused on treatment outcomes of those hostel clients in treatment. It became clear that already 20% of hostel

⁷¹ TH DAAT: Hostel clients in drug and alcohol treatment – Audit of Q3 2017/18 client cohort, Matthias Schnepfel, internal paper.

clients only attended one appointment but did not start structured treatment.

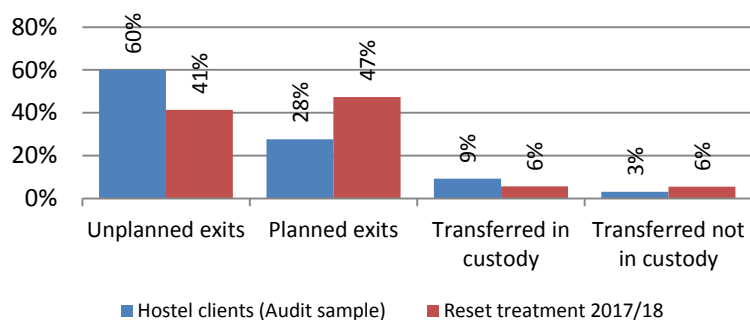
Out of those who actually started treatment:

- 61% of clients were currently in treatment⁷²
- 23% of clients had dropped out at this point in time
- 11% of clients had left treatment successfully (drug / alcohol free or occasional user).

Analysis of existing discharges revealed that treatment successes of hostel clients were poorer than the overall Reset treatment cohort.

Around 60% of those hostel clients were discharged in an unplanned way, a rate substantially above the overall Reset client cohort.⁷³ Also, planned exits of hostel clients (28%) were below overall client cohort (47%). In addition, Hostel client more likely to go to prison (9%) while engaged with treatment.

Chart: Treatment outcomes of hostel clients



(Source: Local data, audit of Q3 2017/18 data)

⁷² On the day of the DAAT / Reset audit 25/06/2018

⁷³ Reset client cohort – treatment outcomes taken from Reset NDTMS Adult activity report Q4 2017/18

10.7.2 Rough sleeping in Tower Hamlets

This section presents information about people seen rough sleeping by outreach teams in Tower Hamlets. Information is derived from the Combined Homelessness and Information Network (CHAIN), multi-agency database recording information about rough sleepers and the wider street population in London.⁷⁴

Services that record information on CHAIN include outreach teams, accommodation projects, day centres and specialist projects such as the Greater London Authority (GLA) commissioned No Second Night out (NSNO). The system allows users to share information about work done with rough sleepers and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated.

In these reports, people are counted as having been seen rough sleeping if they have been encountered by a commissioned outreach worker bedded down on the street, or in other open spaces or locations not designed for habitation, such as doorways, stairwells, parks or derelict buildings.

375 people were seen rough sleeping in Tower Hamlets in 2017/18. This represents a 16% decrease compared to 2016/17. Around 5% of London rough sleepers were seen in Tower Hamlets.

Table: Rough sleepers in Tower Hamlets and London

	12/13	13/14	14/15	15/16	16/17	17/18
Tower Hamlets	331	324	377	395	445	375
London	6,437	6,508	7,581	8,095	8,108	7,484

(Source: CHAIN Rough sleeping data, Tower Hamlets)

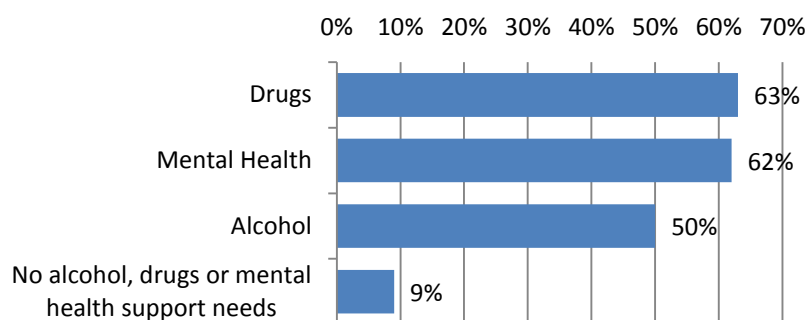
Around 50% people seen rough sleeping in the borough during the year were new rough sleepers (flow, new to TH), while 31% fell into

⁷⁴ CHAIN, which is commissioned and funded by the Greater London Authority (GLA) and managed by St Mungo's, represents the UK's most detailed and comprehensive source of information about rough sleeping.

the stock category (also rough sleeping in 2016/17), and 19% were returners (those who had a gap in rough sleeping history).

The CHAIN data demonstrates that nearly two thirds of rough sleepers in Tower Hamlets had Alcohol and Drug related support needs. Also, 27% of rough sleepers had support needs which included Alcohol, Drugs and Mental Health support.

Chart: Drug and alcohol needs of rough sleepers (%)



(Source: CHAIN Rough sleeping data, Tower Hamlets 2017/18)

It is also important to note that around 74% of all rough sleepers in Tower Hamlets had the experience of institutions including Armed forces, care and prison. The largest group out of those were clients in contact with the prison system (150 rough sleepers).⁷⁵

Recommendation

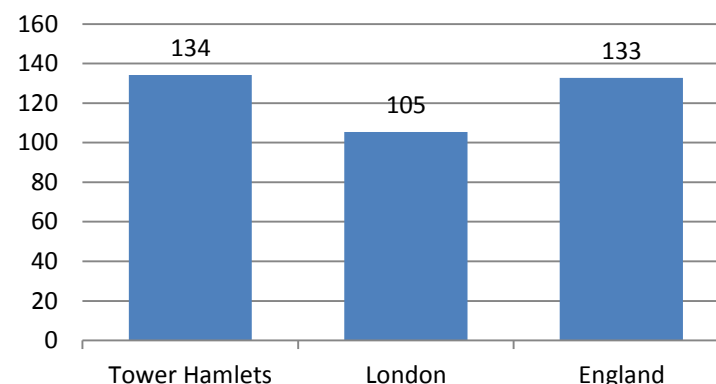
- Rough sleepers and hostel clients remain a key target group requiring specialist support
- Tower Hamlets Substance Misuse service to support local Housing First Pilot
- Ensure that in-reach into hostels is resourced sufficiently
- Explore if additional Reset satellites can be provided at local hostels including Riverside House

⁷⁵Source: CHAIN Rough sleeping data, Tower Hamlets 2017/18

10.8 Benefits and employment

The rate of residents receiving benefits because of addiction issues is above the London average but close to the England average. See chart below.

Chart: Claimants on benefit due to alcoholism per 100,000 populations (crude rate)



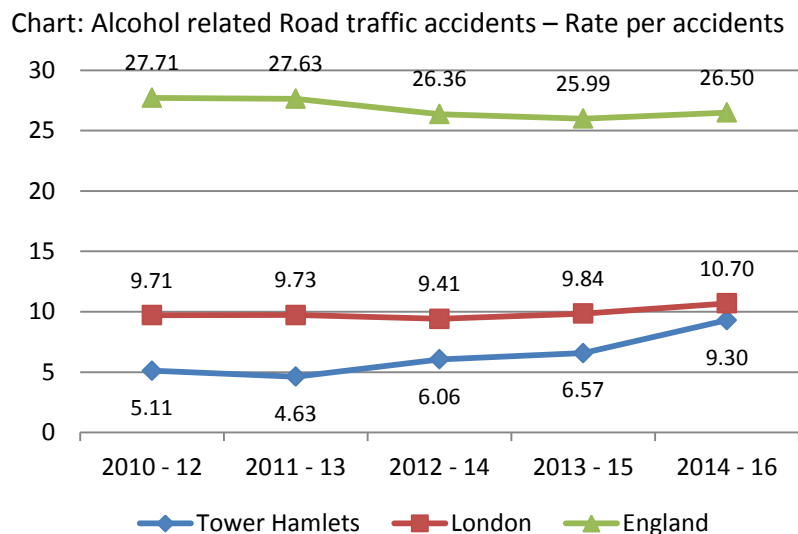
(Source: PHE Fingertips, 2016)

Discussion with services user revealed that the impact of universal credit is serious and clients are worried about their financial and housing situation potentially leading to criminality or prostitution. One anxious and worried service user told us that: “I had £37 left to buy food for me and my child the rest of the week.”

10.9 Road Safety – Alcohol related Road traffic accidents

Alcohol consumption is responsible for around one in every seven deaths in reported road traffic accidents in Great Britain. Final estimates for 2013 show that between 220 and 260 people were killed in accidents where at least one driver was over the drink drive limit, around 1,100 were seriously injured and the total number of casualties of all severities was 8,270.

This data covers reported road accidents (of all severities) in which at least one driver failed a breath test (crude rate per 1,000 accidents). The data shows, while rates in Tower Hamlets increased slightly in the period 2014/16, rates were below national and London averages.



(Source: PHE Fingertips, 2016)

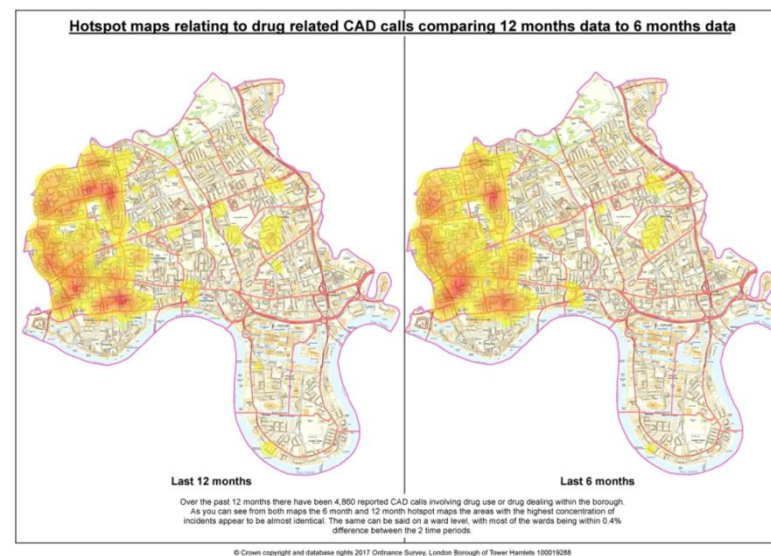
10.10 Criminal behaviour and drugs

Drug related activities in Tower Hamlets

The CAD calls are calls from the public covering various issues of concern. For this analysis, all drug related calls between Nov 2016 and Oct 2017 were analysed. The analysis shows the hotspots of those calls over the last 12 months and when they occur (time and date).

Over the period Nov 2016 to Oct 2017, 4,860 calls were made concerning drug use or drug dealing within the borough.

Map: Hotspot map drug related calls in Tower Hamlets

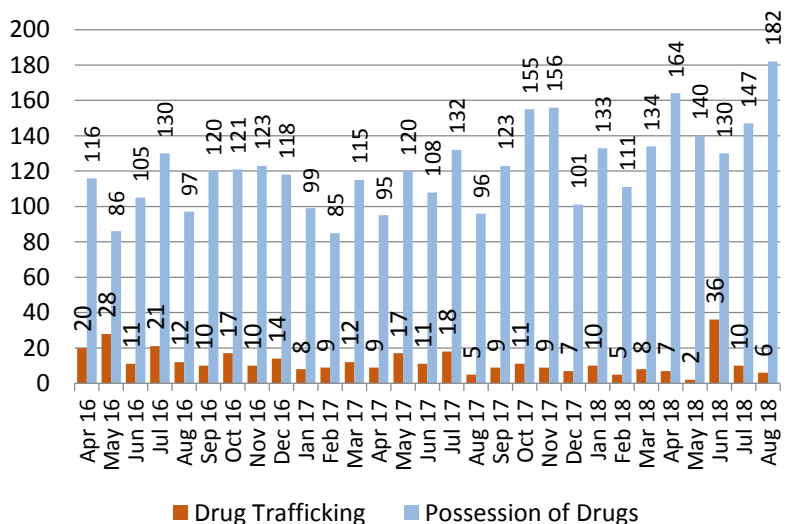


The majority of calls came from wards in the west of Tower Hamlets including St. Peter's, Whitechapel, Spitalfields, Weavers and Shadwell indicating the existence of street based drug dealing.

Possession of drugs

Drug possession data is also used as a proxy to understand local drug use and drug buying behaviour. Data covers the time period January 2017 to early November 2017 and was sourced from the MET Police CRIS data base. The chart below shows that drug possession offence numbers have increase over the last 12 months, correlating with an increase of enforcement activities in the borough.

Chart: Offences Drug trafficking and Possession of drugs in Tower Hamlets (n)



(Source: MET Police Dashboard)

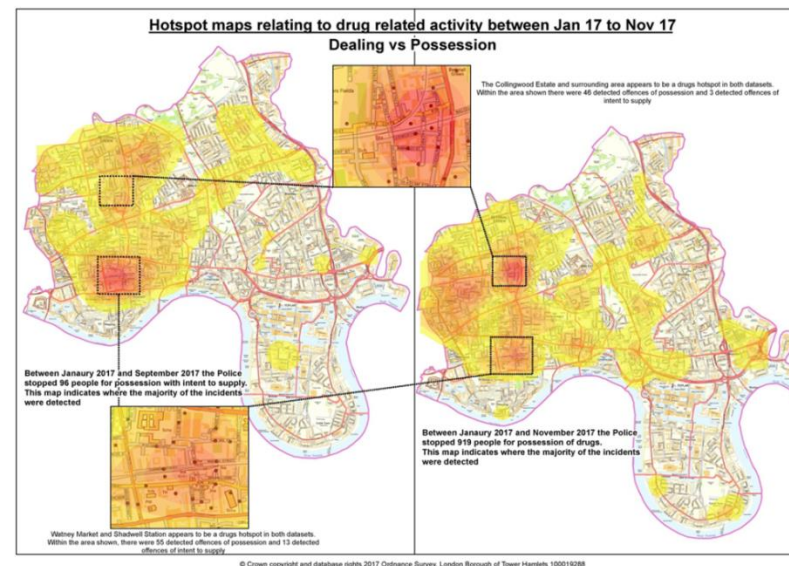
Analysis of suspect data showed that individuals suspected for possession of drugs had Cannabis on them (96%). The largest group of suspects were males, young adults and of Bangladeshi ethnicity. The majority of suspects were local residents (75%). However, on weekends, the proportion of non-residents increased.

Possession with intent to supply / trafficking

The chart above shows that drug trafficking offences recently peak (June 2018), a trend based on the MET Police “Operation Continuum”.

MET CRIS data shows that suspects of possession with intent to supply (those supplying drugs) were mainly men, aged below 35, local residents and of Bangladeshi ethnicity.

Map: Hotspots drug related activities Dealing & Possession in Jan to Nov 2017



Costs of drugs in the borough compared to London and national average

The table below summarises the costs of selected drugs in the borough, London and on national level. Overall the data shows that addiction to drugs comes at a large financial cost with high purity cocaine and methamphetamine the highest. The price for a portion of drug often stays the same but purity and weight can change.

The data below only shows marginal differences in drug prices in TH, London and England. However, ecstasy in Tower Hamlets might be cheaper compared to London and the National average. Please note that local data is based on information collected by key workers from clients while London and National data is based on test purchases.

Table: Cost of drugs in Tower Hamlets, London and National average

	National average*	London average*	Tower Hamlets estimate
Heroin	£10 for 0.1 gram / In general, purity up but bag size down	0.1 for £10	0.06 gram for £10 15£ for 0.2 gram
Cocaine (lower purity, 40%)	£30 to £40 a gram	N/A	£25 to £50 a gram
Cocaine (higher purity, 70%)	£80 a gram	£120 a gram	£100 a gram
Cannabis - Skunk	n/a	n/a	£10 a gram
Cannabis - Resin	n/a	n/a	£10 for 2g
Ecstasy	£5 to £15 a tablet	n/a	£5 a tablet
MDMA powder	£40 a gram	n/a	45 a gram
Spice	n/a	£30 to £60 a gram	£25 a gram
Ketamine	£20 to £30 a gram	n/a	£20 a gram
Amphetamine	£5 a gram	n/a	£5 a gram

(Source: Drug wise insights report 2016 and local keyworker reports Nov 2017)

10.11 Hospital episodes – Alcohol related

Hospital episodes with Alcohol-related conditions

Alcohol-related hospital admissions are useful to understand the impact of alcohol misuse in an area. Alcohol related hospital episodes are measured using two indicators, a broad measure and a narrow measure.⁷⁶ However, this analysis focuses only on incidents relating to the narrow definition of alcohol related conditions.

Data discussed includes Alcohol-related conditions. *Alcohol-related conditions* include all *alcohol-specific conditions*, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example hypertensive diseases, various cancers and falls.

Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis.

The analysis is presents the total number of alcohol related admission and admission by age standardized rates allowing for a better comparison between Tower Hamlets and other areas including London.

⁷⁶ Broad measure:

Persons admitted to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children.

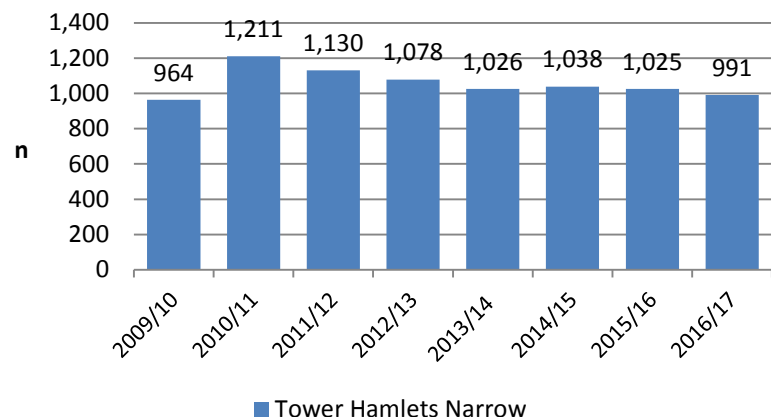
Narrow measure:

Persons admitted to hospital where the primary diagnosis is an alcohol-attributable code or one of the secondary codes is an external alcohol-attributable code. Children aged less than 16 years were only included for alcohol-specific conditions and for low birth weight. For other conditions, alcohol-attributable fractions were not available for children.

Hospital episodes with alcohol-related conditions (Narrow)

In Tower Hamlets, admissions to hospital with alcohol related conditions (narrow) have been falling steadily to 991 a years since the peak in 2010/11.

Chart: Total Admissions to hospital episodes with alcohol-related conditions (Narrow) 2009/10 to 2016/17 in Tower Hamlets

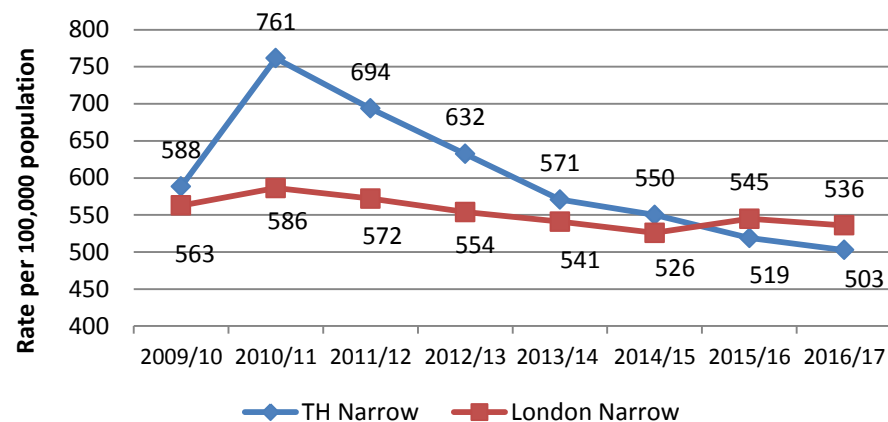


(Source: PHE LAPE alcohol related admissions - Narrow)

Age standardised alcohol related hospital admissions

The age standardized rates show a similar trend of falling admissions as described above but the data is arguably better to compare areas. The admissions based on the narrow definitions fell in Tower Hamlets to 503 and in London to 536 in 2016/17. The gap between London and Tower Hamlets has now closed and the borough performs overall better than the London average.

Chart: Age standardized rate per 100.000 - Admissions to hospital episodes with alcohol-related conditions (Narrow definition) 2009/10 to 2016/17

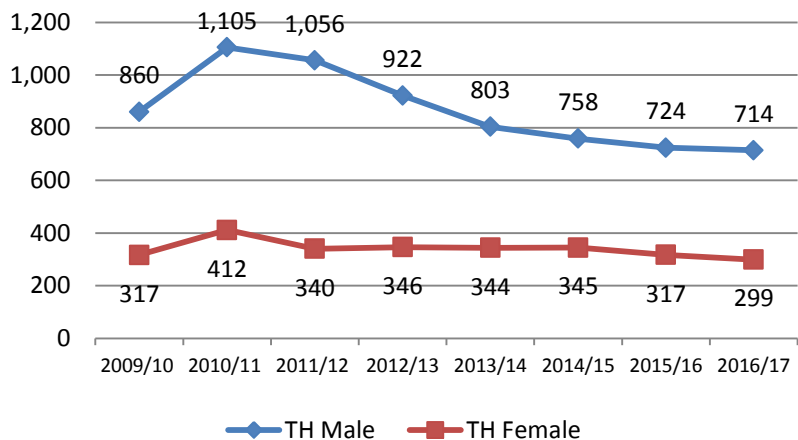


(Source: PHE LAPE alcohol related admissions - Narrow)

Hospital admissions with alcohol-related conditions by gender

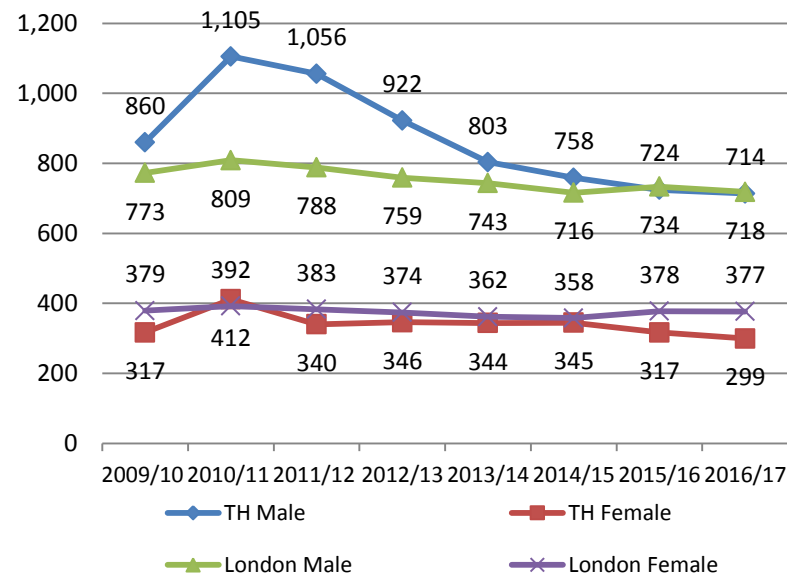
The analysis by gender shows that the overall decline of age standardized admissions is based on falling male and female admissions. While reduction of male admission has been pretty continuously over the last 7 years, female admissions have dropped noticeable over the last 2 years only.

Chart: Admissions to hospital episodes with alcohol-related conditions (Narrow) – Age standardised rate



(Source: PHE LAPE alcohol related admissions - Narrow)

The age standardised rates below (narrow category), support the earlier reading of the London and Tower Hamlets trends. Tower Hamlets male and female admission rates are falling while London rates remain stable. The Tower Hamlets rate for males is now very close to the London rate, while the female rate in Tower Hamlets is considerable below the London rate.



(Source: PHE LAPE alcohol related admissions - Narrow)

Recommendations

- Alcohol related hospital admission and ambulance call outs remain high, indicating demand for preventative work and treatment interventions.
- While the numbers of alcohol clients in treatment are increasing, successful referrals from the local hospital (Royal London Whitechapel) and A&E remain small. The pathway between Royal London Hospital and Reset Treatment requires further attention and work is necessary to develop a closer relationship to increase successful referrals.

Chart: Age standardized rate per 100.000 - Admitted to hospital episodes with alcohol-related conditions (Narrow) 2009/10 to 2016/17

11 Value for money

It is well established that drug and alcohol misuse and dependency can lead to a range of harms for the user including:

- Poor physical and mental health and ultimately death,
- Unemployment,
- Homelessness,
- Family breakdown, and
- Criminal activity.⁷⁷

Those harms will impact on individual, families and wider communities. However, investing in treatment services to reduce drug and alcohol misuse and dependency will not only help to save lives but will also substantially reduce the economic and social costs of drug and alcohol related harm.

Research has shown that every **£1** invested in drug treatment results in a **£4** benefit to society. For many drug users, engaging in treatment can be the catalyst for getting the medical help they need to address their physical and mental health problems. Treatment for young people will create even larger benefits of £7 to £8 for each £1 invested. (Source: PHE, Why Invest 2018)

Value for money analysis helps to make informed decisions about how to spend money effectively on services that improve lives, opportunities, health and wellbeing.

The information below shows how local drug and alcohol services benefit Tower Hamlets residents and society overall.

⁷⁷ Source: Health Matters: Preventing drug related deaths March 2017

Below is a snapshot of one year's social and economic return resulting from 2016-17 local investment in drug treatment.

Estimated benefits included the reduction of crime, improvements in health and social care including savings for the NHS and the LA as well as improvements in quality-adjusted life years.

Impact of drug and alcohol treatment⁷⁸

Drug treatment is not just benefiting the individual in reducing drug related harm and helping the client to move closer to recovery, it will also achieve wider benefits to local communities and society as a whole.

PHE data estimates that drug treatment in Tower Hamlets in 2016/17 prevented a significant number of criminal offences. The preventions of nearly 46,000 offences meant, that more than 18million pounds of costs to society where avoided. See tables below.

In 2016/17, drug treatment in Tower Hamlets benefited the NHS and the Local authority by around 1.75 million pounds.

Table: Positive Impact of investment in drug treatment – Benefits to Tower Hamlets in 2016/17

Estimated Number of crimes committed before treatment entry	Estimated % change after starting treatment	Estimated crimes prevented per year after starting treatment
141,003	-32%	45,790

(Source: PHE Commissioner Tool, 2017)

⁷⁸ Source: PHE Commissioner Tool, 2017

Table: Average crime related costs in 2016/17 in Tower Hamlets

	Costs before starting treatment	Costs after starting treatment
Social costs	£ 4,360	£ 2,944
Economic costs	£ 28,741	£ 19,408
Social & economic costs	£ 33,101	£ 22,352

(Source: PHE Commissioner Tool, 2017)

Table: Average benefits of treatment in 2016/17 in Tower Hamlets

	Gross benefits
Social costs	£ 2,462,000
Economic costs	£ 16,231,000
Social and economic costs	£ 18,693,000

(Source: PHE Commissioner Tool, 2017)

Table: Additional benefits resulting from drug treatment in 2016/17

	Other benefits resulting from treatment
Benefits to NHS & Local Authority	£ 1,766,000
Quality adjusted life years (QALYs)	£ 4,491,000

(Source: PHE Commissioner Tool, 2017)

Impact of alcohol treatment

Alcohol treatment has an important role to play in preventing alcohol harm including crime and disorder, ASB and sexual offences. However, unlike drug related crime, acquisitive crime is usually not related to alcohol misuse. See table below.

For that reason, actual numbers of crime prevented by alcohol treatment in Tower Hamlets are significantly lower. PHE data estimates that alcohol treatment in Tower Hamlets in 2016/17 prevented 425 criminal offences. Nevertheless, the positive impact on the health and quality of life of each client is currently difficult to quantify. See tables below.

Table: Positive Impact of alcohol treatment in 2016/17

Estimated Number of crimes committed before treatment entry	Estimated % change after starting treatment	Estimated crimes prevented per year after starting treatment
1,148	-37%	425

(Source: PHE Commissioner Tool, 2017)

Table: Average crime related costs in 2016/17

	Costs before starting treatment	Costs after starting treatment
Social costs	£ 930	£ 586
Economic costs	£ 1,648	£ 1,038
Social & economic costs	£ 2,579	£ 1,624

(Source: PHE Commissioner Tool, 2017)

Table: Average benefits of treatment in 2016/17

	Gross benefits
Social costs	£ 123,000
Economic costs	£ 217,000
Social and economic costs	£ 340,000

(Source: PHE Commissioner Tool, 2017)

Table: Additional benefits resulting from treatment in 2016/17

	Other benefits resulting from treatment
Benefit to NHS & Local Authority	£ 97,000
Quality adjusted life years (QALYs)	£ 548,000

(Source: PHE Commissioner Tool, 2017)

Benefits of non-structured treatment

It is not possible to produce a 'total benefit' figure for non-structured treatment. However, as there is good evidence for the cost-effectiveness of interventions within non-structured treatment, it is likely that the total benefits of the treatment system may be even higher.⁷⁹

⁷⁹ Source: PHE, Why Invest 2018

Further information

This Substance Misuse Needs Assessment was produced by the Tower Hamlets Drug & Alcohol Action Team. The document was written by Matthias Schnepel (Tel: 020 7364 4612.)

Appendix 1: Glossary of Abbreviations

ATR	Alcohol Treatment Requirement
BBV	Blood Borne Virus
CCA	Community Care Assessment
CCG	Clinical Commissioning Group
CJS	Criminal Justice System
CMI	Chief Medical Officer
DAAT	Drug and Alcohol Action Team (Tower Hamlets Commissioning Team)
DIP	Drug Interventions Programme
DH	Department Of Health
DRR	Drug Rehabilitation Requirement Order
DRD	Drug-related death
DUO	Drug Using Offender
DV	Domestic Violence
ETE	Education, Training and Employment
GP	General practitioner
GPWSI	General Practitioner with Special Interest in Drugs and Alcohol
HO	Home Office
IBA	Identification and brief advice
IDU	Injecting drug user
IOM	Integrated Offender Management
JSNA	Joint Strategic Needs Assessment
LAPE	Local Alcohol Profiles for England
LAS	London Ambulance Service
LBTH	London Borough of Tower Hamlets
LCPF	London Crime Prevention Fund
MOPAC	Mayor's Office for Policing and Crime
MSM	Men who have sex with men
NDTMS	National Drug Treatment Monitoring System
NFA	No fixed abode
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPS	New psychoactive substance
NTA	National Treatment Agency for Substance Misuse (now part of Public Health England)
NWPHO	North West London Public Health Observatory
OASys	Offender Assessment System
OCU	Opiate and/or Crack User
ONS	Office for National Statistics
OST	Opioid substitution treatment
PACT	Prescribing Analysis and Cost Data
PCT	Primary Care Trust
PHE	Public Health England
PHOF	Public Health Outcome Framework
SMNA	Substance Misuse Needs Assessment
TOP	Treatment Outcome Profile
VAWG	Violence Against Women and Girls
VFM	Value for Money

Appendix 2: Key definitions

Chemsex	Chemsex is a term for the use of drugs before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience. Chemsex commonly involves crystal methamphetamine, GHB/GBL and mephedrone, and sometimes injecting these drugs (also known as slamming).
Club drug	A collective term for a number of different substances typically used by people in bars and nightclubs, at concerts and parties, before and after a night out.
Community Setting	A structured drug and alcohol treatment setting where residence is not a condition of engagement with the service. This will include treatment within community drug and alcohol teams and day programmes (including rehabilitation programmes where residence in a specified location is not a condition of entry).
Drug-related death / drug misuse death	<p>Annual figures published by the Office for National Statistics (ONS) since 1993 cover deaths in England and Wales related to “drug poisoning (involving both legal and illegal drugs)” and to “drug misuse (involving illegal drugs)”.</p> <p>ONS’s definition of a drug misuse death is “(a) deaths where the underlying cause is drug abuse or drug dependence and (b) deaths where the underlying cause is drug poisoning and where any of the substances controlled under the Misuse of Drugs Act 1971 are involved.”</p> <p>Where people do suffer drug poisonings while in treatment, these are overwhelmingly classed as drug misuse, so this definition may be seen as more relevant to this population. However, many of those who die in treatment are not included under either definition as they die from causes other than poisoning.</p>
Episode (treatment)	A set of interventions with a specific care plan. A client may attend one or more interventions (or types) of treatment during the same episode of treatment. A client may also have more than one episode in a year. A client is considered to have been in contact during the year, and hence included in these results, if any part of an episode occurs within the year. Where several episodes were collected for an individual, attributes such as ethnicity, primary substance, etc. are based on the first valid data available for that individual.
Intervention	A type of treatment, e.g. structured counselling, community prescribing.
New psychoactive substance (NPS)	Chemical substances that produce similar effects to ‘established’ drugs (like cocaine, cannabis and ecstasy). Originally created to side-step legislation, an increasing number are controlled under the Misuse of Drugs Act but all remaining are now covered by the Psychoactive Substances Act.
Non-opiate	Any drug other than those that act on opioid receptors (heroin, methadone, buprenorphine and others).
Opiate	A group of drugs including heroin, methadone and buprenorphine acting on opioid receptors.
Re-presentation	A clients returning to treatment within 6 months after being discharged successfully.
Residential Rehabilitation	A structured drug and alcohol treatment setting where residence is a condition of receiving the interventions. Although such programmes are usually abstinence based, prescribing for relapse prevention prescribing or for medication assisted recovery are also options. The programmes are often, although not exclusively, aimed at people who have had difficulty in overcoming their dependence in a community setting.
Structured drug treatment	Structured drug treatment follows assessment and is delivered according to a care plan, with clear goals, which are regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions.
Successful completion	A term that describes a client that completes treatment successfully as either: ‘treatment completed drug free’ – no longer requiring any structured drug treatment interventions and judged by the clinician not to be using heroin (or any other opioids) or crack cocaine or any other illicit drug or ‘treatment completed occasional user (not heroin and crack)’ – the client no longer requires structured drug treatment

interventions and is judged by the clinician not to be using heroin (or any other opioids) or crack cocaine. There is evidence of use of other illicit drug use but this is not judged to be problematic or to require treatment.

Treatment naïve

Waiting time The period from the date a person is referred for a specific treatment intervention and the date of the first appointment offered. Referral for a specific treatment intervention typically occurs within the treatment provider at, or following, assessment.

Appendix 3: Service user involvement and workshops with professionals

The data analysis and findings of this document have been tested and enriched by qualitative work with service users and staff in a variety of workshops and focus groups. The following sessions were conducted as part of this SMNA.

Date	Title
16 th Jan 2018	Workshop with Somali Service user and Somali community at MIND TH (18 participants)
18 th Jan 2018	Workshop with Somali community at MIND TH (13 participants)
22 nd March 2018	Workshop with Recovery Support Service staff (8 participants)
24 th April 2018	Workshop with Outreach and Referral service staff (5 participants)
20 th June 2018	TH Substance Misuse Forum (20 participants)
27 th June 2018	Workshop with Reset Treatment staff (16 participants)
26 th July 2018	LBTH DAAT Board (12 participants)
16 th August 2018	Reset treatment Pre-residential treatment group (6 participants)
16 th August 2018	Reset Treatment Service users group (3 participants)
17 th August 2018	Recovery Support Service users workshop (4 participants)